

Learning Lessons Review – Father Alan Griffin

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This report deals with the death of a much-loved man. A man who will be missed by family, friends and an entire community across both the Roman Catholic Church and the Church of England. As you read this report, I would ask that you remember the impact Father Alan Griffin's (Father Alan) death has had on so many people. Whilst the report will seek to improve practice in the future so these circumstances do not repeat, it cannot deal with every emotion that arises from his death. It is important that we respect his memory and do all we can to support those who have been impacted by his loss.

As the Reviewer I would like to send my very sincere condolences to Father Alan's family, friends and all who were touched by his death.

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Executive Summary

This Learning Lessons Review was commissioned following the tragic death of Father Alan Griffin. Father Alan had been a priest in the Church of England before retiring and later joining the Roman Catholic Church where he again was ordained as a priest.

At the inquest into his death the coroner, having heard evidence from a number of people, issued a 'prevention of further deaths notice'. Such notices carry with them a responsibility for individuals and / or organisations to take action to address issues raised. They are, as their name suggests, extremely serious, formal statutory notices that require immediate consideration (the recipient has 56 days in which to respond) and action by those who receive them. The content of this notice is addressed within this report. This review has analysed the areas of concern raised by the coroner and provides further context on some subjects. It is important to say from the outset that the review agrees completely with the coroner's observations.

The review has examined specific areas of practice that impacted directly on Father Alan. These include, but are not exclusive to, methods employed to collect information, assessment of the information, sharing of the information and treatment of those being investigated. The Reviewer also considered leadership, systems and culture. Whilst the impact these matters had on Father Alan are dealt with specifically, the report also contains comment on the wider culture and opportunities for learning and improvement.

Much of this review deals with information disclosed by an influential senior member of staff who was leaving his post within the diocese. The way in which this information was obtained, recorded, assessed, actioned and then shared with the Roman Catholic church are all analysed. There is considerable learning for individuals, the Diocese of London and wider church contained within this analysis.

Comment – It is important that the reader considers the terms of reference for this review when reading the recommendations made. This is a learning lessons review; its purpose is not to hold individuals to account. Decisions made and actions taken by individuals are discussed in this document. Whilst there is clear learning for individuals, of greater concern are the systemic issues which need to be addressed. It was these issues that resulted in poor decisions being made which impacted on Father Alan.

The review makes a number of recommendations for improvement and comments on specific areas of practice. The information passed regarding Father Alan had a significant impact on him. The disclosures were uncorroborated, remained untested and did not amount to allegations of wrongdoing. The way in which the information was assessed and acted upon was disproportionate and opportunities to challenge and take responsibility for the investigation were missed at a senior leadership level. Despite representations from Father Alan there was an unacceptable delay in disclosing allegations to him, leaving him with no idea what safeguarding professionals wanted to talk to him about. Information shared with the Roman Catholic church was inappropriate and failed to highlight welfare

concerns including a previous suicide attempt. Of major concern is the way in which Father Alan's HIV status was considered and shared with other professionals.

The review then examines the impact of wider issues including culture and leadership. The lack of accountability across the diocese, missed opportunities that occurred as a result and communication are all analysed.

A total of seventeen recommendations are made to improve practice and prevent similar situations repeating. Some improvements have been made prior to receipt of this report but it is important that those who commissioned this review and senior leaders continue to seek continued improvement in all aspects highlighted in this document if real change is to be achieved. This change has to be lived with senior leaders and priests at parish level, both applying the lessons learned and taking responsibility for seeking improvement. Where there is dispute there has to be negotiation and compromise rather than intransigence.

Introduction

1.1 This review was commissioned following receipt of a report written by the Senior Coroner for Inner North London¹. Different versions of the report, commonly known as a Regulation 28 report or Prevention of Future Deaths report, were written for and sent to the Archbishop of Canterbury, Roman Catholic Church and other interested parties following an inquest into the death of Alan Griffin. Whilst the Regulation 28 notice, which this review will concentrate upon, was addressed to the Archbishop of Canterbury it clearly refers to matters that centred on the Diocese of London. That said it should also be recognised that it highlighted issues for the Church of England on a national scale. Her Majesty's Coroner delivered a report that detailed her view, having heard the evidence, that there is a risk that future deaths will occur unless action is taken. In the circumstances, it is her statutory duty to report her findings to relevant parties. The report sets out ten key areas of concern for the Church of England. These concerns are detailed in section 7 of this report. The concerns of the coroner are central in much of the observations, comment and recommendations made in this review.

1.2 The Archbishop of Canterbury was required to respond to the coroner within 56 days of receipt of the report. The response, which was completed by the Diocese of London,² included a section (5) that assured the coroner that a 'Lessons Learned Review' would be carried out. The Church set out an initial timeframe for the review and then went on to detail the objectives as:

- To examine the Diocese of London's handling of information relating to the late Fr Alan Griffin in the light of the Coroner's Regulation 28 Report.
- The Review will set out a simple and accessible chronology of events.
- It will identify lessons to be learned and how they should be acted on, which will enable the Diocese of London and the Church of England to take steps to enhance and improve their handling of matters relating to conduct and safeguarding.
- The Review will consider the effectiveness of procedures, areas of service improvement and development needs and will establish what lessons can be learned regarding the way in which information is responded to, recorded, assessed, shared and managed.
- The overall purpose of the Review is to promote learning and improve practice, not to apportion blame.

¹ Copy of the Coroners regulation 28 notice can be found at <https://www.london.anglican.org>

² Full copy of response can be found at <https://www.london.anglican.org>

- It will make recommendations about what could be done better in the Church of England to help prevent such a death taking place again.
- With the co-operation of the Roman Catholic Diocese of Westminster, it will seek to understand how information was shared and acted upon between the Diocese of London and the Roman Catholic Diocese of Westminster and set out lessons that should be learned to improve this.

1.3 An Independent Reviewer (the Reviewer) was commissioned and Terms of Reference³ (TOR) were provided. The Review was the work of the Independent Reviewer alone, overseen by a Steering Group which provided challenge and administrative support. The group consisted of senior clergy, a leading safeguarding professional for the Church of England and an independent member. It was chaired by the General Secretary of the Diocese of London. The Reviewer reported to this group regularly on the progress of the review. The issue of consultation regarding the TOR is one that has been raised by a number of individuals who have spoken to by the Reviewer. This matter will be dealt with in full later in the report when culture and trust are discussed. The TOR set out the objectives of the Review and expectations regarding contact with family and friends, sharing of drafts and publication. The objectives mirror those detailed in the response to the coroner.

1.4 An original target completion date of December 2021 was set. This date was not achieved and given the number of individuals who sought to speak to the Reviewer, papers provided and issues to consider, was never likely to be met. It should also be noted that the coroner expressed surprise that the Learning Lessons Review had not already been commissioned when the Inquest commenced. The time taken to commission the report, complete the process and provide a report has resulted in frustration for the family.

Comment – The organisation, co-operation and information provided by the Diocese of London has been excellent throughout the Review process. The Steering Group has met regularly and supported this process. A learning point would be for more achievable and realistic timescales to be put in place to conclude such a process.

1.5 This review has been offered a number of sometimes opposing views by people interviewed during the process. Some of these views fall outside of the TOR and do not add to the circumstances that relate specifically to Father Alan's death. That said, it is not unusual for a review to offer greater breadth if it will assist in improvement, some of the issues raised will therefore be commented upon.

1.6 A number of recommendations for improvement will be made, individuals will wish to address their own part in what took place and reflect on any individual learning. Where

³ Full Terms of Reference can be found at <https://www.london.anglican.org>

learning for individuals is apparent it is important that they are supported to make improvements to practice and knowledge by those who supervise them.

1.7 One significant overarching feature that runs through this report is that of accountability. Accountability, or more accurately, a lack of it features heavily in much of the evidence presented to the review. There is clear evidence of a lack of accountability in the following;

- The Head of Operations (HOps) for the Two Cities area of the London Diocese and his role or duties.
- How the information about Father Alan was received and acted upon.
- Responsibility for monitoring the progress of the investigation that followed, including consideration for the impact the investigation had on Father Alan.
- The management of the Coronial process.
- In a wider context the role of Parish Priests and their accountability to the church hierarchy including the bishop.

It is also clear that accountability is an issue that has far wider impact across the diocese. Based on the analysis completed for this review it is clear that the London Diocese should consider wholesale change in its approach to accountability. This review has seen evidence that the need for such change is recognised by the current Bishop of London. This will be dealt with in greater detail later in this report when considering culture.

Methodology

2.1 The Reviewer used a blended approach for this review. He was provided with a significant number of papers by the Diocese of London. These included, but were not exclusive to, transcripts of the inquest, witness statements, papers used to provide the evidential basis of submissions to the coroner, details of actions taken to improve service provision both pre and post inquest, response to the Regulation 28 notice, case files and a copy of the 'Two Cities Report'⁴. An entire document review has taken place.

2.2 Whilst many of these documents will be discussed later in the report the importance of the Two Cities Report needs to be acknowledged from the outset. This report details information, and in some cases allegations, about a total of 42 individuals who are all attached in some way to the Church of England. The Two Cities referred to are the Cities of London and Westminster. The document, and its impact on individuals will be discussed in more detail within this report. The Reviewer made the decision that he would concentrate on the entry that details information about Father Alan and has therefore not read the remainder of the document. References to specific detail arise from interviews and other documents provided.

2.3 The Reviewer offered to meet with anyone who wished to speak to him about the Review. As a result, he has spoken to a number of individuals who knew Father Alan or feel that they can comment on the Review because of their own personal circumstances. Whilst it would be inappropriate to identify individual contributors, the Reviewer would like to take this opportunity to thank everyone who took the time to speak to him. Many of these conversations were difficult but people's candidness has afforded the Reviewer the best opportunity to compile a report that meets the TOR and offer recommendations for improvement.

2.4 The Reviewer has spoken to an individual who represents the family of Father Alan and as a result gained valuable insight into the impact of the circumstances that preceded his death. In addition, a close friend of Father Alan provided observations to the review. These included significant challenges regarding the review process, those involved (including the Reviewer), culture and competence. All of the comments, views and observations of this individual were significant when analysing the information provided to the Review.

2.5 The Reviewer then considered policy and procedure supplied to him before and at the time of Father Alan's death. New policy and procedures put in place post the death have also been considered in this report.

2.6 The final stage of the process was the completion of this report. The report has been considered in draft form by Father Alan's family and the Steering Group. Where an individual's practice has been commented on, they have been offered the opportunity to read these sections of the report and respond.

⁴ The Two Cities Report is a document that gives brief details of the information passed during interviews with the Head of Operations. The report was compiled by the Safeguarding Manager with oversight from the Director of HR and Safeguarding.

2.7 It is important that appropriate steps are taken to anonymise individuals wherever possible within this review. This is an extremely difficult process in nearly all review documents. It has proved almost impossible when writing this report. Individuals' roles within the diocese are such that they will be easily identifiable, whilst they are not named it would take very little effort to become aware of their identity. To leave roles out would leave this document far too difficult to understand. The Reviewer would invite the reader to concentrate on the lessons learned, particularly any systemic learning rather than concentrating on individuals. It should be clear that, as per the TOR provided this review does not seek to apportion individual blame or culpability.

Chronology of Significant Events

3.1 This section of the review seeks to set out significant events that impacted on decisions made, actions taken and ultimately the death of Father Alan. It also sets out Father Alan's journey to The City of London and then the Roman Catholic Church. Whilst the Reviewer is seeking to provide some background and context it is not possible, nor is it appropriate, to detail all aspects of Father Alan's life. One of the most significant features of this process has been the impact that an initial lack of respect for an individual's privacy has had. As such this review will not seek to detail any individual's personal life beyond information that impacted on Father Alan.

3.2 It should also be noted that some sections of this chronology deal with events that involve the Roman Catholic Church, specifically the Archdiocese of Westminster Safeguarding Team. Whilst this process has not sought to review the actions of other agencies it is imperative that it examines the actions of the London Diocese once information was passed to their counterparts in the Roman Catholic Safeguarding team.

3.3 Father Alan Griffin was born in 1944. He was an extremely intelligent man who had gained a BA & MA at Trinity College Dublin between 1966 and 1969. He was awarded a PhD in 1971 having studied at Peterhouse Cambridge.

3.4 In 1975 he undertook his ordination training at Sarum & Wells Theological College and in 1978 he was ordained as a Deacon. In 1979 he was ordained as a priest. There then followed a number of different ministry postings including duties at universities where he also lectured. He spent much of his career in Exeter, lecturing and having ministry roles in local parishes. There was a short spell abroad.

3.5 In 2001 Father Alan became the Rector of St James Garlickhythe and St Andrews-by-the-Wardrobe in the City of London.

3.6 During his time in the City of London there were some significant dates that impact on this review. In 2010 Father Alan was diagnosed as HIV+. Information provided to this review is contradictory regarding how others became aware of his HIV status. It is extremely important to note that the review has been informed that in time the virus became undetectable in Father Alan's blood and as such, there is strong scientific evidence that he would not have been able to pass the virus on through sexual contact. Father Alan's viral load has not been confirmed by an independent expert, however, when someone with HIV takes effective treatment, it reduces their viral load to undetectable levels. This means the level of HIV virus in the blood is so low that it cannot be detected by a test. Studies carried out have indicated that having an undetectable viral load for 6 months or more means it is not possible to pass the virus on during sex. The Terrence Higgins Trust provides details of these studies. There is no evidence to suggest Father Alan's viral count was considered by those who chose to investigate him.

3.7 In April 2010 Father Alan attempted to take his own life. He informed his family that the sole reason for this attempt was the distress he was suffering having discovered his HIV status. Whilst this review cannot say with any certainty why he attempted to take his own

life and does not seek to contradict the information provided by the family it is significant that, in addition to his health issues, comment has been made that he was having difficulties within his parishes. The reviewer has received conflicting information about this with some descriptions of 'strained' or difficult' relationships being referenced. Other accounts describe him as an excellent priest who did much to improve his parishes. He retired from the Church of England in January 2011.

3.8 In April 2011 Father Griffin was received into the Roman Catholic Church. In June 2012 he was re-ordained as a priest in the Roman Catholic Church.

2019

3.9 In February 2019 the HOps, having announced his plan to leave his position, began a series of meetings with senior church officials to 'download his corporate memory'. This person was also described as the Head of Operations for the Archdeaconry of London. During these meetings he shared information on forty-two individuals, including Father Alan.

3.10 In August the 'Two Cities Report' was compiled detailing the information passed. As part of this report an action plan was completed to deal with the information passed on, this included Father Alan. In September 2019 an independent safeguarding investigator was commissioned to assist with the case (this individual was described as a private investigator by the family of Father Alan and is discussed in greater detail in section 6.9). In October it was agreed at a meeting between one of the Diocesan Safeguarding Advisors who had taken on the day-to-day role of case officer and senior managers that contact should be made with Father Alan. On either 30th October or 1st November, the case worker contacted Father Alan via the phone. He explained that he was now a priest in the Roman Catholic Church and declined to deal with the London Diocese Safeguarding Team (DST). Senior managers and clergy were informed of his stance and a decision was taken to share concerns with the Roman Catholic Safeguarding Team.

3.11 On 1st November a summary of information was sent to senior management and clergy for their comment prior to forwarding it to the Roman Catholic Church. One senior manager expressed concern and advised that gaining legal advice should be considered, this was never done. On 5th November the same summary was sent to the Roman Catholic Safeguarding Team that covered the area Father Alan now ministered in.

Comment – It is fair at this point to assume that Father Alan thought he was being investigated by the safeguarding teams, both in the Diocese of London and the Roman Catholic Church. It is also clear that he did not know who or what this investigation involved.

3.12 In November details of the person staying with Father Alan in his home were verified. This was deemed necessary by the DST having received information that indicated he had a companion living at his address. In fact, Father Alan had requested that a person be allowed to stay in his home to assist him, this request was necessary as part of his tenancy

agreement with the diocese. As part of Father Alan's retirement package, the Diocese of London had provided him with a home initially free of charge and then significantly below market rent for life. It was after this arrangement was put in place that he took the decision to leave the Church of England. The Diocese continued to make the house available, hence his request for permission for someone else to share the accommodation. Father Alan also submitted a Disclosure and Barring Service application; this was required by the Roman Catholic church.

3.13 On 2nd December Father Alan attempted suicide by overdose.

2020

3.14 In April Father Alan received his DBS certificate. Between April and October, he underwent a series of therapy sessions during which he discussed his wish to 'get through' the investigation.

3.15 In May and June Father Alan was contacted by the Roman Catholic Safeguarding Team, he received no details of the 'allegations' being investigated but was told that concerns raised by the Church of England would need to be addressed.

3.16 In early August Father Alan wrote to the case worker in the Roman Catholic Safeguarding Team complaining about the lack of disclosure he had received.

Comment – It should be noted that this complaint comes some ten months after Father Alan was first contacted by the DST. Those in possession of the information had held it for at least eighteen months, there were a number of missed opportunities to assess, scrutinise and direct the investigation during this time.

3.17 On 2nd September following consultation between the two safeguarding teams Father Alan received a letter from the Roman Catholic safeguarding team giving some disclosure, specifically wanting to discuss his HIV status, the safety of others and any involvement with 'rent boys'. There follow exchanges where Father Alan seeks legal advice, a meeting is arranged and then cancelled. The main issue between Father Alan and the safeguarding professionals seeking to meet with him continued to be a disagreement regarding disclosure. Father Alan was never spoken to about the information and no further disclosure was provided. The family and friends of Father Alan are clear that he was appalled by the content of the letter he initially received and horrified that his private health information had been disclosed. He was also distressed by the fact that those trying to meet with him insisted that it should be done in person during the pandemic. At this point Father Alan was 76 and was been asked to meet face-to-face with three investigators. The issue of disclosure is addressed later in this report.

Comment – The issues of who was leading the investigation at this point needs to be examined in any future de-brief. It should be clear who has responsibility for the investigation and actions that are taken.

3.18 On 8th November Father Alan died, taking his own life.

3.19 On 12th November the inquest into Father Alan's death was opened.

2021

3.20 The inquest was re-opened in June / July 2021 and evidence was heard by the coroner. On 9th July the Archbishop of Canterbury received the Regulation 28 notice from the coroner.

3.21 In September this review was commissioned.

Information Passed on by the Exiting ‘Head of Operations’ (HOPs)

4.1 In early 2019 the HOPs for the Two Cities area of the London Diocese decided to leave, resigning from his position. He has told the review that he had been engaged in work within the diocese since 1997. The review has been informed that this employment initially took the form of various administrative posts working for churches within the diocese before he took up his post as HOPs around 2009, having been recruited under the leadership of the previous Bishop of London. This is significant when considering his influence and the fact that he chose to leave soon after the current Bishop of London came into post. Her insistence on greater accountability appears to have had significantly influenced his decision. It is abundantly clear that this individual was allowed to function with little accountability or supervision during the tenure of the former bishop. Had such accountability and supervision been in place then many of the issues referred to in later interviews would have been resolved at the time they were allegedly taking place. Whilst this review has seen no job description of the role from interviews conducted, including one with this person, it seems the main functions included dealing with clergy housing, raising funds and other building issues. These were not exclusive and it is apparent that he carried out specific tasks assigned to him either by the bishop or the Archdeacon of London. It should also be noted that the post was created by the Bishop of London in his capacity as ‘corporation sole’ and was not funded by the London Diocese. The holder was not therefore employed by the diocese, no personnel file appears to have been kept on him and it is difficult to understand where the role sat in terms of hierarchy and more importantly accountability. Such arrangements appear to be made at the sole discretion of the bishop who employs the individual and would have to be funded either from the bishop’s own working costs allowance from the Church Commissioners, or from some private stream of funding. Having spoken to other senior clergy this may not have been a unique situation. Whilst it is slightly out of the scope of this review, it is important to acknowledge the issues that may arise if such employment arrangements take place: these include lack of adherence to safer recruitment policies, lack of supervision, accountability, codes of conduct, and lines of support for the individual.

Comment – The employment status of the HOPs has been the cause of much debate and conjecture during this review process. He was not employed by the Church in his role as HOPs, some have described him as a consultant but this review has found no evidence to support this title. Despite the uncertainty the fact remains that he was a person who held significant influence through his role and his association with the bishop. The review will continue to describe him as HOPs. The significance of how he was employed is addressed in recommendation 1 and 2.

4.2 In this case the fact that the individual was not employed by the London Diocese gives rise for further concern as it could be seen as excluding him from being seen as a whistle blower within current policy. The diocese has a published policy for whistle-blowing but it relates to their employees and volunteers, the HOPs was neither. It is incumbent on the Church of England to ensure where individuals are employed by bishops to work within their office that these matters are dealt with and documented. The risk posed to the Church, the

community and those employed is significant and this review would recommend that it is dealt with as a matter of urgency.

4.3 What is abundantly clear from interviews is that this person held a significant amount of power and influence in the Diocese. This is important when considering the impact of the information he shared on his exit from the organisation. This influence was created largely through his relationship with Church hierarchy, specifically the then Bishop of London and archdeacon's. It is also significant that when a new Bishop of London was appointed and plans were put in place to increase accountability this person chose to leave.

Recommendation 1 – The Diocese of London should ensure that all staff who are employed by role holders including Bishops, Archdeacons and others who have a private office are the subject of safer recruitment. They should have job descriptions, terms of employment and all other employment rights and conditions afforded to those who are employed by the wider organisation. Their position should be known to the wider church community and they should be recruited in an open and transparent manner. They should be aware of whom they are accountable to and have clear line of supervision and support.

Recommendation 2 – The Bishop of London should refer the issue detailed in recommendation 1 to the House of Bishops to seek assurance that National policy and guidance is being delivered in the key area of recruitment. The House of Bishops should consider reminding the wider Church of the need to be aware of and to use existing guidance. <https://www.churchofengland.org/safeguarding/safeguarding-e-manual/safer-recruitment-and-people-management-guidance>.

4.4 Having decided that he wished to leave his post the HOPs had a meeting with the current Bishop of London. During this meeting the HOPs describes a conversation taking place about his 'institutional memory'. This apparently referred to his relationships, knowledge of individuals and parishes within the diocese. He states that the bishop was keen to capture as much of his knowledge as possible. A decision was made for him to meet with the Archdeacon of London and discuss the information he held.

4.5 The HOPs stated he believed the conversations that followed were simply him downloading information he had accrued during his twenty-two years in his roles within the diocese. He was clear that he did not expect the actions that followed. The meetings have been described as a 'brain dump' and it is apparent that there was little initial consideration given to the consequences of what may have been spoken about. In fact, there it is clear that very little, if any, planning took place before the initial meeting with the Archdeacon. No one considered who should be present, what issues may be raised, how the conversation should be recorded and how the information should be managed. The approach taken could be seen as a significant influence on the way in which the HOPs viewed the process. Good practice would have been to ensure this meeting was formal with procedures and expectations set out from the outset.

4.6 The fact that this matter was dealt with by an archdeacon, an individual with authority and seniority within the Church, but no specific safeguarding training or background, has also been perceived to be significant by the family. Whilst it is accepted that the Archdeacon of London was the most appropriate person to carry out this initial interview, his continued involvement raises issues. The family highlight the fact that he was simply not qualified to conduct the interviews and that his participation could have influenced less senior people involved in the process. These are both valid observations and it will become clear that the interviews that followed are not considered good practice by this review. The HOps had no specific line manager but he had worked with the archdeacon and his predecessors. This review accepts that archdeacons are senior clergy but they are also useful generalists, people who hold all sorts of knowledge and information, pastoral and practical. It is not a presumption that something is being escalated if it is given to an archdeacon to deal with. In this situation, save for the question regarding neutrality that follows, it is difficult to see who else would have been approached to conduct the interview. It should also be noted that the archdeacon was familiar with some of the individuals discussed in that meeting. In fact, when interviewed for this review the HOps saw this as a positive, stating 'having the Archdeacon at the meetings was useful as he knew many of the characters'. The accuracy of this observation depends wholly on what information is about to be disclosed. An alternative way forward may have been for this meeting to be conducted by an independent person who would not have an established view on the individuals being discussed. The arrangements for the first interview were understandable in the circumstances. However, the decision regarding the conduct of further interviews, specifically who should be present and under what conditions they took place, was not well considered.

4.7 The HOps was initially spoken to by the Archdeacon. Realising that he was receiving what he believed to be significant information, this individual took notes that he kept, this is good practice. Having been concerned regarding some of the information passed to him he consulted the Director of Human Resources and Safeguarding. This again is a senior post and the job title would infer that the role holder had significant knowledge or resource at their disposal to manage both HR and safeguarding issues. This review has been provided with evidence (in terms of practice outcomes) that indicates relevant senior staff have not received sufficient training to meet the developing demands of all parts of their roles. The increased focus on safeguarding in recent years, should have focussed the Church and Diocese on this issue. In this case and potentially others, the combination of the HR and safeguarding functions has highlighted a concerning systemic issue. It is clear that decision-making authority and safeguarding expertise should always be vested in the same people. If this is not the case it could result in confusion regarding lines of accountability and the roles and responsibilities of individuals. The role holder's expertise in this case was primarily in HR and not in safeguarding, this left this person and the diocese in a vulnerable position when dealing with safeguarding issues. The role title and responsibilities given to this individual pose systemic questions for the diocese and wider Church. It is imperative that any individual who is the Director of Safeguarding has significant experience and training if they are to carry out their duties. Their role is vital in terms of leadership, accountability and confidence in the entire safeguarding system.

Comment – The introduction of a safeguarding lead has reduced the vulnerability and risk in this critical area. The review believes that the diocese should consider the governance

and supervision of this individual, ensuring they report to the correct individual and have access to required expertise / advice. This may require investment in terms of staff recruitment to the role or significant training for individuals already employed.

4.8 Given the fact that the Archdeacon believed there might be safeguarding issues within the information he received, good practice would have been to hold a strategy or planning meeting about how to take this matter forward. This meeting (a core group meeting) should have included HR, safeguarding, legal and pastoral professionals who could have assessed the information given, planned the next necessary steps, considered policy/guidance and dealt with pastoral care for all involved. This would have afforded the diocese the opportunity to react to the information in a proportionate, informed manner. Risk assessments could have taken place and the information given could have been tested. This review would have expected that if such a meeting had taken place further interviews would have been conducted by HR and Safeguarding professionals. The status of these individuals should not have mattered, their selection to complete the interviews should have been based purely on expertise.

Recommendation 3 – Where information that has the potential to impact on safeguarding is known then it should be referred to the safeguarding team for assessment. Once this assessment is complete safeguarding protocol must be adhered to with appropriate meetings, planning, investigation and oversight being put in place. This should not be deviated from on the basis of an individual’s position within the organisation.

4.9 A decision was taken to interview the HOps again. This time the interviews were conducted by the Archdeacon and Director of HR and Safeguarding, as already detailed this was not good practice. A third interview took place, again conducted by the same individuals. A fourth interview then took place and at this stage the Safeguarding Manager was also present. The Safeguarding Manager has been spoken to and believes she was only present because there was no minute taker available. This perception is not accepted by the Director of HR and Safeguarding who maintains she was there in her capacity as Safeguarding Manager and had been encouraged to actively participate in the process. All those who conducted the interviews have assisted this review. It should be noted that the Director of HR and Safeguarding has recognised many of the mistakes made in terms of the conduct of the interviews. This demonstrates positive learning on the part of this individual.

4.10 During the interview process the HOps was asked if he wished to be dealt with as a whistle blower. He declined to be interviewed under this policy stating that he felt he was simply passing on information, much of which was already known and had been acted upon. It is unclear exactly what information was given to him and what he was told about whistleblowing policy including the protection it offers. It is accepted that he was offered the opportunity to be dealt with as a whistle blower. The London Diocese now has a published whistleblowing policy, it did not at the time of the interviews. However, those interviewing him have stated they did inform him that he could be dealt with as a whistle - blower. The current policy follows the normal template for whistleblowing, one which has been in existence for a number of years and would have been easily accessible. It is clear

that the information he was giving would fall into areas covered by such policy⁵. The fact that he was offered the opportunity to be dealt with under such policy is good practice.

Comment – It would have been good practice for the HOps to have been provided with a copy of whistleblowing policy. His reasons for not wishing to be dealt with under this framework should have been recorded and challenged where appropriate. This would ensure that there was evidence that this policy had been considered, offered and its benefits explained.

4.11 Over a total of four interviews, lasting over 9 hours the HOps gave information that involved forty-two individuals. It is not for this review to comment on each piece of information provided, its veracity or how it should have been dealt with. This report will examine the information passed that relates to Father Alan and how it was dealt with in detail. However, the process for dealing with this information is extremely important, it gives context to decisions made in Father Alan’s case and affords the London Diocese and wider church an opportunity to examine practice and learn important lessons.

4.12 As previously stated, the HOps was clear when interviewed for this review that he believed he was having what can only be described as a ‘chat’ with colleagues as he exited the organisation. There were aspects of good practice within the interviews that took place. The interviews were noted and these notes were passed to the HOps to check for accuracy. He was afforded the opportunity to correct them and distinguish between ‘fact and rumour’. A safeguarding professional became involved in the final interview. It is difficult to reconcile the HOps view that he was having a chat, with the fact that he had taken part in nine hours of interviews and had been asked to read through notes to confirm what he had said. Whilst this may have been his initial perception it is logical to conclude that by the time the process had been completed, he would be aware that there would be consequences and actions required regarding some of the information he had shared.

4.13 Having concluded the interview process a decision was taken to hand the information to the DST for review. This review has found that there was a prevailing culture of passing information that fell outside of safeguarding to this team for assessment and action. The review understands that, of the information given, only two pieces had aspects that were assessed as requiring a safeguarding investigation. It has been observed that up to twelve of the cases had information that related to safeguarding within them. Whilst this may be the case, it remains that only two were deemed as requiring further action by the DST, one of those was relating to Father Alan. The remainder were either deemed as having been dealt with or were passed to the Archdeacon for his consideration and action. As already stated, the use of appropriately skilled interviewers to take the initial information would have allowed the information to be assessed, challenged and actioned immediately. However, given the fact that those conducting the interview were unable to do this, good practice would have been to call a strategy meeting or core group made up of professionals from a number of disciplines to assess the information. This would have afforded an

⁵ [Church of England Whistleblowing Guidance](#)

opportunity to decide which information required HR intervention, safeguarding intervention, pastoral intervention and which could be deleted as uncorroborated gossip.

Comment – A positive aspect of good leadership is recognising who is the best person with the best skills and experience to deal with situations, affording them the opportunity to deal with the situation, supporting and leading them. To engage such individuals is a skill but does not absolve leaders of responsibility or relieve them of their accountability.

Comment – Representations have been made to the review that point to a current culture of ‘fear of getting safeguarding issues wrong’ within the Church of England. This results in individuals not wishing to hold risk or make decisions and could explain some of the decisions made in this case. This review can not come to any informed conclusions as to whether this is a wider cultural issue or simply the view of a small number of individuals. It is something that further training and reflective practice sessions could be used to address.

Recommendation 4 – There should be guidance provided by the Diocese of London detailing when to refer matters to safeguarding professionals, including the DST. This should refer to and promote National Guidance that is already in existence. Any guidance should encourage referrals and dialogue with safeguarding professionals so appropriate advice can be sought. This is particularly important when considering conduct and discipline matters v safeguarding referrals.

4.14 The DST reviewed all the information given and a document that became known as the Two Cities Report was written. This document detailed information about the forty-two named individuals, including Father Alan. This document has been provided to the review and several of those named in it have spoken to the Reviewer. The impact of this document has been far reaching. It has caused individuals some considerable distress and added to a culture of mistrust between clergy and senior leaders within the Two Cities. This culture appears to this review to be born out of a number of underlying issues and will be discussed later in this document.

4.15 The creation of a document that lists uncorroborated and untested information about individuals has the potential to give a false impression to those who read it or are named in it. In fact, interviews conducted for this review have confirmed this to be the case. Whilst it is clear from interviews with those who dealt with the information, each case was judged individually, to create a single report may give the impression that they are being responded to as a collective. This review has sought an update from senior leaders on the status of the report. Four questions were asked and responses (some are summarised) are listed below:

What is the current status of the report, are your enquiries into the information within it complete?

All enquiries other than those of a safeguarding nature were completed in the last quarter of 2020.

The Diocesan Safeguarding Team reviewed the document. A number of issues were identified and progressed and these enquiries are complete. Some issues related to cases that had already been dealt with by the Diocesan or National Safeguarding Teams and have been reviewed as part of the PCR2.

Has everyone mentioned in it been contacted and offered a copy of the information that relates to them?

Everybody who was the subject of the assertions in the report has been contacted and offered a copy of the information that relates to them, with one exception where the individual was deceased.

The information provided to individuals has been redacted on legal advice to remove references to third parties. None of the communications with those individuals, nor their requests for the information, nor the redacted paragraphs, nor their responses on receipt of the information are held on their blue file (personnel file).

The decision not to contact anyone who was not one of the 'forty-two' was taken on the basis of GDPR/DPA principles: namely that the information was being shared as though it were a Subject Access Request by those named in the report. Information relating to third parties was not therefore shared.

What has been the outcome of the information contained within the report? Were there any disciplinary measures taken, investigations conducted etc?

Much of the material contained in the report was immediately dismissed as having the nature of gossip. Nothing of this nature was pursued in any way. None of the information received was considered to reach a threshold which would trigger action under the Clergy Discipline Measure. Four individuals were spoken to about issues raised.

What do you plan to do with the information? Will it be destroyed or recorded against individuals on their personnel records?

Prior to the death by suicide of Alan Griffin the intention had been for all copies of the report held by the Diocese to be destroyed or deleted once the actions arising from it had been completed. Following the inquest into AG's death the renewed intention has effectively, to date, been the same: for all copies of the report held by the Diocese to be destroyed or deleted once the Independent Review and any resulting actions were completed. The coroner would also be requested to destroy her copy of the document.

4.16 These responses show that the information provided has now been assessed by the diocese, individuals have been provided with redacted copies and all necessary action concluded. Decisions made by those receiving the information resulted in a small group of people including senior leaders being presented with this document. This was done on a

'need to know' basis in order to minimise knowledge of its content. It appears to this review that these circumstances were so unique that there was a lack of assessment, planning and action regarding the document.

Comment – Had the information been assessed and dealt with in a more expedient manner then the conclusions reached would perhaps have been more palatable to those who were named in the report. This delay and non-disclosure have added to the belief that there was a lack of transparency about the entire process. This in turn has masked the fact that, with the exception of Father Alan's case decisions have been reached

Recommendation 5 – The Diocese of London should now destroy all copies of the Two Cities Report, retaining only one 'master copy' whilst litigation / complaints are considered by those named in it. Where any information is retained about an individual, other than in the master copy, that person should be informed of what information has been retained, where it is held and for what purpose. Each of the forty-two mentioned within the report should receive a letter confirming the destruction of the report, details of information retained about them or confirmation that no information is retained.

Information Given Specifically Regarding Father Alan and the Diocese Response

5.1 It should be noted that this section of the report deals with untested, uncorroborated information provided by one individual (HOPs). Much of this information presented was challenged and discredited at the Inquest. Whilst it is important that the information and response is analysed for the purpose of the review, this part of the report does not seek to validate it in any way. In fact, much of it is now acknowledged as lacking any credibility. During the interview process with the HOPs a disclosure was made about Father Alan. This disclosure is detailed in the Two Cities Report. The next paragraphs summarise the information given; they are not a verbatim account from the report but do rely on its content.

5.2 The report starts, *'Regarding Alan Griffin's use of rent boys'*. This term and its misuse are of paramount importance to this review. The term was widely used in the 1980s and was commonly used to refer to young, adolescent male sex workers. It has been accepted that this term was never used by Father Alan and that it was in fact used by the HOPs.

Comment – The use of this phrase is so critical to the action that followed, its origin should have been confirmed. The fact that this was not discovered before the inquest was significant and could have prevented further investigation and disclosure.

5.3 The HOPs commented that he found the conversation about Father Alan difficult to have. He stated that the previous Bishop of London was prepared to turn a 'blind eye' to behaviour that was not criminal. He described that the bishop had first-hand knowledge of Father Alan's social life and had actually stated that he had seen Father Alan in a social setting with 'a different man on his arm' every week. He goes on to explain that he felt the bishop would 'not have wanted to ask the question in order to avoid being told the answer.' This illustrates a divisive issue that has been at the centre of this review - the Church of England's stance on homosexuality. Again, this issue is so complex that it could not possibly be dealt with in significant detail by this review. At the same time, it cannot be ignored. There is clear evidence that the way Father Alan was treated was, in part, influenced by the Church and individuals' conscious and unconscious bias around his sexual orientation. This will be discussed in greater detail later in the review but it is significant that the information provided by the HOPs indicates that he believed the most senior member of the Church within the Diocese of London was uncomfortable with his behaviour and chose to ignore it because it manifested itself in a manner that may mean he had to confront Father Alan's sexual orientation.

5.4 The HOPs was asked about concerns that Father Alan's companions could have been underage. He was clear that he believed he had 'a type', usually 25-40 years of age. This is significant and was the subject of questions both within the inquest and this review. The HOPs is absolutely clear that the term 'rent boys' was his but that he felt it referred to young men aged 20 – 25 years. He did not believe that Father Alan had ever had sex with children or young people under the age of consent. This matter was the subject of specific questions within the interviews, this was good practice. It is also noted that the HOPs

changed his account from saying Father Alan was 'paying for sex' to Father Alan was 'paying for meals', these different accounts should have raised more concerns about the veracity of the disclosures being made. Given the answers given and lack of any other information, allegation and most importantly evidence, these remarks should not have formed the basis for a safeguarding investigation.

5.5 The document then turns to how the HOps became aware of Father Alan's HIV status. This is an issue that is disputed by Father Alan's family. They believe that the HOps became aware by looking through private documents in Father Alan's home. The HOps states that Father Alan visited him and told him that he had HIV and asked him not to tell the bishop. Despite this the HOps did decide to tell the then Archdeacon of Charing Cross stating he was concerned that he was a close friend of Father Alan and it may help if he disclosed to him. He also states that he ensured he received appropriate medical care. There is nothing to support this claim on the Father's blue file (term used for priest's personnel files).

5.6 There was also information passed that Father Alan allegedly had a sexual relationship with another male priest in the Church of England.

5.7 The HOps described Father Alan as a lonely man, with few friends and very little emotional support from other priests. He states that he was having a difficult time in his parishes and was not well liked. The HOps informed this review that he felt he was a friend to Father Alan, offering support and having regular contact for some considerable time. Father Alan's HIV status appears to have played a significant part in the safeguarding assessment. Two concerns were raised - was Father Alan putting people at risk through sexual contact and what impact was his status having on his own health. The HOps was clear that he had never said Father Alan was putting people at risk through sexual contact.

Comment - It is difficult to understand why, some 9 years after senior Church of England officials became aware that Father Alan was HIV+, the fact that he may have been putting individuals at risk through sexual contact was considered and raised. This review has seen no evidence to support this assumption, neither has it seen evidence of Father Alan being offered support, pastoral care or indeed being talked to about his illness, beyond that detailed briefly by the HOps.

5.8 In April 2010 Father Alan attempted to take his own life. The HOps stated he was concerned that he had not spoken to Father Alan and that he had not been seen 'around' for a couple of days. He went to the rectory where Father Alan lived and found him having taken an overdose. The family are clear that someone else actually alerted the bishop's office that Father Alan's door was locked from the inside and it was this that led to the HOps attending the address. An ambulance was called and the HOps disclosed Father Alan's HIV status to the paramedic. Following this incident, the HOps and Father Alan never had another conversation. It would appear that Father Alan felt the HOps had been indiscreet about his illness.

5.9 In January 2011 Father Alan retired from the Church of England and was given what is described as a generous pension settlement. This included a residence in which to live for the rest of his life. The Church took his 'short life expectancy' into account when offering

the settlement. No 'safe to receive' information was passed to the Roman Catholic Church when Father Alan later joined them. The review has been unable to ascertain if any requests for references were made by the Roman Catholic Church to the Church of England when Father Alan became a Roman Catholic priest. There is evidence, provided in the Coroner's Court, that the Roman Catholic Church did receive a letter from the then Bishop of London regarding Father Alan. Given the sparsity of information recorded on Father Alan's personnel file and the dated nature of the files content it is difficult to envisage that anything it did contain this would have prevented him from taking up office.

Comment - If a request is made for disclosure regarding the suitability of an individual clergy person to take up office or employment with another agency, the Church of England should, if requested, supply a written response detailing any concerns that would inhibit the taking up of this role. When such a request is made within the Church of England, this follows a standard format, set out in a Clergy Current Status Letter (CCSL, known colloquially as a "safe to receive"), and always includes safeguarding information. When an individual clergy person moves either to a different Province of the Anglican Communion or to a different denomination (in the case of Father Alan, to the Roman Catholic Church), there is no agreed format and a reference would only be supplied if requested by a representative of that denomination.

5.10 It may be helpful to summarise the information given above so this review's analysis, comments and recommendations can be better understood. Father Alan disclosed his HIV status (or the HOPs found out about his HIV status) in 2010. At this time, he held office within the Church of England and had responsibilities for two parishes in central London. He was known to the HOPs who worked in the same area. The HOPs stated that there were 'sightings' of him with other men. Father Alan was believed to be gay. This review believes that comments made by the HOPs such as 'he was seen with different men on his arm' were judgemental, based on assumptions and homophobic stereotypes and consequently led to an unfair assumption that Father Alan was a promiscuous man. The review has been provided with a counter argument to this and it is included to provide balance and afford the opportunity for the reader to reach their own conclusion. If Father Alan had been seen with a different woman on his arm every week, a similar assumption of promiscuity might have been made, which might have been challenged. The problem was that no-one challenged what might have been perceived as promiscuity, regardless of whether it was straight or gay. In either case, promiscuity would have been 'conduct unbecoming a member of clergy', and if this assumption had arisen, it should definitely have been challenged. Therefore, this was not a matter influenced by assumptions or homophobic stereo-types.

Comment – Senior members of the Church of England were aware of Father Alan's sexual orientation and his HIV status in 2010. This review has seen no evidence that he was offered any support, pastoral care or advice at this time beyond that allegedly supplied by the HOPs. In fact, the behaviour described indicates a fear of dealing with these issues with people choosing to ignore what they think is a 'difficult subject'.

5.12 In April 2010 Father Alan attempted to take his own life. The review has seen no evidence that this led to structured support for him. What appears to have transpired is

that this action was the catalyst for a generous retirement offer. The family state that the retirement offer was the result of the HOps invasion of privacy and subsequent legal advice sought by Father Alan.

5.13 Once retired no further action is documented until, in 2019 the HOps, is interviewed by the Archdeacon and Director of HR & Safeguarding to extract his 'corporate memory'. At this time disclosures are made about forty-two individuals including Father Alan. By this time Father Alan has joined the Roman Catholic Church and been ordained as a priest.

5.14 A decision is taken to pass the information to the DST for assessment. This leads to the production of the Two Cities Report in which information regarding Father Alan is detailed. This report will deal with the action taken and results in the next section.

Recommendation 6 – The Diocese of London and wider church should consider producing a means of delivering the following fundamental message. If any employee, volunteer or person otherwise associated with the Church of England discloses significant illness they should be offered support and help. Their disclosures should be dealt with confidentially and not disclosed without their express permission and consideration of current legislation. People should guard against making ill-informed judgements and treat individuals with respect and compassion. Whilst the review acknowledges that these are values many people use daily it is important that lessons are learned from this case and these values are re-enforced.

5.15 The HOps also went on to explain that the diocese had received a letter from Father Alan approximately twelve months earlier. This resulted in Father Alan being allowed to have a 'young man' move in with him. The letter had sought permission for the person to move into Father Alan's house, such permission was required under the terms of his occupancy of the house owned by the Church of England. The public suggestion was that this individual was a carer, not a lover. Again, the term 'lover' rather than partner is an example of how language can impact on the way we interpret information provided to us.

Recommendation 7 – The Diocese of London and the wider church develops a training package that can be used to inform people of the impact language can have. This package should inform the whole church community of how the language we use can have a negative impact on people's perception. This is particularly important to those who lead and guide us. In this case terms including 'rent boys' 'different man on his arm' 'lover' and 'young man' invoke unjustified emotional responses from some. These examples can be used and developed into other areas where our language can have a disproportionate effect on others.

Assessment of the Information and Steps Taken

6.1 As already detailed a decision was taken to ask the DST to assess the information passed during the interviews with the HOPs. It is the view of this review that this decision was fundamentally flawed. There was a clear view put forward during this review that this team was used as a back stop for a number of concerns that simply did not fall within its remit. The team was not well resourced and it was inappropriate for them to be passed information that fell outside their remit. Safeguarding is a specialist, often highly stressful environment in which to work. A referral to safeguarding professionals can unfortunately carry with it some significant stigma. In this case a number of individuals' conduct was being assessed by this team. The majority of these cases were clearly not safeguarding and only two were judged to require further action by the DST. It is clear from interviews that there was a lack of direction given by senior staff involved directly in this case. The entire process lacked planning, direction and leadership. The lack of early assessment and the significant delays in progressing decision-making processes impacted on Father Alan. Comment that some legal advice was sought to confirm decisions made regarding the assessment of information contained in the Two Cities Report has been provided to the review. There is no such evidence of legal advice being provided specifically about aspects of Father Alan's case. Whilst the review believes the decision to take no further action did not require legal advice, if concerns remained then this would have been an appropriate course of action.

Comment – The Church of England has published guidance entitled 'Practice Guidance: Responding to, assessing and managing safeguarding concerns or allegations against church officers'.⁶ This extensive document gives excellent advice and direction for people dealing with safeguarding concerns. Had the information amounted to a safeguarding allegation or concern this document and its guidance should have been followed. However, it is the opinion of this review that the information did not amount to an allegation or concern and therefore it is not appropriate to judge individuals' actions against it. It is accepted that those who dealt with the allegations made against Father Alan would have been wise to consider the good practice outlined in the document including the key areas of oversight, assessment and core group meetings. There is no evidence that this took place.

The fact that the information was passed to the safeguarding team for assessment and remained with them illustrates another area of concern. Whilst it is imperative that people are encouraged to communicate with safeguarding experts, seeking advice regarding concerns they have, it is equally important that, if information does not reach the threshold for the safeguarding team to investigate, a decision is made as to how the matter will be progressed. This is most likely to happen when confronted with a safeguarding versus conduct issue. Without appropriate steps and guidance, it is likely that similar circumstances could occur, with the wrong teams dealing with matters that are outside of their remit.

6.2 During this review comment has been made that the Church of England relies too heavily on retired police officers to conduct safeguarding investigations. It was suggested that safeguarding teams should be multi-disciplinary and include a lawyer. Whilst this

⁶ [Responding PG V2.pdf \(churchofengland.org\)](#)

review agrees that the best teams are taken from across a number of agencies with a wide variety of experience it is clear that this must be balanced against the need to employ people with the best knowledge, experience and practice. It should be noted the team who dealt with the information passed about Father Alan was managed by a person with a Local Authority background, the case officer was previously employed by the probation service and there was person with a social work background on the team. A former police officer was the final member of the team but another former officer was contracted to help with the 'investigation'. This was a multi-disciplinary team. Perhaps even more important is the question of how diverse these teams are? London is a diverse community and as such those who hold professional positions within the Diocese should represent the community they serve. A more diverse team can deliver greater challenge and offer greater cultural competence and understanding.

Recommendation 8 – The Diocese of London and wider church should complete an audit of its current safeguarding professionals. This audit should include previous professional background and diversity characteristics including race, gender and sexual orientation. The results of this audit should shape future recruitment strategy.

6.3 Having looked at the information given regarding Father Alan a decision was made to undertake an investigation. There is no evidence of a strategy meeting, core group or multi-discipline meeting to discuss the information. There is little evidence of anyone considering the length of time that had passed, the lack of corroboration and that fact that this was information as opposed to an allegation.

6.4 This review has spoken to the person who was given the responsibility for progressing the investigation. It is clear that they felt this was a situation that required a conversation with Father Alan, preferably with another member of the clergy to ensure that he was looking after himself and that the person he had sought permission to live with him was an adult. She made a request for this to happen to the Archdeacon of London but having received no reply she took the decision to contact Father Alan herself. She went on to describe it as a 'quick win' and gave a clear impression that her main concern was for Father Alan rather than any other vulnerable individuals. It is clear that there were tensions between staff and management within the DST that did not help with how this matter was dealt with. This impacted both in terms of leadership, oversight and co-ordination.

Comment – At the crux of this case is how the information given by the HOps about Father Alan was interpreted. Following assessment, it is clear that the information was investigated, this implies that the information received was perceived to be a safeguarding allegation. This review has found no evidence to suggest that any safeguarding allegation was actually made. The issues focussed on were, or could have been, dismissed through some basic evaluation of the information. The use of the term rent boys was discussed in the interviews and should have been dismissed, it was made clear that no allegation was being made that father Alan had been involved in sexual activity with anyone under the age of consent. The person who moved into Father Alan's home was an adult and the request for him to live in the premises was made and approved in the correct manner. There is no evidence that Father Alan was putting

individuals at risk through sexual contact. The review has found that this was a view supported by the case worker.

This review has concluded that without further corroboration the information did not warrant a formal investigation.

Recommendation 9 – The DST develops and publicises a threshold document for referrals. This document should include the guidance on information required to assess what action is required. Further policy and guidance documents should set out how investigations will be carried out. These should include details such as strategy discussions, referrals to other professional bodies, recording information and standards for investigation.

6.5 Father Alan had by this time been ordained to the Ordinariate (2012) within the Roman Catholic Church and ministered in the Westminster Diocese. In late October 2019 the case worker decided to call Father Alan and discuss matters raised with him. They wanted to seek clarity on his HIV status to establish if this was a risk, establish the age of the man living in his house and enquire about his own welfare. This conversation lasted some thirty seconds with Father Alan declining to speak to the case worker or meet with them as he was now under the authority of Roman Catholic church.

6.6 On 1st November a summary of information was sent to the senior managers who had interviewed the HOPs for their comment prior to forwarding it to the Roman Catholic Church. This initial step, seeking the view of managers, was good practice on the part of the Safeguarding Adviser (case worker). However, the fact that those in senior positions did not robustly challenge the exchange of information with the Roman Catholic Church is of concern. To understand the decision to share information with another ‘agency’ the review has relied upon the decision made that there were safeguarding concerns. However, to share single strand information that deals with sensitive, private matters including individual’s medical history is something that should be considered extremely seriously. Good practice would have been to meet, consider the status of the information, seek legal advice if necessary and then record a detailed rationale for the exchange. This review does not believe, on the evidence presented, that the circumstances justified the exchange that followed.

Recommendation 10 – The Church of England issues guidance to safeguarding teams regarding minimum standards for information exchange. This should include ‘sign off’ by a suitable safeguarding lead. The Church of England should also support the development of Information Sharing Agreements with other professional bodies.

Recommendation 11 – The London Diocese should commission a GDPR expert to consider the legality of retaining information passed by the HOPs. This should extend to the Two Cities report. Its conclusions should be considered in the training now offered to the DST and wider church community.

6.7 On 5th November the same summary was sent to the Roman Catholic Safeguarding Team that covered the area Father Alan now ministered in. The information exchanged has been shared with the review and it details concerns already discussed in this report

including Father Alan's HIV status, rent boys and the man who now lived in his home. Whilst the review does not believe this information should have been shared, of further concern is the omission of the fact that Father Alan had previously tried to take his own life. If information was to be shared then it is clear that it would be viewed as a referral and impact on the individual. Given his history it is difficult to understand how the information was passed without reference to his attempted suicide. Had the Roman Catholic Church been made aware of the fact that Father Alan had previously attempted suicide it may have impacted on how they dealt with him. It should be noted that the case worker who passed the information has accepted that the Roman Catholic Church should have been informed of this, it is an issue that troubles her and one for which she apologised in the coroner's court. Whilst there is learning for individuals surrounding this decision it is also important that such issues are avoided in the future through the implementation of Recommendation 10. Systems must be put in place that give clear, unequivocal guidance on information sharing. It is important that this is not viewed as an individual mistake but one that requires systemic change.

6.8 It is helpful to give some context around the DST at this time. Interviews conducted by this review have revealed a team that was not fully functioning. Individuals were under immense stress because of work and personal private issues. There were issues between the Safeguarding Adviser (case worker) and Safeguarding Manager all of which impacted on the conduct of this case. Absence and staff leaving resulted in a decision to engage a safeguarding professional to conduct a review of some of the cases detailed in the Two Cities Report, this included Father Alan's case.

6.9 This individual was a retired police officer and has been described to the Reviewer by the family as a private investigator. Whilst those who commissioned this individual have described him as an independent safeguarding investigator this again underpins the importance of considering the language we use. It is the view of the family that what transpired was that an extremely vulnerable man (Father Alan), with little knowledge of what was being alleged was told that a private investigator, who was a retired police officer was now involved in the case. It is reasonable to assume that this must have heightened Father Alan's anxiety. For professionals involved in safeguarding it is imperative that they consider the impact all communications have on those they deal with. This is further evidence of the impact language has.

6.10 The engagement of this individual was an appropriate decision once it was decided to investigate the disclosure given about Father Alan. This investigation had 'stalled' and it was in Father Alan's best interests to progress it. In fact, the delays in dealing with major issues such as disclosure were having an adverse effect on him. Describing him as a Private Investigator was not good practice. This title increased Father Alan's anxiety.

6.11 Father Alan was now aware that he was the subject of inquiries by the DST. Having told them he was now a member of the Roman Catholic Church it is a fair assumption that he believed his current church authorities would be contacted. It is also clear that he did not know who or what this investigation involved.

6.12 In November 2019 details of the person staying with Father Alan were verified. Father Alan also submitted a Disclosure and Barring Service application.

6.13 On the 2nd December Father Alan attempted suicide by overdose. Whilst it is not possible for this review to know why Father Alan made this attempt it would be safe to conclude that having been informed he was the subject of a safeguarding investigation is likely to have had an adverse impact on his mental health. That said it is recorded that having received therapy between April and October 2020 he discussed his wish to get through the investigation. This review has found no evidence to suggest that the Church of England were aware of this attempted suicide.

6.14 In May and June 2020 Father Alan was contacted by the Roman Catholic safeguarding team. A decision had been taken not to provide details of the allegations being investigated but he was told that concerns raised by the Church of England would need to be addressed. Given the nature of the allegations it is difficult to understand why no disclosure was made. This decision may be addressed with reviews being conducted by the Roman Catholic Church but as the information was 'held' by the DST good practice would have been for them to lead on disclosure. The review understands that there are situations where disclosure needs to be carefully managed. However, in this case there were no other parties to consider, affording Father Alan the opportunity to consider the information would not have put anyone at risk and the behaviour described happened some nine years ago.

Recommendation 12 – This review should be used to refresh safeguarding professionals' understanding of risk regarding disclosure. Whilst the interests of complainants, witnesses and other vulnerable parties should always be considered this should not be done in isolation. The rights and welfare of those being investigated should also be considered. If decisions are made to withhold disclosure, then a detailed rationale should be recorded and risk assessment completed.

6.15 The impact of this lack of disclosure on Father Alan is further illustrated when, in early August 2020 Father Alan wrote to the case worker in the Roman Catholic Safeguarding team complaining about the lack of information he had received. This letter was sent some ten months after he was first contacted by the DST. Those in possession of the information had held it for at least eighteen months. The lack of progress made in this case could be attributed to a number of factors, this review will not speculate on them. What is clear is that nobody seemed to consider the impact this was having on Father Alan, there was a lack of management oversight and accountability for the process. The issues were simple, there were no significant enquiries to be made and therefore the investigation should have been concluded in a relatively short period of time.

6.16 On 2nd September following consultation between the two safeguarding teams Father Alan received a letter giving some disclosure, specifically wanting to discuss his HIV status and the safety of others and any involvement with 'rent boys'. There were then exchanges where Father Alan seeks legal advice, a meeting was arranged and then cancelled. The main issue continued to be a disagreement regarding disclosure. Father Alan is never spoken to about the information and no further disclosure is provided. The family point to the adverse

impact non-disclosure had on Father Alan's mental health, something this review has a great deal of sympathy for and believes was completely avoidable.

6.17 On 8th November Father Alan tragically took his own life.

6.18 The review has commented on the fact that the information given by the HOPs was not tested. It is important to record the fact that when interviewed he commented "Why didn't they come and check with me if they were going to start an investigation? Most of the conversation was about Cinnamon Street (Father Alan's home). Health and activities were asides, I never implied that Alan did anything illegal'. Whilst he was provided with notes of conversations to sign, accurate good practice would have been for a safeguarding professional to speak to him, consider the veracity of his account and test the information given.

Management of the Coronial Process and Response to the Regulation 28 Notice

7.1 An inquest was opened into the death of Father Alan in November 2020. Evidence was heard in front of Senior Coroner over a number of days in the summer of 2021. This review has spoken to the individual within the DST who dealt with enquiries from the coroner's office. This person was candid about mistakes made and highlighted the fact that the safeguarding team was understaffed with excessive workloads at the time. There is individual learning for this person which they acknowledge.

7.2 Of greater concern is the apparent indifference shown to aspects of the inquest by the Diocese of London. Whilst it is accepted that not all individuals concerned were aware of the inquest it was clear that Father Alan had taken his own life during a time when he believed himself to be under investigation for safeguarding issues. Whilst it could not be known if other factors were going to play a part it would have been relatively straight forward to recognise the fact that the court may seek to examine the part this investigation played in his death. As such the Diocese should have done all within its power to assist the court. It is the view of this review that the Diocese should have requested Interested Party status. This issue was raised but initially was declined on legal advice.

7.3 The family had requested disclosure from the Diocese prior to the inquest, this was never received. Witnesses were given little notice of the fact that they would be required to give evidence. Attending any court can be a daunting experience, particularly in such tragic circumstances. Those I have spoken to were given little support or advice on how proceedings would be conducted.

Recommendation 13 – A review of how requests from Coroners are managed should take place. Experienced individuals should be identified to be a single point of contact, including legal experts and all safeguarding staff to receive training on the coronial process, affording them the best opportunity to support inquests and those who are impacted by them.

7.4 It is also important to recognise that without the inquest it is unlikely that any learning review would have taken place. The coroner, having heard all the evidence issued a Regulation 28 prevention of further deaths notice. This notice was the catalyst for this review.

7.5 The Terms of Reference for this review require the Reviewer to examine the Diocese of London's handling of information relating to the late Father Alan Griffin in light of the ten specific concerns and three further issues set out in section 5 of the coroner's Regulation 28 report. To ensure this section of the TOR is complete the next section of the report will look at this part of the report specifically.

7.6 The Regulation 28 letter contains the following observations and comment from the coroner:

On 12 November 2020, one of my assistant coroners, Sarah Bourke, commenced an investigation into the death of Alan Howard Foster Griffin, aged 76 years. The investigation concluded at the end of the inquest on 2 July 2021. I made a narrative determination as follows. "Alan Griffin hanged himself at home on Sunday, 8 November 2020. He killed himself because he could not cope with an investigation into his conduct, the detail of and the source for which he had never been told'.

The investigation had been ongoing for over a year and was being conducted by his former Church of England diocese and subsequently also by his current Roman Catholic diocese (to whom the Church of England had passed a short, written summary of allegations that contained inaccuracies and omitted mention of Father Griffin's earlier suicide attempt on learning of his HIV status).

Father Griffin did not abuse children. He did not have sex with young people under the age of 18. He did not visit prostitutes. He did not endanger the lives of others by having sex with people whilst an HIV risk. And there was no evidence that he did any of these things. He was an HIV positive (viral load undetectable) gay priest. Death by suicide."

7.7 Section 5 of the document details the coroner's concerns. She writes that in her opinion, there is a risk that future deaths will occur unless action is taken. They are set out below and are accompanied by comment. Each of the areas detailed are the subject of wider analysis within this review.

- *The purpose of the meetings with the head of operations was not made clear to all who attended. The 42 entries ranged from descriptions of past convictions that had been dealt with and recorded, through current safeguarding concerns that might or might not have been acted upon, to what witnesses described as gossip. These 42 entries were not accompanied by signed statements setting out distinct allegations. The origin of the information in the entries was, in places, obvious and factual, but in places entirely nebulous.*

Comment – The HOps stated he believed he was having a casual conversation with colleagues as he exited the organisation. There is little evidence that the initial purpose of the meetings or the consequence of the information being passed was ever considered by the HOps or those interviewing him. This casual approach meant that whilst he was afforded the opportunity to check notes taken, he was never asked to make a formal statement. This review has reached the conclusion based on a number of interviews, that those interviewing him did not believe the information reached the threshold for such a formal step, specifically that the information given regarding Father Alan did not amount to any specific safeguarding allegation.

- *The head of operations' allegations were never clearly listed at the outset and appropriately verified with him. He told me in evidence that he had never alleged that Father Griffin had abused children. He said that he had never alleged that Father Griffin had sex with minors. And he said that he had never alleged that Father Griffin*

had sex whilst HIV+ and believing himself to be an infection risk. His recollection was confirmed by others who were present. Nevertheless, these were the allegations that were passed on to the Roman Catholic (RC) Church by the CofE. The head of operations told me that no safeguarding concern ever came to his attention regarding Father Griffin. His only concern for Father Griffin, he said, was that he was being bullied by parishioners. However, he did not mention this bullying in the meetings that formed the basis of the Two Cities report

Comment – The comments made by the coroner have found to be accurate and fair by this review. There is one issue and that is with the interpretation of the information passed to the Roman Catholic Church. Whilst this review accepts unreservedly that the way in which Father Alan was made aware of the information or allegation was not good practice it is important when considering the way future disclosures are dealt with that the Diocese of London considers the difference between allegations and information. The information being considered in Father Alan’s case did not amount to an ‘allegation’ that warranted the lack of disclosure given.

- *What the head of operations did say in his meetings in 2019 was that Father Griffin had told him he had “used rent boys,” which the head of operations understood to mean he had visited adult male prostitutes. The archdeacon emphasised the importance of this being Father Griffin’s phrase. The phrase appeared repeatedly throughout 2019/20 church documents relating to Father Griffin’s actions. Notwithstanding the view expressed to me by the head of operations that the phrase related to visiting adult male prostitutes, it formed the basis of the allegation of sex with minors. I put it to the director of HR & safeguarding that it is an unusual phrase to hear in 2021, and yet the term rent boys appeared elsewhere in the Two Cities Report. She told me that the head of operations had used the phrase from start to finish in the meetings that led to the entries in respect of the 42 members of the clergy in London & Westminster. However, she said in court that, as there was no record anywhere that the head of operations had described Father Griffin himself using this term, she now concluded that the head of operations had not actually said this. I recalled the head of operations on the last day of inquest to ask if it was possible that this had in fact been his own term rather than Father Griffin’s. He immediately said yes, the term was his term and Father Griffin had not used it. He said that Father Griffin had never used the term rent boys. He thought that Father Griffin was generous with hospitality and paid for meals out and perhaps he had misinterpreted that. He said that Father Griffin had never actually said that he had paid for sex. Yet in an investigation lasting over a year, the head of operations did not volunteer these details and nobody obtained them from him. I made a finding of fact at inquest that Father Griffin did not pay for sex.*

Comment – Again this review found the coroner assessment of this key issue to be wholly accurate. The HOPs confirmed when interviewed by the Reviewer that the term Rent Boy had been used by him and not Father Alan. This term is incredibly

misleading and should never have been used in these circumstances. Despite the inevitable connotation this phrase carries it was still being used by the DST when they passed information to their Roman Catholic Church. The fact that no apparent efforts were made to corroborate or dismiss this term was a missed opportunity.

The archdeacon told me that he had not wanted to ask questions of the head of operations in the meetings, even to check the source of the information he gave, for fear of interrupting his flow. The archdeacon was emphatic that he wanted the head of operations to get everything out. The way the archdeacon described the head of operations' brain dump meetings, seemed to me more akin to a description of the disclosures of a victim, rather than the recollections of a twenty-year career by a retiree. The archdeacon seemed to envisage that others might interview the head of operations at a later stage, but nobody thought that was needed. Thus, nobody fully explored what the head of operations actually meant when he volunteered his recollections; what he was actually alleging; and the source for his disclosures and any allegations.

Comment – This review has found that other than some questions regarding the age of the men Father Alan was alleged to have favoured as partners there was no evidence of any attempt to corroborate, prove or disprove the veracity of the information given by the HOps. This appears to stem largely from the fact that the wrong people were conducting the interviews. The failure to recognise this and employ safeguarding colleagues to deal with the interviews was a missed opportunity to make an informed assessment of the information being given at the earliest opportunity. If others were expected to conduct further interviews, then good practice would have been to ensure such interviews took place.

- *The head of operations said in evidence that he was simply giving information, it was not his decision what information was recorded, rather he left that to the archdeacon and the director of HR & safeguarding. The archdeacon told me that it was not his call to decide what was and what was not gossip, and so he had asked the director of HR & safeguarding to be present at subsequent meetings with the head of operations. The director of HR & safeguarding told me that it was not for her, but for the safeguarding professionals to make an independent assessment and to decide what allegations were investigated and how. The safeguarding manager said that she was invited to the meetings simply as a note taker and that she had recorded "Allegation is this person has HIV and with knowledge continued to sleep with people" because that is what the archdeacon wrote in his note of the first meeting with the head of operations, not because she had made an independent assessment of this. The archdeacon said that the first note was inaccurate, he knew it was inaccurate because it was hastily taken down, and that is why he had asked for a formal notetaker to attend subsequent meetings. However, the safeguarding manager said that nobody told her this, and on receipt of the document describing the allegation that he knew had not been made, the archdeacon did not correct the document, nor did the director of HR & safeguarding. The former police officer*

investigating said that the validity of allegations should be assessed, but that he was not at the original meetings. The safeguarding adviser said that decisions about how to proceed, such as engaging an investigator, had already been made by the time she was brought in to take action. Thus, nobody took responsibility for steering the direction of the process from start to finish and for making coherent, reasoned, evidence-based decisions that made sense in the context of the information that was available to the team as a whole.

Comment – The Coroner describes the lack of planning, structure, leadership and accountability that was present throughout the interview process. This review has found that the casual approach to the interviews undermined the process. What followed was a completely flawed process with a number of decisions being made based upon information obtained in a way that did not test its veracity or make it clear that action would follow. There was little evidence provided of good leadership or challenge that followed.

- *As I have indicated, the archdeacon told me that he placed great weight on the information given by the head of operations that Father Griffin had told the head of operations that he had used rent boys. However, regarding the record of “concerns of possible child exploitation”, the safeguarding manager told me that she had made a mistake, and that this phrase had been mistakenly copied and pasted from another entry. She did not believe that there was any evidence of sexual activity with a minor, nor any reason to investigate that, but her typographical error was never noted and corrected, either by her or by anyone else.*

Comment - The fact that there was no evidence that Father Alan had sexual activity with a minor is highlighted throughout this review.

- *The safeguarding manager recommended in the same document that legal advice should be sought before proceeding, but her recommendation was not acted upon. There was no record made of why this was not acted upon and the director of HR & safeguarding told me that legal advice should have been sought. There seemed no overarching, coherent strategy.*

Comment – There is some confusion regarding this point in the evidence provided to the review. Whilst the comments made above would indicate no advice was given this is contradicted by information passed to the reviewer. What is clear is that any advice that was received had no significant impact on Father Alan’s case. It did not result in a detailed strategy being formulated or even the more obvious decision to desist from any further action.

- *The safeguarding adviser who was tasked by the safeguarding manager with dealing with investigation, thought that an approach should be made to Father Griffin by a member of the clergy on a welfare basis. She told me she had thought that the church’s involvement should simply be about supporting a vulnerable man. She emailed the archdeacon asking him if the clergy could make an approach to Father Griffin, but such an approach did not take place, and so she herself spoke briefly to*

Father Griffin to make initial contact. During this brief conversation, Father Griffin explained that he was now a Roman Catholic priest, so the safeguarding adviser sent an email to her Roman Catholic safeguarding counterpart. The email disclosed Father Griffin's HIV status; it was inaccurate as to detail; it did not properly represent her view of the allegations; and it did not include reference to the fact that Father Griffin had attempted suicide when diagnosed as HIV+ approximately nine years earlier. She told me that the errors she made within this email were the consequence of her concurrent very difficult personal circumstances, in the context of short staffing. The email was seen by the archdeacon and the safeguarding manager before it was sent, but neither made any substantive amendment. Insufficient regard was paid to ensuring scrupulous accuracy, and completeness of relevant information, in the communication with a different organisation. There seemed almost to be a lack of recognition that the Roman Catholic Church was a different organisation.

Comment – The lack of challenge or oversight given prior to this information being shared with the Roman Catholic Church was a missed opportunity to recognise the fact that it should not have been sent to them. Good practice would have been for senior managers and / or clergy to meet with the safeguarding advisor and discuss the case. They should have given a clear indication that this information was not suitable to be shared in its current state. A decision should then have been taken to either take no further action or provide an investigation plan in any areas that warranted further action.

- The safeguarding adviser who contacted the Roman Catholic Church told me that she viewed Father Griffin's situation purely in terms of welfare and supporting a vulnerable man. She said she did not consider that there was any substance whatsoever to the allegations. However, she was a safeguarding officer and she contacted another safeguarding officer, disclosing confidential information, so this was treated as a safeguarding referral. If it was not meant to be a safeguarding referral, then the professionals dealing with the matter were the wrong people.

Comment – This review has found this observation to be of critical importance when considering the impact this process had on Father Alan. It is clear that he believed he was under investigation by the DST. The stress he was under was then compounded by the refusal to disclose the allegations / information by the Roman Catholic Church. The DST cannot absolve themselves of all responsibility on this point having supplied the information that was withheld. It is of paramount importance that the impact such investigations or perceived investigation have on those being investigated is considered and risk assessed. Investigations must be fair and balanced to all concerned.

- Thus, the allegations against Father Griffin passed on to the Roman Catholic Church were supported by no complainant, no witness and no accuser. There was no concern raised by a victim of abuse, by a child, parent, teacher, youth worker or other witness. No person said they had been or had witnessed any concerning behaviour, save that Father Griffin had been seen to have dinner with men in an Italian

restaurant, for which he might have paid the bill. The CofE safeguarding adviser finally tasked with dealing with the matter did not consider that there was any safeguarding concern. And yet on this basis, Alan Griffin found himself to be under investigation for over a year, without ever having the allegations and their source plainly set out for him.

Comment – This observation again is supported fully by this review. The length of time taken to deal with information that did not amount to an allegation is significant in this case, not least of all because of the impact it had on Father Alan. Processes must be put in place to ensure matters are dealt with expeditiously with appropriate review and oversight.

7.7 The Coroner, having detailed her matters of concern then made the following comments:

Usually, I find that I am able to summarise matters of concern succinctly. However, in this instance I find that I am unable to convey the breadth of the systemic and individual failings that have come to light during the course of this inquest without such a level of detail, and I am worried that if I do not include this detail then learning will be lost. This is particularly in the context of the lack of full engagement by the Church of England in the inquest process until June 2021. It is often the case that organisations have already themselves recognised their errors and have undertaken meaningful attempts at improvement by the time of the inquest. This was not the case here. It was only after the inquest had been resumed and part heard in May 2021, and witnesses from the Church of England had been called to give evidence in late June 2021, that the Church of England decided that a learning lessons review would be worthwhile. With the notable exception of the safeguarding advisor who was finally tasked with the investigation into Father Griffin, I found in the main that a lack of appropriately meaningful reflection had been undertaken by the witnesses from the Church of England. I then received submissions on behalf of the Church of England regarding any prevention of future deaths report. These submissions impressed upon me that referrals to child protection and safeguarding professionals must not be reduced and urged me not to include any concerns that may be taken as a criticism of clerics or staff for not filtering or verifying allegations. It seems to me that a duty of care and competence in a situation such as this one is not in any way incompatible with the moral duty, we all have, and the legal duty that bodies such as the church have, to try to keep children and the vulnerable safe. That this appears to be in issue for the Church of England confirmed my preliminary view that, reluctantly and unusually, I should write in the detail that I have in this report.

7.8 This review has already described its surprise at the apparent indifference displayed towards the coronial process. It is clear that the significance of this inquest was simply not recognised. Recommendations regarding training have been made earlier in this chapter.

7.9 The issue of balancing the need to encourage the referral of safeguarding issues against the rights of those accused or under investigation should, in the opinion of this review, never have been an issue. It only became an issue when the information was acted upon. The information received did not amount to an allegation that required an investigation to

be completed, therefore there was no risk to anyone including the person referred to in the disclosure. Whilst referrals or contact should be encouraged it is also of the utmost importance that those accused are treated with care and dignity. The simple issue is one of assessment / triage. People need to have confidence in a system that deals with such allegations in a fair and balanced manner. This information did not reach the threshold for investigation, it should have been assessed as such and no further action taken.

7.10 The Diocese of London has recognised the need for change and improvement in its safeguarding systems. Many of the issues outlined in the notice written by the coroner have been addressed in improvements detailed in section 9 of this report. These improvements coupled with recommendations made in this report and a desire for continuous improvement will provide the best opportunity to ensure these circumstances do not repeat themselves.

7.11 A similar document was sent to the Roman Catholic Church by the coroner. This review is not commissioned to comment on the practice of the Roman Catholic Church safeguarding team. That said it is clear that there is learning for both safeguarding teams, individually and as a collective. Recommendations have already been made to improve information exchange, recognising the impact non-disclosure has on those under investigation. In addition to the recommendations already made the following should be considered.

Recommendation 14 – Both the DST and Roman Catholic safeguarding teams undertake a joint de-brief and reflective learning session regarding this case.

The Impact of Culture

8.1 This review has spoken to a number of individuals who would see themselves as belonging to the Church of England community. The Independent Reviewer has been struck by the wide range of cultural differences and stances on key issues that have been exposed to him during interviews and on examination of the facts of this case.

8.2 Whilst it is important that this review does not seek to offend individuals it would be inappropriate not to mention some cultural aspects that have clearly affected this case. The Reviewer is conscious that people hold strong and sometimes very differing beliefs but it is only through examining the impact of these that learning can be maximised.

8.3 **Homosexuality** – Father Alan was a gay man. This review is clear from many of the interviews conducted that the Church of England and many of its members have a less than transparent view on matters relating to sexuality or sexual orientation. The fact that the official position is less than clear (see for example ‘Issues in Human Sexuality’ and also evidence given to Independent Inquiry into Child Sexual Abuse by the former Archbishop Rowan Williams) means that matters are not able to be discussed openly and issues around lifestyle are often avoided, when sometimes they need to be addressed. It is clear from interviews that such issues impacted on this case, with an apparent discomfort to discuss Father Alan’s lifestyle other than in the form of misguided hearsay and biased supposition. This review is of the view that, especially in a community of faith, honest conversations are crucial particularly when it comes to dealing with sensitive matters relating to wellbeing.

8.4 There are some within the Church who do not accept homosexual relationships at all, others are more liberal with views varying from partial to complete acceptance. This variance of views has been apparent throughout this review process. It is clear that this culture of mixed messages, with some views bordering on complete intolerance impacted the way Father Alan lived his life. It is also the opinion of the Reviewer in this case that the current culture impacted on the way he was dealt with.

8.5 The initial disclosure given to the Archdeacon was full of supposition and interpretation that was influenced by Father Alan’s sexual orientation. Terms such as rent boy, always having a different man on his arm, being a risk to others because of his HIV status and the presumption that he would have a short life expectancy all fall out of individuals’ views of his sexual orientation. The review has not seen evidence of overt homophobia but it is clear that there was a great deal of bias, sometimes unconscious, around decisions made in this case. This bias was a result of underlying homophobia that influenced decisions made. It is perhaps too simple to ask what would have happened if Father Alan had been heterosexual but is also difficult to envisage the DST being tasked with investigating a priest who enjoyed the company of a number of women unless of course there were questions regarding vulnerability of those people or abuse of power on the part of the priest. The way in which the information was given, assessed and acted upon was influenced by individuals’ views of his sexual orientation.

8.6 The fact that gay men and women are uncomfortable exposing their sexual orientation within the church community brings with it many issues. Personal privacy should always be respected but the reality is, as illustrated in this case, it can result in unwarranted assumptions and hurtful behaviour. It may also prevent individuals seeking counsel and pastoral care for themselves. Father Alan, having been diagnosed as HIV+ clearly did not want the wider church to be aware. This is completely understandable but this review has also considered if the prevailing attitude of the church with regard to homosexuality impacted on his decision. He was in a vulnerable position, one in which support may have assisted him. The depth and breadth of support, understanding and pastoral care was limited because of his sexual orientation.

8.7 As previously stated, this is far too great an issue for this review to deal with in any great detail. That said it is imperative that the Diocese of London considers the impact bias towards people because of any difference, including those who are LGBT+, has on the work they do.

Recommendation 15 – The Diocese of London and the Church of England evaluates training given on anti-discriminatory practice. This should include unconscious bias. A mandatory training package should be developed and delivered to encourage non-discriminatory practice.

8.8 It is also important to recognise ongoing work by the Church of England in this key area. The 'Living in Love and Faith' project evidences commitment to a more open discussion regarding human sexuality. This review has been advised by senior clergy that it is clear that the Canons (ecclesiastical law) of the Church of England state that marriage is between one man and one woman. Within the Church of England there are those who believe that this rules out any other form of sexual relationship for Christians. They interpret the Bible as affirming that view. There are others within the church who take a different line, believing that life-long monogamous relationships between people of the same sex can be equally lifegiving and equally reflect God's will for the flourishing of human beings as expressed through the scriptures. The legacy of these differences, coupled with the reality that there are LGBT+ clergy and lay people in the Church of England, has led to the Church of England's current official stance.

8.9 Recognising the significance of these issues and the differences of belief and practice which exist alongside the canon law relating to marriage, the Church of England has initiated a listening and learning exercise, the Living in Love and Faith Project. This has involved producing a range of resources exploring 'Christian Teaching and Learning about Identity, Sexuality, Relationships and Marriage' from biblical, theological, historical and scientific perspectives. The project was launched across the whole of the Church of England in November 2020, and churches have been using the book, course, films, podcasts and library to explore the issues. There has been a national process of collating feedback from the whole church, the closing date for which has just passed. The College of Bishops, House of Bishops and General Synod will now take this project forward and propose ways in which the Church of England might agree a direction of travel for the future.

8.10 When the Living in Love and Faith Project was launched in November 2020, the Bishop of London offered to meet with any groups in the Diocese who felt particularly vulnerable in relation to the public conversation. One of the groups which responded to that invitation is made up of clergy who identify as LGBT+. During meetings with this group a proposal emerged from conversations which was to form an LGBT+ Advisory group for the Diocese. The purpose of this group would be to look at the impact of diocesan processes and practices on the pastoral care and sense of belonging of LGBT+ people. At the time of writing this review, one LGBT+ member of clergy from each Area of the Diocese has been asked to join the group, which will be chaired jointly by an Archdeacon and an LGBT+ member of clergy. The group will raise issues relating to the pastoral impact of diocesan processes and practices and those issues will be taken to the College of Bishops and Senior Staff group of the Diocese for consideration.

Comment – This group may be an appropriate advisory group to enhance any actions taken on a number of the recommendations made in this review, particularly Recommendation 15. The formation of the group is good practice and offers a real opportunity to enter into positive dialogue with the LGBT+ community.

8.11 **The relationship between senior clergy and parish priests** – The structure of the Church of England hierarchy appears on the face of it quite straight forward. Bishops are appointed as leads for geographic areas (or on specific areas of ministry), archdeacons support the bishops and parish priests are responsible for their own specific areas. It is of course more complicated with other roles taking on various responsibilities. However, having spoken to a number of clergy across all levels of responsibility it is clear that this hierarchy depends completely on the relationship between senior clergy and parish priests. This review heard on more than one occasion that parish priests were ‘in charge of their own parish and did not have to do what the bishop said’. Again, it is not for this review to comment on the leadership structure of the Church of England but the impact it has had in this case cannot be ignored.

8.12 A decision was taken at the highest level to engage in a process that resulted in a report being compiled that detailed information about forty-two individuals. This report, which included Father Alan, has resulted in a number of individuals coming to an adverse view of the senior leadership within the Diocese of London. The rationale for what appears to be a deep-seated mistrust varies widely. It is apparent that there is some opposition to women being ordained into senior positions with individuals simply not willing to accept the leadership of a woman or the ministry of a female bishop. Whilst this is a factor in some cases, what is far more apparent is that there was and continues to have been a significant breakdown in communication between senior leaders, those directly involved and the wider church community. This is further illustrated by confusion regarding input of the clergy in the TOR for this review. The review has been informed that some of those named within the Two Cities Report were promised they would be consulted. This information was passed to the steering group who took the decision not to engage in this consultation exercise. This decision was not communicated to all the individuals concerned (representation has been made that the decision was passed on to some individuals) who now wrongly see it as a ‘broken promise’ by a senior leader. In fact, this review has been told that the leader

involved challenged the decision but the process still did not take place. There is some confusion as to how this situation came about but the result is the same. This breakdown has fuelled the mistrust to a point where even the smallest of issues are raised to an extraordinary level. If the impact of the Two Cities Report is to be learned from then it is important that there is a shift in culture and expectation on both sides. Those in senior leadership positions have to make difficult, often unpopular decisions. This has to be accepted by those who work with or for them. They then have to be prepared to provide an open, honest rationale for those decisions and engage with those who are affected as a result. Parish priests should consider the impact of their behaviour across the wider church. They are leaders within their parish but their actions will often have a wider impact, they should be mindful of the fact they are part of a wider organisation and as such should promote a shared ethos wherever possible. Accountability for actions, behaviour and decisions taken at all levels is crucial for a culture of confidence at all levels of an organisation.

Comment – The introduction of a new Bishop of London who has promoted change and increased accountability appears to have resulted in the resignation of the HOPs and some significant resentment amongst clergy within the London Diocese. Change often brings challenge that can impact in a positive or negative way. This review believes that the Two Cities Report has fuelled resentment, adding to uncertainty amongst a group who had functioned in a very different way under the guidance of the previous Bishop. It is important that accountability is felt across the entire diocese and that change is given an opportunity to improve practice.

Recommendation 16 – The Diocese of London considers the learning from the commission of the Two Cities Report. Learning should include exchange of information between decision makers and those affected. It should also highlight why decisions were made and at what seniority. This process should be aimed at rebuilding trust and ensuring that all involved understand the responsibilities individuals have in their day-to-day roles.

8.13 **Pastoral Care** – One significant issue that was apparent in this case was the lack of pastoral care provided to Father Alan at several points. The review has found that there were significant missed opportunities to offer pastoral care to a man who was vulnerable. The HOPs described Father Alan as a man who was lonely and received little support from fellow priests. If this was, as described, the view of him then support should have been offered. This became even more important when his HIV status was known. Such support can be discreet and would have afforded an opportunity to be supported with his HIV diagnosis.

8.14 Further opportunities to support Father Alan were missed when he was informed, he was under investigation. The case worker recognised this and suggested that any conversations with him should be conducted by a member of the clergy. At this point Father Alan was in an extremely vulnerable situation and every effort should have been made to ensure he received appropriate support. It is simply not good enough to say ‘he was a member of the Roman Catholic Church’, every effort should have been made to ensure he was being supported. This could have been done through a co-ordinated

approach or by the Church of England had the advice of the case officer been taken and Father Alan been spoken to by clergy regarding the information.

Recommendation 17 – All safeguarding investigations should include a risk assessment that considers the creation of a written plan for pastoral care for the person being investigated.

8.15 Protect the reputation of the church and its senior leaders at all costs – The view that the Church of England takes a position that its primary concern should be to protect its reputation and that of its senior leaders has been offered to this review. It is understandable that aspects of the case involving Father Alan could give rise to this view. The fact that it took the issuing of a Regulation 28 notice to recognise the need to produce a formal review is in itself concerning. The lack of engagement in the inquest process and lack of disclosure to the family has given credence to the view that the Church did not consider this matter worthy of further investigation or review. Whilst this review cannot say this decision was based on an attempt to prevent damage to the Church's reputation, it does have sympathy with those who are of that opinion. It is important to note that since being commissioned the Reviewer has seen no evidence of the diocese trying to protect its reputation. In fact, the openness of individuals interviewed and the review group who oversaw the process has indicated a genuine appetite to acknowledge that lessons need to be learned if improvements are to be made.

8.16 Leadership – It is essential that the Church has strong, experienced leaders who are capable of making informed decisions. There is evidence of a lack of leadership in many aspects of this case. Decisions made regarding the conduct of the interview, assessment of the information provided, sharing of the information internally and externally, contact with Father Alan, support / supervision of junior staff and the coronial process have already been discussed. It is apparent that leaders either took wrong decisions or simply hid from plain view when asked to lead. There was no co-ordinated strategy, no risk assessment and little evidence of taking responsibility. It is accepted that leaders make wrong decisions, good leaders learn from them.

Comment – it is important that leaders are offered opportunities to reflect on their own performance. This clinical reflection time is essential to development and improvement.

8.17 Challenge – It is apparent that there was prevailing culture where challenge was not seen to be a positive influence in the DST. This review has been informed that this lack of challenge impacted practice and decision making, or where information was shared with senior colleagues about complex or high risk or high-profile cases, or difficult decisions. There have been significant improvements made in this key area with steps being taken to embed culture change, specifically measures that will value communication, challenge, and learning. This is evidence of positive change.

Improvements Already Made

9.1 This review was commissioned some considerable time after the death of Father Alan, primarily as a result of the Regulation 28 notice served by HM Coroner. Whilst the review contains a number of recommendations and comments aimed at improving practice for the future it should be recognised that the Diocese of London has already made significant changes with a view to improving service provision. It has not waited for this review; indeed, the review has been informed that some of the improvements were being put in place prior to the inquest into Father Alan's death, this is at odds with the commentary given by the coroner in her Regulation 28 notice. This review acknowledges that much of this change has been driven by many of the same senior leaders who were in place when decisions were made that led to this review. It is accepted that mistakes were made and improvement was necessary, this is good practice on their part. The review was provided with a large amount of material that shows briefings and efforts being made to ensure improvements were considered and prioritised. The paragraphs below summarise the key changes made.

9.2 It is clear that at the time of the interview with the HOs and subsequent investigation into Father Alan the safeguarding team was not appropriately resourced. A significant member of staff left the team having been offered better remuneration by an external agency and this left others overwhelmed with work, some felt unsupported. The team was certainly not fully resourced at the time of the inquest. As a result, since the summer of 2021 vacancies have been filled and in addition the Trustees have agreed to substantially increase the number of staff in Safeguarding.

9.3 Initial changes made and plans to improve systems and practice appear to have been the result of a number of cases in which the Director of HR and Safeguarding had become aware of the need for significant practice and systems improvement. This has resulted in an uplift of staff and the creation of a Head of Safeguarding role. This role is key to service improvement and is evidence of good practice and positive change by the diocese. It is apparent that the need for improvement had already been recognised prior to the inquest into Father Alan's death. This review believes that the interpretation of the coroner may be, in part, based on the lack of improvement plan associated with Father Alan's case. It is clear that this case was not singled out as an opportunity to learn prior to inquest.

9.4 Other improvements identified by the DST as having been put in place prior to receipt of this report include:

- The development of a referral/triage system, with supervision from the Head of Safeguarding. This will ensure that matters are separated out into safeguarding, non-safeguarding conduct. Initial and ongoing assessment of risk (including mental health) are carried out with appropriate follow up action by a designated case holder.
- The development of a casework management tracking system for all referrals into the safeguarding team to record timely progress against key milestones and ensure a

structured review process (including risk and mental health) during the lifetime of a case.

- Delivering additional GDPR training specific to safeguarding to ensure staff in the Diocesan Safeguarding Team are competent and confident to ensure information that is shared is recorded and audited, and that the principles of information sharing are applied lawfully and proportionately. In due course this will be delivered to senior staff involved in handling personal and safeguarding related data to support their practice and decision making.
- The development of an overarching improvement plan to include medium/longer term lessons learned/ Past Case Review 2 recommendations and recommendations from other reviews.
- Improved operational practice standards including improved Core group practice, oversight of all safeguarding agreements and timely review, the implementation of daily operations meeting to review the previous day's referrals and any specific case issues, fortnightly team meeting to consult, embed learning and good practice, communication plan to highlight good practice including a Monthly Safeguarding newsletter and in consultation with key stakeholders, safeguarding webpages renewed, a programme of DSA led parish safeguarding audits and the implementation of the Parish Safeguarding Dashboard (used by 27 dioceses).

9.5 This review has spoken with the new Head of Safeguarding and they are keen to receive the learning from this review. Perhaps the most important information offered to the review by this individual was the recognition that change was required and continuous improvement had to be central to a new culture within the DST.

Conclusion

10.1 This review has examined the circumstances that preceded the tragic death of Father Alan Griffin, specifically the conduct of an investigation carried out by the London Diocese Safeguarding Team. The primary purpose of the review is to identify learning in an attempt to improve practice and minimise the chance of these circumstances recurring.

10.2 The review has found that there are significant areas of learning for the Diocese of London and Church of England. A total of seventeen recommendations have been made but it is hoped that learning can also be gained from reading the report, studying the circumstances and understanding the wider cultural issues that prevail within the Church.

10.3 Some of the observations offered may be seen as direct criticism of individuals. Whilst the review is clear that there is learning for individuals involved in this case it should be recognised by the reader that systemic learning will provide the basis for greater improvement. It is hoped that the recommendations made will improve practice across the entire Diocese rather than simply improving individuals' practice.

10.4 Recommendations may lead to changes in policy and practice but it is important that the Diocese then considers the outcome of these changes, the 'so what' question needs to provide consistent challenge if learning and positive change are to have true impact. This review would encourage the entire Church community to learn from Father Alan's death.

Chris Robson

Independent Reviewer

Recommendations

<p>Recommendation 1 – The Diocese of London should ensure that all staff who are employed by role holders including Bishops, Archdeacons and others who have a private office are the subject of safer recruitment. They should have job descriptions, terms of employment and all other employment rights and conditions afforded to those who are employed by the wider organisation. Their position should be known to the wider church community and they should be recruited in an open and transparent manner. They should be aware of whom they are accountable to and have clear line of supervision and support.</p>
<p>Recommendation 2 – The Bishop of London should refer the issue detailed in recommendation 1 to the House of Bishops to seek assurance that National policy and guidance is being delivered in the key area set of recruitment. The House of Bishops should consider reminding the wider Church of the need to be aware of and to use existing guidance.</p>
<p>Recommendation 3 – Where information that has the potential to impact on safeguarding is known then it should be referred to the safeguarding team for assessment. Once this assessment is complete safeguarding protocol must be adhered to with appropriate meetings, planning, investigation and oversight being put in place. This should not be deviated from on the basis of an individual’s position within the organisation.</p>
<p>Recommendation 4 – There should be guidance provided by the Diocese of London detailing when to refer matters to safeguarding professionals, including the DST. This should refer to and promote National Guidance that is already in existence. Any guidance should encourage referrals and dialogue with safeguarding professionals so appropriate advice can be sought. This is particularly important when considering conduct and discipline matters v safeguarding referrals.</p>
<p>Recommendation 5 – The Diocese of London should now destroy all copies of the Two Cities Report, retaining only one ‘master copy’ whilst litigation / complaints are considered by those named in it. Where any information is retained about an individual, other than in the master copy, that person should be informed of what information has been retained, where it is held and for what purpose. Each of the forty-two mentioned within the report should receive a letter confirming the destruction of the report, details of information retained about them or confirmation that no information is retained.</p>
<p>Recommendation 6 – The Diocese of London and wider church should consider producing a means of delivering the following fundamental message. If any employee, volunteer or person otherwise associated with the Church of England discloses significant illness they should be offered support and help. Their disclosures should be dealt with discreetly and not disclosed without their express permission. People should guard against making ill-informed judgements and treat individuals with respect and compassion. Whilst the review acknowledges that these are values many people use daily it is important that lessons are learned from this case and these values are re-enforced.</p>
<p>Recommendation 7 – The Diocese of London and the wider church develops a training package that can be used to inform people of the impact language can have. This package should inform the whole church community of how the language we use can have a negative impact on people’s perception. This is particularly important to those who lead and guide us. In this case terms including ‘rent boys’ ‘different man on his arm’ and ‘young man’ invoke unjustified emotional responses from some. These examples can be used and developed into other areas where our language can have a disproportionate effect on others.</p>
<p>Recommendation 8 – The Diocese of London and wider church should complete an audit of its current safeguarding professionals. This audit should include previous professional background and diversity characteristics including race, gender and sexuality. The results of this audit should shape future recruitment strategy.</p>
<p>Recommendation 9 – The DST develops and publishes a threshold document for referrals. This document should include the guidance on information required to assess what action is required.</p>

Further policy and guidance documents should set out how investigations will be carried out. These should include details such as strategy discussions, referrals to other professional bodies, recording information and standards for investigation.

Recommendation 10 – The Church of England issues guidance to safeguarding teams regarding minimum standards for information exchange. This should include ‘sign off’ by a suitable safeguarding lead. The Church of England should also support the development of Information Sharing Agreements with other professional bodies.

Recommendation 11 – The London Diocese should commission a GDPR expert to consider the legality of retaining information passed by the HOps. This should extend to the Two Cities report. Its conclusions should be considered in the training now offered to the DST and wider church community.

Recommendation 12 – This review should be used to refresh safeguarding professionals’ understanding of risk regarding disclosure. Whilst the interests of complainants, witnesses and other vulnerable parties should always be considered this should not be done in isolation. The rights and welfare of those being investigated should also be considered. If decisions are made to withhold disclosure, then a detailed rationale should be recorded and risk assessment completed.

Recommendation 13 – A review of how requests from Coroners are managed should take place. Experienced individuals should be identified to be a single point of contact and all safeguarding staff to receive training on the coronial process, affording them the best opportunity to support inquests and those who are impacted by them.

Recommendation 14 – Both the DST and Roman Catholic safeguarding teams undertake a joint de-brief and reflective learning session regarding this case.

Recommendation 15 – The Diocese of London and the Church of England evaluates training given on anti-discriminatory practice. This should include unconscious bias. A mandatory training package should be developed and delivered to encourage non-discriminatory practice.

Recommendation 16 – The Diocese of London considers the learning from the commission of the Two Cities Report. Learning should include exchange of information between decision makers and those affected. It should also highlight why decisions were made and at what seniority. This process should be aimed at rebuilding trust and ensuring that all involved understand the responsibilities individuals have in their day-to-day roles.

Recommendation 17 – All safeguarding investigations should include a risk assessment that considers the creation of written plan for pastoral care for the person being investigated.