Regulation 28: Prevention of Future Deaths report

Alan Howard Foster GRIFFIN (died 08.11.20)

THIS REPORT IS BEING SENT TO:

1.

Chair
Catholic Standards Safeguarding Agency
39 Eccleston Square
London SW1V 1BX

1 CORONER

I am: Coroner ME Hassell

Senior Coroner Inner North London

St Pancras Coroner's Court

Camley Street London N1C 4PP

2 | CORONER'S LEGAL POWERS

I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.

3 INVESTIGATION and INQUEST

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."

4 CIRCUMSTANCES OF THE DEATH

Information was passed to a diocesan safeguarding adviser of the Roman Catholic Diocese of Westminster, by a diocesan safeguarding adviser of the Church of England Diocese of London & Westminster, regarding Alan Griffin. Father Griffin had previously left the Church of England and had taken holy orders in the Roman Catholic Church. After receipt of some information, the Roman Catholic safeguarding team investigated.

5 CORONER'S CONCERNS

During the course of the inquest, the evidence revealed matters giving rise to concern. In my opinion, there is a risk that future deaths will occur unless action is taken. In the circumstances, it is my statutory duty to report to you.

The MATTERS OF CONCERN are as follows.

 The safeguarding team of the Roman Catholic Diocese of Westminster did not exercise sufficient professional scrutiny of the allegations that came to them from the Anglican safeguarding team. This was partly because they gained a false sense of security from the fact that the allegations came from the Church of England.

However, there was more that could have been done to establish the exact nature of the allegations and whether these were credible. The Catholic safeguarding team asked for disclosure from the Anglican safeguarding team and most particularly for the source of the allegations. When they did not receive either of these, they should have insisted.

The Catholic safeguarding team met with Father Griffin on 23
June 2020 to discuss his DBS check. That would have been an
ideal opportunity to discuss the Church of England allegations that
would have shortened the process considerably and the
opportunity was lost.

- 3. Father Griffin then asked to know the allegations against him before he attended another meeting with the Catholic safeguarding team. The safeguarding team felt that the information was not theirs to give because it came from the Church of England, but Father Griffin should have been provided with a note of the allegations promptly.
- 4. The Roman Catholic Diocese of Westminster was unaware of Father Griffin's attempted suicide nine years earlier. However, it could still have been more proactive than it was in ensuring that he had maximum pastoral support.
- 5. The Catholic safeguarding team volunteered at inquest that they did not deal with the investigation into Father Griffin promptly and they apologised for this. The very first telephone call was placed to the Catholic safeguarding adviser on 30 October 2019. The delay was therefore significant and it was harmful.

This was in part because the Catholic safeguarding team were waiting for the engagement of the Anglican safeguarding team to enable a joint approach to be taken. When it was clear that such engagement was not forthcoming (whether for reasons of sickness or anything else), the Catholic safeguarding team should have gone back to the local authority designated officer (the LADO) and recommended that they continue without further input from the Church of England.

6 ACTION SHOULD BE TAKEN

In my opinion, action should be taken to prevent future deaths and I believe that you have the power to take such action.

7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 3 September 2021. I, the coroner, may extend the period.

Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.

8 COPIES and PUBLICATION

I have sent a copy of my report to the following.

- , sister in law of Father Griffin , partner of Father Griffin , friends
- Most Revd Justin Welby, CofE Archbishop of Canterbury
- formerly of the CofE Diocese
- , formerly of the CofE Diocese
- Cardinal Vincent Nichols, RC Archbishop of Westminster
- HHJ Thomas Teague QC, Chief Coroner of England & Wales

I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest.

The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response.

9 DATE

SIGNED BY SENIOR CORONER

09.07.21

ME Hassell