Regulation 28: Prevention of Future Deaths report

Alan Howard Foster GRIFFIN (died 08.11.20)

	THIS REPORT IS BEING SENT TO: **1. Most Reverend Justin Welby** **Archbishop of Canterbury** **Church of England** **Lambeth Palace** **London SE1 7JU**
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** The investigation into Father Griffin began because the head of operations of the Anglican Diocese of London & Westminster was retiring in 2019, and suggested to his archdeacon that he undertake a “brain dump” of information he had acquired over the preceding 20 years. The archdeacon agreed. The two met in early February 2019, and then subsequently with the director of human resources (HR) & safeguarding, and a note taker. The head of operations’ recollections were used to create a document called the Two Cities audit report 2019, describing 42 members of the clergy of the London & Westminster Diocese of the Church of England (CofE).
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. 1. 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. 2. 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.

3. 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.

4. 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.

5. 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.

6. 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.

7. 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.

8. 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.

9. 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.

10. 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 the subject of 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.

It is rare that I write at such length in a prevention of future deaths report.

	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.
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. • [redacted], sister in law of Father Griffin • [redacted], partner of Father Griffin • [redacted], friends • [redacted], formerly of the CofE Diocese • [redacted], formerly of the CofE Diocese • [redacted], chair, Catholic Standards Safeguarding Agency • [redacted], chair, Charity Commission for England & Wales • 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*