CATHOLIC SAFEGUARDING STANDARDS AGENCY (CSSA)

Diocese of Hexham and Newcastle Safeguarding Review Report

June 2023

Contents

Introduction

The Catholic Safeguarding Standards Agency (CSSA) review of safeguarding in the Diocese of Hexham and Newcastle was commissioned by the Apostolic Administrator, Archbishop Malcolm McMahon, after discussion with the CSSA. It was prompted by reported safeguarding concerns that had been made separately to the Archbishop and CSSA. Those discussions occurred following the resignation of the Diocesan Bishop, Robert Byrne C.O.

The CSSA welcomed this request for an independent report and the Archbishop's subsequent agreement to publish in full, the CSSA findings. We believe this represents an example of the transparency and openness reflected in the Independent Inquiry into Child Sexual Abuse (IICSA) Roman Catholic Church Investigation Report 2020.

CSSA work in Hexham and Newcastle was in two stages. The first stage was to conduct an audit of current safeguarding practice against our agreed 8 standards. This audit provided sufficient evidence to demonstrate that, whilst there are a number of areas for further improvement, current safeguarding practice meets the minimum standards. This is a new process for the Catholic Church in England and Wales and as such dioceses would not be expected to achieve the highest grades at this point. The CSSA does however expect dioceses to reach minimum standards and to produce an action plan detailing how they will achieve those higher standards.

Part Two of this report examines leadership, governance and culture specifically related to the tenure of Bishop Byrne. It deals with issues raised by a number of individuals from the diocese. This section of the report raises serious issues in relation to the way in which safeguarding professionals and process, both in specific cases but also more widely, were undermined. This led to people being put at risk of harm. Failure of leadership ultimately means failure of safeguarding. Our report outlines both the strengths of the safeguarding team and the leadership failures. It should be read, as such, in its entirety.

At the outset of the Review, the Chair of CSSA, Nazir Afzal OBE stated that, "there should be no doubt that we will leave no stone unturned when it comes to keeping people safe, and this includes investigating the safeguarding culture in Hexham and Newcastle".

There are also two separate independent reviews. A review requested by the Dicastery for Bishops via the Papal Nuncio[1] and a review by the Charity Commission. These reviews are being conducted in isolation of this Review.

[1] Papal Nuncio is defined as a diplomatic representative of the Pope having ambassadorial status.

Scope & Methodology

The Review was undertaken in accordance with a Terms of Reference developed by CSSA and agreed with Archbishop McMahon. The CSSA Chief Executive Officer, Stephen Ashley, met with the trustees of the Diocese on the 18th January 2023 who unanimously agreed the Terms of Reference as set out.

The full Terms of Reference are included in Appendix A and provide an overall purpose of examining "the culture, governance, processes and practice of safeguarding in the Diocese of Hexham and Newcastle". This Review incorporated a baseline audit and an assessment against each of the eight national safeguarding standards established by the CSSA and agreed by the Bishops' Conference of England and Wales[3]. The 'baseline audit' is a process developed by the CSSA and as such is a new methodology for the Catholic Church in England and Wales. The CSSA is currently nearing the end of a pilot scheme using this base line audit process.

CSSA made a call for information, which resulted in a number of people coming forward to share their experiences of safeguarding in the Diocese, both in writing and through telephone calls, virtual and in-person meetings.

Audit fieldwork began on Monday 23rd January 2023, and, in view of this short timeframe, no self-assessment was requested of the diocese. Information was therefore derived from the following sources of information:

Interviews

In person, virtual or telephone interviews were undertaken with a wide range of Diocesan personnel and stakeholders, of which full details are provided in Appendix B. Others were spoken with in the course of the Review or having responded to the public call for information. Material gained from these sources has informed the Review, but will not be directly cited, in order to preserve individual anonymity.

Focus groups

Two virtual focus groups were completed during the week commencing 23rd January, one for parish safeguarding representatives and one for clergy. These were attended by five and six representatives, respectively. Reviewers would like to thank attendees for their participation at short notice.

Meeting observation

A member of the Review team attended the Diocese of Hexham and Newcastle's Diocesan Trustee Safeguarding Committee meeting on Wednesday 8th March 2023, as an observer.

[3] The Catholic Bishops' Conference of England and Wales is the permanent assembly of Catholic Bishops and Personal Ordinaries in the two member countries.

Surveys

In order to capture the perspectives of as many individuals within the Diocese as possible, links to anonymous online surveys were sent to all parish safeguarding representatives and clergy (priests and deacons). A paper version was also made available to the small number of parish safeguarding representatives who did not have an email address.

The survey was open during late January and February. Responses were received from 62 members of the clergy and 82 parish safeguarding representatives, both of which represent a little under half of the total. Findings are included throughout the report and more detailed reports have been provided to the diocese.

Case audits

There were 44 safeguarding cases that had been opened and managed by the Diocesan safeguarding team that had been reported within the agreed timeframe. CSSA quality assurance analysts undertook 11 full audits of safeguarding cases. This represents 25% of the cases opened during this period. Cases were picked to provide a broad sample of the types of cases managed by the safeguarding team.

Cases audits were primarily completed through review of the PAMIS electronic case management system used by the Diocese, although paper files were also accessed for some older records. Where additional context was required, auditors spoke with case workers. Individual case audits[2] were completed, with a summary of grades provided in Appendix C. Audit reports have been separately provided to the Diocese. Findings from case audits are included throughout the following report.

All 22 safeguarding plans[3] in place, as of the 22nd January 2023, were reviewed as part of a separate exercise, with the findings primarily referenced under Standard 5 (Management and support of allegations), below.

Three analysts were involved in this element of the Review, with reports moderated by the Quality Assurance Manager, in order to ensure consistency.

Document review

Throughout the Review process the Diocese of Hexham and Newcastle have been requested to supply a range of documents in order to evidence how they implement the safeguarding standards. Other documents have been specifically requested to triangulate information received from other sources. Documents received are recorded in Appendix D.

Statement of Bishop Robert Byrne

Bishop Robert Byrne provided a significant statement in response to a number of written questions asked of him by the Review Team. He was invited to provide a written response and did so insofar as he was able. In the course of his response, he confirmed:

[2] Case audit reviews files for evidence of compliance with relevant policy and practice standards in addition to considering the quality of the work undertaken in achieving positive outcomes and ensuring that those at risk are suitably safeguarded.

[3] A safeguarding plan is a set of agreed actions and strategies designed to manage on-going risk of abuse.

"I take this opportunity to state that I fully support the aims and work of the CSSA. I share their commitment to safeguarding standards which are for the benefit of all within the Church. This has always been and remains my position."

Diocesan Context

The Diocese of Hexham and Newcastle is situated in the north-east of England and consists of the whole of Northumberland and County Durham, together with Hartlepool, Darlington and part of Stockton-on-Tees. This places the Diocese amongst the larger, geographically; with the most populous areas being the cities of Newcastle and Sunderland, toward the centre of the diocese. The diocese consists of 135 parishes (including 173 churches), which are organised into 18 parish partnerships and five episcopal areas. Parishes are served by approximately 112 priests and 42 deacons, with some of the 32 retired priests also providing supply ministry. The Bishop is supported by a Vicar General and six episcopal vicars, the latter each having responsibility for a parish partnership and a thematic area, for instance the care of the clergy.

The diocesan safeguarding team are based at the curial office in Newcastle and consist of a Safeguarding Coordinator, a safeguarding advisor and three administrators. There has been significant changes in personnel during the last 15 months, including periods with fewer staff members, which will be cited as a factor within this report for some areas in which performance has not been as expected. The geographical extent of the diocese is such that the teamwork with 10 local authorities and 3 police force areas.

The history of the Safeguarding Coordinator role is of some relevance to elements of this Review. The four post-holders were in role during the following dates and are referred to by number within the case studies:

Safeguarding Coordinator 1 (until 2009)
Safeguarding Coordinator 2 (2009 – 2017)
Safeguarding Coordinator 3 (2017 – 2021)
Safeguarding Coordinator 4 (2022 – present day)

In common with other dioceses, the first post-holder was a cleric. The current post-holder was employed by the diocese as a safeguarding advisor from 2018 until they assumed the co-ordinator post. While a Safeguarding Coordinator has consistently been in role for over 20 years, the safeguarding advisor role (or its earlier equivalent) has not always been filled, including during an eight-month gap before the current post-holder was employed in August 2022. Line management for the Safeguarding Coordinator is provided by the Chief Operating Officer (COO) now, although has previously rested with their deputy. The Safeguarding Coordinator provides line management for the Safeguarding Advisor who, in turn, line manages the administrative staff (currently four).

This report similarly references the tenures of four bishops:

Bishop Ambrose Griffiths (1992 – 2004) deceased
Bishop Kevin Dunn (2004 – 2008) deceased

Bishop Seamus Cunningham (2009 – 2019)
Bishop Robert Byrne (2019 – 2022)

The use of names within the report

We have (as required by law) anonymised the identities of survivors. To enable the swift publication of this report, we have also anonymised the identities of people who are the subject of allegations and who remain alive. We have anonymised convicted perpetrators who, at the time of publication are subject to further criminal investigations in order to ensure that there is no risk of compromising such investigations. We have used real names in the case of persons who are convicted perpetrators no longer known to be subject to further legal proceedings or in the case of those who are deceased.

In addition, we have used the real names of the Bishops of the Diocese of Hexham and Newcastle, on the basis that their tenures are in the public domain and, as such, it would be impossible to maintain anonymity whilst producing a legible report.

Acknowledgment

CSSA would like to thank all those who have taken the time to speak to reviewers or contact the Agency in other ways about their experiences in the Diocese of Hexham and Newcastle. We acknowledge that, for some who chose to speak about personal matters, this was an act of considerable courage.

Part 1

Baseline Audit Findings

Audit measures the quality of practice and compliance against the agreed national safeguarding standards with the aim of improving safeguarding delivery. A baseline audit is an initial audit to determine how a diocese is performing in ensuring safety and meeting national requirements. Ratings reflect the level of progress being made within each standard. Auditors rate each standard individually in addition to providing an overall rating[4]. Ratings range as follows:

Below basic – the church body is not meeting minimum requirements	Basic	Early progress	Firm progress	Results being achieved	Comprehensive assurance	Exemplary – the church body excels and is a model of best practice

Baseline audit grading

OVERALL GRADING FOR THE DIOCESE OF HEXHAM AND NEWCASTLE	**EARLY PROGRESS**
Standard 1 - Safeguarding is embedded in the Church body's leadership, governance, ministry and culture	Early Progress
Standard 2 - Communicating the Church's Safeguarding Message	Early Progress
Standard 3 - Engaging with and Caring for those who report having been harmed	Early Progress
Standard 4 - Effective Management of Allegations and Concerns	Firm Progress
Standard 5 - Management and Support of Subjects of Allegations and Concerns (respondents)	Early Progress
Standard 6 - Robust Human Resource Management	Early Progress
Standard 7 - Training and Support for Safeguarding	Firm Progress
Standard 8 - Quality Assurance and Continuous Improvement	Early Progress

[4] Detailed information about audit processes can be found at: Our Quality Assurance Framework (catholicsafeguarding.org.uk)

Standard 1: Safeguarding is embedded in the Church body's leadership, governance, ministry and culture

1. The recently agreed (December 2022) diocesan *Commitment to Survivors*, available on the website, clearly states its zero-tolerance approach to abuse and that "every complaint made to us will be thoroughly examined, recorded and investigated". Though less clearly stated, the same principles are evident in the safeguarding policy, which is applicable to all diocesan personnel and was approved in June 2019. Feedback received in clergy and parish safeguarding representative (PSR) focus groups suggested that this approach was well known by those groups, although they were less certain about the understanding of safeguarding amongst parishioners. Evidence from case audits would support the application of this approach, with a number of examples of safeguarding concerns being promptly reported by priests to the safeguarding team (even against the wishes of the person making the disclosure) and of prompt action being taken as a result.

2. There was evidence that safeguarding risks were not always fully considered. A common example was a failure to include the safeguarding team or share information with them, which is potentially indicative of a tendency for parts of the Curia[5] to work in isolation. This has led to situations in which a priest, subject to a safeguarding plan due to concerns about his boundaries with children, was appointed to a school academy trust directorship. Similarly, a former employee, in respect of whom concerns had been identified about their management of safeguarding, was appointed to two school governorships. CSSA reviewers requested that these appointments were reconsidered by the Diocese during the course of the Review and these situations were addressed. This raises a wider issue around formal information sharing arrangements between education services and the safeguarding team in the Diocese when making appointments. Similarly, a safeguarding team perspective is not always seen to be integral to the planning of activities. For example, co-ordinator 4 had to request in early 2023 to be part of the Lourdes pilgrimage core management group. The diocese has recognised the need for further clarity in respect of safeguarding arrangements for the Youth Ministry Trust charity, which is a connected company.

3. While this Review report will set out a number of areas of improvement that are required to safeguarding practice within the wider Diocese of Hexham and Newcastle, the work of the current safeguarding team generally follows current safeguarding practice and meets the minimum required standards. This applies to both individual case management and the broader safeguarding arrangements. Many interviewees referenced the safeguarding team going above and beyond what was expected of them, and it was clear to reviewers that they often worked beyond expected hours both in response to individual cases and to promote safeguarding more widely within the Diocese. Safeguarding team members have reported areas where the need for development has been identified, for example Disclosure and Barring Service (DBS) checks[6] and the quality of recording and have taken steps to make the changes that are within their remit. It is therefore imperative that

[5] The government and court of the Roman Catholic Church, with the Pope in the highest position, in this case referring to the administrative functions of the diocese of Hexham and Newcastle.

[6] DBS checks are the means by which organisations can check whether prospective employees or volunteers have convictions or other adverse information held about them. Standard 6 includes a more full consideration of this topic.

their expertise is recognised and supported by all the diocesan leadership, in order to implement changes that will be required as a result of this Review, and to ensure that safeguarding is central to future diocesan activity.

4. Legal responsibility for safeguarding sits with trustees; with the Bishop, as chair, effectively head of, and responsible for, safeguarding within the diocese. It was notable that in focus groups and surveys safeguarding leadership was seen to come from the safeguarding team, with some explicitly commenting that it has been lacking from the clerical leadership. This is reflected on the Diocesan website in which the introduction to the safeguarding pages is written by the Safeguarding Coordinator, when the Bishop might have carried greater authority.

5. The governance arrangements for safeguarding have to be placed within the context of those for the wider diocese, through its establishment as a charitable company limited by guarantee. This is the legal entity through which the diocese operates, with strategic decisions taken by appointed trustees, who are required to operate within applicable civil legislation[7]. The Bishop, as the chair of the trustees, is responsible for the appointment of individual trustees and for ensuring that there is sufficient expertise to discharge their duties, including their safeguarding responsibilities. During the period under review the company's Articles of Association stated that there could be up to seven clergy trustees and up to four lay trustees[8]. The number of lay trustees dwindled from four in 2021, to three in October 2022 and then two at the time of writing, alongside seven members of the clergy (including Archbishop McMahon, as chair). One of the lay trustees is a recently appointed religious sister, who is treated as a lay person for these purposes. A number of current and former lay trustees were interviewed for this Review, including the former chair of the Diocesan Trustee Safeguarding Committee. Some former lay trustees reported sensing that their input had been less welcome than that of the clergy trustees; while other interviewees, both lay and clergy, characterised the board as having two tiers of members, as opposed to operating as one body of trustees. All existing trustees were spoken to during the course of this Review and recognised, without exception, the need to increase lay representation in order to benefit from the independence and expertise that this can bring. The trustees have previously acknowledged the need to further professionalise the management of the Diocese and agreed a governance review in December 2021. However, this stalled in 2022 and will now be re-instated in the summer of 2023, taking account of learning from the Charity Commission, CSSA, and Canonical reviews.

6. An area of potential disconnect in more recent safeguarding governance has been a tendency for the Episcopal Council (a meeting of the senior clergy, which includes all the clergy trustees and others) to discuss safeguarding matters and, on occasion, make decisions in this respect. This is without the benefit of safeguarding team input, or oversight from the full group of trustees (who do not have access to Episcopal Council minutes). Some interviewees reported a sense that decisions were made in this forum and brought to the board of trustees for rubber stamping (this would apply more widely than to safeguarding issues), while other matters were taken out of trustees' meetings

[7] Regulation is provided by the Charity Commission, which sets out expectations of trustees Charity trustee: what's involved (CC3a) - GOV.UK (www.gov.uk)

[8] In March 2023 these were amended to require up to six clergy trustees and up to six lay trustees, plus the Bishop, as Chair.

into the Episcopal Council. Safeguarding matters discussed in this forum have included training expectations for hospital chaplains, which should have been routed through the safeguarding team and committee to ensure that they were sighted on the matter. More concerningly, the Episcopal Council discussed the response to one particular survivor, which had already been brought to the attention of trustees by that survivor. This risked excluding other trustees from the oversight of a key safeguarding matter for the diocese and resulted in a situation in which Bishop Byrne did not follow a previously agreed decision of the trustees (although the matter was ultimately returned to the trustees).

7. All trustees' meetings during the period under review consistently received a detailed written report from the Safeguarding Coordinator, alongside minutes from the safeguarding commission/ committee, anonymised case management updates, a spreadsheet of progress against objectives and a safeguarding risk register. These form part of the overall assurance papers which include a broader diocesan risk register (incorporating the safeguarding risk register), key performance indicators and objectives. Current and former trustees commented about their confidence in the quality and level of safeguarding information presented. Over the longer term, there was evidence of trustees effectively intervening to address a DBS backlog through the employment of temporary staff (2019/20) and making decisions about training expectations. While this programme of reporting provided a basis for effective oversight by the trustees, there were some questions about its responsiveness to emerging events. The overall risk register, provided to the December 2022 meeting, referenced Bishop Byrne's absence from post (when papers were prepared he had been on sick leave for approximately a month, but had not resigned) and increased the scored risk attached to the Diocesan Trustee Safeguarding Committee on the basis of the resignation of its chair. However, the specific impact on safeguarding governance and practice of either event was not included. The trustees' difficulties in managing contact with a survivor of abuse was not added to the register, which would have been expected. Despite that the trustees appeared well sighted on this issue.

8. This Review covers the time period when changes in diocesan governance arrangements were introduced by the Elliot Review (2020) of safeguarding structures within the Catholic Church in England and Wales[9]. The Diocese of Hexham and Newcastle opted to transition their existing commission into a committee of the trustees, maintaining the same membership of lay and clergy trustees, other religious and clergy representatives, and lay expert advisors. The lay commission chair became a trustee at this point, assuming the lead trustee for safeguarding role (for which trustees agreed a role description in December 2021). Their subsequent resignation in October 2022, due to concerns about Bishop Byrne's leadership of safeguarding, means that the expectation contained in the terms of reference of the group being chaired by a lay trustee and having two lay trustee members, is not being met. At their December 2022 meeting the Terms of Reference were amended by trustees to allow a member of the clergy to chair (in practice the role had been assumed by a religious, as opposed to a diocesan, priest at the December meeting). Notwithstanding

[9] The Elliott review was an independent review of safeguarding structures, commissioned by the Bishops of England and Wales. Where We Started (catholicsafeguarding.org.uk)

the undoubted capability of the interim chair, who is safeguarding lead for his Order, no members interviewed saw this as a long-term solution.

9. While the group's Terms of Reference have changed to reflect their new status, members interviewed, and a review of the minutes did not indicate a discernible change in the content of the meeting. Given that the group is now a committee of the board, with the attendant legal responsibilities that this brings, as opposed to an independent advisory body, it would be expected that future meetings would start to reflect this change. A linked area for consideration is the maintenance of a case discussion element within the committee remit. This has the potential to blur the role of trustees from providing strategic oversight into operational management. An alternative model would be for the creation of a separate case oversight panel, which has been seen to be effective in other dioceses. A detailed case update report is provided to board of trustees' meetings.

10. Irrespective of the foregoing observations about the changed remit of the committee, evidence would suggest that the commission has functioned well for a number of years, benefitting from an able and committed chair alongside a stable group of lay expert advisors. There is evidence of active oversight of safeguarding cases and the provision of expert advice, although this is not routinely recorded within individual case records. Structures are in place for the reporting of data and case information into the group, alongside progress against rolling objectives and a risk register, while the chair presents an annual safeguarding report to the trustees each June. It is understood that the recently resigned chair was working with the Safeguarding Coordinator to develop an action plan to support the delivery of the safeguarding standards. This was not brought to the committee prior to the chair's resignation and should be a priority for their successor (the Safeguarding Coordinator has since further developed a draft plan). Like the trustees, the Diocesan Trustee Safeguarding Committee has also experienced the recent resignation of a lay member and a specialist advisor. These urgently require addressing to ensure that the group maintains an independent expertise and perspective.

11. A more recent challenge for the committee has arisen following its recommendation that a priest (Father H), against whom there is a lengthy history of safeguarding concerns, should be required to receive a therapeutic intervention, as recommended by an independent assessment report. When this was refused by the priest, the committee recommended that he was removed from ministry. However, the clerical hierarchy, beginning with Bishop Byrne, have not implemented this recommendation. In itself, this is not outside process: the committee's role is to provide a recommendation in order to inform the Bishop's decision making. However, this situation has revealed a lack of process for situations in which a recommendation is not followed, including how this could be escalated. In practice, the decision was simply reported to the next Diocesan Trustee Safeguarding Committee, but without any formal means for discussion or challenge between meetings. The Safeguarding Coordinator has proposed a more robust system of recording recommendations and the Bishop's response, but the situation relating to this particular case remains to be resolved, although it is understood that the priest concerned has now indicated a willingness to receive therapeutic intervention. This is a broader national issue, including the question as to how concerns in respect of a Bishop should be escalated.

12. Over the last six months there has been a reduction of safeguarding expertise from the trustees' board with the resignation of the Safeguarding Committee Chair. In addition the discussion of safeguarding matters within the Episcopal Council has weakened safeguarding governance. This has served to undermine safeguarding processes in the diocese, through the exclusion of safeguarding professionals' advice.

Standard 1 Strengths:

1.1 Commitment to survivors demonstrates intent for a zero-tolerance approach to abuse;
1.2 Evidence of a zero-tolerance approach to abuse within cases audited;
1.3 Effective provision of oversight of case management by the commission/ committee.

Standard 1 Areas for development:

1.4 Provision of clear safeguarding leadership and communications by the Bishop and clergy hierarchy;
1.5 Ensure that a culture of safeguarding and inclusion of a safeguarding team perspective is evident in all areas of diocesan activity;
1.6 Ensure an appropriate balance of lay and clergy trustees, in accordance with the recently amended Articles of Association;
1.7 Return to lay chairing of the Diocesan Trustee Safeguarding Committee;
1.8 Ensure that all safeguarding matters are routed through proper governance channels;
1.9 Consider whether case oversight might be provided by a case management overview panel;
1.10 Agreement of an action plan to support the delivery of the safeguarding standards;
1.11 Ensure that all areas of diocesan activity receive proper safeguarding team input and information sharing.

Standard 2: Communicating the Church's safeguarding message

1. The communicating of the Church's safeguarding message was something of a mixed area for the Diocese. The development of formal safeguarding communications plans and mechanisms for feedback from stakeholders were both in their very early stages, but there was evidence of communications in practice. The diocese does have a communications strategy which has six objectives, including the creation of a PR and Social Media Plan. The current focus however is on developing the infrastructure to enable improved communication of the messages. Individual departments or projects may then develop their own communications plan, with the support of the Head of Communications, in order to determine what their messages are and how these will be shared. Discussions had begun to develop a safeguarding communications plan late last year, and CSSA had been approached for support in this respect but have been paused due to the likely need to re-shape messages as a consequence of this Review. There is a recognition of the need to involve stakeholders in the development of this plan.

2. Both clergy and PSR surveys indicated that three-quarters of respondents agreed that there was a clear message in respect of safeguarding from the diocesan leadership. In contrast, clergy

respondents most commonly cited communications as the area in which development was required. The substance of these responses tended to be that there was a need for a tailored safeguarding message for individual groups of people within the diocese (e.g. volunteers, parishioners etc.) and for better communications between different elements within the diocese. PSRs also felt that communications with the wider Church community could be improved but spoke positively of the communications that they received as PSRs from the safeguarding team. Both groups referenced the need to convey that safeguarding is more than DBS checks. In both surveys only two thirds of respondents indicated that they made use of posters in buildings to communicate the safeguarding message. While this is clearly a format with its limitations, it is also readily available and a discreet means to make safeguarding contact details available for anyone who would want them.

3. The diocese supported the Day of Prayer for survivors of abuse in May 2022 with a Mass celebrated by the Bishop in the cathedral, on which occasion the Bishop wrote to all clergy emphasising the importance of the church's response to abuse (this letter is publicly available on the Diocesan website). This visible safeguarding leadership could have been expanded to include a tailored message to the wider public. Similarly, the Bishop (or senior clergy in current circumstances) could provide the public front to the safeguarding pages of the website and the *Commitment to Survivors* document. Safeguarding team communications with PSRs and clergy are primarily through monthly updates of DBS checks that are coming up for renewal. These are sometimes supported (on one occasion in the last six months seen) by other safeguarding information. Surveys indicate a good level of responsiveness from the safeguarding team to individual contacts.

4. Case audits demonstrated appropriate contact from the safeguarding team with the local statutory agencies, while links were also seen with organisations that can support survivors. Work was seen with a number of the local authorities and police forces within the diocese, and it was positive that successive Safeguarding Coordinators have been willing to challenge other agencies to ensure that actions are taken.

<u>Standard 2 Strengths:</u>

2.1 Emerging work to develop a safeguarding communications plan;
2.2 The majority of clergy and PSR feel that there is a clear leadership safeguarding message.

<u>Standard 2 Areas for development</u>:

2.3 The inclusion of stakeholders within the development of the safeguarding communications plan;
2.4 The development of tailored safeguarding messages for all within the diocese;
2.5 Provision of visible public safeguarding leadership by the Bishop and senior clergy;
2.6 Review decision making processes for situations in which the reputation of the charity is a consideration, ensuring always that effective safeguarding procedure prevails.

Standard 3: Engaging with and caring for those who report having been harmed

1. As noted under Standard 1, the Diocese of Hexham and Newcastle has recently agreed a *Commitment to Survivors,* which is published on its website. This document encourages survivors to come forward and clearly sets out what service they can expect to receive. Having only been agreed in December 2022 it is too early to identify any impact that this document may have, although it is non-controversial.

2. Any assessment of the overall engagement with and care for those who report having been harmed within the Church environment is complicated by the intensely personal nature of the impact of abuse and the need for a unique and individual response to each survivor Consequently, any audit will attempt to assess both the overall service offered and how it is tailored to meet individual needs. A range of views were evident throughout the Review, some illustrative of persistent and well-received interventions, however it was also clear that a number of survivors feel significantly let down by either the overall response of the Diocese or of elements within it.

3. By way of broader context, the diocese does not have any formal contractual link with a local provider of survivor services, as some dioceses do. This would have the benefit of providing a means by which survivors can be signposted to a specialist service without having to make any contact with the diocese, although it is acknowledged that local options are limited. (Currently the Diocesan website does provide links to some national and local charities and counselling services are accessed through a local provider.) Consequently, survivor contact is managed by the safeguarding team both of whom are former police officers, with experience of working with survivors of abuse. In practice, there was also evidence of their making use of Safe Spaces[10] and being able to access counselling services for survivors. The case audits undertaken as part of this Review and the situations outlined in Part 2 of this report do suggest the need for a more developed pathway for responding to and providing support to survivors, establishing the roles of all diocesan personnel and including a wider range of specialist provision.

4. Within case audits evidence was seen of the Safeguarding Coordinators working with survivors over sustained periods of time in which they were encouraged and allowed to engage on their own terms, indicating a survivor led approach. Counselling was routinely offered, and it was made known that the offer would remain open, if it was not immediately accepted. In one case audit support was seen to be provided throughout and following the period of a criminal trial in which the alleged perpetrator was found not guilty. The Safeguarding Coordinator provided an example of a survivor they had developed a bespoke response for, through their work with Safe Spaces and the clergy hierarchy within the diocese; this positively resolved the survivor's longstanding unhappiness with the Church's response to their experience of abuse. Other cases indicated less successful work with survivors. In one case, a complainant raised the dioceses long standing failure to act on their concerns in relation to a priest.

[10] Safe Spaces is an independent advocacy and support service for adult survivors of church-related abuse in the Church of England, the Church in Wales and the Catholic Church in England and Wales.

5. Reviewers had conversations with and received anonymous submissions from a number of individuals who felt let down by their response from the diocese (it is acknowledged that this will not be a representative sample of everyone who has had contact with the diocese). A persistent theme from this group, and also seen within some case audits, was a lack of pastoral support provided to survivors – this was mostly with reference to the clerical response, although is clearly an element that the safeguarding team should consider in formulating their individual responses. One element that was seen repeatedly and could be easily resolved, was an expectation placed on survivors who wanted a meeting with the Bishop to contact his secretary to arrange an appointment. This places an unnecessary barrier to the meeting in front of the survivor and could be immediately and easily resolved by the person making the offer (including the Bishop) also making the arrangements for the meeting.

6. Information gathered confirms that Bishop Byrne was willing to and did meet with survivors of abuse, alongside Safeguarding Coordinator 4. He had received safeguarding training as a Bishop and a priest, including specific input around engagement with survivors at an event in Valladolid, Spain. Feedback from meetings with survivors was that they were not always successful. While there may be particular reasons why an individual meeting is or is not productive, what this does illustrate is the difficulty involved in, and skill required to, work with survivors of abuse, particularly as a representative of the organisation that the survivor is likely to hold responsible for their experiences. This emphasises the importance of relevant and effective training in this respect, planning for meetings and for systematic reflection on and learning from these experiences, which does not appear to have consistently occurred. More recently, the Safeguarding Coordinator reports informally asking survivors for feedback when it is apparent that their involvement is drawing to a close.

Standard 3 Strengths:

3.1 The diocesan website includes a clear commitment to survivors;
3.2 Evidence seen in case audits of the safeguarding team working with survivors and referring to appropriate services and thereby putting the commitment to survivors into practice.

Standard 3 Areas for development:

3.3 Ensure that a clear pathway for engaging with survivors is in place, both in terms of the responsibilities of diocesan personnel and access to a range of specialist services;
3.4 Ensuring that survivors receive a consistent pastoral response from the clergy;
3.5 Balancing the need for legal advice and representation with the pastoral response;
3.6 Ensuring that survivors can easily arrange meeting with the Bishop;
3.7 Provision of specialist training for all involved in meetings with survivors;
3.8 Embedding of mechanisms to systematically learn from the experiences of survivors.

Standard 4: Effective management of allegations and concerns

1. The expected response to and management of allegations and concerns is set out in the diocesan safeguarding policy. This, in turn, references CSSA national policies and practice guidance as the

source of more detailed information about specific elements of practice. In the longer term it would be preferable to develop diocesan versions of CSSA documents in order to reflect local practice (including confidentiality and information sharing).

2. The eleven cases audited provided a broad cross-section of the types of work that a safeguarding team can be involved in. All received a prompt response, and three required notifications from the diocese to statutory authorities. Other referrals came from statutory authorities or from other organisations who had already made the referral to statutory authorities. On these occasions prompt actions were taken, be they contact with the complainant or subject. Two similar cases are worth highlighting as positive practice. In each a partial disclosure was made to a priest, both of whom made a report to the safeguarding team within one working day. Due to insufficient information being provided to make a report, arrangements were made to work with the survivor to support further disclosure, which did allow eventual reporting to statutory authorities. Finally, there was also evidence of a prompt response to a concern that did not meet the threshold for reporting to statutory authorities but needed a pastoral response – it is positive that the need for action was not lost.

3. Cases audited were generally managed effectively and decisions was made by the safeguarding team and complied with the Safeguarding Standards. There was clear evidence of working in conjunction with statutory authorities, including of appropriate challenge to ensure progress. Checks were made with statutory agencies before sharing information about allegations with respondents. There was evidence of measures being taken to provide support for both complainants and respondents.

4. The primary areas of concern in respect of the management of allegations are the quality of recording and management oversight. The Diocese purchased the PAMIS electronic case recording system in 2019 and gradually moved the management of cases on to the system in the following years. Some paper files have been scanned and uploaded on to PAMIS, while there remain older files that have not been uploaded. However, it is clear that PAMIS has not been used effectively, with over half of cases audited requiring improvement in this respect. This was evident in records being created considerably after events referred to, not being in chronological order, or having clear gaps. No chronologies were seen on case records. More recent recording (since the team has been fully staffed) has been of a better standard and it is imperative that these improvements in case recording are maintained.

5. Case records do not include clear evidence of management oversight which, to some extent, reflects a lack of arrangements in this respect. The Safeguarding Coordinator is line managed from an employment perspective by the COO and has externally purchased professional supervision – this does not include individual case supervision. The safeguarding advisor is line managed by the co-ordinator and does receive case supervision from them along with the same externally purchased professional supervision. While not within the remit of the Review to determine how, it is clear that arrangements for reflective case supervision are required. In turn this would allow for greater recording of analysis and rationales for decision making within case records. Some supervisory oversight is also provided by the Diocesan Trustee Safeguarding Committee, which routinely

discusses and provides expert advice on active cases. This is not seen to be routinely recorded within case records. This also forms the route by which information about allegations is passed to trustees.

6. The Diocesan Trustee Safeguarding Committee receives a brief anonymised overview of cases, with supplementary information provided by the Safeguarding Coordinator, in person, at the meeting. Committee case discussions tend to focus on practical actions needed in the management of cases, without there being a more reflective element to learn from allegations or the response (the one exception seen by this Review would be the trustee commissioned review reports in one case). Once a permanent committee chair is appointed, they should develop this element of its work, with the annual report to trustees being an obvious route for sharing learning.

7. The Review Team were made aware of a number of concerns relating to safeguarding practice during Lourdes pilgrimages, primarily in the mid-2010s. During this period the pilgrimage had a safeguarding lead, who travelled with the party, and agreed safeguarding processes. However it is clear that the investigation of, and response to, allegations was not always transparent, which has resulted in a legacy of issues that individuals involved with the pilgrimage do not feel to have been satisfactorily resolved. As a consequence of Covid restrictions, the 2023 pilgrimage will be the first to take place since 2019. In order to provide further time to review safeguarding arrangements there will be no groups of children travelling, although it would be possible for families to travel with their own children. Safeguarding arrangements will be necessary though for adults at risk, including the medically vulnerable. As previously noted, the safeguarding team are now represented on the Lourdes pilgrimage core management group. It is therefore critical that their expertise is utilised to ensure that future pilgrimages are able to operate safely and that any safeguarding allegations or concerns are responded to and resolved (working with another diocese in this respect would likewise serve to embed effective safeguarding practice for pilgrimages).

<u>Standard 4 Strengths:</u>

4.1 Policy expectations for the response to allegations of abuse are in place;
4.2 In practice allegations are responded to promptly and safely managed;
4.3 More recent improvements in case recording.

<u>Standard 4 Areas for development</u>:

4.4 Agreement of local policies and procedures to ensure that local arrangements in respect of national policies are clear;
4.5 Agreement of expected standards for case recording to ensure that developments in recent practice are embedded and maintained;
4.6 The introduction of arrangements for individual case supervision;
4.7 Recording of case supervision and committee discussion on individual case records;
4.8 Ensuring that the Diocesan Trustee Safeguarding Committee uses case discussions to learn from the managements of allegations and apply this to future practice.

Standard 5: Management and support of subjects of allegations and concerns (respondents)

1. A number of interviewees identified a need to improve the Diocese's response to, and support for, subjects of allegations – this primarily referred to clergy subjects. This was evident in case audits, although there was also some indication of a recent improvement in the management of safeguarding plans.

2. In cases audited the subjects of allegations were only spoken with once agreement had been reached with statutory authorities, including consideration of what information could be shared. Initial meetings to advise the respondent of the existence of an allegation involved the Safeguarding Coordinator and a senior clergy member. Respondents were able to access advice from a canon lawyer, with the Diocese being advised by its Chancellor. Where necessary, prompt arrangements were made for the voluntary withdrawal of priests from ministry. During the review period learning from one case had resulted in a change in practice, whereby the Bishop's letter was amended to make it clear that he is requesting a voluntary and without prejudice withdrawal from ministry, rather than requiring this. This brings practice in line with national guidance[11]. Thereafter there was evidence of prompt agreement of safeguarding plans and risk information frameworks (RIF)[12], however swift completion was sometimes at the expense of quality. In some cases there was evidence of the Safeguarding Coordinator providing extensive support to the respondent, including making links with other sources of specialist support.

3. Two specific elements of support provided require some attention. Firstly, the Diocese has no readily available accommodation options for priests who are required to leave their presbytery and who are unable to reside in other presbyteries. In two case audits this resulted in priests residing in short term rented accommodation, which may not be suitable. The diocese did maintain a property for this purpose, but disposed of it in 2019, due to the reputation that it acquired. This is consequently an area that would benefit from consideration on a national basis to learn from good practice and identify principles that dioceses might use. Secondly, arrangements for support are ad hoc. While there is a role for allowing respondents to choose their own support person, the diocese should have a pool of suitably trained people available. Levels of contact with the subjects of plans was not always maintained as agreed and in two cases resulted in significant periods without any interaction being recorded, either by the safeguarding team or nominated support person. More positively, the social worker for retired clergy was seen to provide effective support and an independent means of monitoring wellbeing.

4. A consistent theme in case audits was that RIF and safeguarding plans were not updated and reviewed either following the emergence of new information or at expected routine intervals (the seemingly standard practice setting an eight week review period for plans where there is an ongoing investigation is neither practical nor necessary given the length of many police investigations). Reduced safeguarding team staffing during the first eight months of 2022 will have been a factor in this respect, however the issue was not confined to this period. A similar exercise to that carried out to improve the timeliness of safeguarding plans, outlined below, should be carried out to ensure

[11] Management of Allegations and Concerns Practice Guidance (catholicsafeguarding.org.uk)
[12] A template used to identity and minimise risks.

that all RIF are up to date, of a sufficient standard, and that ongoing contact is maintained with all respondents.

5. Where forensic risk assessments were required, these were commissioned and used to inform future risk management, for example resulting in the ongoing withdrawal from ministry of one priest. While out of the control of the Diocese, it is noted that difficulties were caused by the distance that subjects are required to travel to access these assessments and any follow up interventions.

6. In addition to the case audits, all 22 safeguarding plans in place on the 23rd January 2023 were reviewed. This was clearly an area of work that had benefitted from the increased safeguarding team resource since August 2022, with ten having been reviewed and signed in the autumn period. Consequently, 11 of the 12 active plans had been reviewed within the expected timeframe. Nine of the remaining plans (four with subjects in custody and five for laity who are no longer attending Mass) should be considered for closure by the committee (the final plan is for a lay subject who refuses to sign, but who is monitored adequately). Safeguarding plans were seen to be fit for purpose although improvements could be made to the wording of restrictions and support elements, and through the inclusion of contingencies.

7. One case audit highlighted an issue that requires consideration both in terms of the general principle and within the specific context of this case. It relates to a situation in which a lay person, who was also employed by a Catholic charity not linked to the diocese, required a safeguarding plan. The parish priest of the church that the lay person attended was also subject to a safeguarding plan. The parish priest then became responsible for the implementation and monitoring of the lay person's safeguarding plan. Given that there were concerns about the parish priest's own risks and ability to create and maintain a safe environment, it would seem anomalous and potentially unsafe for him to be responsible for another safeguarding plan. However, this has to be balanced with him being the incumbent parish priest at the church that the lay person already attended.

8. Despite the Diocesan Chancellor sitting on the Diocesan Trustee Safeguarding Committee, there was little evidence on case records of the co-ordination of statutory and canonical investigations. Practice was seen to be that the Chancellor is advised following the conviction of a priest for child sexual abuse offences, but that there is not an ongoing flow of information beforehand, save through the Chancellor's membership of the committee. Consequently, we found no evidence of correspondence between the Diocese and the Dicastery for the Doctrine of the Faith. While cases in which no conviction is secured are inevitably more complicated, there was no evidence of any canonical processes being considered in the one case that fell into this category. Equally, there are older cases where there have been convictions, in which it is not clear from safeguarding records whether any canonical steps were considered, or taken.

<u>Standard 5 Strengths:</u>

5.1 Allegations were discussed with subjects promptly with appropriate clergy support;
5.2 Risk assessments and safeguarding plans were quickly completed and implemented;

5.3 Recent improvements in ensuring that safeguarding plans are reviewed within expected timeframes set by the CSSA standards.

Standard 5 Areas for development:

5.4 Introduction of quality assurance mechanisms to ensure that all RIF provide robust assessments that are updated at routine intervals and following significant changes;
5.6 Consider the suitability of accommodation arrangements for clergy subject to allegations;
5.7 Establish a pool of suitably trained support people for subjects of safeguarding plans;
5.8 Embed mechanisms for ensuring that risk information frameworks and safeguarding plans are reviewed at agreed intervals;
5.9 Ensure that regular contact is maintained with all subjects of safeguarding plans;
5.10 Ensure that links between safeguarding and canonical processes are referenced in case records.

Standard 6: Implementation of robust human resource management

1. Trustee and safeguarding commission/ committee minutes from the last four years demonstrate that active oversight is provided to ensure that DBS checks are in place, although there was less attention paid to other aspects of safer recruitment processes, for example whether references are sought. That said, the safeguarding team were able to articulate robust safer recruitment processes for PSRs. Similarly, PSR and clergy responses to surveys and within the focus groups focused on the DBS element of the safer recruitment process. It can therefore be said with some confidence that the need for DBS checks is well known amongst those responsible.

2. Historically, the Diocese accumulated a significant backlog of DBS renewals for volunteers. This was discussed by trustees in September 2018 who approved the employment of additional short-term administrative capacity starting in 2019. The backlog was addressed by late 2019/ early 2020. Unfortunately, with a diocesan standard of three yearly re-checks, this has had the consequence that a significant number of re-checks have all become due in the last six months, however not to the degree experienced in 2018. Trustees have again exercised a degree of oversight and the backlog has been brought down from over 500 at the start of 2023 to 292 reported to the 22nd March board meeting (this is in the context of there being over 3,000 DBS eligible volunteer roles and the safeguarding team processing 100 – 120 checks per month). It is understood that fewer than 292 people will actually require checking due to some volunteers holding multiple roles that are recorded separately and others having stepped down, but not notified the safeguarding team. It is nevertheless critical that this backlog is eliminated due to the potential for unidentified risks. In contrast, all clergy DBS checks were in date. Good practice was seen in safeguarding team attendance in parishes to promote DBS completions and in monthly email updates to PSRs identifying any volunteers whose DBS checks are nearing their renewal date. To reduce the potential for a similar backlog in three years, all volunteers are being encouraged to join the online update service.

3. Parish priests and PSRs are supported to safely recruit volunteers through the provision of flowcharts and forms on the Diocesan website. This would be enhanced by the adoption of the draft volunteer strategy, *In Humble Service*, and associated implementation plan. These aim to provide a framework for the recruitment and work of volunteers, of which safeguarding forms one element. They additionally provide the means to remove a volunteer from role, which would enable a situation to be addressed in which the safeguarding team have concerns about one PSR (this is an area in which national guidance is also developing). As noted under Standard 1 there have been situations in which safeguarding information has not been shared within the curia, resulting in an inappropriate appointment to a school governorship. Policy and practice in this respect should also be reviewed.

4. Visiting (including overseas) clergy are notified to the safeguarding team by the Diocesan Chancellor when he becomes aware of them. Arrangements are then made for appropriate checks and training, dependent on where they were arriving from and the nature of their proposed ministry. In practice though, the safeguarding team reported not always being made aware of all clergy visiting the diocese, which often comes down to individual priests not notifying the curia – this is an area that should be emphasised in safeguarding training. This is also reflective of the safeguarding team not being informed of safeguarding related matters as necessary.

5. Not all decision making in respect of appointments of existing clergy, where there are safeguarding concerns, was seen to be defensible. In a case referred to previously, a priest was appointed to a prominent role, despite safeguarding concerns being raised by both the Safeguarding Coordinator, Diocesan Trustee Safeguarding Committee Chair and a previous Bishop. Under canon law the Bishop is the final decision maker in respect of appointments. However, this situation emphasises the importance of the provision and recording of clear and unambiguous recommendations by those with safeguarding roles. Equally, it may then be necessary to consider notifications to statutory agencies where appointments are made that carry a safeguarding risk (it is acknowledged that national guidance in this area is developing). In a second example, a priest was appointed to the directorship of a school academy trust, despite being subject to a safeguarding plan for concerns in respect of his risk to children. These decisions were made despite a knowledge of the safeguarding concerns on each occasion. This illustrates the need for Bishops to work closely with their safeguarding teams when making clergy appointments and for the clear recording of advice and the rationale for the final decision. Reviewers were nevertheless satisfied that, following a trustees' commissioned review, appropriate measures are now in place to ensure that Bishop's House clergy files are clearly marked to show when a safeguarding file is also held.

6. A further area for development was indicated by a case audit in which the respondent priest had been received into the Catholic Church after a lengthy period of ministry within the Church of England. References had been sought and received from Church of England personnel, including his former bishop, however none were current office holders so could not check Diocesan records. Consequently, safeguarding information was not shared by the Church of England until he had been providing supply ministry for over three years, resulting in a situation where there was an unassessed and therefore unmanaged risk (for the sake of clarity, this was a Diocesan and not an

Ordinariate[13] priest). The failure by the Church of England to share accurate information, in a timely way, has resulted in tragic events elsewhere. It is a matter that is being progressed by the CSSA.

7. Diocesan trustees adopted a new safeguarding service complaints policy and procedure in December 2022, which is available on the website (this is based on the CSSA policy and has been appropriately localised). Prior to the adoption of this new complaints policy and procedure, safeguarding complaints were included within the wider diocesan complaints policy and procedure, and there was no means to complain separately in a safeguarding related matter. There is no clear path that enables an individual to complain about the Bishop. This is a matter for national consideration.

8. It is too early to judge the success or otherwise of the new policy. Reviewers were aware of a small number of safeguarding complaints that had been investigated under the old policy, despite its apparent restriction. These complaints had not been resolved as quickly as might have been possible, although it is recognised that some issues in terms of the speed of response are outside the Diocese's control. The Diocesan complaints log is reviewed, as a whole, at the Staffing and Remuneration Committee and also reported to each board of trustees' meeting. Relevant learning derived from complaints in these fora should be reported to the Diocesan Trustee Safeguarding Committee to further develop safeguarding practice.

9. The diocese has an agreed whistleblowing policy, although this has never been published externally and is currently under review. One area that requires consideration in this respect is the fact that clergy are ineligible under canon law to access the policy, in effect, making them ineligible to be a whistleblower with the protections this would bring (this is a national issue, linked to their employment status). Trustees had identified this issue in an internal review in early 2023 and agreed the need to provide a mechanism by which clergy can speak up without fear of reprisal. The weakness of the policy as it stands is that all whistleblowing concerns are funnelled upwards within the Diocesan hierarchy, which understandably may give someone considering whistleblowing cause for concern should their issue relate to a person within the hierarchy. In practice, it is known that a small number of members of the clergy have expressed a desire to whistle blow in respect of safeguarding concerns, but have not found open channels through which to achieve this. This is a national issue.

<u>Standard 6 Strengths:</u>

6.1 Trustee oversight of and commitment to address DBS issues;
6.2 Recognition of the need to build on current complaints and whistleblowing policy and practice.

<u>Standard 6 Areas for development</u>:

6.3 Ensure that the current DBS backlog is eliminated and ensure that measures to prevent a recurrence of this issue are effective;

[13] The Personal Ordinariate of Our Lady in Walsingham was created in 2011 as a means by which Church of England priests and congregations can be received into the Roman Catholic Church while retaining elements of their distinct heritage and traditions.

6.4 Final agreement of the Volunteer strategy and action plan, including recruitment, role expectations, support, and processes for removal from role;
6.5 Review the policy and practice for school governorship appointments (including of clergy) to ensure that safeguarding information known to the diocese is considered;
6.6 Review processes for incoming clergy and existing clergy appointments to ensure that they follow safer recruitment processes;
6.7 Inclusion of the means to raise a complaint about the Bishop with the complaints policy;
6.8 Ensure learning can be derived from complaints is reported to the Diocesan Trustee Safeguarding Committee and informs practice development;
6.9 Ensure that safe routes for whistleblowing are available to all employees, clergy and volunteers.

Standard 7: Provision of and access to training and support for safeguarding

1. In the absence of national requirements, trustees of the Diocese of Hexham and Newcastle determined in 2019 that clergy, PSRs, employees and lay trustees should complete Educare online safeguarding training every three years. Clergy new to the diocese will receive input from the safeguarding team and all clergy will receive some form of face-to-face safeguarding training annually, be it as part of an ongoing formation day or a standalone event. In recent years this has included input on *Caring Safely for Others*[14]. PSRs will receive individual training on assuming role, with other training events also made available either virtually or in person. Clergy engagement with training has been promoted in written communications by the Bishop, while the Episcopal Vicar with responsibility for the care of the clergy and the safeguarding team will contact individuals to promote the completion of their training.

2. Trustees, through the Diocesan Trustee Safeguarding Committee, actively oversee training, which is included in every safeguarding team report. Monitoring of effectiveness is entirely compliance based, for both Educare and face-to-face training. As of the 6th February, 90% of priests, 86% of assistant priests and 88% of deacons had in date completion; the rate of 22% amongst retired priests is of more concern given that many will continue to provide supply ministry (the safeguarding team reported current efforts being made to address this through support with IT, the provision of diocesan office based training and the loan of laptops). Similarly, 86% of priests had attended the most recent face-to-face training. PSR compliance with Educare was 83%, having increased from the mid-30s% in 2019.

3. While monitoring compliance with training is clearly necessary, it only goes so far in answering the question as to whether the input has been effective (CSSA survey returns from both PSR and clergy would suggest that participants found training to be useful). Currently, feedback is limited to that received from attendees who make the effort to email or otherwise contact the safeguarding team following the event. The Diocese should consider how it can test the effectiveness of its training, both in terms of understanding and on the day experience, and whether it has a longer term impact.

[14] *Caring Safely for Others* was published by the Catholic Bishops Conference of England and Wales in 2020 and sets out pastoral standards for clergy in order to promote safe conduct in ministry.

4. Reviewers were provided with slides used for clergy and PSR training, which were seen to be relevant and appropriate to the intended audience. Training is effectively a one size fits all approach and no one spoken to in leadership roles, including within the trustees or committee members, had received any role specific training (some trustees questioned whether others had sufficient understanding of the legal requirements of their role). The Safeguarding Coordinator recognises the need to develop a more nuanced safeguarding training plan, with early progress having been made in considering the range of roles that training will be required for. The safeguarding team are already encouraged to access local multi-agency training, which could also be included within this plan.

5. Early progress has also been made in securing the engagement of two survivors of church based abuse who are willing to have their story included within training.

Standard 7 Strengths:

7.1 Clear training expectations are promoted by the Bishop and the safeguarding team;
7.2 Compliance is actively monitored and steps taken to address emerging problems.

Standard 7 Areas for development:

7.3 Build on early work begun to provide a graduated training programme with options for a range of roles within the diocese;
7.4 Move beyond monitoring of compliance (attendance) to consider how the impact of training can be assessed more consistently;
7.5 Ensure that retired priests who provide any form of ministry access safeguarding training;
7.6 Completion of work already in progress to include the voices of survivors within training.

Standard 8: Quality assurance of compliance to continually improve practice

1. As previously noted, the Diocesan Trustee Safeguarding Committee Chair, who resigned in October 2022, had begun to develop an implementation plan based on the safeguarding standards. This piece of work ceased on their departure, although all trustees and committee members spoken with recognise the need for this to be progressed as a priority once a new chair is recruited (the Safeguarding Coordinator has already begun work to further develop a draft plan).

2. Ongoing progress against nine objectives, some of which have attached Key Performance Indicators (KPIs), and the diocesan risk register, are reported to the board of trustees and the Diocesan Trustee Safeguarding Committee quarterly (the same documents are also reviewed on a monthly basis by the COO in their supervision of the Safeguarding Coordinator, while the safeguarding team receive a weekly report). While not as broad ranging and developmental as an action plan based on the standards would be expected to be, this does provide some points of reference for meetings and a means of identifying and addressing any slippage, as had been done with DBS re-checks. The objectives have the benefit of providing a consistent framework for the flow of information between the safeguarding team, committee and trustees. This is supported by an annual report. Further transparency of safeguarding arrangements could be provided by the publication of this report, alongside already published committee minutes. One current objective

does relate to the implementation of national policies and there was evidence of policies being introduced throughout the four year review period, although their operation was not routinely reviewed.

3. There is no programme of routine safeguarding case audit, although in the exceptional circumstances of one case trustees promptly commissioned a review of the safeguarding response and thereafter a review of the wider circumstances. The lack of a routine programme of reflective case supervision means that there are no opportunities for learning from cases, or the diocese's response.

4. Resources within the safeguarding team have varied in recent years. This has included periods of additional staffing which enabled the DBS backlog to be addressed, but also a period without a safeguarding advisor in which it was apparent that case work suffered. The safeguarding team is currently fully staffed, although there is a recognition that a further assessment of resourcing will be required on the conclusion of this Review to ensure that the team is able to deliver its recommendations and those within the eventual safeguarding implementation plan.

Standard 8 Strengths:

8.1 Effective mechanisms are in place for reporting against objectives, as they currently stand;
8.2 Established practice of producing an annual report;
8.3 Publication of Diocesan Trustee Safeguarding Committee minutes promotes transparency though transparency could be further improved by publication of the annual report.

Standard 8 Areas for development:

8.4 Development of a safeguarding implementation plan based on the safeguarding standards;
8.5 Introduction of routine case auditing.
8.6 Consider establishing a means to provide reflective supervision to safeguarding team members.

Part 2

Leadership, culture and governance

In part one of our report, under Standard 1, we provided an analysis of safeguarding leadership, culture and governance. In this section, we focus on two specific concerns that have been raised by a number of individuals and which highlight weaknesses in these areas. In our view these specific issues seriously impact on safeguarding practice in the diocese of Hexham and Newcastle.

As stated previously, in this report, we have anonymised survivors and unconvicted perpetrators who are living. We have anonymised convicted perpetrators who, at the time of publication are subject to further criminal legal proceedings. We have used real names in the case of persons who are convicted perpetrators no longer known to be subject to further legal proceedings or who are deceased.

In addition, we have used the real names of the Bishops of the Diocese of Hexham and Newcastle, on the basis that their tenures are in the public domain.

Part 2 A: The appointment of Canon Michael McCoy as Dean of St Mary's Cathedral

1. Introduction

1.1 The CSSA Safeguarding Review team in the Diocese of Hexham and Newcastle was informed of concerns relating to Father Michael McCoy (later made a Canon[15]). These issues were raised by Diocesan clergy and lay employees, past and present, and consisted of the following reported concerns, namely that:

a. the Diocese did not effectively manage risk in relation to historic concerns regarding Canon McCoy;
b. numerous clergy and lay people were aware of Canon McCoy's lack of boundaries but did not report their concerns;
c. there were missed opportunities to intervene in Canon McCoy's alleged offending;
d. Canon McCoy's friendship with key Diocesan figures may have been detrimental to the effectiveness of associated safeguarding;
e. Canon McCoy was inappropriately appointed by Bishop Byrne, with the knowledge of past safeguarding concerns;
f. The survivor who made allegations against Canon McCoy did not feel they were supported in an honest and compassionate manner by senior Diocesan clergy.

[15] Canon - The title Canon is awarded by a diocesan Bishop usually to more senior members of the clergy and is sometimes linked to their occupying a particular role, although the title will apply perpetually.

1.2 This Review is supplemented by a formal case audit of Diocesan actions between notification of a formal police investigation into Canon McCoy and the subsequent suicide of Canon McCoy; this detailed document will be referred to within the current case study.

2. Background and Overview

2.1 Canon McCoy was ordained to the Priesthood in September 1989, and went on to have numerous postings as Parish Priest throughout the Diocese of Hexham and Newcastle. Canon McCoy had significant involvement in Catholic Education and Formation within the Diocese and advised the Catholic Bishops' Conference of England and Wales in that regard. He taught part time at Ushaw Catholic Seminary for some years, he was an individual School Chaplain and Governor, he was involved in running Vocations evenings at schools and he also served as the Diocesan Coordinator for School Chaplaincy and residential retreats for some time. He had a longstanding involvement in the Diocesan Lourdes Pilgrimage within Hexham and Newcastle where he was a member of the Lourdes Core Group and was the Head of the pilgrimage Youth Section for a number of years. In 2019, Bishop Byrne appointed Canon McCoy as the Dean of St. Mary's Cathedral in Newcastle, as well as conferring upon him the title of "Canon".

2.2 Canon McCoy was undoubtedly a very popular priest amongst his parishioners, brother clergy and lay colleagues, but many of these people have subsequently reflected on a different side to Canon McCoy's personality and behaviour. Various safeguarding concerns regarding Canon McCoy were reported to the Diocese over an extended period. These comprised concerns relating to his interactions with male teenagers which did not meet the criminal threshold but nevertheless prompted a variety of safeguarding responses. In 2021, Northumbria Police initiated a formal investigation into historic sexual offending against a single young person under the age of 18 known in this Review as DD. Canon McCoy took his own life before any substantive police enquiries could be made. In May 2022, a Coroner's Inquest found that Canon McCoy had committed suicide in association with the criminal investigation.

3. Historical Safeguarding Concerns

3.1 1996 Concerns

3.1.1 In August 1996, Canon McCoy was reported to be associating inappropriately with young people, particularly teenage boys. This appears to have been reported to Safeguarding Coordinator 1 by Canon McCoy's parish priest of that time. The concern stated that Canon McCoy spent a significant amount of time with two young males. It had transpired that he had been on holiday with one of them, despite having advised his parish priest that he had gone alone and stayed with friends. There were further concerns that Canon McCoy was facilitating underage drinking in local pubs, and that students had made remarks about Canon McCoy allowing certain young people to eat lunch with him in an office. There were no known allegations of abuse connected to the reporting of these concerns. Canon McCoy was warned about his behaviour by both his parish priest and Safeguarding Coordinator 1 in relation to these concerns.

3.1.2 In November 1996, in response to a written, but anonymous complaint, Canon McCoy was given further words of advice. Child Protection training was provided to Canon McCoy.

3.2 2007 Concern

3.2.1 In April 2007, further concerns were raised regarding Canon McCoy facilitating underage drinking by school pupils; this related to a secondary school where he was Chaplain, and the concerns came from Sunderland Social Services, who had been contacted by the concerned mother of a school pupil. Canon McCoy was said to invite young people to his presbytery on Friday and Saturday nights, where they would be allowed to drink alcohol. He would allegedly purchase alcohol for those who could not obtain it themselves, and whilst the invitations had originally only been extended to male school pupils, females were now also allowed to attend. Diocesan representatives attended two statutory meetings, but police attended neither; having decided at an early stage that there were no criminal offences alleged or apparent. The local authority closed their investigation within a fortnight due to the school pupil refusing to engage or corroborate any of the information provided by the school pupil's mother.

3.2.2 As a result of these concerns, which were not substantiated, Safeguarding Coordinator 1 took forward their concerns to the Diocesan Safeguarding Commission and it was agreed that Safeguarding Coordinator 1 would draw up a safeguarding contract for Canon McCoy to sign. This document was prepared and stipulated that Canon McCoy would meet monthly with an Episcopal Vicar to discuss the five restrictions listed therein. These were that he always have another responsible adult present when he was with young people, that he review his friendships with individual families, and the remaining three that he take a range of measures to ensure young people were not able to access alcohol in his presence. Bishop Dunn met with Canon McCoy, and, whilst he discussed the plan with him, he directed Canon McCoy not to sign the document; this direction was subject to considerable resistance from the Safeguarding Commission and Safeguarding Coordinator 1 but, ultimately, Canon McCoy was not required to sign the agreement. Canon McCoy was apparently expected to act in the spirit of the plan going forward, and this was to be monitored by the Episcopal Vicar; however, there are no records of any monitoring available, and the next updates to the file concern a fresh safeguarding concern several years later.

3.3 2010 Concerns

3.3.1 In February 2010, a further safeguarding concern was disclosed via the school chaplaincy team; a young person, known as EE in this Review, had reported that Canon McCoy had breached their personal space and was associating inappropriately with other young persons under the age of 18. The concern alleged that Canon McCoy had offered to take the young person on trips abroad and that he would supply the young person with alcohol. EE was sufficiently concerned and contacted various contemporaries, who raised their own concerns regarding Canon McCoy's behaviour.

3.3.2 In March 2010 a statutory meeting was held as a result of these allegations. Safeguarding Coordinator 2 attended. Police and the local authority confirmed that they would take no further

action. Instead, it would be for the Diocese to conduct an internal safeguarding investigation and notify the local authority if any significant further disclosures were received. The Safeguarding Commission Chair subsequently supervised the file and recorded that the Safeguarding Coordinator should update and reissue the safeguarding contract for Canon McCoy to sign, and that Canon McCoy should be removed from his Lourdes Youth and Vocations roles. The Commission formally stated the need for the contract to be signed when they met the next day.

3.3.3 The Safeguarding Commission met again in April, and they were informed by Safeguarding Coordinator 2 that Canon McCoy's contract had not been signed in 2007 on the instruction of Bishop Dunn (now deceased). The Commission reiterated that it was to be signed now. Bishop Cunningham was aware and recognised the need for this to happen. The Chair again endorsed the file to this effect.

3.3.4 The file makes no explicit reference to any steps taken to obtain Canon McCoy's signature on the safeguarding contract. However, the file does contain a copy of the 2007 document which was signed by Safeguarding Coordinator 2 and Canon McCoy on 10th March 2010. Both signatures were dated in the Safeguarding Coordinator 2's handwriting and there is no indication as to why this was discussed as an outstanding action at the April meeting. Canon McCoy was not removed from any of his roles with young people and, in effect, remained entirely unmonitored until Safeguarding Coordinator 3 came to review the file some nine years later. In relation to this case no abuse was substantiated and it is clear that statutory agencies did not feel the concerns raised met the threshold for further investigation.

3.4 2019 Review

3.4.1 In early 2019, Safeguarding Coordinator 3 was in the process of reviewing their predecessor's files when they discovered the safeguarding agreement drawn up in 2007 and, ostensibly, signed in 2010. Safeguarding Coordinator 3 could find no trace of the plan being monitored in the interim period and formed the opinion that the original agreement should be transferred to the current, formal Safeguarding Plan forms, and Canon McCoy reminded of the terms of the agreement. Safeguarding Coordinator 3 spoke directly with Canon McCoy about this, and he stated that the agreement had not been raised with him again in 2010, and he stated that it was not his signature on the paperwork.

3.4.2 An extraordinary meeting of the Safeguarding Commission was convened to discuss the case of Canon McCoy, and two other urgent matters. The Commission acknowledged that Canon McCoy showed a pattern of behaviour, but in the absence of any fresh safeguarding concerns, they concluded it was unnecessary to put a formal safeguarding plan in place. Instead, Safeguarding Coordinator 3 delivered 1-2-1 safeguarding training to Canon McCoy to reinforce the importance of maintaining appropriate boundaries and adhering to formal safeguarding policies and guidance. It was stipulated that he should follow the principles of the unsigned agreement.

3.4.3 Canon McCoy had been left without a safeguarding plan with its consequent unmanaged risks for a number of years as the result of the apparent inaction of Safeguarding Coordinator 2.

3.4.4 In 2019, the Diocese separately undertook a formal investigation of the actions of Safeguarding Coordinator 2 in respect of the 2010 concern. The Commission found that, on the balance of probabilities, Safeguarding Coordinator 2 had signed the safeguarding agreement themselves in 2010, and Safeguarding Coordinator 2 was required to stand down from various voluntary safeguarding positions within the Diocese.

4. Appointment as Dean of St Mary's Cathedral in 2019

4.1 Bishop Byrne's decision-making in respect of significant clergy appointments was subject to criticism both within and outside of the Diocese; it was suggested that he would make key decisions without any consideration to the wider safeguarding context, and that this was particularly the case where a friend or associate was involved.

4.2 This was notably the case with Canon McCoy who was appointed to St. Mary's Cathedral and the Chapter of Canons, despite having a significant history of safeguarding concerns, as outlined above. Bishop Byrne's knowledge of this safeguarding history became a contested issue, and a subject of some controversy for a survivor and their family. However, both former lay employees and senior clergy have provided clear accounts that Bishop Byrne was notified of concerns relating to Canon McCoy. When Bishop Byrne was installed in the Diocese in 2019, he received an in-person handover from Bishop Cunningham at Bishop's House; Bishop Cunningham provided an overview of the Diocesan clergy and specifically warned Bishop Byrne about safeguarding concerns related to Canon McCoy. Bishop Cunningham advised him that there were historic concerns regarding Canon McCoy and that he should speak to Safeguarding Coordinator 3 about these; after Canon McCoy took his own life, Bishop Byrne reportedly denied to Bishop Cunningham that he knew the history, at which point Bishop Cunningham reminded him of the 2019 conversation in Bishop's House. In June 2019, Bishop Byrne informed the Episcopal Council that he wished to appoint Canon McCoy to the cathedral. Concerns were raised by some of the Episcopal Vicars, who stated that it was an unwise appointment, but Bishop Byrne reportedly made it clear that this was his wish. Nine days later, Safeguarding Coordinator 3 and the Committee Chair visited Bishop Byrne at Bishop's House to discuss the findings of the Diocesan investigation into Safeguarding Coordinator 2; as part of this conversation, Bishop Byrne was verbally apprised of the historic concerns relating to Canon McCoy, in addition to having been emailed the entire summary file prior to the meeting. The cathedral appointment went ahead several months later, without any consultation with the safeguarding team; the appointment to the Chapter of Canons took place shortly afterwards.

5. 2021 Criminal Allegation

5.1 In April 2021, Safeguarding Coordinator 3 was notified by Northumbria Police that they had commenced an investigation into historical sexual offending by Canon McCoy. The offending was said to have taken place against a single child survivor between approximately 2001 to 2007. The Diocese, at the time, was not party to the identity of the complainant or the details of the alleged offending. From receiving the formal notification on a post-Bank Holiday Tuesday, Safeguarding Coordinator 3 put into action a detailed Diocesan safeguarding response to ensure that Canon

McCoy was stood down from public ministry and provided with appropriate support pending the substantive police investigation. Canon McCoy took his own life four days later on the Saturday. Diocesan actions during this short period have been examined in detail in the CSSA case audit, as well as an internal review conducted by the Diocese after Canon McCoy's death.

5.2 In August 2021, solicitors submitted a claim for damages to the Diocese on behalf of DD, who was identified as the complainant for the criminal allegations. The claim relied on a detailed account of Canon McCoy's behaviour over a number of years, from when DD was approximately 11 to 17 years of age.

6. Cathedral Concerns

6.1 In April 2021, following the standing down of Canon McCoy, Safeguarding Coordinator 3 was contacted by members of the Diocesan clergy. They reported that there had been inappropriate gatherings at St. Mary's Cathedral, Newcastle during lockdown. These gatherings were said to have been instigated by Canon McCoy, to have involved a small group of adults and to have involved alcohol consumption. Clergy were concerned for the reputation of the Diocese, with such activities taking place in their Church. These concerns recently became public knowledge, having been published online and picked up by the mainstream press in a variety of articles suggesting that the parties had actually been of a sexual nature. However, Safeguarding Coordinator 3 had conducted an internal investigation in 2021 and found that whilst there had been a group of male adults who would sometimes socialise after cathedral services, in the private residential quarters, there was no sexual element to the gatherings. The sexual orientation of the guests is irrelevant, as is the profession of any lay person in attendance. The Review Team has subsequently seen no evidence to suggest that the cathedral gatherings were anything more sinister than social gatherings during a period of lockdown restrictions. There is no safeguarding element to this line of enquiry and any remaining cathedral concerns were passed to the police for their consideration.

7. Related issues

7.1 The CSSA Review team has spoken with numerous Diocesan clergy and laity who were familiar with Canon McCoy. Whilst some people were approached directly by the team, many people proactively made contact to share their views. It became apparent that Canon McCoy had some complexity of character, and even those who were very fond of him either recognised some of these complexities or described problematic behaviours. These behaviours including over familiarity and inappropriate social contact with young people, allowing illegal consumption of alcohol by young people and offering rewards (e.g. foreign travel) to young people. These might be interpreted as grooming activities.

7.2 It was clear that Canon McCoy had been a hugely popular priest amongst large sections of the clergy and laity. He was considered to be a kind person, as well as a fresh and liberal voice within the Church, and was known for his extensive work with young people, for which he received some national recognition. Indeed, several people reported that he was known as the priest who had

"brought the youth back to the church".

7.3 There were many concerns raised with the CSSA Review team regarding Canon McCoy, and it was evident that some people were aware of issues with his behaviour at the time, and some have subsequently reflected on past matters and seen them in a new light. At the least, Canon McCoy's lack of boundaries was widely recognised, and people acknowledged that Canon McCoy should have been much more vigilant in following safeguarding procedures that would have placed him above suspicion. A clergy friend spoke of being shocked that Canon McCoy allowed young people to refer to him by an abbreviated version of his Christian name, and he advised him that this was a breach of appropriate clergy-parishioner boundaries. Another member of clergy recalled attending Canon McCoy's presbytery to find the door answered by young people who used Canon McCoy's nickname when informing him that he was out. Canon McCoy facilitating underage drinking was widely known.

7.4 Clergy and laity also raised specific and detailed concerns about Canon McCoy's association with young people. This included being overly tactile, favouring individuals, purchasing gifts and alcohol for young people. Young people were found intoxicated in Canon McCoy's presbytery. This is grooming behaviour and should have been identified and reported by those that witnessed it.

8. Analysis

8.1 It is beyond the scope of the current Review to offer evidential proof of any criminal offending on the part of Canon McCoy, or to pass judgement on the likelihood of such offending having occurred. However, Canon McCoy displayed a clear pattern of grooming behaviour over the years. There was an abundance of warning signals which should have given rise to more stringent safeguarding measures, and that the Diocese missed opportunities to intervene to prevent or ameliorate harm.

8.2 To criticise the response to the 1996 concerns would be to act with the benefit of hindsight and an expectation of a safeguarding practice that did not exist at the time. Nonetheless, these two concerns did encompass a range of grooming-type behaviours which ought to have triggered a more robust response in 2007. However, this response was muddled from safeguarding professionals and was then hampered by the actions of senior clergy.

8.3 The records provide a contradictory and confusing assessment of the risk presented by Canon McCoy in 2007. In a meeting of the Prevention and Training Committee, a lay expert expressed concern that Canon McCoy displayed emotional congruence with children, narcissistic traits and an inexplicable desire to spend all of his time with young people. The group expressed concerns that Canon McCoy had failed to respond to previous warnings. Safeguarding Coordinator 1 evidently shared these concerns and pressed for the signing of a safeguarding contract. However, the situation should have given rise to a formal psychological risk assessment of Canon McCoy, which may have provided additional material to enable effective safeguarding measures to be put in place. Despite these concerns being identified, Safeguarding Coordinator 1 subsequently wrote to Children's Services to advise them that no evidence was found to support the allegations, and request that this be passed to the informant "as a matter of justice".

8.4 The 2010 Diocesan response is of significant concern due to the relationship between Safeguarding Coordinator 2 and Canon McCoy, and the evident effect that this had on safeguarding processes. The two were associates who socialised together at work, at home and on holiday. Indeed, Safeguarding Coordinator 2 informed the CSSA Review Team that they had considered passing the investigation to another Diocese but believed that they had a pastoral responsibility to keep it. They did not advise the local authority that he had a conflict of interest due to this association, despite this being a standing point in statutory meetings. Had Safeguarding Coordinator done so, then they may not have been permitted to interview EE regarding the allegations. Indeed, EE now recalls feeling uncomfortable with the Safeguarding Coordinator's interview techniques, in which the Safeguarding Coordinator essentially questioned EE's faith and made EE feel disbelieved.

8.5 The Diocese was right to conclude that Safeguarding Coordinator 2 had, on the balance of probabilities, signed the diocesan safety plan on behalf of Canon McCoy. They confirmed this had occurred without the knowledge or consent of Canon McCoy. On Safeguarding Coordinator 2's own account, the paperwork was inaccessible to anyone outside of the safeguarding team, and that Safeguarding Coordinator 2 was the author of both dates accompanying the signatures. Despite being questioned extensively by the Diocese and CSSA Review Team, Safeguarding Coordinator 2 was unable to provide any sensible account of who had signed Canon McCoy's signature or why they had not themselves gained Canon McCoy's signature as repeatedly directed by the Safeguarding Commission. Safeguarding Coordinator 2 appears to have been disingenuous with both the Safeguarding Commission and the local authority; implying by omission that Canon McCoy was subject to formal monitoring processes. The result was that Canon McCoy was unmonitored for a further nine years.

8.6 Safeguarding Coordinator 2 was well-versed in the history of concerns relating to Canon McCoy, having been Safeguarding Coordinator 1's assistant at the time of the 2007 matter. Safeguarding Commission meetings minutes show that Safeguarding Coordinator 2 was present when the case, and the need to have the agreement signed, were discussed. Safeguarding Coordinator 2 had a relevant career prior to becoming Safeguarding Coordinator, and ought to have been familiar with grooming behaviours. In any event, Safeguarding Coordinator 2 ought to have had much greater professional curiosity and, at the least, arranged for Canon McCoy to be subject to a formal psychological risk assessment. As with the 2007 concern, this may have informed a more robust and effective safeguarding response.

8.7 The 2021 criminal investigation has had a profoundly negative impact on parishioners, not least because of Canon McCoy's advanced standing as Cathedral Dean, Canon and Head of Lourdes Youth Services. Many have questioned how Canon McCoy came to be appointed in 2019 and afforded access to Diocesan youth over such an extended period. Certainly, the Diocese will need to consider how to regain the trust of survivors and the Diocesan congregation in general.

8.8 Bishop Byrne's practice in making clergy appointments exemplifies his disregard for safeguarding procedures, as well as providing examples of tangible damage to the Diocese's standing. Bishop Byrne's assertion that he did not know of Canon McCoy's safeguarding history prior to the cathedral

appointment does not stand up to scrutiny; Bishop Cunningham, a current Episcopal Vicar, and a former safeguarding coordinator and Committee Chair have all reported that they informed Bishop Byrne of some element of Canon McCoy's previous history or unsuitability for such a prominent appointment. Bishop Byrne subsequently also tried to deflect criticism and scrutiny by informing trustees that it was an insignificant role, only for a former lay trustee to highlight to him that it was a very important role in the eyes of parishioners. Indeed, appointing a person about whom serious safeguarding concerns had been raised to such a high-profile position, and rewarding him with an appointment to the Chapter of Canons, will have undoubtedly damaged the reputation of the Diocese in the eyes of survivors and parishioners in general. Bishop Byrne's minimisation of his appointment of Canon McCoy is also undermined by Canon McCoy's clergy file, which shows that Bishop Byrne had offered Canon McCoy, or least discussed with him, the roles of Vicar General and Episcopal Vicar.

8.9 Canon McCoy's appointment was not an isolated incident, as the case of Father H illustrates (referenced at page 14 section 11). There can be no doubt that Bishop Byrne was aware of Father H's history of safeguarding concerns, at least to some degree; he was evidently on a friendly basis with Father H and he was given at least an overview of Father H's history in his June 2019 meeting with Safeguarding Coordinator 3 and the former Committee Chair. In any event, Bishop Byrne again made an appointment with no reference to the Diocesan Safeguarding Team or any clergy or safeguarding files, and a priest subject to a Diocesan safeguarding plan was given a prominent role in an environment where he had proved to be a safeguarding risk.

Part 2 B: Bishop Byrne's association with Father A

1. Introduction

1.1 Bishop Byrne's association with Father A has been included in this Review for a number of reasons. Father A is a priest of a religious order not affiliated to the Diocese of Hexham and Newcastle. Father A he has lived in the diocese for a number of years. He has no official affiliation with the diocese or role within it. He is a registered sex offender (RSO) [16]. In this report his name is anonymised for legal reasons, as there are ongoing court proceedings at the time of publication of this report.

1.2 It is our view that the association of Father A with Bishop Byrne undermined safeguarding professionals and the wider diocese. Father A has been named in media reports and there is a public interest in his activities and how they may have impacted on individuals within the Diocese. Inclusion in this Review is important because it sets out the facts, as they are understood, and survivors of abuse have a right to understand his role in the diocese, as do those who may have had contact with him.

1.3 The CSSA Safeguarding Review team in the Diocese of Hexham and Newcastle received information from a number of sources regarding a concern that Bishop Byrne was believed to be regularly associating with Father A, a RSO. The Review Team heard from Diocesan clergy and lay employees, past and present, who were concerned that this association served to undermine safeguarding practice within the Diocese and indicated a wider disregard for safeguarding measures on the part of Bishop Byrne.

2. Background & Criminal Antecedents

2.1 Father A was ordained a priest in 2005, having made his religious profession[17] in 2003. Before his offending came to light, the Order of which he was a member knew of no concerns relating to Father A. Indeed, he was well regarded within the Order and on a national level with his role working in religious education for the Catholic Bishops' Conference of England and Wales.

2.2 In August 2013, the Metropolitan Police executed a warrant at the priory in which he resided, in response to reports of indecent images of children being downloaded at that location. Numerous devices were seized from different priests as the identity of the person accessing the illicit material was unknown. Father A's computer was examined and found to contain circa 500 illegal images of children (27 of which were at the most serious levels}, circa 5000 prohibited images of children

[16] RSO: Under the Sex Offenders Act 2003 those convicted of certain listed offences are required to register with the police on an annual basis and provide specified personal details. The length of registration will depend on the nature of the conviction. Offenders subject to a registration requirement will be monitored by specialist local police officers.

[17] The solemn admission of men or women into consecrated life by means of the pronouncement of religious vows.

(cartoons and other pseudo-images), circa 70 documents, as well as circa 160 Skype and Yahoo Chat logs, relating to paedophilia; the chat logs dated back at least 18 months prior to the execution of the warrant. Police investigators were satisfied that the images had all been downloaded, and that there was no evidence that Father A had produced any original images of abuse.

2.3 He was subsequently interviewed by police and made partial admissions. He stated that no one else had access to his computer, but that the indecent images must have been unintentionally acquired as part of a bulk download of adult pornographic material. He later pleaded guilty to various related offences and, in Spring 2014, he was convicted of (i) Making Indecent Photograph/Pseudo-photograph of Child x 10 and (ii) Possess Prohibited Images of Children; he was sentenced to eight months' imprisonment, concurrent on all counts, suspended for 24 months. He was made subject to the conditions of a Sexual Offences Prevention Order for a period of five years and was placed on the Sex Offenders Register for a period of 10 years, from conviction.

2.4 Canonical processes were instigated by his Religious Order and they applied to the Holy See[18] for laicisation[19], but this was rejected in early 2015, with a recommendation that Father A discharge a year of penance to undertake therapeutic programmes, and then return to active ministry after a further year of restrictions and community service within the Order. This rejection of a request for laicisation is a serious issue for The Church. The fact that Father A retained his title despite the serious crimes for which he was convicted, will cause confusion both inside and outside the Church and has left Church bodies, including his own Order in an invidious position. The Provincial of the Order resisted Father A's return to public ministry, having assessed his conviction as presenting an ongoing risk to the Order's reputation and his brother priests' safety. He has not since re-entered public ministry. Father A's post-conviction denial of the offence, blaming an absent brother priest, and claiming that he pled guilty under pressure from the Order, also gave cause for concern. This Review is unaware of any evidence to suggest that anyone else had access to Father A's devices or that pressure was placed upon him to plead guilty.

2.5 Father A was subsequently managed by the Birmingham Safeguarding Team, as his Order was in alignment with the Archdiocese. Father A had no formal links with the Diocese of Birmingham. Father A was never resident in Birmingham. The alignment of the Order with Birmingham Archdiocese continued when Father A relocated to the Diocese of Hexham and Newcastle in 2015. Notification of Father A's residence in Hexham and Newcastle was provided to the Diocese of Hexham and Newcastle by the Probation Service as opposed to his Order or the Archdiocese of Birmingham. Although Safeguarding Coordinator 3 became professionally aware of the situation when they took up their post in 2017, it was not until 2019 that they were permitted to take a lead role in locally managing Father A's safeguarding plan. It is usual practice that the aligned Arch/Diocese would maintain overall responsibility for an individual subject to a plan. It would be reasonable for an arrangement to be in place for the day to day management to be assisted by the diocese where the individual resides.

[18] The government of the Roman Catholic Church, led by The Pope.
[19] Laicisation is the process by which a priest is formally dispensed from the clerical state.

3. Association with Bishop Byrne

3.1 Father A and Bishop Byrne, although from separate religious orders, are believed to have known each other for approximately three decades. On Bishop Byrne's own account, Father A was a close personal friend. What is not disputed in this matter is that Bishop Byrne associated with Father A between 2019 and 2022; the nature of this association is, however, contested. Bishop Byrne's account of the association is that this was pastoral, providing Father A with spiritual support during difficult times, and was infrequent.

4. Living Arrangements

4.1 Safeguarding Coordinator 3 first became aware of Bishop Byrne's association with Father A in 2019, not long after being installed in the Diocese. It was at their first meeting that Bishop Byrne stated to Safeguarding Coordinator 3 that he felt lonely and isolated in Bishop's House and wanted Father A to move in with him. They advised Bishop Byrne verbally, and via email, that this was inappropriate due to Father A's status as an RSO. Bishop Byrne made a further request for Father A to live with him in late 2019/early 2020. Father A's order were withdrawing from the Diocese and Bishop Byrne was concerned that Father A would be left alone. Safeguarding Coordinator 3 advised that Father A was not a Diocesan Priest, that it was a matter for his own Order to support him and that, in any event, it was his personal choice to continue to live in the Diocese. Bishop Byrne also raised the matter with the CSSA Vice Chair in November 2021 on a routine introductory meeting. Bishop Byrne stated that he had a friend who had "made some mistakes but had not touched any children". Bishop Byrne explained that he was lonely, and the man needed his support. The Vice Chair made it clear that contact with this male would be wholly inappropriate and expressed his surprise that Bishop Byrne could even think about taking such action.

4.2 Despite this opposition to Father A spending time at Bishop's House, it is evident that he did in fact spend considerable time there, and that he would stay overnight on the premises. This was not confined to when Bishop Byrne was present. Father A was seen frequently at the former Bishop's House when Bishop Byrne was present; they spent considerable time in the private quarters, and Bishop Byrne reportedly stated that Father A was helping him pack up his books and other belongings, in preparation for the move to a new house. When Bishop Byrne belatedly moved to the new Bishop's House, Father A was again a regular presence. Bishop Byrne accounted for this by advising that Father A was helping him settle into the venue as he was a good organiser. Bishop Byrne was apparently quite open about this and indicated to a staff member that Father A would be around "while the house is quiet".

4.3 Father A was known to have his own set of keys to Bishop's House. Bishop Byrne is reported to have allowed Father A access to the private quarters of St. Mary's Cathedral on at least two occasions during this time.

5. Employment Arrangements

5.1 In October 2019, Bishop Byrne contacted Safeguarding Coordinator 3, via email, to discuss possible Diocesan employment for Father A. Work was being completed in the Diocesan archives, and Bishop Byrne requested that Father A be employed in this context. Safeguarding Coordinator 3 refused Bishop Byrne's request on the basis that the files contained sensitive information, and that it would not be appropriate for someone subject to statutory monitoring to be accessing this material. Furthermore, the archives were located within Bishop's House, and Safeguarding Coordinator 3 had already advised on the unsuitability of an RSO spending time at this location. Safeguarding Coordinator 3 was also concerned that allowing Father A to complete this work might send the wrong message to the wider diocesan clergy, as well as presenting a reputational risk for the Diocese. Bishop Byrne was reluctant to accept this advice and insisted that he would revisit the matter with Safeguarding Coordinator 3 in due course.

5.2 In May 2021, Bishop Byrne had cause to meet with a representative of an overseas charity, named in this Review as FF. Bishop Byrne requested that FF facilitate a teaching post within a seminary abroad. Bishop Byrne gave very limited details of Father A's antecedents, but implied that he was only subject to RSO requirements for a few more months. FF subsequently searched online and was shocked to discover the details of Father A's offending. Although he felt misled by Bishop Byrne, he agreed to meet with Father A to discuss the matter. During the meeting, Father A made denials of his guilt, and tried to persuade FF that he posed no risk to young people as his sexual preference was for adult women. FF met with Bishop Byrne for a final time before he returned abroad; Bishop Byrne made further attempts to persuade FF to find employment for Father A. Bishop Byrne reportedly minimised Father A's offending, saying it "wasn't really a big deal", and vouched for him as a longstanding friend and a "great teacher". Bishop Byrne also reportedly made it clear to FF that he was trying to find a way to override the Diocesan Safeguarding Team so as to be able to find Father A paid work in the Diocese and, ultimately, a way back into Ministry. FF ultimately resisted these requests for employment, having decided that Father A would present a safeguarding risk to children and adults at risk within their area of responsibility or the wider community. Bishop Byrne's failure to recognise this himself, displays a fundamental failure to appreciate the basic principles and importance of adequate safeguarding for children and adults at risk.

6. Diocesan Awareness of Association

6.1 Numerous enquiries have been made to ascertain who from the Diocese knew about Bishop Byrne's association with Father A - what they knew and when they knew it. Whilst the 'who' and the 'when' is relatively straightforward, the quality of people's knowledge is a more contested subject.

6.2 Safeguarding Coordinator 3 knew of the relationship in early 2019, on disclosure by Bishop Byrne himself. Safeguarding Coordinator 3 reportedly informed the Chief Operating Officer the same day, having been shocked that Bishop Byrne saw fit to request that Father A move in with him.

6.3 It was in April 2021 that Safeguarding Coordinator 3 and an Episcopal Vicar became aware that the association had endured, and Father A was spending time at Bishop's House. The new Cathedral Dean had been informed of this fact by a lay employee of the diocese, who also worked at Bishop's House and had advised Safeguarding Coordinator 3. In June 2021, Safeguarding Coordinator 3 met

with Bishop Byrne, in company with the Vicar General, to discuss some sensitive matters that had been reported by different people in the Diocese. Safeguarding Coordinator 3 again raised the matter of Father A, advising Bishop Byrne that his judgement in this matter was susceptible to challenge. Safeguarding Coordinator 3 advised that Father A was a difficult person who undermined the safeguarding team and reiterated that any pastoral support should be provided by a Diocesan priest, rather than Bishop Byrne. Although the Vicar General believed at this stage that the association was pastoral, he was aware that Bishop Byrne had taken Father A to the Cathedral and they had associated there with Canon McCoy, that Bishop Byrne had tried to obtain work for Father A in the Diocesan archives and that Safeguarding Coordinator 3 had repeatedly advised Bishop Byrne against the association.

6.4 In October 2021, Safeguarding Coordinator 3 was informed that Bishop Byrne had tried to gain Father A employment with the overseas charity. Safeguarding Coordinator 3 made direct enquiries and was able to confirm that it had not come to pass. It was in December 2021 that the Board of Trustees was formally informed of the relationship by the Chief Operating Officer. The Chief Operating Officer spoke directly with Bishop Byrne regarding this, and he presented some resistance to the Board being notified. However, the Chief Operating Officer was adamant that this needed to happen to enable the Board to take any action they deemed necessary to protect the charity. It seems that whilst they were aware of the general allegations about the relationship, they were satisfied with Bishop Byrne's assertion that he was only providing pastoral support.

6.5 It is in 2022 that the trustees gradually obtained the full details of Bishop Byrne's relationship with Father A. The chair of the Diocesan Trustee Safeguarding Committee had been completing an internal review into the history of Canon McCoy, following his death in 2021. This formed what became known as the 'part 2' of the internal Review in to that matter. The terms of reference of the internal review were amended at a trustees' meeting to include concerns raised about Bishop Byrne and his relationship with Father A. At a meeting in October 2022, Bishop Byrne relayed to an Episcopal Vicar, the Chief Operating Officer and Safeguarding Coordinator 4, that Father A had stayed overnight at Bishop's House on more than one occasion. This was the first time they were aware that father A had stayed overnight.

6.6 An extraordinary meeting of the Trustees Board took place the following week; the chair of the Diocesan Trustee Safeguarding Committee raised some evidence from their internal review. Bishop Byrne denied that Father A was living at Bishop's House, he insisted that he had only visited when he was on the premises, no more than every 10 days and that their relationship was a pastoral matter. Bishop Byrne was challenged by the trustees and they ultimately asked him to leave the meeting so that they could discuss the situation. An Episcopal Council meeting followed this, and Bishop Byrne reportedly apologised for failing to heed advice on the matter. In January 2023, the Board was presented with the full details of the internal review, which included much greater detail about the association. By this time, both the report author and Bishop Byrne had tendered their resignations.

7. Commentary

7.1 Information from multiple Diocesan witnesses clearly evidences a close friendship between Bishop Byrne and Father A; Father A evidently socialised with Bishop Byrne, spent time at Bishop's House during the day and overnight, spent time in the private quarters of St. Mary's Cathedral, and was recommended by Bishop Byrne for employment. We found no evidence to support Bishop Byrne's assertion that he was simply providing pastoral support to Father A. On Bishop Byrne's own account, he first sought permission to live with Father A as he personally felt isolated residing alone in Bishop's House. Safeguarding Coordinator 3 requested in writing that Bishop Byrne provide the details of his pastorally supportive meetings so that they could properly document them on the relevant safeguarding file. This request was not acknowledged or responded to by Bishop Byrne.

7.2 We found no evidence available at this time to suggest that Bishop Byrne provided direct pastoral support to any other clergy who were subject to a Safeguarding Plan.

7.3 It is evident that Diocesan clergy and lay employees were negatively impacted by Bishop Byrne's association with Father A. Numerous Diocesan clergy have reported their disgust that a senior leader would conduct a friendly association with someone convicted of child sexual offences. The fact that the association often took place in St. Mary's Cathedral was also particularly unpalatable to some clergy; not least because the venue is very close to a nursery, but also because it is the Diocese's primary church.

7.4 Without prior knowledge of the offending history of Father A, members of diocesan staff found themselves in his presence, in the case of one employee, against their strong wishes. Whilst we found no evidence that Father A presented a direct risk to these employees, it should be without question that they are allowed full agency in deciding whether or not to spend time with an RSO.

7.5 The association was evidently problematic for Safeguarding Coordinator 3, and their attempts to administer Father A's Safeguarding Plan were made more difficult. Safeguarding Coordinator 3 reported how Father A's attitude became increasingly challenging and confrontational between 2019 and 2021. Records show that Father A sought to undermine and embarrass Safeguarding Coordinator 3 in front of clergy and cross-Diocesan safeguarding professionals in relation to a Review meeting. Father A also sent Safeguarding Coordinator 3 an email the day after they further challenged Bishop Byrne regarding the association. It was clear that Bishop Byrne had reported the content of this meeting to Father A, who had felt sufficiently emboldened to send his response to Safeguarding Coordinator 3's intervention. Whilst Safeguarding Coordinator 3 applied for and was successful in finding a new role outside of the Diocese, Safeguarding Coordinator 3 is clear that the desire to leave was driven by the fact that their role had been undermined by Bishop Byrne and that he had placed children and adults at risk at risk of harm by his disregard for safeguarding processes.

7.6 It is clear that the association presented practical difficulties for Safeguarding Coordinator 4 and the Chief Operating Officer, who had to manage the unfolding crisis when the association became public and, significantly, came to the attention of a Diocesan survivor. Bishop Byrne's lack of candour during this period presented a significant challenge. Bishop Byrne's behaviour in the wake of the Diocesan Trustee Safeguarding Committee Chair's resignation was also highlighted. Rather than

contact the safeguarding team to offer support and consider interim solutions, the day after the resignation saw Bishop Byrne contact Safeguarding Coordinator 4 to request that they check in with Father A to make sure that he was not feeling isolated. The former Diocesan Trustee Safeguarding Committee Chair also reported that they felt that they had no choice but to tender their resignation when it became apparent that Bishop Byrne had repeatedly ignored the advice provided by them and the Safeguarding Coordinators in respect of associating with an RSO; they felt that their position had become untenable due to Bishop Byrne's actions.

7.6.1 Bishop Byrne's association with Father A has undoubtedly damaged both the standing of Bishop Byrne and the Diocese as a whole. The matter has been featured in the media, and has naturally and understandably prompted reactions from those speaking on behalf of survivors and from clergy and laity. Most fundamentally, the association between Bishop Byrne and Father A posed an unacceptable safeguarding risk which should never have happened.

7.6.2 The trust of survivors and their families through the association between Bishop Byrne and Father A is likely to have been severely damaged affecting the ability of the Diocese to engage with them going forwards; something acknowledged by senior Diocesan clergy. Bishop Byrne was cautioned regarding such a relationship by the Diocesan Trustee Safeguarding Committee Chair, Safeguarding Coordinator 3 and at least one member of his Episcopal Council. He chose to ignore these warnings.

7.7 It was not just the Diocesan charity that was put in jeopardy by Bishop Byrne's association with Father A. FF discussed how he felt that Bishop Byrne had abused his position in relation to his requests to facilitate a teaching role abroad for Father A. FF highlighted the inherent danger to the children and adults at risk under the charity's charge had Bishop Byrne's request been acceded to and Father A, an RSO, been employed.

7.8 The association between Bishop Byrne and Father A was inappropriate and undermined safeguarding professionals, other employees and trustees. Allowing Father A unrestricted access to a number diocesan premises, including public and private areas, presented a serious safeguarding risk.

7.9 Bishop Byrne was approached for his views and provided a statement answering pre-set questions, which he asked not to be published.

Summary

The purpose of the CSSA Review was to audit and examine the culture, governance, processes, and practice of safeguarding in the diocese of Hexham and Newcastle.

Our first priority was to examine the current safeguarding practice against the 8 standards.

1 Current safeguarding practice

1.1 We are satisfied that the work of the present day safeguarding team generally follows current safeguarding practice, in that it meets the minimum required standards. In particular:

a. Individual safeguarding cases are appropriately managed.

b. Wider issues such as an increase in overdue DBS re-checks are identified and addressed.

c. Parishes are supported to implement safeguarding processes.

d. Governance arrangements have developed in accordance with national expectations to replace the safeguarding commission with a committee of trustees.

1.2 The CSSA has developed a grading system for use in its audit process. Whilst the overall grading was "Early Progress", effective management of allegations and concerns was determined as reaching "Firm Progress".

2 Culture, Leadership and Governance

2.1 Our review has identified a number of failures of culture, leadership and governance which have undermined the work of safeguarding professionals and left people at potential risk.

2.2 There was a lack of clear and unambiguous support from Bishop Byrne for the Church's position of zero tolerance of abuse. Any statements made by him to this effect were undermined by his association with a priest who is also a registered sex offender and his failure to follow safeguarding advice in terms of appointments, or responses to individual cases. His management of safeguarding was directly cited as a reason for lay trustees to resign, some questioned the selectivity of safeguarding issues with which he would deal, and others questioned whether he fully understood and supported the need for safeguarding at all.

2.3 Governance arrangements for safeguarding have been weakened by the loss of lay trustee expertise and, more recently, lay Diocesan Trustee Safeguarding Committee specialist advisors. The diversion of safeguarding issues to the Episcopal Council has reduced accountability and undermined the expertise of the safeguarding team.

2.4 There is evidence that senior leaders and trustees raised safeguarding concerns both inside and outside of formal meeting structures. There is evidence that the safeguarding team and members of the Diocesan Trustee Safeguarding Committee were concerned about the way in which survivors

were supported and put them at the fore front of their considerations. However, in interviews and focus groups it was apparent to the review team that there were also concerns raised about the 'reputational risks' posed by the issues highlighted in this report. This is a common theme in many safeguarding reviews across many organisations. It is an issue that is extremely difficult to deal with. It is of course unacceptable for senior leaders to address safeguarding concerns based on the degree of apparent reputational risk. However, there is a legal responsibility to consider reputational risk and it is an area in which senior leaders and trustees need support. It is essential that all training, but in particular that related to those in leadership and trustee roles, focuses attention on the damaging effect placing personal or organisational reputation before the care and protection of survivors and/or children and vulnerable adults at risk can have. In any organisation reputational risks will be considered, but senior leaders need to demonstrate that the safety, support and protection of survivors and children and adults at risk, is the first and major priority alongside the integrity of the safeguarding process. Transparency and effective, decisive action in safeguarding matters should be at the heart of the approach by everyone, in particular senior leaders. This approach should not be sacrificed in order to mitigate against a reputational risk. This is highlighted as a national issue in this report because it is clear that there is a huge reputational risk to the diocese in this case and there appears to be little guidance or support for senior leaders or trustees on how to balance their approach to that risk with their responsibilities towards survivors.

3. Decision making process

3.1 It is essential that senior church leaders listen to, and understand, the advice of those with safeguarding expertise. Safeguarding professionals must have the confidence and authority to discuss concerns with senior church leaders and determine together the safest course of action to manage risk. This did not always happen in Hexham and Newcastle.

3.2 When a safeguarding recommendation is made to the Bishop, the Bishop should receive a written briefing by the Chair of the Diocesan Trustee Safeguarding Committee and Safeguarding Coordinator. Following discussion with them, the Bishop should consider the evidence and clearly document their decision, with the rationale for that decision clearly laid out. Where the Bishop decides to contradict the advice of safeguarding professionals, in part or in full, the rationale should be written and presented to the Diocesan Trustee Safeguarding Committee. Bishops have, under canon and civil law (in terms of their role as chair of trustees), the final say in these decisions. On those occasions where they disagree with professionals, they should articulate their rationale for their decision and be clear about how any risk will be mitigated. They should also fully recognise that such a deviation from professional advice should only occur in cases where the advice received from safeguarding professionals is irrational; an occurrence which will happen extremely infrequently. In these cases there should be further consideration by the committee of reporting the concern to a statutory agency (for example, the police, Charity Commission or LADO) where there is a continued risk of harm to an individual.

3.3 Senior church leaders may wish to consider a process by which safeguarding decisions, by the Bishop, can be legitimately challenged within the auspices of canon law. This would accord with the agreed position of the Bishops' Conference, who have adopted IICSA recommendation 3 which states:

"The Catholic Bishops' Conference of England and Wales and the Conference of Religious should publish a clear framework for dealing with cases of non-compliance with safeguarding policies and procedures. That framework should identify who is responsible for dealing with issues of non- compliance at all levels of the Church and include the measures or sanctions for non-compliance."

There may be a role for the new National Tribunal Service in this regard.

3.4 In the diocese of Hexham and Newcastle decisions to override the advice of professionals undermined safeguarding and potentially placed people at risk of harm. The Bishop did not explain his decisions to contradict specific safeguarding recommendations or indicate how risks would be mitigated. The Bishop displayed a lack of understanding of safeguarding practice and placed the needs of himself and associates over the safety of potentially vulnerable individuals. This was unacceptable and dangerous practice. Ultimately, where leadership fails, safeguarding fails. Professionals in the safeguarding team were let down by this failure in Hexham and Newcastle. This was compounded by the fact that safeguarding professionals have no means or process, within the Church, to formally challenge the Bishop's decision and seek adjudication from an independent authority.

4 Provision of support and pastoral care

4.1 There should be a clear and unequivocal offer of support to survivors and any person who wishes to raise safeguarding concerns. The diocese has recently agreed and published *Commitment to Survivors,* however this is not underpinned by a clear pathway. It does not set out roles, responsibilities and expectations of all involved. This can result in a situation where responsibility rests too heavily with the Safeguarding Coordinator. Those who need support may fail to receive it in the way that they need it, when they need it.

4.2 A number of those spoken with during the review felt that the diocesan response was lacking in care and compassion, despite the hard work of some individuals. Both the development of a pathway and effective response will require specialist training for those involved; consideration should be given to either a specialist post whom survivors can work with or making formal arrangements with an external provider.

4.3 More formal and established arrangements for managing respondents of complaints are also required in order to reduce the need for the safeguarding team to develop solutions on an ad hoc basis following an allegation.

5 Appointments

This review has identified a number of appointments to diocesan positions (including school foundation governors and directors) and clerical roles that have been made, despite existing safeguarding concerns about the person in question. For example, Father Michael McCoy's appointment to his role as Dean of the Cathedral, was made in the full knowledge of a number of safeguarding concerns over an extended time period. Bishop Byrne attempted to find a role for a convicted sex offender both within the diocese and an external charity which was supporting

vulnerable people in a severely disadvantaged country. In addition, a lack of information sharing between departments in the curia has resulted in the inappropriate appointment of school foundation governors. Failure to undertake due diligence in making these appointments further undermines safeguarding process.

6. Transparency

IICSA called for transparency in safeguarding in the Catholic Church. In this case, the immediate appointment of the CCSA by Archbishop McMahon, with a clear mandate to look at all aspects of safeguarding, and in his agreement to publish this report in full, demonstrates a commitment to achieving this transparency. In order for survivors and the wider public to have confidence and trust in the Church, consideration needs to be given to the way in which disciplinary issues are dealt with. In this case, Father A was not laicised, despite his convictions, and the request by his own Order. Throughout the period of the review, the issue of the suitability of Bishop Byrne's appointment has been raised. The Church may wish to consider how the appointment process of Bishops is managed transparently and robustly to dispel fear and suspicion in the wider community.

7. Conclusion

7.1 In interviews and focus groups conducted as part of the review, there was a sense of anger and hurt, sometimes as a result of personal experiences, but often for the hurt caused to survivors and more simply, at the damage which has been done to the Diocese. This was typically balanced by personal experiences of individual clergy and others within the diocese who they continue to hold in high regard.

7.2 Work is already being undertaken to improve and balance governance structures and tackle issues raised during the review. The diocese has been open and transparent with the CSSA review team and new leadership is demonstrating a commitment to continuous improvement.

7.3 The diocese should act urgently and communicate to both the communities of the Church and wider public how they will implement our recommendations to strengthen safeguarding and protect the vulnerable.

Recommendations

Recommendations for the Diocese of Hexham and Newcastle

1. The diocese should acknowledge the impact of this review on those within the diocese, and make clear its renewed commitment to safeguarding those who come in to contact with the Church. This commitment should be made by the Archbishop and trustees.

2. The diocese should develop a clear pathway for engaging with survivors, making clear the role of diocesan personnel, pastoral provision and access to specialist independent agencies. Those coming in contact with survivors should be trained and adequately equipped to provide necessary support.

3. Governance arrangements should be reviewed to ensure that there is sufficient lay safeguarding expertise and that all safeguarding matters are reviewed by those who have the required knowledge, understanding and training. Safeguarding professionals should be viewed as experts and their opinions duly considered. Disagreements and escalation should be clearly recorded and a written process for resolution considered for occasions when disagreements occur.

4. A more robust process should be developed for the use of overseas priests within the diocese, ensuring the engagement of the safeguarding team at the earliest opportunity.

5. Steps should be taken to ensure that the backlog of DBS re-checks is eliminated and mechanisms should be in place to ensure that this does not re-occur.

6. A safeguarding communication plan should be created and implemented, setting out a public commitment to safeguarding. Key people, including survivors, should be included in developing this plan.

7. A safeguarding implementation plan should be developed, outlining the safeguarding priorities of the diocese and stating what will be achieved and by when in developing and maintaining a safe environment.

8. The diocese should consider ways in which to seek assurances on the effectiveness of practice, for example through the undertaking of internal case audits.

9. Arrangements for on-going contact with respondents should be clarified and applied in practice. This should include the provision of appropriate accommodation and support. Respondents should be informed of sources of support available to them.

10. Practice around volunteers should be strengthened through introducing policies to cover safe recruitment, role expectations, and removal from role.

11. The diocesan whistleblowing policy should be reviewed to ensure that there are safe routes for all employees and volunteers to raise a concern.

12. Links between the education department of the diocese and the safeguarding team should be strengthened with a formal information sharing agreement. This should be applied before any appointments are made to prominent roles such as governors, foundation governors and directors. Mandatory reporting by individuals of any prior concerns relating to their suitability to work in such roles should be considered.

National Recommendations

1. The Bishops' Conference should provide guidance as to expected escalation process when decisions of the Diocesan Trustee Safeguarding Committee, or a case advisory panel, are not implemented by the Bishop or his representative.

2. The Bishops' Conference should set out expectations as to how dioceses manage complaints about their Bishop.

3. Specialist training should be provided to Bishops on how to provide appropriate support for those accused or convicted of serious criminal offences.

4. Where canonical investigations have commenced, consideration should be given to any safeguarding matters arising. Any risk should be communicated to the safeguarding team and managed in line with national safeguarding standards.

5. Safeguarding officers should be in receipt of reflective case supervision from a suitably qualified source.

6. Standards for recording of safeguarding matters should be set nationally.

7. All dioceses should consider ways in which to seek assurances on the effectiveness of practice, for example through the undertaking of internal case audits.

8. Dioceses should consider the development of a whistleblowing policy specifically for members of the clergy.

9. Clergy and leadership training should include content describing the damage caused by considering reputational risk above the safety of children and adults at risk. There should be further content examining when and in what forum reputational risk should be considered and an understanding that it cannot damage the integrity of safeguarding process.

10. The Bishops Conference may wish to consider how disciplinary and appointment processes can be made more transparent, to provide reassurance both inside and outside Church bodies.

Appendices

A: Terms of Reference

The Catholic Safeguarding Standards Agency (CSSA) will, at the request of The Most Reverend Malcolm McMahon, Archbishop of Liverpool, carry an unscheduled safeguarding audit of the Diocese of Hexham and Newcastle.

This unscheduled audit will be known as a Safeguarding Review because some of the work will be outside the parameters of our published safeguarding audit process.

Timings

This work will begin on Thursday 19 January 2023. Whilst the CSSA hopes to complete the Safeguarding Review by 1 April 2023, this is subject to change.

Purpose

The purpose of the Safeguarding Review is to audit and examine the culture, governance, processes and practice of safeguarding in the dioceses of Hexham and Newcastle.

The Review will include all of the elements of a scheduled CSSA safeguarding audit, specifically how the eight national safeguarding standards are being met. These elements are published on the CSSA websiteIn addition to these usual elements of an audit, and as commissioned by Archbishop McMahon, in the situation of Hexham Newcastle, the Safeguarding Review may include, but not be restricted to:

- Interviews with key stakeholders including clergy former and present / staff former and present / lay volunteers former and present / survivors as appropriate.
- Case audits – current and past (including older than 12 months as appropriate)
- An focus on culture and governance arrangements around the safeguarding process
- Surveys and focus groups
- Liaison with other stakeholders carrying out parallel investigations including (not restricted to) other statutory and non-statutory agencies. This will include the Charity Commission.
- Consideration of any supplementary documentation as necessary.

The role of CSSA

The Safeguarding Review will be overseen by the current Chief Executive Officer of CSSA, Stephen Ashley, with support of CSSA senior managers.

The Quality Assurance Team, led by Quality Assurance Manager Hayley Brooks, will lead the Review.

At the end of the Safeguarding Review, CSSA will provide a summary of findings. CSSA will offer the Dioceses opportunity to correct factual accuracies.

The Final Executive Summary will be at the sole discretion of the CSSA.

CSSA will publish the Executive Summary on its website and recommend that Hexham and Newcastle also publish the Executive Summary on their website.

It is acknowledged that the Chief Operating Officer in Hexham and Newcastle, and Safeguarding Coordinator, had previously volunteered to be the subject of a pilot baseline audit that would have taken place in May 2023. CSSA will discuss with the dioceses following this Safeguarding Review. It may or may not constitute this pilot baseline audit.

CSSA are offering the opportunity for anyone to provide confidential information to the CSSA Review Team by emailing HexhamandNewcastleinfo@proton.me or anonymously at https://forms.office.com/e/pHLnT00Zix. We ask that this information is shared proactively as widely as possible within the Diocese.

B: Interviews

By role(s) held:

Bishop's secretary
Chief Operating Officer
Diocesan Chancellor and Diocesan Trustee Safeguarding Committee members
Episcopal Vicar and trustee
Episcopal Vicar and trustee
Episcopal Vicar, trustee and Dean of Cathedral
Episcopal Vicar, trustee and Diocesan Trustee Safeguarding Committee member
Episcopal Vicar, trustee and Diocesan Trustee Safeguarding Committee member
Head of Communications
Lay former chair of Diocesan Trustee Safeguarding Committee
Lay Diocesan Trustee Safeguarding Committee expert advisor
Lay Diocesan Trustee Safeguarding Committee expert advisor
Lay trustee
Lay former trustee
Lay former trustee
Lay former trustee
Lourdes Pilgrimage President of Hospitality
Religious Diocesan Trustee Safeguarding Committee member
Religious Trustee
Safeguarding advisor
Safeguarding Coordinator - current
Safeguarding Coordinator 1
Safeguarding Coordinator 2
Safeguarding Coordinator 3
Vicar General and trustee

A further 28 people were interviewed, including some with current or former diocesan roles, either as part of case studies or having requested a meeting following the public call for information.

C: Case audits

CASE	INITIAL RESPONSE	ASSESSMENT	PLAN/REVIEW	MANAGEMENT OVERVIEW/DECISION MAKING	PERSON CENTRED PRACTICE	RECORDING	OVERALL
1	Good	Good	Requires Improvement	Requires Improvement	Good	Requires Improvement	Good
2	Good	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement
3	Good	Good	n/a	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement
4	Good	Good	Good	Requires Improvement	Good	Requires Improvement	Good
5	Good	n/a	n/a	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement
6	Good	n/a	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement
7	Good	Good	Requires Improvement	Good	Outstanding	Good	Good
8	Requires Improvement	n/a	Requires Improvement	Requires Improvement	Requires Improvement	Good	Requires Improvement
9	Good	Insufficient	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement
10	Requires Improvement	n/a	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement
11	Good	n/a	Good	n/a	Good	Good	Good

D: Survey for Clergy – Hexham and Newcastle Diocese

Survey for Clergy - Hexham and Newca:

E: Survey for Parish Safeguarding Representatives – Hexham and Newcastle Diocese

Survey for Parish Safeguarding Repre

F: Chronology of significant events

20th March 1992	Ambrose Griffiths OSB ordained Bishop
1996	Safeguarding Coordinator 1 starts in role
August 1996	Safeguarding Coordinator 1 warns Canon McCoy about his behaviour following concerns about his association with two teenage boys
November 1996	Safeguarding Coordinator 1 provides Canon McCoy with child protection training following receipt of a further anonymous concern
25th May 2004	Bishop Kevin Dunn ordained Bishop
April 2007	Following receipt of concerns from statutory authorities in respect of Canon McCoy facilitating underage alcohol consumption, the safeguarding commission recommends that he is required to sign a safeguarding contract. Bishop Kevin Dunn directs him not to sign it
1st March 2008	Bishop Kevin Dunn dies
20th March 2009	Bishop Seamus Cunningham ordained Bishop
2009	Safeguarding Coordinator 2 starts in role (having worked as an assistant to Safeguarding Coordinator 1 for approximately two years beforehand)
February 2010	A safeguarding concern in respect of Canon McCoy's association with a school pupil is received. The Safeguarding Commission again request that a safeguarding contract is signed, which is seemingly done, providing the impression that he will be monitored
2014	Fr A convicted of a series of offences relating to indecent images of children, thereafter subject to a sex offender registration requirement for a period of 10 years
2015	Fr A's religious order's application for his laicisation is refused by the Holy See, his order do not allow him to return to public ministry though. He moves to an address within Hexham and Newcastle, the diocese are notified of his safeguarding plan, although it continues to be owned by the Archdiocese of Birmingham due to the alignment of his order
2017	Safeguarding Coordinator 3 starts in role
2019	Safeguarding Coordinator 3 identifies that Canon Mc Coy's safeguarding contract has not been monitored, he is provided with individual safeguarding and boundaries training
25th March 2019	Robert Byrne CO ordained Bishop
June 2019	Canon McCoy appointed as Dean of St Mary's Cathedral and awarded the title Canon
2019	Safeguarding Coordinator 3 becomes aware of Bishop Byrne's association with Fr A and advises him that it would be inappropriate for him to reside at Bishop's House, advice later provided that it would not be appropriate to employ him as an archivist
September 2020	Publication of the *Independent Review of Safeguarding Structures and Arrangements in the Catholic Church in England and Wales* ("The Elliott Review")
6th April 2021	Safeguarding Coordinator 3 advised by Northumbria police of a criminal allegation against Canon McCoy, he agrees to a temporary withdrawal from ministry and moves to alternative accommodation
10th April 2021	Canon McCoy dies, later determined by the Coroner to be a suicide

April 2021	Safeguarding Coordinator 3 made aware of concerns in respect of inappropriate gatherings at St Mary's Cathedral during lockdown. Subsequent investigations by Safeguarding Coordinator 3 found no sexual or safeguarding element.
April 2021	Trustees commissioned a Review Report of the diocese actions immediately preceding Canon McCoy's death.
May 2021	Bishop Byrne requests that an overseas charity provide employment for Fr A
8th June 2021	Trustees hold 'emerging conclusions' session
23rd June 2021	Trustees received the final Review Report for adoption.
December 2021	Ahead of the implementation of the Elliott Review recommendation to establish a Diocesan Trustee Safeguarding Committee, the existing Commission Chair becomes a trustee with lead trustee responsibility for safeguarding
December 2021	Trustees formally made aware of Bishop Byrne's association with Fr A on the grounds of the reputational risk to the charity
January 2022	Safeguarding Coordinator 4 starts in role (having worked as safeguarding advisor for approximately three years beforehand; the safeguarding advisor role subsequently remained vacant until August 2022)
7th September 2022	First meeting of the Diocesan Trustee Safeguarding Committee, replacing the Safeguarding Commission in accordance with the recommendations of the Elliott Review
12th October 2022	Board of Trustees further discuss Bishop Byrne's association with Fr A, more information in this respect having emerged in the course of a second review into the wider circumstances preceding Canon McCoy's death
21st October 2022	Extraordinary meeting of the Board of Trustees.
October 2022	The Diocesan Trustee Safeguarding Committee Chair resigns from this role and that of a Trustee due to their concerns about Bishop Byrne's leadership of safeguarding
November 2022	Bishop Byrne absent due to poor health
12th December 2022	Bishop Byrne resigns, Archbishop Malcolm McMahon appointed as Apostolic Administrator
13th December 2022	Archbishop Malcolm McMahon meets with Stephen Ashley CSSA CEO and requests a full safeguarding review for the Diocese of Hexham and Newcastle
14th December 2022	Board of Trustees amend the Diocesan Trustee Safeguarding Committee terms of reference to allow a cleric to chair, albeit viewing this as a temporary measure
18th January 2023	Board of Trustees formally agree to CSSA safeguarding review
23rd January 2023	Start of CSSA review activity

G: Documents Provided

1. Policies – Safeguarding, Safeguarding Complaints, Diocesan Complaints, Whistleblowing, Safeguarding Guidelines, DBS flowcharts. Note the safeguarding policy indicates that the diocese have adopted national CSSA policies and practice guidance;
2. Board of Directors (trustees) – all safeguarding papers submitted to the board (including annual reports), together with extracts of safeguarding items from minutes from 2019 to date, including extra-ordinary meetings;
3. Safeguarding commission/committee reports and minutes from December 2021 to date;
4. Episcopal council minutes from September 2021 to date;
5. DBS summary spreadsheet, monthly record of applications, parish spreadsheet example and example of a blemished DBS risk assessment
6. HR documents covering arrangements for safeguarding team supervision and training records;
7. Communications materials from the safeguarding team to parish safeguarding representatives and Bishop Robert Byrne to clergy re training and the day of prayer for survivors of abuse, example of a communications plan for another department;
8. Casework examples to provide evidence of work with survivors in specific circumstances and of links to canonical processes;
9. Training including clergy and parish safeguarding representative training records, slides for training and a draft training needs analysis;
10. Survivors – the diocesan commitment statement;
11. Safeguarding team weekly performance monitoring document for January 2023;

The above list does not include documents provided to support case audits and case studies.