John Smyth Independent Case Review

This document contains in its entirety the independent Executive Summary of the *John Smyth Independent Case Review* by Gill Camina of Universal Safeguarding Solutions. A preface from the Board of Trustees of Scripture Union England and Wales has been included to provide context for the Reviewer's Executive Summary.

Scripture Union

Scripture Union England and Wales

John Smyth Independent Case Review

A Preface from Scripture Union

1. Introduction

In late 2019, the Board of Trustees for Scripture Union England and Wales (Scripture Union) commissioned an independent Review of SU's links with the abuse committed by John Smyth in the 1970s and 80s, and its subsequent handling of the allegations. This Review has now been completed and the independent Reviewer has delivered her Report and extended Executive Summary to us.

The purpose of this document is to explain the context of the Review, draw attention to and explain its main findings and recommendations and provide an overview of the way in which we are responding to these recommendations.

This document prefaces the Reviewer's Executive Summary of the Independent Review. We believe that readers will find the Executive Summary easier to follow if they read this document first. Cross-references to some of the more important parts of the Summary are set out in square brackets below but it is important to note that not all parts of the Executive Summary that contain information relevant to particular points are cross-referenced and so the whole Executive Summary needs to be read.

2. The facts

2.1 The abuse

The abuse that was committed by John Smyth in the UK took place during the late 1970s and early 1980s and involved boys and young men. The evidence of which we are aware, indicates that he gained access to the boys both via his links with Winchester College and by means of his involvement in Christian camps known as "Iwerne Camps" (owing to their being run at Iwerne Minster). The abuse was mainly conducted away from both the College and the camps, but this is not of material significance in relation to the issues that impact Scripture Union. Suffice to say that the abuse was dreadful and involved a number of victims.

2.2 Scripture Union's connection with Iwerne Camps

An important objective of the Review was to establish the extent and nature of Scripture Union's connection with Iwerne Camps (see Objective 3 set out in the terms of reference, which will be found in section 2 of the Executive Summary).

The Review's findings in relation to this matter are set out in paragraphs 6.21-6.33 and section 8 of the Executive Summary. In brief, the Review has found that at the time of Smyth's involvement, Iwerne Trust, another Christian charity, had financial, management and executive control over the Iwerne Camps. Iwerne Trust also in practice oversaw the Christian Unions in some public schools (including Winchester College) and it was teenagers from these schools who attended the Iwerne Camps. [Paragraphs 6.21, 8.3-8.7]

For reasons that are not entirely clear, but which we think may relate to the fact that Scripture Union was an incorporated body whereas Iwerne Trust was not, Scripture Union employed at least three of the people associated with Iwerne Trust during the period covered by the review. However, their employment was funded by Iwerne Trust and the Review has concluded that, in practice, they owed allegiance to Iwerne Trust rather than Scripture Union. These individuals were involved in the Iwerne Camps and in the events following the discovery of the Smyth abuse. [Paragraphs 6.3-6.5, 6.14 and 6.25]

The Review has found that Scripture Union was dissatisfied with the level of its involvement in the oversight of the Iwerne Camps or some aspects of the running of the camps, but the Iwerne Trust kept Scripture Union at arm's length and Scripture Union's leadership at the time proved unable to exercise any meaningful influence over the camps. This caused tension between Iwerne Trust and Scripture Union. [Paragraphs 6.22-6.26]

2.3 Scripture Union's other connection with John Smyth

John Smyth was a trustee of Scripture Union England and Wales from 1971 to 1979. The Executive Summary describes the Review findings in relation to the background to him becoming a trustee and the events surrounding his leaving office. It does not suggest that Smyth gained access to any children or other vulnerable persons as a result of being a trustee. [Paragraph 9]

2.4 The discovery of the abuse and response to it

The Review has found that the first allegation of abuse by Smyth was made anonymously in 1981. An investigation was privately commissioned by Iwerne Trust which produced a report early in 1982, revealing the seriousness of the Smyth abuse. Copies were provided to a number of people within what the Review terms the Iwerne leadership "inner circle", including the three Scripture Union employees working for the Iwerne Trust as referred to above. A copy was also provided to the then General Director of Scripture Union, but this was heavily redacted, and the Review finds that the evidence suggests that there was not full and open disclosure of the facts to Scripture Union. [Paragraphs 6.1 to 6.3, 6.6, 6.14 and 6.16]

The Review has found that those in the "inner circle" decided that the existence of the Smyth abuse should be kept confidential. Smyth was confronted and his association with Iwerne Camps terminated; some churches and other organisations with whom he was connected were warned about him; and he subsequently left the country to go to Southern Africa. Those connected with Iwerne Trust attempted to support the victims but the police were not notified about the matter. [Paragraphs 6.4, 6.8, 6.11 -6.14, 6.19 and 6.29]

The then General Director of Scripture Union was not comfortable with the approach being adopted and expressed this to Iwerne Trust in writing, but he appears to have regarded it as a Iwerne Trust matter and he did not press his concerns. He and a Scripture Union trustee met representatives of Iwerne Trust on at least one occasion but there is no evidence that the Smyth abuse was discussed within Scripture Union. None of the other Scripture Union trustees appears to have been made aware of it. [Paragraphs 6.5, 6.9, 6.10 and 6.15]

2.5 Subsequent events

Following the activity of 1982, so far as the UK is concerned, the matter lay dormant for over 20 years. Smyth remained resident in Southern Africa until his death in 2018. It appears that he continued his abuse, he was the subject of an investigation in relation to this, and subsequently he was unsuccessfully prosecuted in Zimbabwe. [Paragraphs 6.17-6.20]

During the 1990s, the confused relationship between Scripture Union and the Iwerne Trust was resolved. Full responsibility for the Iwerne Camps was unequivocally placed in the hands of a new trust, the Titus Trust. [Paragraph 8.11 and 10.1]

In 2014, the Titus Trust informed Scripture Union of non-recent abuse disclosures relating to Smyth and this information was shared with Scripture Union Trustees. Since then the case has attracted significant media attention, resulted in a police investigation (which was dropped following Smyth's death), and Scripture Union, Winchester College and the Church of England have each commissioned an independent review. [Paragraphs 6.34-6.57]

3. Scripture Union's handling of the Smyth abuse

While the Review found that Scripture Union did not run the Iwerne Camps, it also identifies clear failings in safeguarding and governance on the part of Scripture Union.

i. The failures of the then General Director and a trustee to report the concerns when they were first known to SU to the SU Council or to the police.
ii. Lack of clarity around lines of accountability for safeguarding both within the organisation and when working in partnership with another organisation (Iwerne Trust).
iii. Failure by SU to monitor implementation of operational practices within Iwerne/Titus Trust camps, against those set out for all other areas of SU activity.
iv. Where practices within Iwerne Trust activities were identified as being of concern (and not aligned to SU practice standards), this should have caused SU to terminate its relationship with Iwerne Trust. SU's failure to do so resulted in SU being associated with camps that were run in a way that enabled an individual (and potentially other perpetrators with poor intent) to access victims, to continue to harm children and young adults without effective challenge and to operate without personal consequence.
v. Failure to prioritise the safeguarding and protection of young people above the interests of powerful individuals and organisational considerations.
vi. Failure to make appropriate referrals to the police in order to protect those already groomed and harmed (now adults) and any new victims (from the UK and in Africa) from abuse by Smyth. [Paragraph 6.45]

Most of these failings relate to the period prior to the Smyth abuse being drawn to Scripture Union's attention in 2014. In relation to the period since 2014, the Review has stated that the collective initial Scripture Union response to the 2014 disclosure was positive and appropriate, and that appropriate responses to the Titus Trust and the Charity Commission are evidenced. However, the Reviewer is critical of the failure to verify with the Police the extent of any information sharing by Titus Trust, the blurring of lines of accountability within Scripture Union in 2014-15 and the failure to request and record details of its then National Director's dealings with the Police in 2017. [Paragraphs 6.41-6.51 and 6.54]

4. The current position

One of the objectives of the Review was to identify any action required to be taken in relation to any individuals who might still pose a risk to children and young people. The Review has confirmed that, although the deficiencies in the historic records make it impossible to be certain that all relevant concerns have been identified and appropriate action taken, all new and additional actions required to be taken in relation to individuals identified through the Review have been taken by the Reviewer. [Section 7 and, especially, paragraph 7.9]

Another objective of the Review was to indicate whether any areas of Scripture Union's current safeguarding policies, practice and governance should be scrutinised or revised in the light of the learnings of the Review. The Review has indicated that assurance can be given that Scripture Union's current practice is compliant with statutory guidance and requirements. Nonetheless, the Reviewer has made a number of detailed recommendations in relation to various matters including further investment in specialist internal safeguarding expertise, improved language in some of Scripture Union's documentation, the better embedding of Scripture Union's expressed values into its procedures, the safeguarding of those transitioning to adulthood, and the completion of a further safeguarding learning and training needs analysis. [Section 10 and paragraphs 12.2 and 12.4-12.9]

5. Other recommendations

The sharing of relevant documents with the Church of England's independent Reviewers was an objective of the Review and the Reviewer has confirmed that she and both the Church of England and the Winchester College independent Reviewers have liaised with one another and shared information during the conduct of their Reviews. The Reviewer has also made recommendations relating to the sharing of her full report with the independent Reviewers conducting a review on behalf of the Church of England [Section 11 and paragraph 12.1] and also a recommendation relating to counselling for victims. [Paragraph 12.3]

6. Our response

Scripture Union England and Wales remain deeply saddened by the accounts of abuse suffered by the victims of the late John Smyth, a trustee of Scripture Union from 1971 - 1979. That such acts were carried out by an individual associated with Scripture Union is a matter of profound and sincere regret for us. We are very much aware of the pain caused by these events and deeply regret the additional hurt and prolonged trauma caused by historic failings in the handling of the allegations and knowledge of the abuse. We recognise that this has extended the suffering of victims and their families and are very sorry for the ways that SU's handling of the case contributed to this. We are grateful to those who took the time to share their experiences and evidence in the course of this Review.

We recognise that the publication of this Executive Summary will be difficult for those who experienced the abuse of John Smyth and have made further counselling support available for those affected. To maintain anonymity, anyone wishing to claim this support should ask their therapist to contact us at safeguarding@scriptureunion.org.uk where they will be able to claim for up to six sessions at a reasonable rate. We will ask the therapist to confirm that they are accredited with the BACP, and to declare that they are working with a client who has disclosed themselves as a victim of John Smyth. For those who are not victims but find themselves affected by any of the issues raised by these documents, thirtyone:eight provide a free and confidential listening service at 0303 003 1111.

We are aware that some readers will be disappointed that we won't be publishing the full Report. The Executive Summary, which has been both produced and signed off by our independent Reviewer, is a substantial document that presents the material findings and recommendations of the review that relate to Scripture Union or are otherwise within the Terms of Reference of the review. The full Report contains more detail and also material that the Reviewer has uncovered in the course of her months of work which may be relevant to matters within the terms of reference of the Church of England's independent review. We are offering to make the full Report available to the Church of England's independent reviewers with a view to assisting them in assembling evidence that is relevant to the issues that they are considering.

Our safeguarding practices today are significantly improved since the time in which these events took place, and the Review acknowledges this. The Trustees' intention in commissioning this review was to ensure that lessons are learned from these events and the Reviewer has made recommendations. The safeguarding and protection of those in our care continues to remain of the highest priority and the Scripture Union Executive Team will work through these recommendations in detail in order to ensure that best practice is maintained.

The Board of Trustees
Scripture Union England and Wales
March 2021

Scripture Union

John Smyth

Independent Case Review

Executive Summary Report

4th March 2021

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1. Introduction

1.1 Scripture Union (SU) is a registered children's charity in England and Wales (Charity Registration Number 213422) and a company limited by guarantee (Company Number 00039828).

1.2 There are over 130 SU movements around the world working in around 120 countries, all of which are united by SU's aims, belief and working principles. This Review only considers connections between John Smyth and evidence relating to the role and responsibilities of SU England and Wales.

1.3 SU has undertaken two independent reviews of its non-recent[1] child abuse and child welfare cases. These reviews reported their findings in May 2015 and in April 2017. The John Smyth abuse case was not included in those reviews which had covered 'completed' cases only.

1.4 Further to the closure of the Hampshire Police case into John Smyth, after his death in 2018, SU announced publicly its intention to undertake a lessons-learned review of its connections with John Smyth. It had indicated that this review would take place after ongoing civil proceedings against a third party (Titus Trust). However, the launch of the Church of England's (CofE) review of the lessons which it can learn from its handling of John Smyth-related matters means that it was timely for SU to bring forward the date of its Review. By so doing, it aims to ensure that relevant information will be available to be shared with the CofE's independent reviewer.

1.5 SU records indicate that John Smyth had connections with the organisation from January 1969 to June 1979. To fulfil the objectives of the Review, it has covered the period from the late 1960s to the present time.

1.6 The terms 'victim', 'survivor', those 'harmed by' or 'abused by' are used interchangeably in this Report. The author recognises the importance of language, its impact and the very different connotations of these words. Experiences, perceptions and preferred language vary considerably, however, and therefore it felt inappropriate to choose one term over another but there is a clear need to acknowledge this. It was noted that the term 'victim' was that most commonly preferred by those who had experienced being harmed by Smyth as the impact of the abuse for many is current and has not diminished.

1.7 The Reviewer has sought to ensure that the voice of each victim who has contributed to this review is embedded and clearly heard to ensure that no learning is lost. To do this, without identifying each individual and potentially adding to the trauma that they have already suffered (and continue in many cases to suffer), the Reviewer has used generic terms and descriptors. Their shared narrative surrounding John Smyth may confirm or contradict the many past and current accounts of individuals and organisations and is respected, irrespective of blame.

1.8 The term 'abuse' is used by the Reviewer throughout rather than 'alleged abuse' as no individual interviewed, or account shared in recent or historic documents, has sought to deny that John Smyth inflicted significant harm upon those who have been identified as victims. Most have identified his actions as unbelievably brutal, extreme and criminal. It was not unwise activity between consenting adults. Any possibility of prosecution has now passed because of Smyth's death in 2018.

1.9 Evidence available to the Reviewer suggests that there are at least 26 victims identified in the UK and as many as 96 victims in Southern Africa. There have also been two confirmed deaths of boys at Camps in Zimbabwe led by John Smyth and a number of attempted suicides amongst his UK victims.

2. SU Smyth Review Terms of Reference

2.1. The objectives of the Review are as follows:

Objective 1: To provide the Board with an informed assessment of the rigour of SU's handling of allegations and disclosures relating to the John Smyth case

Objective 2: To identify any new or additional actions required to be taken in relation to any individuals who may still pose a risk to children and young people as a result of any lack of actions taken against them when concerns regarding them were previously raised

Objective 3: To provide the Board with an informed assessment of the rigour of the governance and associated oversight of the residential events at which grooming and abuse allegedly occurred

[1] See IICSA guidance regarding language and terminology https://www.iicsa.org.uk/key-documents/1412/view/independent-inquiry-into-child-sexual-abuse-iicsa-vscp-terms-phrases.pdf (accessed 16/01/2021)

Objective 4: To provide the Board with an informed assessment of the governance processes in place regarding John Smyth's trusteeship of SU, including the recruitment processes and monitoring of his influence on and involvement in activities relevant to the work of SU

Objective 5: To indicate whether any areas of SU's current safeguarding policies, practices and governance arrangements should be scrutinised or revised, and

Objective 6: To share relevant documents with the Church of England's independent reviewer.

2.2. The overriding aim of the Review is to allow the Board to be able to demonstrate that SU is a transparent organisation which takes seriously its responsibilities to children and young people placed in its care and is willing to address any incidents which were not properly handled in the past. In order to achieve this aim and these objectives the Review included a desktop review of SU's safeguarding framework, including current policies, procedures, guidance and practices and consultation with staff.

2.3. This Executive Summary has been subject to scrutiny, feedback and considerable consultation with SU and its Safeguarding Advisory Group prior to submission, with a view to its adoption by the organisation and publication.

3. Other Reviews and Inquiries

3.1. By the end of 2019 SU, Winchester College and the CofE had each commissioned Independent Reviews of the John Smyth case to consider the evidence, the learning from this for each organisation and recommendations arising.

3.2. Full cooperation was established between all three independent review teams from June 2020 onwards. Further information about this is set out in paragraph 4.4 and section 10 below.

3.3. The Anglican church in England and Wales is one of fourteen investigations undertaken by the Independent Inquiry into Child Sexual Abuse (IICSA)[2]. It has become apparent that during the course of the Review that some elements of the findings of each of the John Smyth reviews will be relevant to the IICSA's purview. The abuse of victims, although described in terms of extreme violence, has consistent and clear indicators of grooming and sexual framing (see paragraphs 6.6 and 6.12). The Review has revealed clear evidence of grooming, extreme physical abuse and of sexual abuse of both young people and young adults (groomed as children). The following should be noted:

- The Ruston Report states that: *"the psychiatrist describes it as suppressed masochistic sexual activity"*
- It has been indicated that Smyth's interest and drivers for the abuse were linked to his sexuality and sexual attraction to his victims[3]. Victims describe how Smyth sought to limit any intimate relationships they had as young adults through expressing his disapproval, framing this as weakness and linking this '*sin*' to beatings.
- The Coltart Report[4] (paragraph 55) described Smyth's behaviours within Zambesi Ministries Camps as '*sexual sadism*', '*voyeurism*' and '*paraphilia*' (sexual deviations).
- Victim accounts consistently describe kissing, stroking, fondling and nudity in the context of the relationship with Smyth, during and after physical beatings.

4. Methodology

4.1. Amongst other things, the review considered all electronic and paper records held by SU regarding John Smyth's involvement with SU, the work of the Iwerne camps and the governance arrangements in place at the time when it is now known that the abuse of boys and young men by John Smyth was being perpetrated. This included archived files, papers, resource materials, handbooks and correspondence from 1948 onwards, Trustee/Council meeting minutes from July 1965 onwards and Schools Committee minutes (including VPSC and ISC minutes) from 1948 onwards, through to the present time. Supporting information, such as the governance structures in place and the operation of the Iwerne camps was also reviewed. Additional historic information as requested was provided in all cases where available e.g. records relating to ex-gratia pension payments, former staff leavers, staff appointments and progression (into and between SU roles) and application

[2] Independent Inquiry into Child Sexual Abuse: https://www.iicsa.org.uk/

[3] CofE Interview of David Fletcher undertaken 10 January 2020 – full transcript shared with consent

[4] David Coltart (19th October 1993). R*eport on Mr John Smyth and Zambezi Ministries.* Documents held by Messrs Webb, Lowe and Barry Solicitors (Bulawayo, Zimbabwe). Provided by an Interviewee to the Reviewer but also accessed online at: http://static1.1.sqspcdn.com/static/f/970485/27843432/1519927496303/The+Coltart+Report+on+John+Smyth+1982.pdf?token=nq

records.

4.2. Interviews were undertaken with those individuals who have been identified from the records as being likely to hold substantial further information relevant to the meeting of the review's objectives or who approached the reviewer directly to share relevant documents and supporting information. Statements[5] from former staff members were also provided. The CofE reviewers have interviewed the majority of identified UK victims of Smyth. Winchester College's reviewers have interviewed victims who were former pupils, some of whom have not spoken to the CofE reviewers. These are not individuals whose names, in most cases, are known to the Reviewer or to SU.

4.3. Many individuals identified by the Reviewer as of interest in this case are now deceased, elderly, frail or significantly unwell. During the time period when interviews were scheduled the COVID-19 pandemic restrictions resulted in an adjusted approach to interviews, with remote interviewing where appropriate and a small reduction in the number of face-to-face interviews undertaken.

4.4. It was agreed that any evidence held by the CofE review team relating to SU employees and relevant to this review's Terms of Reference would be shared and consent would be sought by both Review leads from interviewees to share transcripts with each review to avoid duplication of interviewing. Such communication and cooperation between the reviews has continued throughout the review process and has sought to ensure that key documents were provided to the relevant reviewers in a timely manner, so that the final reports accurately reflected the events that took place. The Winchester reviewers have cooperated positively with SU but no recorded or documentary information has been shared by the Winchester review with SU.

4.5. A desktop review of current safeguarding arrangements has been conducted, including child protection and linked policies, guidance, workforce development practices and governance arrangements in place today within SU. There is clearly a limit to what can be understood of an organisation's practices within a desktop review such as this and, consequently, it is difficult to be sure that all relevant matters relating to SU's current policies and practices have been fully taken into account. This desktop review was, however, supported by meetings with and information provided by SU's senior staff with key responsibilities for safeguarding (SU's Mission Development Director, Company Secretary and Head of Mission Event Operations). The current safeguarding framework review did not include stakeholder consultations or attendance at activities/events which would have afforded greater insight as this was not supported within this commission. Extensive information and feedback has been gathered from senior staff members mentioned, the Chair of Trustees and the safeguarding lead trustee which has been integrated and has served to inform this review.

4.6. The identities of victims and survivors who have contributed to this Review are held in confidence (and maintenance of that confidentiality has been explicitly requested by many of those providing evidence) Where names of contributors who are not current or former staff members have been included openly, it has been with their expressed permissions. The Reviewer has recommended that contributors are provided with a copy of the Report[6] before it is shared more publicly to ensure that they are prepared and aware of how their contributions are integrated into the Review's findings.

4.7. Every effort has been made to verify the information obtained and detailed in this report. The Reviewer is satisfied, from the evidence made available, that this Report is correct.

5. Background

5.1. John Jackson Smyth was born in Canada on 27 June 1941. Smyth died in Cape Town on 11 August 2018.

5.2. Subject summary timeline:

- Born into a strict Plymouth Brethren family in Canada
- Educated at Strathcona School, Calgary
- Senior Brethren reportedly expelled his family from the Brethren fellowship which reportedly had a profound effect upon Smyth
- Studied Law at Trinity Hall, University of Cambridge
- Called to the Bar at Inner Temple in 1965

[5] Statements from former SU Head of Schools (1960s-1980s) and former SU Director of Field Ministries (1980s-2008) dated 29/05/2015 and 3/2/2017 respectively

[6] Reviewer meeting with SU safeguarding leads on 28/01/2021

- Licensed as a Lay Reader in the Diocese of Winchester in 1971
- Became a Queen's Counsel in 1979 at the age of 37
- Iwerne Trust camp leader 1964 (earliest record identified) until 1984 (latest record on camp leaflet)
- Iwerne Trust Trustee 1970 to April 1982 (Chair of Iwerne Trust Trustees from 1974 until end of 1981)
- SU Trustee (November 1971 – June 1979)
- Applied for Ordination in the Church of England 1981 (turned down)
- **The Ruston Report** authored by Revd. Mark Ruston (documented the abuse of 22 children and young people, circulated to recipients on 18 February 1982)
- Studied Theology as an independent student at Trinity College Bristol 1983
- Emigrated to Zimbabwe August 1984 - Reports and allegations of abuse continued in Zimbabwe, but despite this, attempts to seek Smyth's prosecution were not progressed.
- Allegations of abuse continued, and Smyth was charged with 'culpable homicide' in relation to a boy's death in December 1992 and five counts of criminal injury in relation to incidents at a camp in April 1993 where five boys were harmed. The prosecution was discontinued when it was successfully argued by Smyth's legal team that the prosecutor had a conflict of interest.
- **The Coltart Report** collated by a lawyer, David Coltart[7] in October 1993 (evidence indicates that John Smyth's abuse of boys and young men continued in Zimbabwe within the camps of Zambezi Ministries for at least a further decade).
- Left Zimbabwe in 2001 and returned to legal practice in South Africa.
- **The Stileman Report**[8] (Compiled by Titus Trust's Operations Director, dated 18 July 2014 and provided to Titus Trust leaders 22 July 2014)

5.3. The most notable direct connection between John Smyth and SU is that he was a trustee of SU from November 1971 to June 1979.

5.4. John Smyth is recorded in SU archived records as a co-opted member of the Schools Committee offering legal expertise from 17th January 1969 to 10th December 1971. In 1971 he became both a formal Schools Committee member and a Council member/trustee. Smyth is however recorded as being present at seven SU Schools Committee meetings between 22nd November 1974 and 3rd December 1976.

5.5. Additionally, John Smyth was a volunteer at Iwerne Camps after being appointed as an Officer/leader by E.J.H. Nash pre-1965. The Ruston Report indicates that he was a Iwerne Trustee from 1970 to 1982 and Chair of Iwerne trust trustees from 1974 for eight years. Iwerne Camps were camps focused upon pupils from private schools which were identified as being the elite/top schools in the country. This Review seeks to clarify the nature of the relationship between these camps and SU in practice.

5.6. Titus Trust documents provided by interviewees (victims and their advocates) indicate more detailed information about Smyth's volunteering across Iwerne Trust activities which were not identified through SU's records. This information was not held by SU and has now been added to SU archives. According to Titus Trust records, Smyth was an Officer at various Iwerne camps held each summer at Clayesmore School, Iwerne Minster and at conferences held each New Year in Eastbourne (for students) or in Oxford (for sixth formers) and, each Easter, at Iwerne Minster. His attendance at one or more camps held during the summers of 1975-1981 and at Easter in 1975, 1977, 1978 and 1979. They record that Smyth attended Winter conferences in December 1976/January 1977, January 1981 (student conference in Eastbourne), and January 1982.

6. Objective 1: To provide the Board with an informed assessment of the rigour of Scripture Union's handling of allegations and disclosures relating to the John Smyth case.

A. The events of 1981/2

6.1. External sources and evidence shown to the Reviewer but not held by SU indicate that the first anonymous allegation was received by David Fletcher on 16 March 1981.

6.2. This evidence indicates that John Smyth was challenged about what he was doing by many people including the following who were, or had been, connected with SU:

· Revd. David Fletcher (SU employee 1967-1986)
· Revd. Mark Ruston – Round Church, Cambridge (listed as an SU trustee 1977-1979)
· Revd. (RJB) John Eddison (Chair of Iwerne Trust, formerly a SU employee 1942-1981)

[7] David Coltart's Report (19th October 1993). See paragraph 3.3
[8] Stileman, James. Report for the Trustees of the Titus Trust dated 19th July 2014

6.3. Revd. Ruston wrote a comprehensively compiled report on the abuse that was circulated to a number of people on 18th February 1982. This included Revd. John Eddison who had just left SU employment and SU staff members Revd. David Fletcher, Revd. Timothy Sterry (then SU Staff Worker for Preparatory Schools) and Peter Wells (SU Field Staff Worker (Iwerne Minster).

6.4. When asked directly[9] about whether SU had been informed in 1982 of the allegations and evidence of abuse David Fletcher indicated that he regarded his employment by SU as a technicality as the money to pay for his camp work and salary was raised through the Iwerne Trust. He explained that he made decisions about what should happen next in relation to the abuse by Smyth with the support and backing of his Iwerne seniors, but it was only after decisions had been made and actions taken that it was recognised that SU should be informed because of this employment link.

6.5. David Fletcher's description of his employment status with SU indicates that it was more in theory than in practice and his loyalties and respect lay with Iwerne. The delay in informing SU is clearly indicated. There is evidence in papers from SU's archives that this was well recognised. A report authored by Alan Martin reflected the learning from a major review of SU activities which was agreed by Council in 1979 and continued into the 1980s. In the report Alan Martin states: '*The Committee soon realised that there was a tendency for some staff members to regard SU as a flag of convenience under which they could carry out their individual calling, without reference to the rest of the Movement. Indeed, that tendency was also evident in some departments as a whole'.*[10] By the time that that SU were told anything of the concerns by the Iwerne leadership, almost every decision about Smyth's management had been made. It is evident that Alan Martin (then General Director of SU) and Derek Warren (an SU trustee and a lawyer) were both aware of the concerns and engaged in meetings and conversations relating to the Iwerne Trust's management of these concerns, without full disclosure or sight of the report, as early as April 1982[11]. What was shared with SU included the Ruston Report, but not until August 1982 and in a very redacted form. It is clear that Alan Martin's support for the actions taken by Iwerne Trust was based upon very limited knowledge of the facts. This Review has found no evidence of full and frank disclosure at any time. It is not known how much information about the disclosures of abuse was shared with the trustee and lawyer Derek Warren as no detailed record of his involvement has been traced, other than in communications between Iwerne leaders which have been shared by the CofE reviewers. There is no evidence that the Ruston Report was shared with Derek Warren.

6.6. The Ruston Report states that '*the scale and severity of the practice was horrific*[12] and the brutality of the '*horrific beatings'* described by thirteen of the twenty-two victims identified in February 1982 was very clearly identified as criminal. It states that '*the system'* operated by Smyth *'seems to have "conned" men into accepting the beatings',* thereby identifying coercion, control and grooming behaviours and indicating that the beatings could not be described as consensual. It is apparent from this report that it was known that a number of those who were assaulted had been children at the time that the process started. All Winchester pupils were referred to as 'men' from the point of entering the College and this practice has continued. The report states that *'the psychiatrist describes it as suppressed masochistic sexual activity (or sadistic in the operators)'.* The report also states: '*it was willfulness, not blindness for John Smyth and his operators – they knew what they were doing was evil'.* The report indicates that at least two other individuals were involved in the administration of beatings with Smyth, both of whom were young men '*brought into sharing his "ministry"'*.

6.7. Despite this, the Reviewer has seen evidence that many, including those Iwerne leaders employed by SU, sought to minimise the severity and scale of the abuse and have still found it possible to justify failures to report and protect. Victim-blaming by those linked to the case, in the face of widespread rumours, is widely evidenced in recordings and documents shared with the Reviewer. In the accounts of victims and their advocates, this has included turning a blind eye to or minimising the abuse, denying it, blaming victims by framing what happened to them as wholly consensual, failing to acknowledge any failings in protecting children, failing to share information or make reports to the police, or covering up allegations of assault and abuse.

6.8. Revd. John Eddison's role in coordinating the response to the Smyth concerns emerges clearly from the

[9] David Fletcher interview with CofE Reviewers 10 January 2020

[10] *An Institutional Memory, by Alan Martin (General Director 1978-1986). Strictly Private*. Dated *'late 1980s'* (Chapter 4, Page 12)

[11] Scanned copies of letters between Iwerne leaders have been shared by external sources with the Reviewer which evidence this and which are included in the Chronology (entries 68 and 70)

[12] Ruston, Mark. Ruston Report dated February 1982 - drafted for a meeting of Iwerne Leaders to be held on 16th March 1982

evidence shared by the CofE reviewers when combined with that already collated by the Reviewer. It is important to note that Revd. Eddison left the employment of SU in September 1981, before the disclosures of Smyth's abuse were made, and was therefore acting in his capacity as Chair of the Iwerne Trust (1981-1987).

6.9. Alan Martin indicates in a memorandum dated 14/04/1982, that he was:

> *'at a disadvantage, although I know J.S. I do not know the others involved, and therefore lack the background knowledge which obviously affected decisions which have been made.'*

Alan Martin raised questions about why Smyth '*was nonetheless vouched for by some of the Iwerne leaders'* when parents and others raised concerns. He questioned how many individuals had previously raised suspicions, what these suspicions were and how these had been investigated. He also raised concerns about the decisions not to inform the Winchester Headmaster or one victim's father. He states that he *'would still favour a frank disclosure*'.

6.10. In this memorandum Alan Martin also refers to a '*third person who is part of this ministry with J.S. and who I gather has been involved for four years. I know nothing about him, and it may well be that he has dropped out in favour of* █ [Victim 1 initials indicated].' Alan Martin states that he acknowledges that all decisions have been made by people very close to the events and that he is '*just recording my impressions from the touch-line'*. He raises the need for urgent psychiatric assessment and intervention but also identifies the co-abusers as potentially at risk and in need of help. It is clear that Alan Martin is raising appropriate questions and challenges and expressing concerns about the potential for continuing abuse by Smyth. He demonstrates deference however by stating that he is not being critical of the Iwerne leaders' decisions but has a very limited overview of the events and understanding of the rationale for the decisions that have been made. His assessment of seriousness mirrors that captured by Revd. Ruston in his report, but it is unclear whether the report has yet been shared with him.

6.11. No report of the abuse by John Smyth was made by SU to the police or statutory agencies until 2017, over 30 years after the time of the Ruston Report.

6.12. Various justifications have been suggested for the failures to report the abuse, but the Ruston Report evidenced criminal assault, extreme abuse and grievous bodily harm against at least 22 children and young people before Smyth left the UK in 1984. The evidence that Smyth used his position of trust and power to access, exploit and abuse victims is consistent from all evidence seen by the Reviewer. Individuals and groups were targeted and isolated. Coercive, controlling and grooming behaviours were described which clearly indicated that the beatings could not be described as consensual. It was known that a number of those who were assaulted had been children at the time that the process started. Whilst the abuse was extreme and physical, there is clear and continuous sexual framing of the abuse. The accounts of victims consistently describe the requirement for all parties to be naked during the beatings and describe Smyth kissing, stroking and fondling them after beatings in contrast to the brutality and trauma of the beating they had just experienced. They each also describe how their physical attractiveness and sporting physiques led to their selection by Smyth in contrast to their peers.

6.13. Whilst Revd. Fletcher was clear that support for victims was delegated to him, it is unclear how that decision was made and by whom. There is no evidence that the names of the victims have been shared at any time by the Iwerne Trust with SU and therefore allocation of any direct support to each 'boy' (victim) could only have been through the Iwerne Trust.

6.14. Evidence confirms that the Iwerne leadership 'inner circle' did not share evidence and information about Smyth's abusive behaviour with SU's leadership and trustees until after decisions about the management of the allegations had been made. This information was shared with key individuals within the Iwerne circle of allegiance which included Revd. David Fletcher and Revd. Tim Sterry, both of whom were employed by SU as staff with responsibility for the VPS / Iwerne Camp work. It also included Revd. John Eddison who had just retired as SU's Team Leader for VPS at the end of 1981. This has been confirmed by Revd. Fletcher in his interviews as part of this review and with the CofE reviewers.

6.15. There are clear failures in information sharing by the Iwerne Trust which are compounded by failure by Alan Martin to clarify all of the information which should have been available to SU. This undermined his ability to make an informed and defensible decision about how the concerns were responded to and managed. Whilst Alan Martin (SU's General Director), is recorded as challenging the Iwerne leadership in relation to their responses and assessment of risks at the time that concerns about John Smyth were shared with him and with Derek Warren (SU Trustee) between April and August 1982, he does not overtly criticise the delay in

information-sharing by the Iwerne Trust. Nor does he assert SU's absolute right to have full disclosure in terms of governance and accountability. This is a critical error in judgement, as is the apparent failure to inform the full trustee body. There is no evidence that any trustee other than Derek Warren was informed of the abuse. From the reviewed records it is unclear whether this deference was related to an entrenched respect and reverence for the authority of the church. What is evidenced from SU archives is Alan Martin's acknowledgement in a paper for SU Trustees dated February 1986 that '*We are not good at handling conflict, and I hope that aspect of our life as a fellowship will be built into staff development programme.'* The paper also has additional handwritten notes on it stating *'I am not good at handling conflict. Nor is the movement*[13]*'.*

6.16. Evidence suggests that there was not a full and open disclosure by the Iwerne Trust leadership in either 1982 or 2014. Whilst SU were reassured that these concerns had been fully managed by Iwerne and had not arisen at Iwerne camps, Smyth had been an SU Trustee until June 1979 and this should have prompted more rigorous exploration of the nature and seriousness of any concerns.

B. Smyth leaves the UK (1984)

6.17. In 1984 John Smyth, a charismatic and prominent Barrister and Christian leader left the UK without explanation. It is the Reviewer's conclusion that this cannot have gone unnoticed or unquestioned in legal, educational or Anglican circles. Smyth has been Chair of the Iwerne Trust until 1981/2. He had also reportedly been turned down in 1981 by Bishop John Taylor of Winchester in his application to be sponsored through the ordination process by the Church of England in 1981. At the time he left the UK, Smyth had been studying at Trinity College Bristol (an evangelical Anglican theological college where qualifications are validated by Durham University) for a year in 1983.

6.18. It is documented that John Smyth began working for Africa Enterprises in Zimbabwe in 1984. In 1985/1986 SU Zimbabwe became aware that John Smyth was running Christian Camps and missions in independent schools in Zimbabwe linked to Zambezi Ministries and the National Director of SU Zimbabwe met with Smyth to address concerns. In 1993 evidence was collated by a lawyer in Zimbabwe (hereafter called the Coltart Report) after failed attempts to progress Smyth's prosecution for alleged abuse of boys in Christian camps that he had been running in Zimbabwe for nearly a decade since his move from the UK in 1984. This referenced the Ruston Report and also the extent and nature of abuse in the UK prior to his emigrating.

6.19. There is repeated reference across many sources to the requirement of John Smyth to sign an undertaking to cease any further engagement in *'young people's work'*, with accompanying pressure to leave the country. Implementation of this agreement was undertaken by Iwerne Trust leaders. There is clearly a question whether any of the individuals involved in managing the potential safeguarding risks posed by Smyth in the wake of the disclosures of abuse genuinely believed that an individual as powerful and openly refuting of any wrongdoing would comply with a '*gentleman's agreement'*. Equally, the encouragement of Smyth to emigrate transferred a continuing risk of significant harm to young people in another country. It is clear therefore that the need to protect children and young people outside of a UK context was not considered a priority. There is firm evidence that John Smyth was encouraged to leave the UK by senior Iwerne staff and alumni. Revd. Fletcher confirmed that this suggested action was discussed extensively and, with the support of mature ex-campers, included in a letter written to Smyth by Revd. Eddison. Both Revd. Fletcher and Revd. Eddison were or had been employed by SU at the time it is known that Smyth's abuse was happening.

6.20. The SU movement is an international one. Each national movement is an independent and separately controlled and managed organisation, each is part of the global Scripture Union Movement with a shared founder and history dating back 150 years and *'each is committed to the same Aims, Belief and Working Principles'*[14]. It has become apparent to the Reviewer that this is not always understood outside of SU. The widely held and expressed perception of those who have contributed to the Review has been that the international SU movements are/should be collaborative. Many have challenged the apparent failures in safeguarding information-sharing in relation to John Smyth between international SU organisations and failures to work together to ensure that the welfare of children and young people was prioritised. The need for SU movements to work together across international boundaries to agree robust safeguarding information-

[13] Paper titled 'Taking Stock. A personal view by Alan Martin, Dated February 1986 on SU branded paper evidenced as circulated for the attention of SU Trustees. Extract is point number 9 on page 3.

[14] https://content.scriptureunion.org.uk/what-we-do/su-around-world (accessed by the Reviewer 17/01/2021)

sharing protocols, in order to ensure that individuals of concern cannot move between activities linked to them on a global basis, is more important now than ever.

C. The relationship between SU and Iwerne Trust

6.21. It is widely documented that the Iwerne Camps developed quite separately from SU from their inception. SU documents dated 05/09/1946 describe the origins of the relationship between SU (known then as the Children's Special Service Mission or CSSM) in 1945/6. The General Secretary of the CSSM was Dr John Laird. In his autobiography he speaks of becoming aware of the increasing success of the work of the "Bash"[15] Camps at Iwerne, and that he and the Council of CSSM "*decided to back him [Nash] with such financial and moral support as he might need*." There is no reference to managerial responsibility. The papers indicate that Iwerne Camp leadership had responsibility for raising funds to meet all of the expenses of the staff. The management role of SU extended to HR and payroll services. Whilst this suggested an employment relationship with SU, Iwerne retained financial, management and executive control.

6.22. Iwerne's separateness and secrecy and the acknowledged mistrust between the Iwerne Trust and SU is very clear from documents seen by the reviewer. SU staff members working within the VPS / ISCF camps are only described as 'Iwerne Officers' and SU is framed as the 'anonymous parent body' in relation to participants.

6.23. An important document from 1982 which illustrates the links between SU and Iwerne Trust charities states that, '*The Iwerne Trust is an Independent charity which helps to finance the work of SU in public and preparatory schools. As well as contributing towards salaries, it is responsible for meeting travelling and offices expenses for the staff concerned'.*

6.24. Interviewees consistently viewed Iwerne and Titus Trust as one and the same organisation with SU framed as quite separate, despite their full understanding of the links (individuals, employment and financial) which this review has evidenced.

6.25. The evidence of Iwerne Trust not providing information to SU mentioned above is consistent with the evidence seen by the Reviewer that from their inception those leading Iwerne camps and schools work, including SU Varsity and Public Schools (VPS) staff who were part of a tight circle of closely aligned individuals, sought to operate completely outside of SU control. Interviewees, former staff statements and SU archived records consistently indicate that Iwerne operated like an independent franchise and these individuals were answerable only to their own trustees and key leaders. Where the Iwerne Camps and staff are the subject of SU Council minutes and relating to relationships and agreements around the delivery of independent schools work, these tensions are often explicitly described and the degree of autonomy (and friction) between SU and its Iwerne 'employees' is evidenced repeatedly.

6.26. Within the SU Schools Team there is recurrent evidence that the Iwerne Minster approach fell outside SU endorsed practices and caused expressed discomfort. Despite this, archived records indicate that, in the face of forceful and dismissive responses to reasonable questioning or challenge from the highly educated and powerfully confident Iwerne staff (who argued that their unique target audience justified this difference), SU staff deferred or resorted to the path of least resistance by delegating leadership. Where there is evidence that when SU leadership raised challenges, external scrutiny was rigorously rejected by Iwerne officers and their forceful responses repeatedly led to a 'let them get on with it' approach, despite issues of SU accountability. SU could have considered terminating the relationship with Iwerne but there is no evidence that it did so. It thus accepted this unsatisfactory position.

6.27. It is important to note that, of the camps facilitated through the Iwerne Trust and its Officers, SU records only indicate the existence of A, B and C camps (camp descriptors used by Iwerne Leaders for Easter and Summer Camps) held at Iwerne Minster and also the Lymington Camps. Iwerne alumni who were interviewed by the Reviewer highlighted that there were other camps which were never supported in any way through SU. This included 'Iwerne D' camps in Ireland, which were led by Revd. Jonathan Fletcher (David Fletcher's younger brother) and entirely separately from the camps at Iwerne Minster with a select group of boys each summer. No SU record of the existence of these camps has been identified by the Reviewer. There is no evidence to suggest that Revd. Jonathan Fletcher (despite being Revd. David Fletcher's brother and linked through Iwerne

[15] Eric John Hewitson Nash (1898-1982), known universally as 'Bash', was an Anglican Christian Evangelist who developed camp ministry in the top thirty public schools in the UK. Bash camps started at Iwerne Minster in 1932 under the Home Missionary Fund.

Trust and Anglican churches to many other individuals named in this review) has at any time had any employment/deployment links to Scripture Union

6.28. The familial context within which Iwerne operated is also repeatedly referenced. The themes of loyalty, brotherhood, family ties stronger than those with natural relatives, exclusivity, and keeping things 'in-house' are raised and evidenced recurrently in relation to the Iwerne Trust. Around two-thirds of all child sexual abuse reported to the police is perpetrated by a family member or someone close to the child within a 'familial context'. This would include the faith settings described in a Iwerne Trust context. Whilst Smyth's beatings were physically and emotionally abusive, there were also clear and referenced sexual abuse indicators. Abuse within the 'church family' is now well evidenced and this familial context should never be under-estimated in terms of the belief that there is a shared faith and values which inform behaviours and a potentially false sense of safety that this can create. The key consideration is whether the abuser feels like family from the child's point of view. Many of Smyth's victims were isolated from natural family and other networks of support. Issues of coercion and control are strongly evidenced in relation to Smyth's behaviour towards those with whom he had developed strong familial ties and loyalty.

6.29. It is apparent from the evidence shared with the Reviewer, that the expressed Iwerne leadership policy position throughout the period of the review was that the 'Kingdom' and God were best served by avoidance of any sharing information outside of Iwerne and the need to protect the reputation of the organisation and any individual linked to it despite the seriousness of the harm inflicted being captured accurately by Mark Ruston's report. Revd. David Fletcher indicated in his interviews with both the SU and CofE Reviewers that he was tasked with supporting the victims. This was however in a context where victims and those parents who were aware of concerns were effectively told that it was important to keep things quiet and manage the risks and impact without external assessment or support. Alan Martin's recorded responses did demonstrate a personal victim focus in 1982 but this did not lead to positive protective action or appropriate internal information-sharing. In 2015 SU records indicate a more victim-focused approach but the lead for clarifying concerns and liaising with Iwerne Trust and statutory agencies was taken by SU's National Director not the organisation's designated safeguarding staff.

6.30. A recurring theme in this review is the way in which one person's judgement (or that of a group of powerful individuals) is considered better by virtue of their background, status and affiliations and the views of others are dismissed and discredited in a way which alienates victims, other professionals and parents. The course of action recommended and taken by Iwerne Trust appears to have made those outside of the Iwerne inner circles negate their own views and assessment. Deference is shown by SU throughout the period of this review to senior clergy and ordained individuals whose primary loyalty, even where they are employed by SU, appears to be to the Iwerne Trust. From the reviewed records it is unclear whether this deference was related to an entrenched respect and reverence for the authority of the church, as there are other factors identified recurrently which inhibit challenge and which potentially may have undermined maintenance of a victim focus, including social class and status. The evangelical Anglican church leadership in England and Wales was, and continues to be, demonstrably dominated by wealthy, socially elite, highly educated white males. This is also reflected in the Iwerne leadership and clergy involved in the management of the Smyth concerns. The individuals who received full disclosure of Smyth's abuse have all been described by victims as having '*huge social polish'* which made them very convincing, dominant and persuasive.

6.31. It is critical that risks related to social class, socio-economic status, ethnicity, race, familial faith settings, culture and disability are acknowledged, accepted and considered if future safeguarding concerns are to be responded to appropriately. Perceptions of privilege can increase the risks to some children and reduce their access to statutory support.

6.32. SU responses demonstrate that the absence of clear policy and procedures creates significant safeguarding risk. Reporting processes were unclear and inconsistent prior to SU's adoption of a formal child protection policy in 1998, although it was not uncommon for charities not to have safeguarding policies in place at that time. Informal information-sharing and failing to work in partnership with statutory agencies to collate information, assess risks and share both expertise and learning is a very ineffective way of managing safeguarding concerns.

6.33. Further information about the relationship between Iwerne Trust and SU is given in section 7 below.

D. Recent Years (2014 - 2018)

6.34. Apart from the disclosures to Alan Martin and Derek Warren in 1982, there is no evidence that the abuse disclosures were discussed with SU until 2014. SU's records (emails and file notes) indicate that the organisation was told of non-recent abuse disclosures in a telephone call from James Stileman (Titus Trust Operations Director) to Revd. Hastie-Smith (SU's then National Director) on 2 October 2014. Victim accounts and the volume of evidence provided by the Coltart report, suggests that it is implausible that no senior SU staff were aware of the concerns surrounding Smyth's continued abuse of boys in Africa. This was also noted by Revd. Hastie-Smith in a file note in October 2014 when he states that '*Apparently, the incident is 'well known' and involves a number of high profile individuals ……. It is hard to see how this incident has remained 'secret' for so long.'*[16] A lack of professional curiosity appears to underpin the explanations given as a rationale by Revd. Hastie-Smith when questioned by the Reviewer[17] for why concerns about John Smyth were not pursued by him or others or were easily dismissed. Revd. Hastie-Smith states that by his own assessment, he must have been either '*grotesquely insensitive*' or '*extraordinarily incurious'* as he had never become aware of anything nor did he ask any questions prior to 2014. Victims stated that they felt there was a level of '*willful ignorance'* demonstrated by the wider evangelical community and that '*seemingly comprehensive accounts were actually studies in obfuscation'*.

6.35. In October 2014 SU records indicate that SU's then Chair of Trustees and Managing Director were immediately informed in accordance with SU's safeguarding policy and procedures. Revd. Hastie-Smith reported to them that the Titus Trust lawyers had advised Titus Trust to call the police and that this action had been taken. The Titus Trust police referral in 2014 was never shared with SU, despite repeated requests which are evidenced.

6.36. At interview, the victim who is the subject of these 2014 disclosures explained that he had initially sought counselling and support in March 2012. It is clear from this that the victim considered that responsibility rested primarily with the Titus Trust and that this was also reportedly the Titus Trust view as recorded by Revd. Hastie Smith[18]. There is no record or evidence shared with the Reviewer of any direct approach for support ever being received by SU from any one of Smyth's victims. In response to this victim's approach Titus Trust took forward both conversations and actions relating to the funding of counselling and to the management of the information that was shared with the police.

6.37. SU records indicate that a letter was received from ITN on 26 January 2017 to alert SU to the Channel 4 Smyth documentaries and that this was ''*the first occasion that SU had been informed of the identity of the perpetrator and victims.'* Whilst this was clearly the understanding of SU's safeguarding staff at the time of writing, the evidence sourced from external sources have demonstrated that this is factually incorrect. By then the Stileman Report, in its redacted form which named Smyth throughout, had been shared with SU via Revd. Hastie-Smith on 15 January 2015. Revd. Hastie-Smith had also been involved in meetings where Smyth's identity and those of others involved were discussed. It is evidenced that Revd. Hastie-Smith knew identities of the perpetrator and at least one victim from October 2014. There has been no evidence seen or shared with the Reviewer that Revd. Hastie-Smith shared this information with other SU staff and, as has already been outlined, Revd. Hastie-Smith led all communications in terms of meetings and direct conversations with Titus Trust in relation to this case.

6.38. SU records indicate that Revd. Hastie-Smith informed the Board that he had spoken directly with Bishop Paul Butler[19] about the matter in May 2015. Bishop Paul was reportedly advocating an inquiry. There is no SU record of this meeting or detail about the conversation between these individuals, but it took place at a time when it is now clear that Revd. Hastie-Smith knew the identity of the perpetrator and had seen the redacted Ruston and Stileman Reports.

6.39. In July 2014, James Stileman (a Titus Trust trustee) delivered a report on the John Smyth case to the Titus Trust

[16] Chronology entry 136. File note authored by Revd. Hastie-Smith dated October 2014
[17] Telephone interview undertaken on 18 March 2020 by the Reviewer
[18] Chronology entry 136. File note authored by Revd. Hastie-Smith dated October 2014
[19] Bishop Paul Butler was an employee of SU 1987 to 1994 and appointed SU President in 2012. He was also Chair of the Churches National Safeguarding Committee

trustees, which was seen by 17 people. None of these seventeen individuals have links to SU other than Revd. David Fletcher who left SU's employment in 1986 and Iain Broomfield (SU Senior Schools Worker, 1987-2000).

6.40. SU (Revd. Hastie-Smith) requested a '*copy of your dossier*' from the Titus Trust on 13 January 2015, including a copy of the Serious Incident Report sent by Titus Trust to the Charity Commission on 29 October 2014. Titus Trust documents detailing the allegations of Smyth's abuse were shared with SU on 15 January 2015. Both the Ruston and Stileman reports were shared with the SU in significantly redacted forms (the Reviewer has seen a copy of only 12 redacted pages of the 70-page report). By this time Titus Trust had notified the Charity Commission. SU records indicate that the Titus Trust informed SU that, following their report to the Charity Commission, the Commission '*had no regulatory concerns*', but a copy of the Serious Incident report was not shared despite SU requesting this.

6.41. Revd. Hastie-Smith's interview account, and his recorded responses, in SU archives, to the Stileman report in 2015 (along with those of SU's safeguarding team and the then Chair of Trustees), appear to confirm that the collective initial SU response to the 2015 disclosures was positive and appropriate. The recorded response in all records seen is one of seeking transparency, an expressed wish to act in line with SU's safeguarding procedures and frustration over the limited ability of SU to reach out to this and other victims. The email exchanges have been seen by the Reviewer and indicate Revd. Hastie-Smith's wish to ensure that Titus Trust had access to appropriate media management advice and indicates a level of commitment to working in partnership with Titus Trust. Revd. Hastie-Smith assured SU that Titus Trust had confirmed that they had taken all necessary and appropriate action.

6.42. The Smyth allegations were first recorded as being discussed with SU's Trustees at a meeting held on 28 January 2015, following receipt of the redacted Stileman Report. The full records of concerns about John Smyth and the identities of victims and their disclosures were never shared by Titus Trust and are still not held by SU. Unredacted documents and copies of the Titus Trust police report and Charity Commission Reports were repeatedly requested from Titus Trust but none of these was ever shared. An exchange of letters between SU's Company Secretary and Titus Trust's Operations Director in September 2015 indicates a sustained effort over nearly an eleven-month period by SU's leadership and safeguarding leads to clarify the information held by Titus Trust and to seek full information sharing. This includes asking for assurances that the Local Authority Designated Officer (LADO) had been appropriately informed, and that all information had been shared with the police. The requested evidence of a LADO referral and confirmation of the evidence shared with the Police were not received. SU electronic records evidence that SU's Company Secretary continued to liaise with the Charity Commission and the communications illustrate how difficult it was for SU to secure full information sharing from Titus Trust despite consistent requests for this, and which has not been achieved to this day.

6.43. SU Board minutes dated 28 January 2015 indicate that the Charity Commission contacted SU to ask what information was known to SU after the organisation was implicated in the Titus Trust Serious Incident Report. Papers indicate that legal advice was sought, and that prompt and fully transparent email responses were provided to the Charity Commission (all email communications between the SU Company Secretary and the Charity Commission between 20 January and 14 September 2015 have been shared with the Reviewer). In addition, informed and appropriate safeguarding advice was provided by the organisational Lead for Safeguarding (who did not take on the operational safeguarding lead role until September 2015) and the Company Secretary in line with SU's safeguarding policy and procedures at that time.

6.44. The Reviewer has concerns that despite very appropriate responses to Titus Trust and the Charity Commission being extensively evidenced, the overall SU response recorded in the context of the information shared by Titus Trust in 2014/15 fell short of verifying the extent of any information sharing by Titus Trust directly with the Police. Revd. Hastie-Smith was informed of a non-recent abuse case being managed by Titus Trust in a phone call from James Stileman on 2nd October 2014. Smyth is not named in any record of SU communications internally or externally, nor is the victim who had stepped forward to seek support. It is acknowledged that no communications could be made by SU to victims at this time or subsequently as their identities were not known to SU through the receipt of information from victims, from Revd. Hastie-Smith or from Titus Trust. No police referral was made by SU in 2014/15. Revd. Hastie-Smith and the SU Board were aware of this as it is recorded in SU Board meeting minutes[20].

[20] Minutes of Board Meeting 30/09/2015 S. 62/15 (Chronology entry 161) summarises SU's position

6.45. Clear failings in safeguarding governance are demonstrated by SU prior to and including 2014-2015. These failings include:

- The failures of Alan Martin (General Director) and Derek Warren (SU trustee) to report the concerns when they were first known to SU to the SU Council or to the police.
- Lack of clarity around lines of accountability for safeguarding both within the organisation and when working in partnership with another organisation (Iwerne Trust).
- Failure by SU to monitor implementation of operational practices within Iwerne/Titus Trust camps, against those set out for all other areas of SU activity.
- Where practices within Iwerne Trust activities were identified as being of concern (and not aligned to SU practice standards), this should have caused SU to terminate its relationship with Iwerne Trust. SU's failure to do so resulted in SU being associated with camps that were run in a way that enabled an individual (and potentially other perpetrators with poor intent) to access victims, to continue to harm children and young adults without effective challenge and to operate without personal consequence.
- Failure to prioritise the safeguarding and protection of young people above the interests of powerful individuals and organisational considerations.
- Failure to make appropriate referrals to the police in order to protect those already groomed and harmed (now adults) and any new victims (from the UK and in Africa) from abuse by Smyth or those linked to him.

6.46. Lines of accountability for safeguarding were blurred prior to the end of 2015. The action taken by the now operational safeguarding lead (end of 2015 to December 2020) and the Company Secretary and endorsed by the Trustees was therefore informed by incomplete information-sharing by the Titus Trust and limited access to direct meetings and conversations with Titus Trust's Operations Director (James Stileman) which were predominantly undertaken by the National Director. The SU staff member who is identified as having lead responsibility for safeguarding in 2014/15 appears to have played no part in the management of the case.

6.47. Revd. Hastie-Smith now describes his '*involvement on multiple levels*'[21], as he was immersed in both the Iwerne Trust and University peer circles impacted by Smyth's influence. His full disclosure would not have been necessary if the case had been managed, and communications with the Titus Trust led, by SU's designated safeguarding lead rather than him. This level of accountability sits with SU. It is the Reviewer's view that Revd. Hastie-Smith's conflict of interest should also have been declared in 2014/2015. Revd. Hastie-Smith had been involved with those linked to Iwerne, to use his expression, "*on multiple levels*": he had been involved with Iwerne camps for many years (before joining SU) and, therefore, knew many of the people involved in them at a personal level; he was aware of the identity of an anonymous alleged victim who has spoken publicly about the Smyth matter; a number of his peers at Cambridge University were victims and survivors, and he had been one of David Fletcher's curates at St Ebbes, Oxford. These matters were formally declared to the Trustees of SU in February 2017. However, the Reviewer has seen no evidence that they were declared in 2014/15 and they should have led to the communication with Titus Trust being led by SU's designated safeguarding lead rather than Revd. Hastie-Smith.

6.48. In retrospect SU should have clarified with the police what information had been shared with them and ensured that all of the information held by SU at that time was in the Police's possession. This would be considered current best practice in the light of recurrent learning from Serious Case Reviews which highlight the danger of assuming that others have made full disclosure and the need to take organisational responsibility for ensuring that information sharing has not been incomplete/selective. The Reviewer is confident from the evidence of current case management practice that SU's designated safeguarding leads would require evidence that another organisation or individual had made a full referral and would ensure that any information that was held by the organisation in relation to concerns was shared fully and appropriately with statutory agencies.

6.49. A copy of the police report made by Titus Trust was not forthcoming, but a police case reference number was provided. The Reviewer notes that Stileman's response on 23/09/2015 indicates only that a '*brief summary of information'* was provided to the police and the allegation was discussed. The Ruston Report alone would have indicated that the number of victims, their ages and the severity of the abuse would have necessitated police action. Stileman also makes it clear that no further information is to be shared with SU as the information already provided reflects what has been shared with the police. SU records indicate on six occasions

[21] As stated in Revd. Hastie-Smith's interview with Reviewer 18/03/2020

between 16 March 2015 and 7 September 2015 that confirmation of a LADO referral being made was requested of Titus Trust by SU. A letter dated 7 September 2015 from SU's Company Secretary to the TT operations Director states that, '*assuming that the Police and LADO, as appropriate, have been informed, there is little more that SU can practically do at this stage*.' James Stileman responded that that all necessary had been taken: '*no referral to the LADO has been made as the abuser lives outside of UK jurisdiction and therefore is deemed not to present a continuing risk to children'*. The implication that the risk to children outside of the UK is not a consideration does not appear to have been appropriately challenged nor is there any recorded consideration of SU making this referral. The wider risk of significant harm to children overseas or the potential risks associated with the considerable influence and power Smyth had established over his UK victims, which had led to at least one other individual becoming complicit in perpetrating the abuse, were ignored. The Reviewer could not find any SU record which explained the failure to acknowledge these wider safeguarding risks or to take appropriate action to address these risks in 1981 or in 2015.

6.50. SU should not have 'assumed' anything and had a responsibility to verify directly with the statutory agencies (Police and LADO) that they had received the full unredacted information collated by the Titus Trust. This action was not taken. A victim focus is missing. At no point is there any record of the potential for many more children and young people to have been abused by Smyth (or others linked to him) in Africa or in other contexts being considered. The Reviewer has confirmed, through direct communication with the lead DCI from Hampshire Constabulary on 17 September 2020, that the Police *'have had sight of the Rushton* [*sic*] *Report from several sources although there is no way of knowing whether we have had sight of the full report. I have seen the report from James Stileman, although this was redacted to NOT show the names of the 2 individuals you mention as I was informed that they were not related to the John Smyth concerns. I have also seen a copy of the report referred to as the Coltart report.'*

6.51. This clear indication of inappropriately limited information-sharing with statutory agencies should have raised concerns about the need for SU to speak directly to the police in a context where SU were clear that they had received insufficient information to enable a full assessment of risk or identification of victims. In light of what is now evidenced in relation to a co-perpetrator, other individuals of concern noted on the unredacted cover letter to the Stileman Report (not held by SU) and the ages of some of the victims, a LADO referral would have been wholly appropriate. Only Iwerne/Titus Trust were aware of this.

SU highlight their experience of having contacted a LADO regarding a person of concern living overseas is that they LADO will not take such referrals but signpost to the Police. In the JS case SU were aware that the Police were involved. Whilst this is true, SU did not verify what information was held by the police or raise the need for them to demand disclosure of the unredacted Stileman Report which indicated individuals of concern who were actively involved in Education in the UK. Had SU actively engaged with the Police and the Police had also been more challenging of their need to see unredacted materials, these failures in information-sharing by the Titus Trust may well have been addressed at an earlier stage and made the appropriateness of LADO involvement clear. As with the majority of serious case reviews there are failures across a range of agencies and organisations in the Smyth case.

6.52. A number of sources indicated that in 2015, following the disclosure of the Ruston Report to SU, both the then Chair of Trustees and National Director expressed a willingness to reach out to victims. At interview, an advocate for the victims explained that Iwerne had its own very clear corporate identity and culture and it was this that victims identified with. It was reportedly recognised and explicitly stated by several victims at that time that it was not a SU response which was sought. Whilst this may have been true for the individuals represented at the time, the perceived failure to extend an offer of support from any of the religious organisations linked to Smyth to those still struggling with the legacy of Smyth's abuse has, from the accounts of victims and their advocates, increased the impact of the abuse.

6.53. The joint financing of an offer of counselling for survivors was agreed between CofE, SU and Titus Trust and a draft agreement dated 27th March 2017, between CNLR Horizons Limited (a CIC) and The Archbishop's Council to provide counselling services was seen by the Reviewer. The schedule of Services states that weekly sessions should be offered to referred clients, 12-15 sessions *'(face to face with a matched counsellor who will be identified as 'both highly experienced and able to work with developmental trauma. All practitioners will be deemed to be able to meet the client's needs for a range of support.)*' The wording of a SU statement promoting an offer of support to victims was agreed between SU and Hampshire Constabulary in 2017. This signposted

victims to the police, to the appropriate CofE safeguarding web page and to the Thirtyone:eight contact number. The invoices for this work (in February and November 2018) indicate that very few individuals took up this offer. Victim accounts suggest that the links to CofE Diocesan safeguarding leads, the church's central safeguarding team and Thirtyone:eight created a block because of either previous adverse experiences of seeking support through members of the Anglican clergy or a perceived lack of independence from the Anglican church.

6.54. In February 2017, after the Channel 4 Smyth documentary aired and a further victim shared his account, Revd. Hastie-Smith disclosed to SU's safeguarding lead that he thought he might be able to identify another individual involved who worked in Education. It is clearly evidenced that Revd. Hastie-Smith was immediately advised by SU's Safeguarding Lead and Company Secretary to inform the police. It is recorded in an email from Revd. Hastie-Smith that this advice was taken and that he made this referral on the same day (also reportedly offering continuing cooperation from SU should the police require this) but there is no record within the SU records and archives of a referral reference number, what was reportedly shared by him or whether that individual had any connections with SU. Irrespective of Revd. Hastie-Smith's leadership position, details of who he had spoken to, when this had taken place and a reference number should have been requested and recorded.

6.55. When contacted by the Reviewer, the Officer in Charge of the Smyth investigation at Hampshire Constabulary stated: '*I have looked through our documentation but unfortunately can find no record of a referral made by Rev Hastie Smith on or around the 6th Feb 2017 so cannot give you a reference number. We did have contact from a number of individuals immediately following the Ch4 documentary in Feb 2017 but can find no reference to Rev Hastie* [sic] *in any of these*[22]'. Revd. Hastie-Smith was given the opportunity to respond to the Police's assertion that no referral had been received but he has not responded to a request for clarification of his position to the Reviewer or to SU.

6.56. A review of information held in SU archives relating to John Smyth led to SU making a direct referral to Hampshire Police (Operation Cubic) on 29th March 2017. The evidence of immediate and complete sharing of historic concerns to the statutory agencies again highlights the modelling of robust safeguarding practice by the current SU safeguarding team, with full trustee support. It was confirmed by Hampshire police in an email dated 19th February 2019 that '*this case has now been closed following the death of John Smyth'*.

6.57. Despite the failings in the 2015 and 2017 case reviews in respect of the period prior to 2014 (see paragraph 8.6 below) and those during 2014-16 noted above, there is clear evidence of safeguarding concerns which have been reported to SU in recent years being taken very seriously and responded to by the SU safeguarding leads appropriately and promptly.

7. Objective 2: To identify any new or additional actions required to be taken in relation to any individuals who may still pose a risk to children and young people as a result of the (any) lack of actions taken against them when concerns about them were previously raised.

7.1. The only indication held by SU that indicated that there were additional perpetrators within the Iwerne camps during the time of SU's links with Iwerne Trust and its activities, comes from the Stileman Report and redacted Iwerne/Titus Trust papers. Victims, survivors and their advocates assert that there are other individuals who posed a risk to children and young people within the Iwerne Trust's activities, but it has been clarified with those interviewed that, to their knowledge, none of these were employed by or were known to SU in any volunteer capacity at the time of these concerns or subsequently.

7.2. There are many reasons why there would inevitably be under-reporting of concerns about individuals whose behaviours and attitudes may have raised safeguarding concerns historically. SU has undertaken two independent reviews of its non-recent child abuse and child welfare cases in 2014/15 and 2017 and this should give confidence to the organisation that, where relevant information has been recorded and retained by SU, all appropriate actions have been taken to address concerns. This should not however lead to any level

[22] Email on 17 September 2020 at 12:08 from DCI to the Reviewer in response to emailed referral of information sent 15 September 2020 at 16:28.

of complacency. The scale and complexity of this case suggests that the concurrent reviews may yet identify new information relating to SU. Disclosures of both current and historic abuse across all sectors in the UK have risen through the period of the coronavirus pandemic and both previous independent SU reviews highlighted significant shortfalls in both the recording of concerns and in external reporting.

7.3. Trauma responses can be compounded by other issues including cognitive dissonance as illustrated where Smyth's victims describe ways in which they tried hard to hold onto their beliefs and perceptions about him and his indoctrination which had led to strong feelings of love and attachment in the absence of consistent carers. In isolation from perspectives other than that of an abuser, and with harsh treatment interspersed with intermittent demonstration of kindness and affection, a perceived inability to seek help or be believed has been evidenced. These issues are very prevalent in Smyth victim accounts and have led to descriptions of extreme trauma within a loving context, guilt and denial of abuse, which had potential to confuse those around them or further block disclosure. The Smyth Reviews collectively are likely to support a consistent clarity of understanding around the nature and impact of Smyth's abuse and increase requests for support from victims.

7.4. The Reviewer has searched SU archives to explore whether SU holds any information about individuals named in the Stileman report or by interviewees, or if any of them are linked to SU employees in any way. The information held by the Reviewer which relates to individuals not identified as being linked to SU has been shared with the Police and/or the other Smyth Reviews appropriately. This action has been taken by the Reviewer to ensure that all additional information is collated, and any outstanding actions are taken by those organisations to address concerns.

7.5. Through commissioning this independent Review, the SU Trustees have ensured that all necessary action in relation to known individuals who potentially presented a continuing safeguarding risk has now been taken. This does not preclude there being other individuals of concern linked to Iwerne Trust activities which historically offered optimum conditions for those with poor intent to access, groom and abuse young people.

7.6. The previous independent case reviews, the second of which was undertaken by the current Reviewer, both identified that SU's standard of record keeping was consistently poor. The second Review found that only 160 case files had been allocated numbers over a period covering nearly four decades (pre-1976 up to and including 2014). A further 135 records had no file number allocated. It was almost impossible to identify staff, volunteers, or participants retrospectively on the basis of the information recorded, even where significant concerns are indicated. The records indicated that at least seventeen concerns should have been referred out to external agencies at the time of concerns being recorded or identified. This is 10.6% of the cases allocated reference numbers[23]. The findings and recommendations of the 2017 independent review in relation to record keeping standards and failures to make appropriate external referrals are relevant to this case as they cover the relevant time periods.

7.7. Such incomplete record keeping and unexplained failures in record keeping/retention demonstrate a lack of historical rigour in relation to safeguarding record keeping.

7.8. For many victims and survivors, the impact of the Covid-19 pandemic (anxiety, mental health crises, isolation, unstable domestic circumstances and relationships, lack of access to appropriate support etc.) has increased their current trauma related to non-recent abuse. The Independent Inquiry into Child Sexual Abuse (IICSA) has also raised public awareness of abuse in faith sector settings and the expectation that victims will be heard and responded to positively. The impact of severe trauma and the context in which Smyth's victims' accounts have been dismissed or suppressed is now understood more comprehensively. SU's response to the Smyth Review is keenly awaited by many of those who have shared evidence, including victims, and a number of individuals have stated that they believe and expect that others may step forward to share concerns if this Review's findings and responses to its recommendations serve to increase confidence in the current organisational commitment to safeguarding. With three concurrent Smyth Reviews likely to be reporting in 2021, there is potential for the impact upon victims (known and yet to be identified) to be powerfully negative if careful consideration is not given to timing and management of communications.

7.9. Only information available has been analysed against this objective and the deficiencies in the historic records make it impossible to be certain that all relevant concerns have been identified and appropriate action taken. However, all new and additional actions required to be taken in relation to individuals identified through this case

[23] Scripture Union Safeguarding Historic File Review Final Report March 2017

review and in this report have been taken by the Reviewer. If SU is in receipt of new information or further disclosures at any time from individuals who have previously been unable to share concerns, this should be treated as current safeguarding risk and SU should immediately ensure appropriate partnership working and information-sharing is supported with the statutory agencies.

7.10. The following actions are confirmed:

- The minutes of the SU Schools Committee held on 1/10/1976 (S. 128/76) note that Smyth had given a report to the Committee about a fatality which had occurred at Iwerne Minster. No further information is available to Reviewer. This information was referred to the Police by SU's Company Secretary on 31 March 2017.
- Details of individuals consistently named by victims as having been instrumental in facilitating Smyth's introduction to the Christian Forum at Winchester College and in supporting his contact with pupils were shared with the Winchester College Reviewers. They were also shared with the Officer in Charge[24] of the Smyth Investigation. Both actions were taken by the Reviewer. Neither individual has any identified links to SU.
- All linked clergy (who have been Anglican without exception) where concerns have been raised in the course of this Review have been shared with CofE Reviewers in line with the agreed information-sharing principles between the consecutive Smyth Reviews.
- Information relating to Iwerne volunteers named in the Stileman Report was shared with the Police. Supporting information was shared with the Police by the Reviewer after the Police disclosed that they had not previously seen these names as they only had redacted papers.
- The Reviewer recommended to the Police that they seek a full and unredacted copy of the Stileman Report from the Titus Trust by email on 17 September 2020 as neither SU nor the Reviewer have an unredacted copy.
- The police communication that no referral could be found in relation to Revd. Hastie-Smith or during the period following the 2017 Channel 4 documentaries was shared with CofE Reviewers.

7.11. Action related to the review of the SU safeguarding framework, including matters such as suggested policy and practice guidance improvements, are dealt with under other Objectives.

8. Objective 3: To provide the Board with an informed assessment of the rigour of the governance associated oversight of residential events at which the grooming and abuse allegedly occurred.

8.1. The Reviewer identified a confidential schools paper dated November 1969 which evidenced that a context of strongly maintained separation between the schools work and cultures of SU and the Iwerne schools work had prevailed for decades. It also evidences SU's frustration with this situation and failure to successfully bring the Iwerne camps in line with organisational practices and governance. It includes significant adverse feedback around the camps being socially narrow/divisive; teaching by doctrine; group pressures and 'embarrassing boys' and states that VPS staff '*have opted for a closely knit operation, over which they have complete personal control'*.

Within the paper the actual line of control between SU and Iwerne is clarified as '*no control'*, merely liaison with the Schools Secretary (for administration) and the Schools Committee (for finance only). This paper also sets out very clearly and explicitly just how independent the Iwerne Camps were and how their leadership, unlike that of other SU Schools activities, was controlled by a small group of key leaders and personalities. Of these, Revd. David Fletcher and Revd. John Eddison (R.J.B. Eddison) are involved in the responses to the John Smyth concerns from 1981 until the time of Smyth's death.

8.2. Where the Iwerne Camps and staff are the subject of SU Council minutes and relating to relationships and agreements around the delivery of independent schools work, these tensions are often explicitly described and the degree of autonomy (and friction) between SU and its Iwerne 'employees' is evidenced repeatedly.

8.3. Iwerne Trust Campers, including former leaders and victims, who have shared information, evidence and recollections from the period when they were involved for the purposes of the review describe the following context in the years before John Smyth's abuse was recognised in 1982:

[24] All references to the Police in this paragraph indicate the DCI from Hampshire Police (the Officer in Charge of the Smyth investigation

- The relationship was spoken of as being '*under the aegis of Scripture Union'*, but quite separate. Campers were aware that SU existed and ran camps/activities for other children and young people outside of their school and social circles but had never seen it as relevant to Iwerne or their experience.
- SU was described by interviewees who were involved in running the Iwerne and Lymington camps as a provider of administration support and very occasionally of paper resources, e.g. the daily Bible reading notes were available for use at Christian Unions/Forums within schools work but victims explained that Iwerne Officers prepared individual scripture reading guidance for those pupils/participants allocated to their mentorship. SU materials were reportedly not used at Winchester College within the Christian forum.
- Where parents '*were nervous about Iwerne or concerned that it was a cult*', the SU links might be promoted or explained reportedly, but not otherwise.
- SU was not viewed as '*sound enough'* by the Iwerne network as it was seen to be too liberal and not conservative enough in its handling of Scripture. As such, Iwerne schools work was seen as superior in its calling and in operation it was '*not beholden to Scripture Union*'.
- Iwerne appointed its own staff from within its officer base and SU then approved the appointments, reportedly with no participation in the appointment process. This means that SU held overall responsibility with no level of involvement or formal acknowledgement by Iwerne. In retrospect this should never have been allowed but, at the time that this occurred, very minimal scrutiny of volunteer recruitment was a universal issue within the children's workforce.

8.4. It is noted that the archived camp brochures seen by the Reviewer contrast significantly between Iwerne camps and SU camps. The SU Holiday brochures are clearly branded but the Iwerne brochures state that '*parties are held under the auspices of the Varsities and Public Schools Camps'* and do not mention SU. A change in Iwerne Minster Holiday brochure branding and promotional materials is noted from 1986 with SU logos clearly displayed.

8.5. Iwerne holiday brochures seen by the Reviewer notably lack any information about behaviour, standards or safety. The Reviewer's view is that this would have been normal during this time as the need to be clear about behavioural expectations within residential and volunteer settings was not widely acknowledged until the Warner Report[25] in 1992.

8.6. One interviewee stated that when his parents raised concern about him attending camps at Iwerne they were reassured that these were SU camps. He stated that this was the only time he had been aware of any SU link as he was introduced to the Iwerne Trust through the school's Christian Union where there had been no reference to SU. His view was that this was used to give the camps '*an air of respectability'* and implied oversight if concerns were raised. This might provide some additional context as to why Iwerne maintained arrangements with SU as an administrator for the VPS/Iwerne workforce when their ethos and working practices were so evidently discordant.

8.7. Minutes of the SU Schools Committee dated 27/11/1980, record the proposal and agreement that functional responsibility for VPS work as a whole, of leadership and of direct line management oversight of VPS/Iwerne work would be formally delegated to Revd. David Fletcher by SU's then Head of Schools. This appears to be an acknowledgement that attempts to manage this work by the SU Schools team were wholly ineffective. Although Revd. David Fletcher was an SU employee, he was a Iwerne Trustee and his post was fully funded by the Iwerne Trust, as were those of SU staff Peter Wells and Revd. Tim Sterry.

8.8. It is clear from both the SU records and those shared by external sources which were reviewed, the accounts of victims and the information provided by Revd. David Fletcher at both SU and CofE Interviews, that the Iwerne residential events offered an optimum environment for any individual who, like Smyth, had poor intent. A number of concerning themes were evident:

- an over-developed sense of group allegiance and belonging;
- a strongly cultivated suspicion of and disregard for 'outsiders';
- an elite view which insisted that an unnegotiable requirement was that individuals were 'assured' e.g. had an absolute belief that they were always right. The views of others, alternative thinking and

[25] Department of Health (1992). *Choosing with Care: Warner Report – The Report into the Committee of Inquiry into the Selection, Development and Management of Staff in Children's Homes*

challenge were not welcomed. This is a feature of radicalisation in many instances of exploitation and abuse within faith organisations/movements;

- issues of deference: it was noted that it was '*easier for ordained staff to overcome resistance of headteachers and chaplains to external influence than other staff*'[26]. This also applied to those with significant social status and powerful personalities. This is evidenced in many current and historical cases of alleged abuse within a faith setting where the moral authority of clergy has been widely perceived as beyond challenge or reproach;
- group identity and the right to belong is based upon compliance, allegiance to 'sound' doctrine and an assertion that individuals were only accountable to each other and the organisation;
- the use of its own language to reinforce identity and separateness;
- 'buy in' to the Iwerne values and behaviours are valued and doing anything, including sharing information outside of those (and hierarchical groups of power within this) is framed as betrayal;
- encouragement of long-term and private relationships based upon expectations of loyalty, continuity, letter writing and visits which extended to weekly visits once boys progressed to University with no oversight at all. Dependency and fear of rejection are strong blocks to disclosure;
- the abuse of trust, power, confidences and information - largely focusing upon issues of sexuality and relationships - which was used to shame and humiliate those who were harmed. Persuading vulnerable young people that the disclosure of even '*minor impure thoughts*' was necessary/noble and that suffering to atone for these failings provided a more direct route to a closer relationship with God reserved for an elite few;
- the misuse and misrepresentation of Biblical Scripture to justify and celebrate the infliction of suffering and pain. Those who did not believe in the absolute truth of Scripture were presented and described as '*the enemy*' (an expression still used by Revd. Fletcher) and therefore it was almost impossible for the victims/SU/non-ordained professionals to challenge anything that was presented as supported by Scripture;
- the belief that all who lead in evangelism are individuals of high integrity. Many undoubtedly are but, where this is never questioned, it provides an open door for those with poor intent; and
- a strong family-framed context. Disclosing harm or abuse within a family context can leave an individual very isolated and with a fractured sense of identity.

8.9. The Iwerne philosophy was heavily focused upon the development of personal and continuing one-to-one relationships with children and young people between camps which was actively promoted and encouraged. This culture was replicated in SU practices over the same period. Although SU's 2015 case review report (see 6.7 above) was positive about the potential benefits to young people of post-event communications, whilst stating the need for appropriate safeguards to be in place, SU's independent case review report in 2017 highlighted this as an area of risk. Without safeguards, there is a high level of potential risk in relation to grooming and inappropriate communications with children and young people. An exploration of the current SU policy and practice guidance indicated that practice in this area has changed since 2017 and contact between events is now more limited and subject to explicit parental consent having been given. Under the direction of the event leader a volunteer may be asked to send an SU-branded postcard or a Christmas card to a guest. Contact must never take the form of spiritual mentoring. The Reviewer remains concerned however that event/mission leaders, who are only required to engage with learning about safeguarding as a small element of a one-day annual training day, have responsibility for endorsing and overseeing any continuing contact between team members and children after events. The Reviewer raised concerns about the lack of consistent oversight and supervision of this area of practice and as a result SU has taken steps to reduce the degree of discretion of volunteers in relation to post event communication.

8.10. SU has altered its practices in relation to the recruitment of volunteers significantly in recent years. At the time when the Review commenced it was evidenced that references for SU volunteers were not consistently verified and this was highlighted by the Reviewer as an area of risk. The Reviewer understands that all references are now checked and there are two randomised processes to supplement this checking: first, a random sample of the references are followed up by telephone; secondly, a random sample of applicants are

[26] VPSC Principles and Method Private Paper dated March 1970. SU Archives

interviewed. SU state that this is an area of practice which is kept under regular review, but the Reviewer has identified this as an area of high risk and made recommendations to support improved practice and consistent implementation of safe recruitment processes including interviews for all volunteers.

8.11. As indicated above, prior to the transition of Iwerne Trust into the Titus Trust in 1997 and with this the formal removal of any SU governance links with Iwerne, clear failings in governance are demonstrated by SU in relation to the VPS/Iwerne camps and activities. The lack of clarity around lines of accountability and any monitoring of implementation by SU of operational practices within Iwerne camps, may have been a factor in an individual (and potentially other perpetrators with poor intent) being able to access victims.

8.12. Evidence of individuals, including some of those in the employment of SU, not being sufficiently observant, curious or challenging has emerged as a prevalent theme. None of the victims viewed the lack of curiosity demonstrated over many years by key individuals identified within this Review as believable. They understandably present this as evidence of denial, abdication of responsibility or an indication of dishonesty. Interviewees and their advocates described this as '*willful blindness'*, '*willful ignorance' and* '*studies in obfuscation'*. Organisational learning is however clear, and the Reviewer is confident that this no longer characterises current SU practice at national level.

8.13. Robust and quality assured welfare planning for residential events which ensure consistency and strong central governance is of paramount importance. This is particularly important where such high levels of responsibility are delegated to a volunteer workforce. The development of a template welfare plan for events which provides greater detail and raises the profile of safeguarding with SU volunteers is included in the recommendations arising from the policy framework review and recommendations linked to Objective 5 of the review. SU consider that the elements of such a plan are covered but are willing for their arrangements to be scrutinised with the involvement of Thirtyone:eight and the Safeguarding Advisory Group of SU.

8.14. SU's archived records evidence continuing and acknowledged challenges in managing staff involved in VPS/Iwerne schools work and the dismissal of SU's repeated attempts to assert organisational leadership and consistency within Iwerne practices. Notwithstanding this, it is clear that historically there have been failures in oversight and governance by SU in relation to Iwerne Trust activities. If it was impossible to impose consistent operating standards and Iwerne's divergent practices caused the level of discomfort evidenced in this report, SU should have considered terminating the operational relationship between SU and Iwerne Trust.

9. Objective 4: To provide the Board with an informed assessment of the governance processes in place regarding John Smyth's trusteeship of Scripture Union, including the recruitment process and monitoring his influence on and involvement in activities relating to the work of Scripture Union.

9.1. From examination of SU Council Minutes between 1967 and 1972, it appears that:

a) it was general policy that an individual should serve as a member of a SU Committee before being considered as a trustee, and

b) names were put forward to Council who would then decide whether to approach those individuals. Appointment was therefore by invitation rather than through an open application process. The process by which John Smyth became a member of SU Council appears to have been standard for that time.

9.2. The minutes of the SU Council Meeting on 29th September 1971 state that:

> '*Mr. John Smyth has been added to the Schools Committee with a view to Council Membership. Members of that Committee agreed he would make a useful contribution to Council discussions but wondered if his work as a barrister would prevent regular attendance at Council meetings. The General Director was therefore asked to enquire if Mr. Smyth would be able to commit himself to Council membership, in which case he should be invited to join the Council.*'

It makes absolute sense in terms of robust governance that the performance and behaviours of individuals are assessed in a committee role before consideration of their suitability for a Council/Trustee appointment. In Smyth's case, the process appears to have been very artificially implemented in order to expediate his appointment as a trustee which placed him in a significant position of power and influence without any prior assessment of his suitability to undertake this role.

9.3. Records indicate that John Smyth joined the SU Council in November 1971. SU Archives feature John Smyth in

numerous papers/minutes in the eight years prior to the events of 1982. He is listed in 'The Report to the Council to the Members of Scripture Union' as an official member of Council and as being appointed in November 1971. John Smyth's attendance at SU Council meetings as a trustee is recorded at intervals between 1973 and 1978, but records indicate that he was a SU trustee for a more extended period from 1971 until June 1979 and was a member of SU's Schools Committee for the same period of time. Records were identified within the SU archives that list Smyth as an attendee as the SU's Schools Committee meeting on 27 July 1976 and as attending the SU AGM as a trustee on 25 October 1979.

9.4. In SU Council's Report and Statement of Accounts for the year ended 31st March 1979, minute 64/79 outlining Smyth's 'resignation' from Council states:

> *'MR. JOHN SMYTH The Chairman shared with members the exchange of letter between himself and Mr. Smyth regarding his attendance at Council meetings. Members noted that extreme pressure of business limited his attendance to those meetings where matters of personal interest were being discussed, and they agreed that his offer of resignation should be accepted with appreciation for the long period of service given both on the Council and to the work of the Movement generally. It was further agreed that Mr. Kahn should suggest that Mr. Smyth be regarded as a consultant whose advice could be sought by the Council on any matter. It was assumed that his membership of the Schools Committee would also come to an end.'*

9.5. The wording of the above minute implies that:

- Smyth's attendance was self-serving as his interest was limited to issues of personal interest and not focused upon the organisation's needs or wider Mission.
- His appointment to SU's Council as a trustee was linked to his membership of the Schools Committee and each was dependent upon the continuation of the other appointment. This is not the case. It was and is clearly possible for individuals to be SU Committee members without being a member of Council, so this does not stand up to scrutiny in terms of a supporting rationale. The reasons underpinning this 'assumption' of Smyth's resignation are not explained in any records seen but, by implication, SU appeared to be anxious to bring Smyth's influence and formal involvement within SU to an end.

9.6. SU Council meeting minutes between 30th May and 27th June 1979 indicate that the SU Council chose to interpret Smyth's letters to the Chair of Council as a resignation. Smyth was clear that it was not his intention to resign, he had only sent apologies because his work commitments as a QC had prohibited regular attendance at meetings. Despite his clear response that he had not communicated his intent to resign and his expressed disappointment, it is recorded that Council *'members repeated the view that the relationship of consultant outside of council was more appropriate for John Smyth'*. It is the view of the Reviewer that this action as recorded, combined with his removal from the Schools Committee (where there are no recorded concerns or issues about his attendance at meetings and where these two appointments would not have been directly linked in SU processes at that time or since), appears to indicate that Smyth's time as a trustee had not been something that other members had found comfortable and they were not open to him continuing as a trustee despite his protestations.

It is now apparent that Smyth's behaviours were causing widespread discomfort long before Revd. David Fletcher received the first disclosure (identified in this Review process that this was in a letter received 16 March 1981). No evidence has been seen by the Reviewer that indicates that concerns about Smyth were shared with SU before Alan Martin was informed verbally of concerns in April 1982.

9.7. Responsibility for trustee recruitment currently lies with the Chair of Trustees. A selection group, usually comprising trustees and members of Council, is formed as specific needs arise. The group assesses the composition of the Board, giving specific consideration to vacancies requiring particular specialist skills. The trustees themselves may proactively approach and co-opt additional trustees to fill vacancies and such appointments are effective until the next Annual Meeting. The Articles of Association provide for a minimum of six and a maximum of twelve trustees. Neither the advert or the Trustee Role Profile provided identify a commitment to, and understanding of, safeguarding as a core requirement despite SU being set out as a Children's Charity. The Reviewer notes a significant number of positive procedural changes since 1970-72 but this element should be more clearly promoted. Board positions are now advertised and a formal application process with conscious assessment and shortlisting against skills, experience and areas where the applicant can strengthen the existing membership in these areas. Applicants are interviewed twice by groups comprising the Chair, at least one other Board member and at least one other Council member. References are taken up

and an induction process is implemented for all new Board members.

9.8. It is stated by SU that all trustees receive comprehensive induction training, information and support to acquire the necessary detail of how SU and the Board work, so that they can play a full part in discussion and decision-making. Every effort is made to broaden trustees' knowledge on an individual level so that they are up to date with the whole of the Movement and the Strategic Plan. Where there has not been any previous involvement, care is taken to introduce them to the Movement, with emphasis on the Statement of Aims, Belief and Working Principles and on the Strategic Plan.

9.9. SU's '*New Trustee Induction Pack*' (2018) however, states that participation in induction processes run principally for new staff is encouraged, but not mandatory, both for new trustees and by way of a 'refresher'. It does not list the Safeguarding Policy or a Code of Behaviour/Conduct. The Charity Commission guidance '*The essential trustee'* (Guidance CC3a) and '*Charities and Risk Management*' *(Guidance CC26)* are listed within the induction process but neither of these guidance documents makes overt reference to safeguarding and protecting stakeholders except under operational risks where lack of beneficiary welfare or safety are noted. All new and serving trustees are encouraged to attend or participate in a local, regional or national SU holiday, mission or other event as part of their induction and ongoing development. Again, this is not mandatory. No training requirement is listed at all in relation to safeguarding.

9.10. The Reviewer is advised that safeguarding induction and training is now mandatory for all trustees and that the process has been revised to emphasise these safeguarding responsibilities. The current process for the recruitment and induction of Trustees is very different from that which existed 50 years ago. The reviewer has, nonetheless, made various detailed recommendations and suggestions for consideration with a view to the improvement of the safeguarding elements of the process.

10. OBJECTIVE 5: To indicate whether any areas of Scripture Union's current safeguarding policies, practice and governance should be scrutinised or revised.

10.1. There is no record of SU having a specific safeguarding policy in place in the 1970s and early 1980s. In common with most other similar organisations, the first formal child protection policy for SU was introduced in 1998. The first significant mention of child protection in SU archives was within a report from the Director of Field Ministries in May 1999 shortly before the Titus Trust took over complete ownership and management of the VPS work. The report notes the need to '*ensure that all groups are updated in Child Protection procedures'*.

10.2. There is no evidence in the SU responses recorded that any consideration was given in 1982 to the need for changes to policies, procedures, awareness raising or practice guidance to ensure the opportunities exploited by Smyth to perpetrate the abuse of boys were addressed. The Iwerne practices that may have facilitated Smyth's targeting of children included practices that did not align with those expected within SU activities and which were among the things that caused significant tensions between SU and Iwerne as far back as 1970.

10.3. Irrespective of whether it was believed abuse had not occurred directly in the context of the Iwerne Camps, failure to consider Smyth's abuse within this context of practice concerns by those SU personnel who were aware of the abuse left children and young people without adequate support and at continued risk of abuse from Smyth and potentially from others with poor intent. Assuming that risks only related to this individual may have left others to continue to practice in ways which offered those with poor intent opportunities to groom and abuse children instead of SU ensuring that a rigorous assessment of risks within the context(s) in which concerns had arisen was undertaken.

10.4. Evidence from this review and the learning from serious case reviews across all sectors indicate failures to recognise risks and increased vulnerability for those aged sixteen and over and from peer-on-peer abuse. A focus upon the safeguarding of younger children and low levels of awareness can create opportunities for individuals with poor intent, particularly in relation to sexual exploitation and abuse, to target older service users/guests and young volunteers without adequate recognition or challenge.

Currently the organisation's adult safeguarding and protection framework is very much a 'bolt on' and does not adequately reflect the moral or statutory duty of care that SU has for these groups or the risks identified in this case. This area of safeguarding is not currently sufficiently supported by appropriate training and learning opportunities. Issues around exploitation, grooming, coercion, control, consent and competency and some of the challenges in accessing appropriate support for adolescents and adults need to be addressed far

more comprehensively in SU's policies, guidance and workforce development.

10.5. A more transitional approach to safeguarding would serve to prevent assumptions being made around an individual's age and supports necessary consideration of wider contextual factors and diversity issues which might increase risks for individuals. This would effectively support more holistic safeguarding risk assessments and thereby reduce the possibility of misinterpretation and misrepresentation of the vulnerability of victims as is evidenced in this case. The organisation's safeguarding framework needs to be developed to address the increased risks related to adolescence and those transitioning into adulthood more comprehensively and meaningfully.

10.6. The SU policy framework, guidance and training strategy needs to be revised in order to raise awareness of issues of trauma to ensure that indicators are not missed or misinterpreted. This is a very specialist area of practice and there is no inference that anyone within SU or facilitating SU activities should become 'expert' in this topic, but it should be explicitly referenced in the current framework. The faith sector, and the positive support it can offer, attracts individuals of all ages who are survivors of trauma (care leavers, those who are displaced or isolated, those who have experienced abuse in other contexts etc.) and it is critical that this is an area of increased awareness within SU's workforce.

10.7. Learning from safeguarding case reviews, both nationally and locally, is that a lack of professional curiosity can lead to missed opportunities to identify less obvious indicators of vulnerability or significant harm. This is evident in SU's responses to the information shared by Iwerne leaders. Taking the explanations and information offered and, in full knowledge that information sharing is incomplete, demonstrated undue reliance upon the accounts and information provided by other organisations. Accepting the Titus Trust's communications at face value led to failures in multi-agency working and in the application of objective, professional judgement. There was a very evident loss of victim focus.

10.8. The need to challenge those who resist information sharing in the interests of safeguarding and to escalate concerns to the statutory agencies more readily is essential learning in this case.

10.9. By the time SU were contacted by Titus Trust in October 2014, significant improvements in organisational awareness and ownership are demonstrated by SU and a formal child protection policy had been in place since 1998. The organisation's Safeguarding Lead and Company Secretary gave clear and appropriate case management advice to senior leadership and trustees in line with the policy in place at that time, which was accepted and acted upon with no evident internal challenge or disagreement. Objectivity, independence, experience and expertise are vital elements to effective, informed and defensible case management. SU's current safeguarding leads have demonstrated transparency and modelled best practice in terms of case management responses in relation to this case. Lines of accountability for safeguarding are now clear. Even when other organisations or SU staff/volunteers (irrespective of seniority) indicate that this action has already been taken, safeguarding leads should demand evidence of this and should always ensure that any relevant safeguarding information held by the organisation is shared with statutory agencies appropriately. Duplication of information-sharing never increases risks for the vulnerable whereas assumptions relating to information-sharing significantly increase risk for all stakeholders.

10.10. The shortcomings evidenced from when SU received the disclosures from Titus Trust in 2014 onwards (see paragraph 6.34) focus upon failures to verify with the police what information had been shared and a demonstrated trust in and deference to Titus Trust leadership, who gave assurances that all appropriate action had been taken. This same trust in relation to information-sharing and external referrals was demonstrated by SU internally prior to lines of safeguarding responsibility and accountability being clarified in late 2015. As indicated in paragraph 6.54, in relation to Revd. Hastie-Smith's communication with the police (notwithstanding Revd. Hastie-Smith's leadership position), details of who he had spoken to, when this had taken place and a reference number should have been requested and recorded.

10.11. The Reviewer has been fully supported by the leadership team and trustees of SU throughout and any support or access to materials and individuals requested has been responded to with full and comprehensive cooperation. The review has also evidenced a high level of transparency and commitment to safeguarding from the current staff leading the organisation's safeguarding responses, but this is only a small part of their very significant senior leadership roles and responsibilities.

10.12. Assurance can be given that SU's practice is compliant with statutory guidance and requirements. SU is a strongly value-driven organisation but it was difficult for the Reviewer to identify how the values, attitudes

and behaviours of staff and volunteers are explored consistently prior to recruitment and deployment or at any stage through induction, supervision, learning opportunities or performance management processes. From 2015 onwards, it is clear from this Review that SU were investing in building a safeguarding framework and practices that reflects the key requirements set out in statutory guidance for safeguarding and protecting children and adults at risk[27]. That progress has continued but there is still room for improvement as this Report highlights. The Reviewer has considered the materials made available as described in paragraph 4.5 above and has made a number of detailed recommendations and suggestions for consideration in this respect.

11. Objective 6: To share relevant documents with the Church of England's Independent Reviewers

11.1. Whilst many of those who have contributed to and engaged with this review have expressed serious concerns about these Reviews being undertaken separately, it has positively enabled in-depth examination of archived material, evidence and learning for each commissioning organisation. Cooperation between the Reviewers has been very positive in practice despite expressed fears from survivors and their advocates that this might not happen.

11.2. As indicated in paragraph 3.3 above, full cooperation was established between all three independent Smyth Review teams from June 2020 onwards.

11.3. This cooperation has included the sharing of evidence described in 6.10 above and the Reviewer can confirm that all relevant documents have been shared in line with current legislation and, where appropriate, ensuring appropriate informed consent has been secured.

11.4. The evidence set out in this report illustrates the complexity, seriousness, scale and impact of this case. The sharing of key information about any individuals who it is indicated may have been aware of the concerns or who may have been the source of concerns has been implemented by the Reviewer (acting independently but with the consent of SU) between reviews where relevant. The details of all linked clergy have been shared with the CofE and Winchester review teams by SU to ensure that any individual who might have caused harm to children and young people or who might continue to present potential safeguarding risks is subject to appropriate investigation.

11.5. Failure to report child abuse and safeguarding concerns is not a criminal offence within the UK (except in Northern Ireland where the Criminal Law Act 1967 makes it an offence to fail to disclose an arrestable offence, including those against children, to the police). This makes police referral inappropriate in relation to the majority of the information currently held by SU or the Reviewer. The Police are alert to the allegations relating to Smyth and to his alleged co-perpetrator and victims. They are also aware of the identities of former SU staff who failed to report arrestable offences including their links to Smyth and his victims. In addition, individuals named alongside Smyth on the cover letter of the Stileman Report have been reported to the Police as these are individuals who have been subject to previous criminal investigations relating to child abuse. This has been verified by the Reviewer.
Failure to report and respond in line with safeguarding procedures is however a disciplinary offence which can be addressed by the CofE where ordained clergy are the source of concern. All appropriate multi-agency information sharing in the interests of safeguarding has been completed in relation to the information seen and collated in this Review.

11.6. As stated in paragraph 4.6, the identities of victims and survivors who have contributed to this Review are held in confidence (and maintenance of that confidentiality has been explicitly requested). Where names of contributors have been included openly it has been with their expressed permissions. Materials have been shared between Smyth Reviews subject to appropriate permissions and consent being obtained, and to assurances that the commitment to confidentiality guaranteed in the first place is respected and continued into any overarching/new review.

11.7. The Reviewer has fulfilled a public duty to hand any potential evidence to the Police, in accordance with relevant legislation and guidance for the sharing of such information. The CofE's reviewers have existing links to the Senior Investigating Officer for the original police operation relating to the case and are well positioned to ensure direct contact with them appropriately. The Reviewer has, as stated, made direct contact with the

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[27] *Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children* (HM Government, 2018) and *Care and Support Guidance issued under the Care Act 2014* (Department of Health 2014)

Officer in Charge of the Smyth investigation to ensure that no assumptions are made about information-sharing on behalf of SU. If any individual under investigation is found to have had previous employment links to SU, there will be a statutory requirement for information and records to be shared with the Police upon request. All appropriate actions have been taken by the Reviewer in relation to external referrals and information sharing.

11.8. There are very significant overlaps between the reviews and the information which informs their findings which indicate the need for the learning from the reviews to be drawn together. This would mirror best practice as set out in statutory procedures for Child Safeguarding Practice Reviews and Safeguarding Adult Reviews and would retain the focus upon effective learning and improvements that will prevent such harm occurring again. As the Church of England Smyth Review has the longest timescales and greatest breadth, their Review Team are best placed to draw the learning together from each of the Reviews, where this is agreed by the commissioning organisations, and to ensure that any outstanding action required is taken.

11.9. The principles of information-sharing (in line with current legislation and data protection principles and in the interests of ensuring that learning for each organisation is fully informed and to support effective safeguarding and protection of children, young people and adults at risk), have been embedded throughout this review. This is also reflected in the key recommendations of the Reviewer.

12. Key Recommendations

12.1. The Reviewer strongly recommends that SU seeks to agree protocols, in partnership with the commissioning organisations undertaking concurrent John Smyth Case Reviews, that enable the full reports from each organisation's Review to be shared with the CofE Reviewers. Within this recommendation the following issues should be considered as a priority:

a) The conditions set out in paragraph 4.6, in relation to confidentiality, need to be respected.
b) The learning from this review should be communicated appropriately to all key stakeholders, including the victims in an appropriate format which protects the identities of victims and contributors appropriately.
c) Victims and survivors have asked reviewers that they are warned in advance of the completion and release of SU Review reports, given the likely re-traumatising impact of any press interest and coverage.

12.2. Safeguarding is core business for a children's charity, particularly one facilitating residential holidays, camps and activities which present greater risks for children and young people. It is recommended that Scripture Union considers the need to ensure that this is reflected more appropriately in the organisation's investment in specialist internal safeguarding expertise and increasing the capacity of the central staff team to:

a) undertake proactive developmental work
b) ensure that the safer recruitment process is implemented consistently and universally in relation to the volunteer workforce
c) monitor compliance and implementation across SU activities and those of mission partners

12.3. The seriousness and extreme nature of the abuse by Smyth and the resulting trauma for victims is severe and current. This must be fully recognised and responded to. Irrespective of blame (including the outcomes reported by each Smyth review), victims and survivors need urgent and comprehensive independent counselling and support. This should be informed by consultation with victims/their advocates whose needs and wishes should be the primary factor influencing how, when and where this is provided to ensure that it is accessible and tailored to their needs. The previous partnership with the CofE to offer counselling to victims was poorly received and responded to. This Review has started the process of responding positively to survivors and victims (whose identities remain unknown to the organisation) and to SU demonstrating a visible commitment to hearing their voices when framing any support responses.

12.4. The Reviewer recommends that the language in safeguarding documents, policies and guidance policies should be changed in order to emphasise the need and expectation for all staff and volunteers to '*share worries and concerns*' (rather than '*refer*' or '*report')* at the earliest stages, thereby lowering the threshold for

safeguarding referrals and reducing anxiety around reporting responsibilities.

Note: *The Reviewer has made a number of very specific recommendations in relation to suggested revisions to current safeguarding policies, procedures and guidance documents (and the need for development of resources and training to support consistent and effective implementation) which are considered in the section addressing Objective 5 of this Review.*

12.5. The Smyth case demonstrates clearly that the workforce of any organisation is both its biggest asset and greatest risk, irrespective of whether an individual is employed or deployed as a volunteer. It is recommended that SU consider embedding its expressed values (through clarifying those behaviours and attitudes which are aligned or not aligned to the organisation's vision and values) into the organisation's safer recruitment, induction, supervision, performance management and disciplinary procedures. This is essential if the influence of powerful individuals, who extol extreme ideologies and behaviours and unquestioning allegiance, is to be consistently challenged and appropriately managed.

12.6. The Reviewer recommends that SU develops a more transitional approach to safeguarding which is explicitly stated within the safeguarding policy and addressed through training and learning opportunities in order to prevent assumptions being made around an individual's age and which aims to ensure that all of the contextual factors and diversity issues which might increase risks for individuals are consistently considered.

12.7. It is recommended that an in-depth safeguarding learning and training needs analysis is undertaken which maps organisational roles and responsibilities against essential safeguarding knowledge and skills. This should address safeguarding children, young people and adults at risk. SU must be able to demonstrate more clearly that it has supported the development of an aware, knowledgeable, competent and confident workforce with clarity about organisational expectations around safeguarding practices and behaviours.

12.8. SU should consider the adoption of a specialist electronic Case Management System to support efficient record keeping, reporting, information sharing, data retention, data retrieval and analysis.

12.9. The SU trustees and leadership team should ensure that the progress evident within SU's safeguarding provision and framework, supporting the positive change in culture and continuous improvement, is sustained. To sustain these improvements, the following are essential:

a) The learning from this review is communicated to key stakeholders, including victims, in an appropriate form and the learning is embedded.
b) A commitment to implementing the recommendations is given, supported within an organisational action plan.
c) A comprehensive safeguarding communication strategy is driven by SU leadership to ensure that a shared and clear vision is understood and maintained.
d) A commitment to inter-agency working and effective cooperation with statutory and partner agencies/organisations in line with best practice continues to be demonstrated.
e) Safeguarding knowledge, competencies and learning are continuously developed and supported internally (see Recommendation 12.7).
f) Safeguarding is given a high profile with its value in supporting the SU mission and influence emphasised.
g) Resources are provided to ensure that implementation of the organisation's safeguarding action plan is supported and sustained.

13. Next Steps

13.1. Recommendations which are accepted can be achieved by integrating them into the existing organisational safeguarding action/implementation plan specifying delegated responsibilities, resources, and timescales.

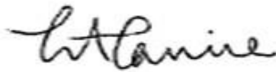
13.2. For many victims and survivors, the impact of the Covid-19 pandemic (anxiety, mental health crises, isolation, unstable domestic circumstances and relationships, lack of access to appropriate support etc.) has increased their current trauma related to non-recent abuse. The Independent Inquiry into Child Sexual Abuse (IICSA) has also raised public awareness of abuse in faith settings and the expectation that victims will be heard and responded to positively. The impact of severe trauma and the context in which Smyth's victims' accounts have been dismissed or suppressed is now understood more comprehensively. The views expressed by many victims that a willful blindness (by individuals and organisations) to the Smyth abuse has prevailed throughout

the past three decades is has now been examined in more detail by the independent Reviewers and given greater cogency and context. SU's response to the Smyth Review is keenly awaited by many of those who have shared evidence, including victims and survivors. A number of individuals have stated that they believe and expect that others may step forward to share concerns if this Review's findings and responses to its recommendations serve to increase confidence in the current organisational commitment to safeguarding.

13.3. With three concurrent Smyth Reviews expected to be reporting in 2021 there is potential for the impact upon victims (known and yet to be identified) to be powerfully negative if careful consideration is not given to timing and management of communications of this Review. There is significant potential for the impact upon victims to be powerfully negative if consultation and planning does not inform the timing and management of communications of this Review.

13.4. The Reviewer requests to be involved in the agreement of these arrangements in order that actions can be taken which enables victims to be appropriately briefed in advance and for support arrangements to be made. The Reviewers commissioned to undertake the concurrent Smyth Reviews have also requested advance notice of any publication or statements.

13.5. Any new information and/or responses to this report should be communicated via safeguarding@scriptureunion.org.uk.



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4th March 2021