

# 7Minute Briefing

# The John Smyth Review

### Introduction

The Independent Learning Lessons Review, authored by Keith Makin and published in November 2024, investigates the Church of England's handling of allegations against John Smyth QC, a former barrister and volunteer leader at Christian summer camps. Smyth perpetrated decades of severe physical, sexual, and emotional abuse against boys and young men in the UK and overseas, with approximately 30 victims in the UK alone.

The report exposes systemic failures by the Church, including inadequate responses to allegations, a lack of action to protect victims, and institutional reluctance to confront the scale of abuse. It provides a detailed account of missed opportunities to intervene, even when senior clergy were aware of Smyth's actions, and underscores the devastating impact on survivors.

The review not only sheds light on historical safeguarding lapses but also offers 27 recommendations to improve practices and prevent future abuse. Key proposals include the establishment of independent safeguarding oversight, the development of international safeguarding protocols, and fostering a culture of transparency and accountability.

Keith Makin emphasises the need for the Church to place survivors at the centre of its safeguarding response and to address cultural and structural weaknesses that contributed to these failures. This review serves as a stark reminder of the importance of vigilance, accountability, and proactive safeguarding measures within institutions entrusted with public trust and care.

## **Findings**

#### **Prolific Abuse**

John Smyth QC, a prominent barrister and volunteerleaderat Christian summer camps during the 1970s and 1980s, perpetrated extensive physical, sexual, psychological, and spiritual abuse. Approximately 30 boys and young men in the UK and 85 in Africa were victimised over five decades.

#### **Institutional Failures**

Despite awareness among Church officials, including senior clergy, the response to allegations was inadequate, amounting to a cover-up. The Church failed to report Smyth to authorities, allowing him to continue his abusive activities, particularly after relocating to Zimbabwe and South Africa.

#### **Leadership Oversight**

The review indicates that Archbishop of Canterbury Justin Welby, who had associations with the camps Smyth led, was informed of the allegations in 2013 but did not ensure a thorough investigation. This has led to increased scrutiny and calls for accountability.

#### The Church's Response

The Church of England has issued an unreserved apology for its failures, acknowledging the profound harm caused to survivors. Commitments have been made to implement the review's recommendations and to cultivate a culture that prioritises the safety and well-being of all individuals within the Church community.

## **Recommendations**

The review outlined **27 recommendations** aimed at driving transformative changes in safeguarding culture, enhancing accountability, and improving responsiveness. These recommendations directly address the critical failings highlighted in the report. Below are the 10 most impactful recommendations, prioritised for their potential to effect systemic change and strengthen safeguarding practices:

- 1. Independent Oversight: Establish a fully independent body to monitor safeguarding practices, ensuring unbiased accountability and transparent handling of allegations.
- 2. Victim-Centered Response: Prioritise survivor welfare by offering dedicated support, clear communication, and pathways for compensation, making them central to safeguarding processes.
- **3. Mandatory Reporting:** Implement a requirement for all allegations of abuse to be reported to statutory authorities, removing discretion and preventing cover-ups.
- **4. Leadership Accountability:** Hold senior leaders responsible for safeguarding failures, implementing robust frameworks for oversight and consequence management.
- **5. Cultural Change:** Foster a culture of openness and transparency, challenging blind respect for authority, and encourage proactive safeguarding at all levels.
- **6. Safeguarding Training:** Mandate tailored, role-specific safeguarding training for clergy, staff, and volunteers to ensure a proactive safeguarding culture.
- **7. Risk Management:** Improve processes for assessing and managing risks associated with known or alleged offenders, ensuring preventive action is taken.
- **8. Survivor Consultation:** Actively involve survivors in shaping policies, ensuring their experiences and insights guide improvements.
- **9. International Safeguarding Protocols:** Develop reciprocal agreements with global Anglican institutions to monitor and address safeguarding risks across borders.
- **10. Whistleblowing Mechanisms:** Strengthen whistleblowing policies to protect and support those who raise concerns, ensuring they can report without fear of reprisal.

https://www.croydonlcsb.org.uk/guidance-and-resources

# A message from the author - Keith Makin

"As we reflect on the lessons from the John Smyth review, there is a critical point I would like to emphasise: the deference aspect of the review and its potential implications for Croydon. The review highlights how individuals in positions of power and authority can exploit deference to gain access to vulnerable individuals. John Smyth's ability to contact and harm vulnerable young men and boys was facilitated by his perceived credentials as a senior Barrister and an expert on Scriptural interpretation. This deference allowed organisations and individuals to overlook critical safeguarding measures."

"In Croydon, this raises an important question: how can we ensure that everyone with access to children is appropriately checked for safeguarding risks? As raised in our recent network meeting, there is a particular challenge in addressing scenarios where individuals gain access to children outside of recognised organisations, bypassing established checks such as Section 11 compliance. While such cases may be rare, their rarity underscores the importance of robust systems to identify and address safeguarding concerns.

We must remain vigilant and proactive in preventing such gaps from being exploited."

# **Improving Practice**

To ensure safeguarding practices remain robust and responsive, it is essential for professionals to engage in critical reflection and evaluation of their approaches. The following key questions are designed to guide professionals in identifying potential gaps, strengthening their practices, and fostering a culture of accountability and continuous improvement.

#### **Independent Oversight**

 How can we ensure safeguarding investigations remain independent, unbiased, and transparent across all levels of the organisation?

#### **Victim Support**

 Are our current processes childcentred enough, and how do we ensure survivors feel heard, respected, and supported throughout the reporting and investigation process?

#### **Cultural Change**

 What practical steps can be taken to address cultural barriers within organisations that may prevent safeguarding issues from being reported or acted upon?

#### **Accountability in Leadership**

 How can we establish clear lines of accountability for leaders, ensuring they are held responsible for failures in safeguarding practices?

#### **Training and Awareness**

 Are we providing adequate and upto-date safeguarding training for all stakeholders, and how do we measure its effectiveness in preventing abuse?

#### **Information Sharing and Collaboration**

 What mechanisms can we establish to share safeguarding information more effectively between institutions, especially in international contexts?

#### **Response to Allegations**

 How do we ensure a swift, appropriate, and legally compliant response to allegations, minimising harm and addressing potential risks proactively?

#### **Evaluation and Continuous Improvement**

 What methods can we use to regularly review and improve our safeguarding policies and practices to reflect emerging risks and challenges?

Read the full report here: <a href="https://www.churchofengland.org/sites/default/files/2024-11/">https://www.churchofengland.org/sites/default/files/2024-11/</a> independent-learning-lessons-review-john-smyth-qc-november-2024.pdf

# What is already happening in Croydon

Croydon has been proactive in safeguarding through several key initiatives and frameworks that align with the recommendations in the John Smyth QC review. Here's an overview of what is already happening:

#### **Independent Safeguarding Oversight**

The Croydon Safeguarding Children Partnership (CSCP) provides independent oversight and coordinates multi-agency safeguarding efforts. CSCP conducts regular multi-agency audits, independent case reviews, and safeguarding practice reviews to identify gaps and improve systems.

#### **Multi-Agency Collaboration**

Croydon has a well-established multiagency safeguarding arrangement (MASA) involving local authorities, police, health services, and voluntary organisations.

#### **Data-Driven Safeguarding**

Croydon has been developing data-driven tools, like the CSCP Safeguarding Review Dashboard, to monitor safeguarding trends, evaluate impact, and identify areas for improvement. These tools provide real-time insights to inform strategic decision-making and operational interventions.

#### **Enhanced Assurance Methods**

The CSCP has adopted a more forensic and evidence-based approach to its assurance methods, aiming to improve multi-agency collaboration and accountability. This involves a thorough analysis of safeguarding practices to

ensure effectiveness and identify areas for improvement.

#### **Victim-Centred Approach**

Croydon has a robust network of support services, such as Early Help, child protection plans, and a new initiative to ensure all practitioners are traumainformed. Specialist support services are available for survivors of domestic abuse, child sexual exploitation, and contextual safeguarding risks (e.g., gang-related harm). Engagement with children and families occurs through consultations to ensure their voices are heard in planning and interventions.

#### **Contextual Safeguarding Practice**

This approach focuses on identifying and mitigating risks to children and young people outside their families, such as exploitation in schools, communities, and peer groups.

#### Joint Targeted Area Inspections (JTAIs)

Partners work together to identify risks, evaluate responses, and implement changes.

#### **Response to Allegations**

There are clear escalation pathways in place for managing safeguarding allegations against professionals and volunteers, coordinated through the Local

#### Authority Designated Officer (LADO).

There is a continued focus on ensuring timely investigations and appropriate action in response to allegations.

#### **Addressing Cultural Challenges**

CSCP is working to tackle cultural and systemic barriers that prevent the reporting of abuse. This includes targeted outreach to marginalised and underrepresented communities to build trust and awareness.

#### **Comprehensive Safeguarding Training**

The CSCP delivers regular multi-agency safeguarding training for professionals, including schools, health providers, police, and voluntary sector organisations. Training topics include contextual safeguarding, child sexual exploitation, and responding to disclosures of abuse. A recent development is that the CSCP has introduced e-learning modules and workshops tailored to specific safeguarding challenges, such as responding to online harm and radicalisation.

