Carlton Glasgow Partnership

Psycholegal & Risk Assessment services & Training

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Psychological Report

Psychological Report regarding:	ISB cohort welfare and mental health
Date of Birth:	N/A
Prepared by:	Mr David Glasgow B.Sc., M. Clin. Psychol.
Date of Assessment(s):	N/A
Date of Report:	10th January 2024

Report Contents:

1. Introduction

1.1. I am a qualified and HCPC[1] registered clinical and forensic psychologist. My brief curriculum vitae appears in appendix I.

1.2. Prior to receiving my instructions in this matter, I had read documents relating to abuse and safeguarding within faith based organisations generally, and within the Church of England (CoE) specifically. In early 2022 I completed the selection procedure to join the CoE panel of independent risk assessors. In pursuit of that I read information on the structure and function of the Independent Safeguarding Board (ISB).

1.3. In the absence of any instructions from the CoE following this, I withdrew from the role of independent risk assessor in June 2023. I have not been consulted or instructed by the CoE for advice regarding either risk assessment in relation to either perpetrators or victims.

1.4. As a forensic and clinical psychologist my work with respect to adult survivors of abuse typically involves a full and detailed psychological assessment of individuals, usually for the purposes of legal proceedings. That is not required here. Indeed, it would be quite inappropriate to attempt the same, not least because documenting case details would inevitably risk identifying the individuals concerned.

1.5. My instructions in this matter are somewhat unusual. I have been invited to investigate and describe the psychological impact on survivors of the effective replacement of the ISB, and to offer advice with respect to their future needs. Those involved constitute a cohort of twelve survivors with varying degrees of involvement with the ISB. There was no obligation for any individual to communicate with me. Communication was therefore as much or as little as each was willing (or able) to discuss their respective experiences and

[1] Health & Care Professions <www.hcpc-uk.org> Council Registration PYL29728

presentation. I also offered to give confidential advice on any matters each might raise on topics within my expertise. (Of course no reference to these will be made in this report).

1.6. It is important to be absolutely clear that this report is not based on an investigation of the facts and circumstances of the demise of the ISB, other than how this was experienced and reported to me by the survivors. I have quite intentionally not read the Wilkinson report[2], in order to avoid being drawn into matters of (potentially disputed) fact and decision making, rather than clinical opinion.

2. Interviews

2.1. As anticipated, not all members of the ISB cohort of survivors were willing (or perhaps able) to speak with me. For those who did not, I can only hope that making the decision did not cause any discomfort or distress. The assumption should not be made that the contents of this report represents either their views, experiences or likely post traumatic sequelae.

2.2. Given the complex and diverse nature of human responses to trauma[3], I expected heterogeneity of clinical presentations. This is indeed what I found. However, core features characteristic of historic interpersonal abuse were present. Which sequelae were prominent varied between individuals, as did post abuse experiences.

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[2] Review of the Independent Safeguarding Board by Sarah Wilkinson of Blackstone Chambers, download available here -> https://www.churchofengland.org/sites/default/files/2023-12/isb-review-report-30-november-2023.pdf

[3] Zoellner LA, Pruitt LD, Farach FJ, Jun JJ. Understanding heterogeneity in PTSD: fear, dysphoria, and distress. Depress Anxiety. 2014 Feb;31(2):97-106. doi: 10.1002/da.22133. Epub 2013 Jun 12. PMID: 23761021; PMCID: PMC3900595.

Dimauro, Jennifer & Carter, Sarah & Folk, Johanna & Kashdan, Todd. (2014). A Historical Review of Trauma-related Diagnoses to Reconsider the Heterogeneity of PTSD. Journal of Anxiety Disorders. 28. 774-768. 10.1016/j.janxdis.2014.09.002.

2.3. In all cases I would describe the severity of symptoms as within the moderate to severe ranges. All individuals had suffered symptoms over long periods of time, some for may years.

2.4. I was not surprised to discover that all individuals experienced and understood the sudden discontinuation of the ISB within the context of their own history as survivors within the CoE. However, I had (perhaps naively) not anticipated the continuing significance of the Church in their spiritual and day to day lives.

2.5. Most survivors of abuse I have previously assessed have broken contact with whatever institution was the context within which they were abused. Sometimes that rift is experienced as a loss as well as a release, but usually it at least allows an opportunity for recovery.

2.6. In this case I encountered individuals who, to varying degrees, continued to feel a spiritual and human connection with the CoE. This had significant clinical implications, particularly respect to some symptoms of trauma. For example, intrusive experiences, anxious arousal, dissociation and defensive avoidance could be acutely exacerbated by church rituals and symbols.

2.7. Sometimes these acute symptoms (which are so characteristic of trauma sequelae) were relatively mild. However, in other cases they constituted extremely visceral adverse responses to sights, sounds and smells. One victim described the transformation of symbols of "*praise, faith and love…into symbols of pain, trauma and self loathing*".

2.8. A related issue was that this cohort of victims had, over a period of years, direct experience of a church that has responded inadequately to safeguarding and (largely sexual) victimisation[4]. They described and illustrated in vivid and personal terms examples of many of the systemic failures that have been documented elsewhere.

[4] In the light of the IICSA and other reports I assume that this is not a contentious statement, or a claim which requires further evidence.

2.9. The most salient complaints were:

2.9.1. A reluctance to investigate allegations

2.9.2. A failure to appreciate or acknowledge the severity of harm caused by abuse.

2.9.3. A denial of continuing risk to others.

2.9.4. An informality and opacity with respect to communications regarding victims' personal details and experiences. Often what was described to appeared to be sharing or use of personal information which would give cause for concern[5].

2.9.5. Inviting victims to contact the police and thus adopting by proxy a criminal standard of proof. ('Beyond reasonable doubt' rather than 'on the balance of probability').

2.9.6. Directing victims to seek support services outside the church; somewhat ironically including calling the Samaritans.

2.9.7. Support offered which proved to be inadequate by virtue of inexperience of the person concerned, lack of qualification, brevity or inconsistency. One victim stated "*I couldn't accept support, because what was offered wasn't support*"

2.9.8. An apparent lack of appreciation of the importance of predictability and continuity of support , as well as trust in the person delivering therapy or counselling[6]. A corollary of this seems to be a further (and false)

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[5] Although compliance with legal requirements is a matter to be determined by the Office of the Information Commissioner

[6] Zoë Chouliara, Jennifer Murray, Ann Marie Coleman, Claire Burke Draucker & Wai Man Anna Choi (2023) Therapeutic trust in complex trauma: *a unique person – centered understanding*, Person-Centered & Experiential Psychotherapies, DOI: 10.1080/14779757.2023.2207107

Bell, V., Robinson, B., Katona, C., Fett, A.-K., & Shergill, S. (2019). When trust is lost: the impact of interpersonal trauma on social interactions. Psychological Medicine, 49(6), 1041–1046. doi:10.1017/S0033291718001800

assumption that a victim can readily (and without distress or risk of harm) disconnect from one supportive or therapeutic relationship and engage with a substitute.

2.10. Some of the above issues were raised with respect to the role of the Interim Support System (ISS), which I understand was established in order to deliver support to victims in anticipation of a permanent system of the same being established.

2.11. It was clear that therapy made possible by the ISS was much appreciated, and self report suggested significant benefit. However victims' accounts indicate the ISS seems to have been associated with administrative difficulties and considerable delay in communication and decision making. These generated great anxiety and uncertainty with respect to continuity of therapy and also other important hopes and aspirations of life which depended on support from the ISS.

2.12. In one case I heard of a therapist who was sufficiently concerned about the possibility of a sudden withdrawal of funding to promise pro bono sessions to ensure that therapy came to a safer and less harmful conclusion. Aside from the professional and financial concerns raised, such insecurity of therapy is significantly anti-therapeutic.

2.13. It also seems that within the ISS there were substantial changes of personnel and procedure, made without consultation with, or any advanced notice to the victims. These changes appeared to be associated with rather abrupt changes to the function of the ISS. One victim described the ISS as "*Chaotic*". Whether that label is justified or not, it is clear that aspects of the the functioning of the ISS significantly increased uncertainty, anxiety and distress.

2.14. It was also reported that communications from the ISS were often experienced as peremptory and overly formal. Even after significant delays in responses to

communications from victims or their advocates, or in making payments, it was reported that there was no acknowledgement of distress or apology.

2.15. Taken together, in some cases, these factors significantly exacerbated trauma sequelae, including self harm and suicidal thoughts, (when neither had been present for some time): *"The irony is that I have been feeling so much better through therapy, but with the stress of the ISS came nightmares, insomnia and self harm"*.

2.16. More than one victim reported that they had been told that the ISS was established as a very temporary structure to be replaced in 3 months by a permanent redress system. The above issues, combined with the apparent extended reliance on a temporary but changing structure was interpreted in different ways. Some concluded that this reflected a lack of resolve or understanding of victims needs. Others felt that they were simply being treated as 'guinea pigs' (within both the ISS and ISB). Yet others suggested they perceived indifference: *"we are simply not important enough to be really taken into account*".

2.17. The point I am making here is not to gratuitously critique the ISS. I have no knowledge of how it was set up, in what ways (or why) personnel and procedures were changed, or how its effectiveness in meeting victims' needs was assessed.

2.18. The important issue is that when the ISB was established, no victim I spoke to had faith that it would deliver results. I have to say I was rather taken aback by this state of affairs, but came to understand it much better within the context of victims' recent experiences with the ISS (and in some cases with other representatives of the CoE)

2.19. One victim stated"*I was aware of the ISB being set up but I was so suspicious, so cautious*."and another *" I was initially very suspicious because I thought I might be re-traumatised yet again*". Others put similar sentiments even more strongly.

2.20. All victims I spoke to stated that both of the independent members of the ISB eventually earned their trust, through patience, manifest understanding and evident expertise. One victim reported remembering feeling quite delighted upon eventually concluding (after considerable doubt and mistrust) *"Here's someone I can trust and work with"*.

2.21. Despite the fact that different individuals were at different stages within the ISB, they were consistent in their accounts that both independent members of the board had inspired a level of trust and hope they had not previously experienced. More than one reported that they felt relieved and confident that their case would be properly and thoroughly considered: "*I was content not to have a timescale, and to leave things in the hands of the ISB*"

2.22. All victims affirmed that they had no warning of the termination of the ISB independent members' contracts. All expressed horror and disbelief that such a decision could be made, and all suffered a significant and acute exacerbation in their (various) trauma related symptomology.

2.23. One stated "*I felt my whole world had collapsed*". Another reported feeling angry with themselves for having placed faith and trust in a system that was so suddenly withdrawn, perceiving little or no consideration or accommodation of risks to victims. *"…this is creating an agonising situation which I could do without because there is enough to deal with just navigating [life events]"*.

2.24. A good deal of suffering was also associated with somewhat compulsive preoccupation with respect to the motivation(s) behind the decision. The event was variously described as the "*collapse*", "*destruction*" and "*sabotage*" of the ISB, the latter clearly indicating a perceived malign intent. These constructions were often not fixed over time, and interacted with both cognitive and affective trauma sequelae, including sense of threat and self-derogation: "*Are we just collateral damage, or did they <u>know</u> how much we would be hurt?*"

3. Opinion

3.1. The termination of the contracts of the independent members of the ISB had serious and adverse consequences for all CoE victims interviewed (who were within various stages of the case review system).

3.2. In most cases the impact reached a threshold of significant harm. Overall, as would be expected, a range of trauma related symptomology were reported, including intrusive experiences, dissociation, defensive avoidance, dysregulation of affect, self derogation and self harm. In some cases some of the symptoms were mild, but most I would characterise as moderate to severe.

3.3. It is also not an exaggeration to state that in some cases this acute exacerbation of symptoms risked life threatening consequences.

3.4. The adverse impact on victims was exacerbated by their previous (post abuse) experiences within the church. Recent difficulties with the ISS were particularly salient in this regard.

3.5. The questions continuing to weigh heavily on victims include how and why their welfare and safety were apparently not taken into account, or at least seems to have been accorded little weight. Most observed with some emotion that they were unaware of any discussion prior to the decision being made[7] for continuity of review, or additional support.

3.6. All victims insisted that they were aware of no evidence that appropriate contingency plans had been made to meet their needs. Some interpreted the events unfolding in relation to the ISB as indicative of a lack of knowledge and understanding of victims' lives. Others regarded events as evidence of a lack of care and compassion, because they believed decision makers would have been warned about possible harm caused to victims, but nonetheless elected to

[7] I understand some arrangements were made for support, after some petitioning on behalf of victims. I have no knowledge of the nature or effectiveness of these.

proceed . Some even suspected possible intentional sabotage of victim focussed systems by individuals long opposed to changes in safeguarding within the CoE.

3.7. Interestingly, more than one person observed that they believe that having been victimised and then re-traumatised over years means that they are prone to react emotionally and strongly to perceived injustice and bureaucracy that fails to support the welfare of those it serves. Although they wish their emotional responses are not so intense, they also feel that they are attuned and sensitive to detecting these issues generally, and specifically in relation to the dissolution of the ISB.

3.8. Clearly the opacity of decision making and uncertainty with respect to motivations has generated a significant degree of mistrust and distress. Space has thus been created for uncertainty and attribution of dismissive or malign motivations. This in turn presents a significant obstacle to future positive and trusting engagement with victims.

3.9. I am in no position to shed light on how or why events unfolded as they did. However, I can say that the questions and concerns of the victims are real and entirely legitimate. They are thus very much issues both for victims themselves, and also safeguarding within the CoE.

3.10. The harms caused by both the ISS and the termination of the ISB need to be recognised and acknowledged. Steps also need to be taken to ensure that future changes of personal or procedure impacting on victims incorporate careful and timely consideration of potential benefit and harms to those victims, and active mitigation of any identified risks.

3.11. Ideally, victims should be represented within any decision making process, but should at least be consulted such that decisions can be properly informed.

3.12. I appreciate that the situation with respect to the ISB was unusual, in that the individuals best qualified to advise on likely victim harms and needs were precisely those whose contracts were planned to be terminated.

3.13. One would hope that such a situation would be very rare indeed, and restricted to circumstances involving egregious professional failures which must be urgently addressed[8]. Notwithstanding the improbability of the situation described, a procedure should be specified for such extreme circumstances.

3.14. With respect to all decisions potentially impacting negatively on victims, I would note that the CoE has recruited a number of independent experts in risk assessment. Psychological risk assessment is not restricted to measurement of individual attributes of a potentially 'risky' individual. It incorporates a much more diverse and systemic assessment of potential harms to individuals and groups of individuals. A number of experts already appointed are therefore likely to be able to offer informed and objective expert opinion on potential harms to victims of any possible decisions/actions.

3.15. If such expertise is not available within the existing panel, I would recommend it is expanded to include appropriately qualified and experienced, victim focussed risk assessors.

3.16. I must allow the possibility that the decision to terminate the contracts of the independent members of the ISB was in fact informed by an expert risk assessment. However, I have to admit that I think it is unlikely that any appropriately qualified expert would fail to highlight the very significant and entirely foreseeable risk of significant harm to victims.

3.17. The most significant challenge going forward will be regaining the trust of victims in any future personnel, organisational structures and procedures . Trust

[8] In saying this I am not expressing any opinion on whatever differences and concerns existed between the CoE and the ISB independent experts. However, I am not aware of any evidence of circumstances which would demand such a response.

was clearly earned by the independent ISB members, in rather challenging circumstances. However, it has clearly now once again been replaced by disappointment, distress, doubt and mistrust.

3.18. Victims vary in the explicit positions they have adopted, but all agree that their safety and welfare have not properly considered or taken into account. Some express anger and frustration, others distress or bewilderment: One stated "*I keep thinking, 'this is my Church, it must eventually do the right thing'*" another commented "*What they do is make us feel like we don't matter*", "*Why did they sack the board? We still don't know*"; "*Anyone. Any ordinary human being who read the explanation given to Synod [for dissolving the ISB] would recognise it as something out of 'Yes Minister'*" and "*Sometimes it feels like we are only really listened to if we go public or start legal proceedings*".

3.19. Another concern raised was how victims can be assured of the independence of any new safeguarding body. One stated "*They're independent until they say or do something [name] doesn't like, then they will sacked or moved*". Others said, "*After what they have done, why should we believe the people they are telling us to trust are really anything more than sock-puppets?*".

3.20. I have to admit that although this clearly is a major concern to the victim cohort, at this stage I can think of no obvious remedial steps that might usefully be taken on this specific issue, beyond recognising the reality and significance of the challenge now facing the CoE. There is an academic literature on the development and significance of trust in helping and supportive services[9]. This is not within my expertise and it may be that seeking expert advice on this may be of assistance .

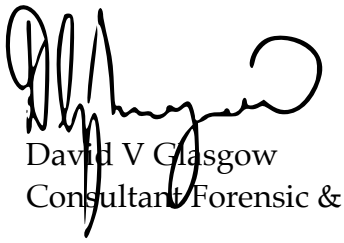
3.21. One essential requirement for any effective action on behalf of victims and survivors is that it must be informed by an accurate assessment and

[9] Behnia, B. (2008). Trust Development: A Discussion of Three Approaches and a Proposed Alternative. British Journal of Social Work, 38(7), 1425–1441. doi:10.1093/bjsw/bcm053

understanding of the range of circumstances of this (and future) cohorts. This does not mean inappropriately sharing personal information, but having an active appreciation of both vulnerability and resilience of the cohort. This report is in some regards a step towards that goal, but should certainly not be regarded as a complete representation of resilience and vulnerability..

3.22. If invited, and with the consent of the victims concerned, I would be happy to offer professional advice on either general principles or specific details of proposed remedial action.

I hope the above is of assistance. I confirm that insofar as the facts stated in my report are within my own knowledge I have made clear which they are and I believe them to be true, and that the opinions I have expressed represent my true and complete professional opinion.



David V Glasgow
Consultant Forensic & Clinical Psychologist

Curriculum Vitae

David Glasgow
Carlton Glasgow Partnership
Honorary Professor, Nottingham Trent University (SOCAMRU)
Director, Child & Family Training, York

Qualification	Registration
BSc (IIi) Psychology	HCPC registered Clinical Psychologist
Master of Clinical Psychology	HCPC registered Forensic Psychologist

Clinical expertise

- Functional assessment of mental health difficulties, needs and risk of harm to self/ others
- Cognitive functioning and capacity (in relation to proceedings, instructions or consent & decision-making)
- Independent assessment of adults and young people detained in prison or mental health units (low, medium and high levels of security).
- Preparing reports/second opinions regarding case records, care plans and therapy in forensic settings
- Contact (predator) & non-contact (IIOC) internet offender assessment.
- Personality disorder assessment (inc. risk and needs)
- Sex offender risk assessment
- Parental risk and capacity to protect
- Complex trauma/PTSD
- Adolescent offenders/abusers risk assessment
- Conduct of investigative interviews with vulnerable adults regarding possible abuse
- Assessment of adults allegedly abused as children (institutions/familial/other)

Summary of Experience

I have worked in the field of forensic & clinical psychology since 1980, when I was employed by Moss Side & Park Lane High Security Hospitals (later Ashworth Hospital). I embarked on Clinical Psychology training at Liverpool University in 1981.

I have been a lecturer at three UK Universities, undertaking forensic research, and developing academic courses:

- Child Protection (Diploma and Masters Degree, Liverpool)
- Gathering Evidence from Children (Certificate, Liverpool)*
- Forensic Behavioural Science (Diploma & MSc, Liverpool)*
- Child Forensic Studies (Diploma & MSc, Leeds)*
- Forensic Studies Programme (Diploma & Masters degree, Cumbria)*

* Course Director

In 1995 I served as forensic course examiner on the British Psychological Society Diploma in Clinical psychology. I have served as external examiner to several UK forensic courses.

I gave evidence at the (1992) Ashworth Hospital Inquiry, and also evaluated High Secure clinical information systems.

I was a founder member of both the Division of Criminological & Legal Psychology (which became the Division of Forensic Psychology) and the Forensic Faculty of the Division of Clinical Psychology of the British Psychological Society. I was chair of the latter between 2000 and 2003.

I have been a member of the National Executive Committee of NOTA, (the national association for the assessment and treatment of sex offenders) and have twice served a member of the NOTA policy committee, developing guidance on multidisciplinary practice, sexually explicit materials, community monitoring of sex offenders.

For two years I was an associate editor of the British Journal of Legal & Criminological Psychology and of the Journal of Sexual Aggression.

My academic posts have always been appointments which included work within NHS (or DoH) settings. I have worked in low, medium and maximum security settings, as well as within community services. I worked for seven years in Calderstones NHS Trust. This is a low-medium secure forensic service and was the largest such NHS provision specialising in adults with a learning disability.

I was Lead Psychologist with the Forensic & Special Care Service of Leeds Community and Mental Health Teaching NHS Trust. I was responsible for a service to community and low security provision, for adults with a wide range of disorders. I also lead a team of expert witnesses which undertook forensic assessments of over 350 adults reporting historical child abuse in children's homes.

I left my academic and NHS posts in 2005, and formed the Carlton Glasgow Partnership, offering a range of forensic and psychological services, including assessments of risk and psychopathology in child protection and criminal proceedings. I also offer risk assessment of professionals whose professional practice may be impaired by mental health problems, sexual deviance, personality problems and substance abuse.

I both conduct and evaluate investigative and forensic interviews with children and adults with disabilities. I was a research team member and interviewer for a European Fundamental Rights Agency project on Child Participation in Civil and Criminal Justice.

For some years the focus of my work shifted away from direct work to development of assessment tools consisting of computer software and tablet apps. I designed two assessment procedures currently available as iPad apps, and shortly to be released on Windows tablets. I am particularly interested in risk factor visualisation using interactive technology.

My recent research activities relate to the development of computer assisted assessments of sexual interest, interpersonal behaviour, motivation to change, and pre-offence behaviours and cognitions.

In addition to the above:

- I regularly attend seminars, conferences & training related to forensic & clinical psychology. My CPD has become increasingly specialised over the years, reflecting changes in my practice.
- I maintain a professional library (currently standing at around 3,500 papers and chapters)
- I have authored or co-authored 30 chapters, papers and reports, mostly on forensic themes.
- Over the past ten years I have presented approximately 50 papers at national and international conferences. The majority related to forensic issues, including forensic interviewing, risk assessment of sex offenders, assessment of internet offenders, and the cognitive assessment of deviant sexual interest.
- I regularly train other professionals in techniques for conducting investigative interviews with children and adults with Intellectual Disabilities or mental health problems.

Between 2015 & 2017 I was clinical lead for pathways and clustering at Bradford District Care Trust. I developed training and assessment tools relating to mental health and risk assessment procedures.

Current Practice

For over ten years I have been engaged as forensic interviewing consultant by Child & Family Training, a not-for-profit organisation developing tools and training for professionals working in child protection. This involves training professionals, developing training materials and working on structured assessment/interviewing tools.

I was also commissioned by a Canadian company, Pacific Behavioural Assessment to develop sex offender assessment tools. PBA published four tools I developed, including a cognitive assessment of paedophile interest. I also developed and maintain a computerised version of Blackburn's CIRCLE, which has been shown to be predictive of violence and aggression in both prison and mental health settings.

I continue to undertake independent risk assessments of adults, parents and adolescents, primarily for courts & Mental Health Tribunals but sometimes for other purposes. I also maintain an interest in new developments in delivery and assessment of mental health care & structured risk assessment.

In 2017 I received the British Psychological Society Forensic Faculty Award for Innovation in Practice.

In 2020 I was appointed Honorary Chair in the Sexual Offence, Crime and Misconduct Research Unit at Nottingham Trent University

Current Memberships

Psychology	Other
Graduate member of British Psychological Society (BPS)	Association of Child Protection Professionals (AoCPP (previously BASPCAN))
BPS Division of Clinical Psychology (DCP)	The Society of Forensic Interviewers (SoFI)
Forensic Faculty of the DCP	International Investigative Interviewing Research Group (iIIRG)
BPS Division of Forensic Psychology	National Organisation for Treatment of Abusers (NOTA)
BPS Special Group for Independent Practitioners	Association for Treatment of Sexual Abusers (ATSA)
BPS Cyberpsychology Section	International Society for the Prevention of Child Abuse & Neglect (ISPCAN)

Current Projects

- New technology in the assessment and interviewing of vulnerable adults and children who may have been abused
- Development of tools & training to support Payment by Results (PbR) in mental health
- Functional analytic discrimination of predatory intent in online messaging
- Profiling internet offenders' sexual interests using automated analysis of forensic digital evidence
- Developing standardised case visualisation in the management of risk of physical and sexual harm

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