

Pemberton Homicide Review

11 am

Anne Snelgrove (South Swindon) (Lab): I am grateful for the opportunity to raise again the lessons that arise from the terrible murders of Julia and William Pemberton. The deaths followed a history of domestic violence to which the police were alerted 15 months before the tragedy. I am proud to follow the lead of my predecessor, Julia Drown, by working with Frank Mullane, the brother of Julia Pemberton, and my constituent, to keep the House's attention on the matter.

Since the murders, Frank has joined the Government's victims advisory panel and has created a registered charity called Advocacy After Fatal Domestic Abuse, of which I am a patron, partly to help families to interact with criminal justice agencies and other bodies when they are trying to establish what happened, and to ensure that learning is identified and applied. The Pemberton homicide review reported in November 2008, five years after the tragedy. The report identified significant recommendations for many agencies, including the police, the local authority, schools, the primary care trust, general practitioners and central Government. The family, some of whom are my constituents, asked for the debate because they do not want us to forget the review, its recommendations or its findings. The family campaign on behalf of the hundreds of domestic violence victims who have urged them to make sure that the PHR is learned from.

It is important that we should congratulate the relevant agencies and individuals who have taken forward recommendations, and that we should give encouragement where findings and recommendations need more attention. We need to ensure that the learning points from the PHR have been identified. I use the word "learning" to avoid any accusation that we want to blame agencies. Blame will not get us anywhere. We are all here to make sure that lessons are learned by all. We need to ensure that everything is done to get the outcomes applied both locally and nationally. There is also the general question of who ensures that the recommendations and learning from voluntary homicide reviews are taken forward. Who brings the wide-angle perspective? The debate is important because no one wants there to be another serious injury or murder after which issues from the Pemberton review are found not to have been dealt with.

First, to give credit where it is due, I, like the Mullane family, want to commend all the agencies for their work following the review, where they have taken forward the recommendations. However, much of the substance of the Pemberton review is in the body of the report and is not reflected in those recommendations. The family want to ask the agencies to go back to the review, and not just to look at the recommendations but to take a holistic view of the substance. It would be useful for those agencies to bring together evidence of where recommendations have been followed, and develop plans to apply all the lessons. Victims and their families deserve a thorough response.

I shall set out some examples of the responses of the police, West Berkshire council and the primary care trust, and give the family's view of how those responses could be improved. Thames Valley police initially responded just to the recommendations in the review, but following a request from the family they developed and shared with them a further action plan in response to the PHR, on which I congratulate them. However, it is the view of the family that that plan should be looked at again. Julia Pemberton's nephew, Desmond Khan, did a great deal of work to identify where the police action plan could be improved. Thames Valley police were then invited to respond. I understand that they are looking at the suggestions, and I ask that they give them due weight.

One suggestion concerns supervision. The PHR found that Thames Valley police officers were “poorly supervised or supported”, and that the situation regarding Julia’s reporting of threats to kill was

“compounded by a lack of policy or supervision to direct and ensure minimum standards.”
The report raised another point:

“Chief Officers must evidence their knowledge of key policies and critical incident management relevant to Domestic Violence.”

That is particularly significant as the report criticised leadership in the force, and the family believe that it demands a full response. They have met academics, police officers and domestic violence workers and strategists, and I am told that they all agree that a lack of intrusive supervision is a major issue when it comes to the effective policing of domestic violence. There are thus issues for Thames Valley police to reflect on and act on. Dr. Carolyn Hoyle, who is reader in criminology at Oxford university, commented that Thames Valley police

“must ensure that the tragic deaths of Julia and William are embedded into its institutional memory in order that the current commitment to helping victims of domestic violence does not wane.”

The family also invite West Berkshire council and primary care trust to take a more holistic view of the review. They have given the two agencies a list of learning points and offered some comments on the council’s actions so far. They tell me that the council took on board some of their comments and said that others will be built into “individual agency action plans”. Will the Minister clarify today what that will mean in practice, and assure the family that it will mean that the agencies will give due weight to the list of learning points they submitted?

The family drew my attention to the part of the review that says that primary care trusts have the opportunity, through their contractual arrangements with general practitioners, to include requirements with regard to domestic violence. In their view the local authority response does not appear to be robust enough. A recommendation of the review is that GPs should be better trained, including, significantly, being told of the risk indicators associated with perpetrator behaviour in domestic abuse. The family highlight one of the council’s actions in response to the recommendation:

“Review training provided to GPs and others on Domestic Homicide as part of the safeguarding framework”.

The family would like clarification on whether all GPs in the authority have been made aware of indicators associated with perpetrator behaviour, because until that happens they feel that to report that action as “complete”—as it has been reported—is incorrect. I am sure we would acknowledge that action plans should be unambiguous and that there should be expressed outcomes, so that we can easily link the recommendation or learning point to an action and then to an outcome. That is what the family suggest.

The review found that

“the weaknesses and gaps in the council’s overall policies and procedures in relation to Domestic Violence did not impact on the outcome”.

However, one expert consulted by the family disputed that that could be concluded from the review. Similarly, the review found:

“The Primary Care Trust had no direct involvement with Julia Pemberton that could have influenced the course of events”.

However, another expert remarked that, had the primary care trust developed services such as a staff domestic violence policy, those might have helped to influence events. The family feel that bringing those views to light may encourage the local authority and primary care trust to develop more services.

There are learning points within the report that should be of interest to the Government as well. One of those is:

“Domestic violence training should be made available for Coroners”.

That seems to me a practical suggestion, and I raised it with the Minister during the passage of the Coroners and Justice Bill.

I now want to consider the question of who ensures that the recommendations and findings in voluntary homicide reviews are taken forward and that individual agency plans are adequate and implemented effectively. Neil Websdale, who is a professor of criminology and the principal project adviser to the national domestic violence fatality review initiative, said:

“The Pemberton Homicide Review constitutes a landmark achievement in the field of domestic violence fatality or homicide review. It is meticulous in its approach, honest in its conclusions and forward thinking in its recommendations. As such, the review sets a gold standard in terms of its detailed appreciation of the complex issues in domestic violence cases and its pressing calls for agency accountability and interagency liaison.”

It is important, when there are lessons to learn, that we encourage all those agencies to ensure that they are learned.

It is equally important to ensure accountability in the process. If the tragic murder of 17-year-old William had been followed up by a serious case review, I believe that it might have attracted the attention of Ofsted. As for the Pemberton review, the family, with the help of a substantial network, have brought a great deal of accountability to the process. I pay tribute to them for that; they have worked tirelessly and did not give up when many others would have.

I ask the Minister to assure the family that, in homicide reviews such as this, the Government will ensure robust accountability. One system that he might want to consider is that used by Ontario. The family have asked me to cite the work of Professor Peter Jaffe, who said that death reviewers there require agencies to come back after one year to explain what progress has been made since their review was published. The family believe that something similar applied in the UK could help agencies to identify and apply all learning points. As I said earlier, the family’s purpose is not to apportion blame but to ensure that similar circumstances do not arise again.

The family was disappointed by the behaviour of some individuals in the agencies during the review period. Julia’s brother-in-law, Mike Mason, has written a concise protocol, including on behaviours, saying how agencies should treat families in this position, and I am pleased that the

Home Office's violent crime unit has asked to see it. I was extremely shocked at much of the family's evidence on that matter.

The review found that the response of Thames Valley police and the council to inquiries by the family after the murders caused the family difficulty—and that is an understatement. Thames Valley police has apologised for that, as well as for its response prior to the murders; and the council, too, has agreed to apologise. That apology is welcome, but the family should not have needed to seek an apology more than six months after the report.

The Pemberton homicide review came into being partly because of the persistence and determination of the family and friends of Julia and William Pemberton, some of whom are here today. The family also had, and continue to have, the assistance of a wonderful friend and empathetic solicitor, John Latham, and a significant network of academics, strategists, media contacts and Members of Parliament from across the House, including my hon. and learned Friend the Solicitor-General. Indeed, she has been giving advice and help to the family for many years, including before she became a Minister. I note the presence today of the hon. Members for Newbury (Mr. Benyon) and for Mid-Dorset and North Poole (Annette Brooke), who represent family members.

The resourcefulness and capacity of the network that the family has at its disposal is not available to all families, so we need to assure the public that when things go wrong our public services are able and willing to correct problems, to identify opportunities and to help victims. The family are aware of the Government's significant efforts to provide services for victims of domestic violence—for example, specialist domestic violence courts, multi-agency risk assessment conferences and independent domestic violence advocates. The Government are developing a homicide review model, and the family welcome the invitation from the Home Office to be a part of that review. The family and I also look forward to the implementation of the strategy on violence against women.

I ask the Minister to assure me that each agency will do more to ensure that all the learning points in the Pemberton homicide review are identified; and that each agency will show, with evidence, that all learning points from the Pemberton review have been applied—or that they will provide clear actions, with owners, dates and outcomes, to demonstrate that outstanding learning will be applied. Will he assure me that accountability structures will be put in place to identify and apply all learning points from the review?

Finally, will the Minister assure me that everything that we can learn from the review is being applied and that its effectiveness is being shared nationally, so that fewer families will go through what this family went through?

The Parliamentary Under-Secretary of State for the Home Department (Mr. Alan Campbell):

I congratulate my hon. Friend the Member for South Swindon (Anne Snelgrove) on securing this debate, which is on a most important topic. I know that she has raised the case of Julia and William Pemberton in the House before, and that she has worked closely with Julia's brother, Frank Mullane, on the question of domestic homicide. I know that tackling domestic abuse in all its forms is one of her priorities. I also acknowledge and welcome the interest shown by the hon. Members for Newbury (Mr. Benyon) and for Mid-Dorset and North Poole (Annette Brooke).

I assure hon. Members that the Government regard tackling domestic abuse as a priority. Certainly, we will not forget the review. I give my hon. Friend a commitment that we will consider the specific points that she has raised today, even if I cannot address each and every one of them now. The debate is timely—if such a debate can ever be timely—coming, as it does, shortly after the closure of the consultation on violence against women and girls. That consultation will help to inform policy and strategy on tackling domestic violence not only at the Home Office but across Government.

I shall speak generally about reviews before turning to the specific points of the present case. In 2005, the Government published the first national domestic violence delivery plan, setting out our commitment to address domestic violence. The plan identified the key outcomes that the Government and stakeholders should be working towards—from prevention through to victim care, and the response of the criminal justice system.

Reducing the number of domestic violence-related homicides is a key national objective. According to the British crime survey, 106 people were killed by their partners or ex-partners in 2007-08. Like Julia and William, many of those victims will have had contact with the police or other agencies. By reviewing the stages that lead to such tragedies, agencies can learn how to react better to situations and to make judgments that can avoid deaths and save lives. It was with that in mind that domestic homicide reviews were legislated for under section 9 of the Domestic Violence, Crime and Victims Act 2004. As my hon. Friend knows, the 2004 Act has not yet been implemented. I shall explain why that is so, and say how the points that she has raised can still inform the process as we move towards implementation.

Domestic homicide reviews are not meant to be inquiries into how a victim died or into who was to blame. Those are and should remain matters to be determined by the criminal justice system. However, reviews should seek to establish whether any or all of the agencies involved responded correctly and in accordance with their own procedures and guidelines. If it was found that agencies could have responded more effectively, it would be for the review body to determine whether an alternative course of action could have prevented the victim's death. The result of the review should be to ensure that agencies can respond appropriately to victims of domestic violence by putting in place the appropriate support mechanisms to help avoid future tragedies.

A consultation on draft guidelines for homicide reviews was published in June 2006. Proposals from that consultation suggested that the review process could be based on the serious case review model. In 2006, a domestic homicide steering group was established to assist with the development of the review process. That group meets regularly, and its input has proved vital in **17 Jun 2009 : Column 100WH** clarifying the detail of the process that a review would take, as well as addressing risks and concerns that have arisen throughout the consultation and development process.

The report, “Learning Lessons, Taking Action”, which was Ofsted's evaluation of serious case reviews in 2008, raised serious concerns about this process, not least about the lack of engagement with the victims' family during the conduct of the review. That was a feature of the legal proceedings prior to West Berkshire safer communities partnership starting the review into the deaths of Julia and William.

Concern was also expressed about the financial burden that domestic homicide reviews would place on local areas, and as a result discussions have taken place between the Home Office, the Local Government Association and the Department for Communities and Local Government to ensure that local authorities can meet their responsibilities. Proceeding with a new process, based

on a system that is clearly not right, would be counter-productive. Any system has to command the confidence of all involved, especially victims' representatives.

My hon. Friend might be interested to know that my officials are in regular contact with Mr. Mullane on this matter. Although we are still at the beginning of the process, this is an opportunity to develop a system that is meaningful and accountable—a word to which she kept returning in her speech—and that makes a real difference to how local areas respond to contact with future victims of domestic violence. We very much welcome, and place great value on, Mr. Mullane's comments and contributions, and I assure her that we will take those points very seriously and, as far as possible, allow them to influence the process. The delay in implementation of the 2004 Act is regrettable, but the Government remain committed to implementation. However, it is crucial that we take the time to ensure that the process that we introduce is the right one.

I shall now turn to the tragic events in 2003. Following the intervention of my hon. Friend's predecessor, Julia Drown, on behalf of the family of Mrs. Pemberton, West Berkshire safer communities partnership undertook a stand-alone review into the circumstances surrounding the murders of Julia and William. The Home Office shadowed the review in the hope that it will provide an insight into how a review might run. Despite the original intention for it to end in March 2006, the review did not conclude until November 2008, and although it made a number of recommendations that could be applied to homicide reviews in general, it concluded:

“The Pemberton case is complex both in terms of the individual circumstances of the incidents and in the context of the development of national policy on homicide reviews. We consider that this review should be viewed as an exception to the model set out in the Draft Guidance rather than a template for future Domestic Homicide Reviews.”

Since November 2003, Thames Valley police has made progress in how it deals with domestic abuse. The leadership for tackling domestic abuse in the force now sits with an assistant chief constable, who chairs a protecting vulnerable people steering group. To support the steering group, the force established a dedicated PVP strategy unit, whose domestic abuse and honour-based violence policies are regularly reviewed.

Each of Thames Valley's basic command units has embedded domestic abuse units whose trained staff are on call to deal with victims in a sensitive and prompt manner. Each BCU has an established risk assessment process that will be superseded by the new DASH risk assessment by the end of 2009. Thames Valley police has been working with multi-agency risk assessment conferences in all BCUs and specialist domestic violence courts in four out of five police areas, with the fifth due to be operational shortly.

Thames Valley police accepted the findings of the Pemberton review and conducted a detailed study of the report that drew out not only the specific recommendations, but—crucially—the observations and comments of the review panel. It will have heard, as I have done, the points made quite rightly by my hon. Friend about the need to take a holistic approach not only to address specific recommendations, but to view these matters as a whole. Individual agencies need to be held accountable to ensure that they deliver tangible outcomes from the review into these tragic events.

The study noted improvements in service delivery since 2003, which it applied to recommendations in the Pemberton review. That formed the basis for an action plan approved by the chief constable and presented to the police authority and the relatives of Julia and William.

The Government believe that a successful, coherent system of review can lead to the goal that we all share of saving people's lives. Like the case of Julia and William Pemberton, many local areas currently undertake ad hoc homicide reviews, which can help local forces and authorities to improve their responses and the support that they offer to chronic victims of domestic abuse.

We remain committed to putting in place a system and guidance that will make a real difference. I wish to make an offer to my hon. Friend and to others who have shown an interest, including family members: I am always willing to meet and discuss the specific points raised, so that, as well as having discussions with my officials in moving this forward, I can, wherever possible, help in that process. It is crucial that we learn lessons and get this right. People who have experienced such tragic events should not find themselves further frustrated, angered and upset by reviews that fail to address all the issues or—crucially—by the failure to learn lessons. We are all committed to tackling domestic violence as a whole. In the future, I hope that a Minister can stand here and say not only that we have made the necessary progress, but that we will not need future domestic homicide reviews.

11.26 am

Sitting suspended.