

EXTRACTS FROM PEMBERTON HOMICIDE REVIEW

Findings:

THAMES VALLEY POLICE – DOMESTIC VIOLENCE

in 2007 HMIC found the “force does not have a written accountability document which details the accountability structure for DV investigations”. “The HMIC report of 2007 identified a number of areas for improvement and we have highlighted in the report issues concerning an accountability document. The HMIC also noted limited evidence of problem profiles or analytical work on domestic violence cases, the lack of integration of Force IT systems and that the sharing of information across protecting vulnerable persons’ disciplines lacked a formal structure with variance across the Basic Command Units. They also noted some slippage in domestic violence training at Basic Command Unit levels and highlighted the need to ensure Domestic Violence Officers continue to have professional development. “

LACK OF STRATEGIC DIRECTION – POOR PRACTICE BY SIGNIFICANT NUMBER OF OFFICERS -

1. “Thames Valley Police did not respond appropriately to the Home Office Circular 19/2000 by creating, maintaining and overseeing a force domestic violence policy. This led to a strategic void which seriously impaired their performance by failing to link, focus and support force resources. It is our view that the provision of services to Julia and William as victims of domestic violence was undermined by a lack of individual and organisational competence that ultimately eroded the confidence of the victims they sought to protect. “ A lack of strategic direction led to “an inconsistent service approach dependent upon individual officers who were often ill-informed, isolated and poorly supervised or supported”.
2. “We heard from one leading academic of a perception that at one time the force seemed so tilted towards restorative justice policy development, other areas may have suffered at its expense.”
3. “...in 2002/3 TVP’s failure to deliver a domestic violence policy, appropriate related guidance, specific training, consistent

supervision and quality assurance resulted in poor practice by a significant number of officers in incidents covered by this review. This in our view constitutes a system and service failure. “ “...TVP’s failure to implement HO 19/2000 had significant consequences for the standard of the police response to Julia, William...as victims of domestic violence”...”...TVP had an obligation under **child protection procedures** to identify potential risk with regard to William; there is no evidence this was ever addressed.”

4. “Members of the Force’s senior management team were aware there was no Force-wide domestic violence policy, procedure or training.” It was left to Local Police Areas to interpret the service required “...It was the responsibility of senior management in the force to quality assure with reference to agreed standards. This was not the case and represents a serious omission”.
5. “...on a number of occasions Julia did not receive a competent police response. We believe she was let down by the standards of basic policing, record keeping and follow up.” ..”...officers failed to investigate arrest and/or interview Alan in Sept 02, and April and May 2003.”...”There is evidence of instances when officers did not attend the scene, thoroughly investigate or link incidents or crimes reported on:
 - a. 14 and 15 Sept 2002 – Threat to kill
 - b. 20 Sept 2002 – Alan missing person
 - c. 20 April 2003 – Glued Locks
 - d. 15 May 2003 – Annotated Affidavit

“...Julia and members of her family made a significant number of contacts with the police in relation to each of these incidents.”

6. “...had the threat to kill been investigated as a serious crime in Sept 2002, the course of events that led to the deaths of William and Julia Pemberton in November 2003 may have been interrupted. Significant opportunities were missed in April and May when information was available concerning the escalating risk to Julia and William which may have led to a more informed police response at a critical time.” “ TVP did not take into account information brought to their attention in the context of their duty to investigate the instances and alleged crimes reported to them.”

7. “Positive intervention by TVP..... may have altered the course of events”
8. There were failures in internal communications technology and systems which resulted in the domestic violence co-ordinator not being informed of incidents

RESPONSE ON NIGHT OF MURDERS – OVER CAUTIOUS – DELAY UNACCEPTABLE

1. “Although there had been a number of incidents at the house the address was still imprecisely recorded....We have concluded that this may have contributed to the difficulties experienced by the call taker in locating the house leading to the repeated questioning of Julia about her address.“ “...it took eleven minutes and repeated questioning of Julia before the call taker was able to identify the correct location of Julia’s house.”
2. “The directions to the house were not included with the flagged information; these would only have been available through the information relating to the Sovereign Call Centre and would have been immediately available if Julia had activated the alarm.” Julia had been advised by the DVC to call 999 in an emergency.
3. “There were significant communication problems experienced by officers responding to the firearms incident on the night of 18 November 2003. The new Airwave radio system was introduced on 18 November without due regard for the operational implications in the event that it was needed in response to an incident that day. We were advised about the problems of communication and of delay on the 18 November due to the Silver Commander not being trained in or having access to the Airwave system available to the Force Tactical Adviser, the Firearms Officers and the HQ Control Room Inspector. We were told that most of the command on the night was done through mobile phones and landline communications. We understand that the plain clothes officers in an unmarked police car who attended the scene were also unable to communicate with the armed officers at the scene. **We have concluded that this was a serious operational failure by Thames Valley Police in its approach to the implementation of major strategic change in the context of a general duty of care to the public and their own staff.”**

4. “communication difficulties which had implications for the transition of command; identification of a suitable rendezvous point; the restricted access to dynamic information using the Airwave radio system; limited intelligence available to the Silver Commander during the operation.”
5. “In seeking to eliminate risk we believe there was an overcautious approach to the deployment of armed officers and management of the incident, which resulted in a delay of six hours and thirty seven minutes between the time that Julia made her 999 call and Thames Valley’s subsequent entry into Old Hallows. It should be noted that during that time the status of Julia and Alan was unknown.”
6. “The length of time taken for the firearms intervention following Julia’s 999 call was unacceptable”

THAMES VALLEY POLICE FAIL TO FOLLOW OWN POLICY AND CARRY OUT REVIEW

1. “It was an error of judgement on the part of Thames Valley Police not to undertake a review of the Pemberton Case to facilitate organisational learning at the earliest opportunity both in relation to the Firearms response on 18 November 2003 and Thames Valley Police’s engagement in the preceding fourteen months with Julia Pemberton and her children as victims of domestic violence. “
2. “We are concerned that in the absence of a review of the Firearms Policy in the aftermath of the Pemberton murders, the serious deficiencies in Operation Saladin were not rectified until October 2004, after the fatal shootings of Vicky Horgan and Emma Walton at Highmoor Cross in June 2004.”
3. “We have concluded that Thames Valley Police and potentially the family also, would have accrued significant benefit had an overarching review or comprehensive strategic debrief been commissioned in the immediate aftermath of the murders. In our opinion the absence of such an approach **resulted in the family suffering protracted and avoidable distress in seeking a timely and comprehensive understanding of the circumstances and events involving their sister and nephew.**”
4. “In the period immediately following the Inquest TVP’s approach to addressing the family’s concerns and enquiries compounded the family’s distress...”

5. **“Thames Valley Police has acknowledged that the Management Services Review provided to the DHR in February 2007 was not written to meet the requirements of the Terms of Reference as agreed by WBSCP on 25 January 2007. As the agency that had proposed the DHR, TVP should have provided a comprehensive internal management review that met the requirements of the Terms of Reference as agreed by the WBSCP on 25 January 2007. It has been necessary for us to engage in a more in depth review process than was anticipated by WBSCP and the Home Office when the review was commissioned. This has had an impact on the timescale and resources required for the review.”**

THAMES VALLEY POLICE AND THE INQUEST

1. “Thames Valley Police did not respond fully and accurately to requests for information from the family in advance of and relevant to the inquest. As a consequence, the family were less well informed in relation to the Inquest than might otherwise have been the case, e.g. the Command and Control log for 18/19 November was not disclosed to the family prior to the Inquest.”
2. “Thames Valley Police did not provide full and accurate information with regard to their contact with Julia Pemberton between September 2002 and November 2003 to the Coroner in advance of the Preliminary Hearing, prior to or at the inquest.”
3. “A number of the conclusions from the Highmoor Cross Review were applicable to the firearms response on 18 November 2003. The Review was available on 6 October 2004, seven days after the Pemberton Inquest. The relevant learning from that Review was not reflected in the information provided at the Inquest.”
4. “We have concluded that the Coroner and the family would have benefitted had Thames Valley Police provided full information of their involvement with Julia and her family from September 2002 including the 18 November 2003.”
5. “Domestic violence training should be made available for Coroners” (page 215).

PRIMARY CARE TRUST

1. “The Primary Care Trust had no direct involvement with Julia Pemberton that could have influenced the course of events” – *Comment – But had they developed services e.g. a staff domestic violence policy there might have been opportunities to influence events.*
2. “In 2002/03 there is limited evidence of strategic leadership by the PCT in relation to domestic violence policy, procedure or practice.”
3. “Training is required for general practitioners and health professionals with regard to domestic abuse” and “...should identify risk indicators associated with the perpetrator’s behaviour e.g. threatening suicide.”
4. “...in relation to those areas where the PCT might reasonably have been expected to provide comment, for example the strategic role of the PCT and the role of the GP, the IMR lacked rigour.”

WEST BERKSHIRE COUNCIL

1. “The weaknesses and gaps in the council’s overall policies and procedures in relation to Domestic Violence did not impact on the outcome in relation to the Pemberton family.” – *Comment - I would dispute this sentence strongly - if the council had provided the array of services which many other local authorities (Hammersmith and Fulham, Greenwich, Islington, Newham, Sheffield, Leeds, Derby and Birmingham) were providing at that time, we cannot know that it would not have made a difference to Will and Julia. Was WBC fulfilling its obligations under Best Value Performance Indicator (BVPI) 225? - For example, all over the UK, Domestic Violence Fora have created HR policies for their member agencies. This may have opened up an opportunity for Julia to disclose / seek help. And was Education an active member of the domestic violence Forum? Was WBC fulfilling its obligations under BVPI 225?*
2. “At the time the council had in place some policies and procedures relevant to domestic violence but these did not cover all services and there was no overarching domestic violence policy or procedure in the council.”
3. “The council was providing some strategic leadership through its Community Safety Strategy ensuring that domestic violence was one of its key priorities; it was included in their first Community Safety Strategy in 1999. The Community Safety Manager supported the Multiagency Domestic Violence Forum. There were contemporary concerns that members of this forum were not well supported by their agencies and were overly reliant on personal commitment. There is no evidence that either West Berkshire Safer Communities Partnership or

- the Domestic Violence Forum were able to provide a robust challenge or were holding their member agencies, including Thames Valley Police, to account for their performance in relation to domestic violence. We learnt that the Domestic Violence Forum was unaware in 2002/03 that Thames Valley Police did not have a Force-wide domestic violence policy, procedure or guidance.”
4. “In considering the one evidenced occasion in May 2003 when Julia informed the school about her and William’s situation, we agree with the current judgement of West Berkshire Council Children’s services. The school, in accordance with West Berkshire Children Protection Procedures 2001, should have notified the police or children’s social services. If this had been done it may have triggered initial interagency enquiries²⁹ to be made which may have linked information held by the school and GP with that held by the police.”
 5. “The school’s management of the case did not help link the available information to that already held by Thames Valley Police, as a consequence an opportunity was missed for this information to inform the police response. “
 6. “This case illustrates the limitations of relying on the assumption that other agencies are acting appropriately. Neither the police or social services had direct contact with William nor did he have the opportunity to share his views and feelings with them. “
 7. “Following the death of William Pemberton in 2003, West Berkshire Area Child Protection Committee should have undertaken a serious case review and the deliberations of the Area Child Protection Committee on the matter should have been recorded. The decision appears to have been based on a lack of understanding of the guidance and on the limited information available from agencies. The absence of a clear audit trail for that decision is unacceptable and has added **to the difficulties experienced by the family of Julia and William in obtaining answers to their questions.**”
 8. “As a result of the failure of West Berkshire Area Child Protection Committee to undertake a Serious Case Review following William’s death, consideration was not given at the earliest opportunity to the circumstances and lessons identified. “
 9. The absence of a Serious Case Review in 2003/4 and of a contemporary record of the reasons for not doing so meant that West Berkshire Council was not able to answer legitimate questions from the family’s MP in 2005 and the family in 2006. West Berkshire Council was also not able to provide us with a clear record of the timing or reasons for the decision.
 10. “The council was not directly responsible for the provision of services to Julia and her family however the IMR lacked a degree of

rigour in relation to those areas where the council might reasonably have been expected to provide comment on the response of the school in relation to William and the response of the Local Safeguarding Children Board after his death.”

11. “The council IMR did not contain evidence to support its conclusion that all services had appropriate policies in place; subsequently we were advised that there was no overarching Domestic Violence Policy or procedure for the council.”

APPENDIX A (NOT PART OF REPORT BUT BACKGROUND INFORMATION FOR THIS DOCUMENT) DID WEST BERKSHIRE HAVE THESE COUNCIL SERVICES ?

(Sanctuary and the educational directory were probably the areas where most local authorities were not meeting Best Value Performance Indicator (BVPI) in 2003 ie 7 & 10))

1. Has the local authority produced a directory of local services that can help victims of domestic violence?
2. Is there within the local authority area a minimum of 1 refuge place per ten thousand population?
3. Does the local authority employ directly or fund a voluntary sector based domestic violence co-ordinator?
4. Has the local authority produced and adopted a multi-agency strategy to tackle domestic violence developed in partnership with other agencies?
5. Does the local authority support and facilitate a local multi-agency domestic violence forum that meets at least four times a year?
6. Has the local authority developed an information-sharing protocol and had it agreed between key statutory partners?
7. Has the local authority developed, launched and promoted a ♦sanctuary♦ type scheme to enable victims and their children to remain in their own home, where they choose to do so and where safety can be guaranteed?
8. Has there been a reduction in the percentage of cases accepted as homeless due to domestic violence that had previously been re-housed in the last two years by that local authority as a result of domestic violence?
9. Does the council's tenancy agreement have a specific clause stating that perpetration of domestic violence by a tenant can be considered grounds for eviction?

10. Has the local authority funded and developed a domestic violence education pack in consultation with the wider domestic violence forum?

11. Has the local authority carried out a programme of multi-agency training in the last twelve months covering front line and managerial staff in at least two of the following groups: housing staff, social services staff providing services in the local authority area; education staff; health staff; and front line police officers?

BVPI (Best Value Performance Indicator) 225 definitions

1. The Directory must list both statutory and voluntary agencies that can provide emergency housing, advice (welfare, housing and legal), counselling and support, and include any local Women's Aid contact details and the National Domestic Violence Helpline. It must be widely distributed and updated at least every two years. A Directory should be available for each district and not just at a county level, as a minimum it should be available on the local authority's website. A directory for services that work with victims of domestic violence can be provided separately from the Directory for Victims of Domestic Violence.

2. 'Places' means the number of rooms providing bed spaces for a woman and her children. Rooms not normally designated as bedrooms should not be counted towards the total. 'Refuge' means emergency accommodation for women and children who have been referred for help having experienced threats to their physical safety. It must provide help, advice and advocacy support as well as being part of an integrated local approach involving partnership with other local and statutory bodies. Calculate 'Local Authority population' using the latest ONS mid-year estimates.

3. The Co-ordinator should be employed at a local authority level (see exemption below) and have responsibility for strategically co-ordinating domestic violence issues throughout the local authority area. Where funding has been provided to the voluntary sector or local partnership to employ a Co-ordinator this will meet the definition as long as their role remains to co-ordinate work in both the statutory and voluntary sectors across the area covered by the local authority.

Exemption – In cases where District Councils fund a county-wide Co-ordinator the District Council will meet the requirements of this BVPI, if the responsibility for ensuring that any county-wide work is implemented at a district level is included in the job description of an existing senior officer for that district.

4. The strategy should have been developed in partnership with all relevant statutory and voluntary partners. It should be supportive of, and aligned with, the authority's Crime and Disorder Reduction Strategy

(CDRP). The strategy should cover a three-year period with an action plan reviewed annually. The action plan should contain at least 50 per cent outcomes that are SMART (Specific, Measurable, Achievable, Relevant and Time-scaled) and include a section on how the needs of BME (black and minority ethnic) communities will be addressed. A Chief Officer and an Executive member in the authority should have been allocated responsibility for its implementation.

5. The Forum should have a mix of statutory and voluntary sector representatives at a senior enough level to aid the implementation of decisions and the strategy action plan. The Forum should be formalised as part of the Crime and Disorder Partnership.

6. The information-sharing protocol must facilitate the exchange of information to enable domestic violence to be effectively tackled across all statutory agencies.

Key statutory agencies are defined as the police, health, housing, social services

and education. The protocol will also provide an opportunity to implement Homicide Reviews where appropriate. It must ensure that confidentiality and victim safety is protected.

7. A sanctuary type scheme must provide security measures to allow the woman to remain in her home where she chooses to do so, where safety can be guaranteed and the violent partner no longer lives within the home. It must be available across tenures where the landlord of a property has given permission for the work to be carried out.

It must consist of additional security to any main entrance doors to the accommodation and locks to any vulnerable windows. Wherever possible it must provide a safe room in the home secured with a solid core door and additional locks. It is essential that this service is only provided where it is the clear choice of the victim. The scheme should be implemented through partnership with the police and/or the voluntary sector that could provide supplementary support. It may be provided directly by the local authority or through a third party funded as part of the local authority's homelessness prevention work through grants that may be available for crime reduction initiatives.

8. The indicator is met if there is a percentage reduction in homelessness acceptances due to domestic violence. Acceptances who were previously homeless in another local authority area should not be included.

Reductions achieved in preventing repeat homelessness should be clearly linked to positive measures adopted to provide genuine alternatives for women to either remain in their own home or be placed in alternative accommodation, removing the need to become homeless.

Alternative accommodation may be secured by arranging a reciprocal property with another social landlord, or a safe management transfer. Any options or measures to prevent repeat homelessness must only be taken with the full consent of the victim of domestic violence.

9. Any clause should make clear that evidence of domestic violence for eviction purposes does not need to rely on a criminal charge. Evidence may be based on a possession action using civil evidence.

10. The domestic violence education pack must have been specifically designed for use in schools and with youth groups. It must aim to challenge attitudes of tolerance to violence and help young people to achieve positive relationships based on mutuality and respect. Schools and youth groups cannot be forced to run a programme on domestic violence but the pack must be easily available and actively promoted. Schools should be encouraged to use the material as part of their PSHE79 or Citizenship curriculum.

11. The training programme must cover domestic violence awareness training, the legal framework, information sharing, and who provides what services to victims of domestic violence with referral and contact points. The programme should be developed in consultation with the Domestic Violence Forum and reviewed by the Forum annually.