A domestic homicide review into the deaths of Julia and William Pemberton

A report for
West Berkshire Safer Communities Partnership

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Authors:
Mary Walker
Margaret McGlade
Jim Gamble

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1. Introduction

1.1 On 18 November 2003, at the family home of Old Hallowes in the village of Hermitage in West Berkshire, Alan Pemberton shot and killed William, his seventeen year old son and Julia, his wife from whom he was separated, and then himself. Julia had told Alan in September 2002 that because of his emotional and psychological abuse she wanted their marriage to end.

1.2 This document is the report of a domestic homicide review set up by West Berkshire Council on behalf of the West Berkshire Safer Communities Partnership. The review has been conducted by an independent panel convened for the purpose with terms of reference described in chapter two. The report concerns the events that occurred during the period between September 2002 and November 2003; the actions of agencies and individual professionals; and the response of agencies and professionals to Julia and William's family following the deaths. It contains the panel's findings and conclusions and the learning we (the panel) have identified together with recommendations to improve services for victims of domestic violence and their children.

1.3 We have considered the actions of the three agencies: Thames Valley Police (TVP), Berkshire West Primary Care Trust (BWPCT) and West Berkshire Council (WBC). We also reviewed the involvement of William's school, the Pemberton family's GP as an independent contractor within the NHS; the private consultant psychiatrist who saw Alan Pemberton; and we met with the Coroner who conducted the Inquest into the deaths on 28 and 29 September 2004.

1.4 Thames Valley Police[1] is the largest non-metropolitan force in England and Wales, covering 2,200 square miles and serving a population of 2.1 million. It covers 16 crime and disorder reduction partnerships (CDRPs), within the areas of two county councils (Oxfordshire and Buckinghamshire) and seven unitary authorities; including the unitary authority of West Berkshire.

[1] Thames Valley Police official website September 2008

1.5 Prior to September 2005 West Berkshire was one of ten basic command units (BCUs). Following a restructuring initiative by Thames Valley Police entitled Challenge and Change the ten were reduced to five BCUs. West Berkshire BCU merged with the BCUs of Reading and Wokingham to form Berkshire West BCU spanning three local authority areas (Local Police Areas) whose boundaries are coterminous with those of the Crime and Disorder Reduction Partnerships. Berkshire West BCU has a population of approximately 437,500 of which the population for West Berkshire Local Police Area is approximately 139,328. The BCU has its own dedicated Public Protection Unit (PPU) which includes Domestic Violence and Child Abuse Investigation Units.

1.6 Thames Valley Police have approximately 4,165 police officers, 3,150 police staff, 250 special constables and 500 police community support officers and some 500 volunteers. The chief officer team comprises the Chief Constable, the Deputy Chief Constable, Assistant Chief Constable Local Policing, Assistant Chief Constable Operational Support, Assistant Chief Constable Specialist Operations and the Director of Resources. [2]

1.7 The PCT in the period covered by this review was the Newbury and Community Primary Care Trust, established in 2001. It served a population of 106,500 residents, covering an area of 200 square miles around west, north and southern Berkshire. Berkshire West Primary Care Trust (BWPCT) was formed on 1 October 2006, from the merger of Newbury and Community Primary Care Trust with Reading and Wokingham Primary Care Trusts.

1.8 West Berkshire Council is a unitary authority. It was created in April 1998 when the former Newbury District Council took on responsibilities from Berkshire County Council, which was abolished. The council provides services for children and young people, community services including housing, environment and public protection.

1.9 The deaths of Julia and William Pemberton have had a significant impact on the lives and well being of the family and friends who remain; they were left with questions about what they or others might have done differently that could have predicted or prevented the deaths of Julia and William and Alan's suicide.

[2] Thames Valley Police official website September 2008

1.10 This review owes its existence to the persistence and determination of the family and friends of Julia and William, their local Members of Parliament, the Attorney General, Baroness Scotland and the willingness of the then Chief Constable of Thames Valley Police to voluntarily participate in the first domestic homicide review in line with section 9 (although not enacted) of the Domestic Violence, Crime and Victims Act 2004.[3] We believe each of the interested parties took part in the hope that any learning might help prevent the deaths of future victims of domestic violence.

Background to the commissioning of the review

1.11 The West Berkshire Safer Communities Partnership Strategy Group took part in the Review at the request of the Home Office. On 6 June 2005 all parties to the West Berkshire Safer Communities Partnership (WBSCP) agreed a proposal to commission a domestic violence homicide review on the terms set out in papers presented to the WBSCP by the then Deputy Chief Constable (DCC) for Thames Valley Police.

1.12 The review was to be conducted in line with section 9 of the Domestic Violence, Crime and Victims Act 2004, though this was not yet in force, *'with a view to identifying the lessons to be learned from the death.'*[4]

1.13 The review process was to be proportionate and sensitive to the facts of the case, the issues raised and the concerns expressed by family members and others.

1.14 The WBSCP prepared Terms of Reference and appointed Verita, a consultancy specialising in the management and conduct of investigations, reviews and inquiries in public sector organisations, to conduct the review. Brian Parrott a former Director of Social Services and at the time a Director of Verita was appointed to chair the review. Jim Gamble a Deputy Chief Constable and the lead for Domestic Violence for the Association of Chief Police Officers (ACPO) and Christine Mann as the Department of Health's National Domestic Violence Coordinator were appointed as expert advisers and members of the review panel.

[3] See Chapter 12 – paragraph 12.152
[4] *Domestic Violence, Crime and Victims Act 2004: Section 9*

1.15 Initial meetings were held by the chair of WBSCP, the chair of the review and members of the family. There were a number of issues upon which it was not possible to reach agreement between the parties. These included the process for appointment of the review chair; contact/communication between the prospective review chair and the agencies whose involvement was to be reviewed; the focus of the review and proposed review process and the family involvement in that process.

1.16 An agreement could also not be reached between the Partnership and the family with regard to the Terms of Reference or the independence of the members of the panel.

1.17 In the family's view, the state's obligations to institute an investigation pursuant to Article 2[5] of the European Convention on Human Rights would not be fulfilled by the proposed review. This was in the context of the Inquest, which had taken place on 28 and 29 September 2004, which had been the narrower form of Inquest.[6] In October 2005 the family made application to the High Court to have the decision to commence the review on 1 October quashed and for an order to be made requiring the Partnership to set up and organise an enquiry after consultation with the family.

1.18 In his judgement on 31 July 2006, Lord Justice (LJ) Moses stated that the family had expressly declined to have Article 2 considered at the Inquest. He went on to say that it had been open to the family to challenge the conduct of the Inquest by way of a judicial review. They had not done this within the required three months and that this '*crucially undermined the application to the High Court'*.

1.19 He stated that the important questions raised by the family concerning what had or should have been done by those to whom Julia had expressed her fears including the police

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[5] Article 2 RIGHT TO LIFE Human Rights Act 1998 Chapter 42
1. Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.
2. Deprivation of life shall not be regarded as inflicted in contravention of this Article when it results from the use of force which is no more than absolutely necessary:
(a) in defence of any person from unlawful violence;
(b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained;
(c) in action lawfully taken for the purpose of quelling a riot or insurrection.

[6] Chapter 12 section: Inquest

would be considered by the review. He went on to consider the family's objections to the terms of reference including the independence of the membership of the panel; and what the family perceived to be their lack of involvement in the review. In summary LJ Moses rejected the family's views concerning the lack of independence of the members of the panel and concluded that the terms of reference provided for the involvement of the family. He noted with regard to the matter of Article 2:

> *'…in my view the review, in combination with the inquest, which has already taken place, will fulfil any obligation, which may exist under Article 2 upon the State to initiate an inquiry.'*[7]

1.20 In October 2006 following confirmation of the judgement the WBSCP made arrangements to re-start the review. They appointed Verita to recommence the review and Mary Walker, an associate of Verita, replaced Brian Parrott as chair. She is an experienced reviewer who has contributed formerly to a wide range of service inspections, case reviews and inquiries.

1.21 Although in the interim Jim Gamble had been appointed as the Chief Executive of (The Child Exploitation and Online Protection (CEOP) Centre he agreed to continue with his commitment to the review. Christine Mann was a member of the newly constituted panel from October 2006 until the end of March 2007.

1.22 On January 25 2007 following consultation with members of the family the final terms of reference (see chapter 2 and appendix A) were agreed by WBSCP. Following consultation with members of WBSCP on the 23 January 2007, the WBSCP chair wrote on 30 January to the family solicitor and to the chair of the review panel confirming that the treatment of the bereaved family would be included in the review.

1.23 Following Christine Mann's resignation from the panel in March 2007 prior to her retirement from the Department of Health, it was not until September 2007 that the WBSCP was able to appoint her replacement to the panel. Christine Mann had been funded by the

[7] Transcript of Judgement LJ Moses 31 July 2006 paragraph 29.

Department of Health and the delay was associated with WBSCP identifying funding for her replacement. That delay has contributed to the overall time required to complete the review.

1.24 Margaret McGlade was appointed to the panel in September 2007. Formerly a Director of Social Services she was the lead on domestic violence for the Association of Directors of Social Services.

1.25 For the expert members of the panel, the demands in time and commitment arising from the review have had to compete with the responsibilities of their full time occupations. In this regard the availability of panel members has had a direct bearing on the timescale required to complete the review.

1.26 The Pemberton case is complex in terms of the individual circumstances of the incidents, the nature and scope of the concerns raised by the family about agency responses before and after the deaths and the length of time, almost five years, since the deaths. The circumstances that preceded both the commissioning of the review prior to the implementation of the national policy on homicide reviews and those that led to the Judicial Review by Lord Justice Moses have also contributed to its complexity.[8] We consider that the Pemberton review should be regarded as an exception to the model set out in the Draft Guidance[9] rather than as a template for future Domestic Homicide Reviews.

1.27 In preliminary discussions between the chair and representatives of the Home Office and the chair of WBSCP the term '*light touch*'[10] was used to describe the nature and scope the Pemberton review. We do not consider this description is appropriate in the context of domestic homicide reviews.

1.28 The review has been funded by the Home Office and the agencies represented on the WBSCP Sub Group; Thames Valley Police, Berkshire West Primary Care Trust and West Berkshire Council. Following confirmation of the terms of reference from the WBSCP chair we

[8] See Chapter 12

[9] *Guidance for Domestic Homicide Reviews under the Domestic Violence, Crime and Victims Act 2004.* Home Office Consultation Document June 2006

[10] On 17 March 2005 an Adjournment Debate took place in the House of Commons concerning the murder of Julia and William Pemberton - the term '*light touch investigations'* was used by Paul Goggins MP to describe the proposed domestic homicide reviews

commenced work in February 2007 for completion in May 2007. It was quickly apparent that this timescale was not consistent with the process required to meet the scope and requirements of the terms of reference nor in the context of the previous challenge to the review process. As noted previously the timescale for the review has also been affected by the time taken to identify a replacement for Christine Mann and other demands on the availability of panel members.

1.29 It was important at an early stage of the review for us to meet with those family members who wished to contribute. We have been greatly helped in undertaking this review by the information and insights provided by Julia and William's family and friends; we appreciate that this will have been a stressful and distressing experience. Their expressed commitment has been to ensure that learning from the review should be used to prevent the deaths of victims of domestic violence in the future and to improve services.

1.30 We are grateful for the cooperation of the agencies, their staff and individual professionals who have contributed to the review. We recognise and appreciate that for those who were involved with Julia, William or Alan this will have been a stressful experience.

1.31 We met with Dr Carolyn Hoyle, who has undertaken research into various aspects of TVP's performance including domestic violence. We also took the opportunity to meet with Roxane Agnew Davies, a clinical psychologist with knowledge of domestic violence in relation to health provision and the chair met with Davina James–Hanman, the Director of Greater London Domestic Violence Project. We are grateful for the useful insights, knowledge and experience they shared with us.

1.32 The review has excluded consideration of how Julia and William died or who was culpable; that was a matter for the Coroner.

1.33 The review was finally completed in November 2008. The following table is based on oral and written information we have received during the review.

Key Dates:

14 September 2002	Julia and her brother reported to Thames Valley Police that Alan had threatened to kill her.
16 September 2002	Julia met with Thames Valley Police Domestic Violence Co-ordinator.
17 September 2002	Julia obtained an Injunction including non-molestation and occupation order with Power of Arrest.
20 September 2002	Alan served with the injunction.
20 April 2003	Locks at Old Hallowes were super glued and the incident reported by Julia to Thames Valley Police.
15 May 2003	Alan delivered Julia's Affidavit applying for the Injunction annotated with abusive remarks to Old Hallowes and Julia and her brother took it to Newbury Police Station and reported history of continuing threats.
28 May 2003	Alan wrote to William enclosing further copy of the annotated affidavit.
9 June	Julia met with Thames Valley Police Domestic Violence Co-ordinator.
10 June	Sovereign Alarm fitted at Old Hallowes.
7 July 2003	Hearing for renewal of non- molestation – Alan gave undertaking and was granted permission to park on the drive when collecting William or C19 for contact.
18 November 2003	Alan shot and killed William and Julia and then himself.

28 and 29 September 2004	Inquests into the deaths of William, Julia and Alan Pemberton.
17 March 2005	Adjournment Debate in the House of Commons concerning the murders of Julia and William Pemberton.
6 June 2005	Deputy Chief Constable Thames Valley Police presented report requesting West Berkshire Safer Communities Partnership to commission Domestic Homicide Review.
19 September 2005	Terms of Reference agreed by West Berkshire Safer Communities Partnership.
October 2005	Application made for Judicial Review by Julia's family to have decision to commence review quashed on grounds that the state's obligations under Article 2 of ECHRA would not be fulfilled by the proposed review.
24 July 2006	Hearing before Lord Justice Moses; 31 July 2006 Judgement.
October2006	Following confirmation of the judgement arrangements were made by West Berkshire Safer Communities Partnership to re-start the review.
30 January 2007	Review Panel received final Terms of Reference.
1 February 2007	Review Panel requested agency internal management reviews and arranged meetings with members of Julia's family.
April 2007	Review on hold following retirement of Christine Mann.
September 2007	Review restarted.
November 2008	Completion of Report.

2. West Berkshire Safer Communities Partnership - Terms of reference

NB. This is an extract from the final terms of reference as agreed on 25 January 2007 and the complete document can be found at appendix A.

This review is commissioned by West Berkshire Council on behalf of West Berkshire Safer Communities Partnership (WBSCP) in response to the deaths of Julia and William Pemberton and the subsequent death of Alan Pemberton in November 2003. The proposed terms of reference have been agreed following discussion with the Home Office.

Background

The review follows after extensive discussions with the relatives of Julia and William Pemberton, the Home Office (including Ministers and officials) and local agencies within the WBSCP. The review will follow the key processes that are outlined in the guidance for Domestic Homicide reviews under the Domestic Violence, Crime and Victims Act 2004 which was published for consultation by the Home Office in June 2006. Where appropriate the guidance will be developed further to reflect local circumstances. This is to ensure that the review is both thorough and robust and that any learning can help inform the final guidance which is to be published by the Home Office in 2007.

Purpose

The purpose of the Review is to:

1. Establish the facts that led to the events in November 2003 and whether there are lessons to be learned from the case about the way in which local professionals and agencies carried out their responsibilities and duties, and worked together to safeguard Julia and William Pemberton.

2. Identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result.

3. Establish the appropriateness of agency responses - both historically and at the time of the incident leading to the homicides.

4. Establish whether single agency and inter-agency responses to concerns about domestic violence were appropriate

5. And as a consequence, identify any gaps in, and recommend any changes to, the policy, procedures and practice of individual agencies, and inter-agency working, with the aim of better safeguarding families and children where domestic violence is a feature in West Berkshire and perhaps more widely in the future.

6. Identify, on the basis of the evidence available to the review, whether the homicides were predictable and preventable, with the purpose of improving policy and procedures in West Berkshire and perhaps more widely.

7. Identify from both the circumstances of this case, and the homicide review processes adopted in relation to it, whether there is learning which should inform policies and procedures in relation to homicide reviews nationally in future and make this available to the Home Office.

The Review will exclude consideration of how Julia and William died or who was culpable; that was a matter for the Coroner and Criminal Courts respectively to determine.

Terms of reference

1) To review events up to the date of the deaths of Julia and William Pemberton on 18 November 2003 unless it becomes apparent to the independent chair that the timescale in relation to some aspect of the review should be extended.

2) To review the actions of the agencies defined in Section 9 of the Act who were involved with the Pembertons and - at the initiative of the chair and subject to their agreement - any other relevant agencies or individuals.

3) To seek to involve the family and include their potential contribution to the review in the way set out in the approach 'b) Family Involvement' (below)[11]

4) To produce a report which:

- summarises concisely the relevant chronology of events including the actions of all the involved agencies
- analyses and comments on the appropriateness of actions taken
- makes recommendations which, if implemented, will better safeguard families and children where domestic violence is a feature.

5) Aim to complete a final overview report by the end of May 2007 acknowledging that drafting the report will be dependent, to some extent, on the completion of agency management reviews to the standard and timescale required by the independent chair.

The Commissioning Body

West Berkshire Council on behalf of the West Berkshire Safer Communities Partnership (WBSCP) which incorporates the Crime and Disorder Reduction Partnership for West Berkshire (CDRP) has commissioned this review and WBSCP have approved these Terms of Reference.

The Chair of the WBSCP (Nick Carter, Chief Executive West Berkshire Council) has been given delegated authority to take decisions on behalf of the WBSCP:

- maintaining a dialogue with members of the family
- liaising with the independent chair to ensure she is able to carry out the remit within the agreed timescale.
- securing the resources required to undertake the Review.
- liaising with the Home Office on matters that are relevant to the roles and responsibility of the Commissioning Body.
- receiving the final overview report from the independent chair.

[11] Reference to paragraph b) in section 'Approach' in full Terms of Reference see appendix A

All other responsibility relating to the Commissioning Body (WBSCP) namely any changes to these Terms of Reference and the preparation, agreement and implementation of an Action Plan to take forward the local recommendations in the overview report will be the collective responsibility of the Partnership.

3. Executive summary

Introduction

3.1 This review was commissioned by West Berkshire Council on behalf of West Berkshire Safer Communities Partnership (WBSCP) in response to the deaths of Julia and William Pemberton and the death of Alan Pemberton on 18 November 2003. Alan Pemberton shot his son William, his wife Julia, from whom he was separated and then himself.

3.2 Julia Pemberton was born on 17 January 1956 and Alan Pemberton on 20 January 1955. They met whilst Alan was at university and Julia was at teacher training college in Southampton and were married on the 26 July 1980. Their children, C19 and William were aged 18 and 15 when Julia reported the death threat to the police in September 2002.

3.3 The review has followed the key processes that are outlined in the guidance for Domestic Homicide reviews under the Domestic Violence, Crime and Victims Act 2004 which was published for consultation by the Home Office in June 2006. It was undertaken in private and comprised formal interviews and a thorough examination of available relevant information.

3.4 Our views and conclusions are based on findings from both the documentary evidence and interview testimony and have been formed to the best of our knowledge and belief.

3.5 The report provides an independent review of the actions of agencies and individual professionals in West Berkshire who were involved with the Pemberton family and identifies learning for those agencies and professionals and the communities that they serve. The report:

- summarises concisely the relevant chronology of events including the actions of all the involved agencies
- analyses and comments on the appropriateness of actions taken
- draws conclusions and identifies learning for the future
- makes recommendations which, if implemented, will better safeguard families and children where domestic violence is a feature.

Summary of events September 2002 – November 2003

3.6 In August 2002 Julia had a mastectomy. During that summer for the first time she told members of her family and close friends how unhappy her marriage had been and that Alan's behaviour had been unpredictable, demanding and controlling throughout their marriage. She had hoped to stay together with Alan until William reached eighteen. Julia had tried to leave at least twice before including about ten years earlier, but Alan's response including death threats had led her to believe that he would kill her.

3.7 In early September 2002 Julia told Alan their marriage was over and that she wanted a separation. Alan wanted the marriage to continue. Over the next ten days his behaviour varied between being contrite and being verbally aggressive towards her. On the night of 13 September before going on a business trip to Spain, Alan told Julia that he wanted the chance to live as man and wife for a specified time at the end of which he would decide if the marriage was working or not, or he would take his own and her life.

3.8 On 14 September as soon as Alan left the family home Julia, frightened and alarmed by what Alan had said, contacted her brother who came to the house to be with her, William and C19. Julia and her brother telephoned Newbury Police Station and reported what Alan had said. The police did not visit the house or investigate Alan's threat to kill Julia although she and her brother continued to telephone and request help over the next two days. On 16 September Julia went to see a domestic violence coordinator (DVC) at Newbury Police Station and told her about the emotional and psychological abuse that she had experienced in her marriage. The DVC provided Julia with a letter supporting her application for an injunction and flagged her address noting that all calls from there were to be treated as urgent. Julia obtained at Reading County Court an emergency injunction with a non-molestation and occupation order and a Power of Arrest.

3.9 Alan was served with the injunction on 20 September; later that day he did not arrive to meet a friend who reported him to the police as a missing person; Alan contacted his friend on the 22 September who advised the police. Over the following months Alan continuously telephoned and sent texts to Julia threatening his own life and hers, involving William and C19; blaming Julia for what had happened.

3.10 In January 2003 Alan left a document on the doorstep of the family home referring to his hatred of Julia for ending the marriage and the way she had done it. He admitted that in September he had threatened to kill Julia if she divorced him but claimed that he had done so in the heat of the moment. Subsequently he admitted to a work colleague that he had planned what to say the night before. He ceased maintenance payments and emptied the joint bank account of a large sum of money. In March Julia filed a petition for divorce.

3.11 Between September 2002 and November 2003 Julia consulted her GP on eleven occasions; Alan consulted the GP for the first of five occasions between March and July, in March 2003. From the end of March Alan was living more or less full-time in Herefordshire with a new partner he had met in October.

3.12 Returning from a holiday with friends on 20 April Julia and William found the locks at the family home had been super-glued. Julia reported the incident to Thames Valley Police; it was not thoroughly investigated nor the domestic violence coordinator notified.

3.13 On 2 May the GP referred Alan to a private consultant psychiatrist with regard to depression and his threats about suicide. Alan tried to cancel Julia's private healthcare cover although she was still receiving treatment for breast cancer. William returned from a visit to his father very distressed and told his mother that he thought his father might kill him as well as her.

3.14 During May, Alan visited the websites howtomurder.com and murder.com on the computer at work. On 15 May he delivered to the family home a copy of Julia's Affidavit[12] which he had annotated with expletives and angry and abusive comments which Julia believed to be further death threats. The envelope was addressed to William and was intercepted by Julia. Accompanied by her brother, Julia took the document to Newbury Police Station where they provided information about the ongoing harassment she was suffering and her fears for her own and her family's safety. A copy of the annotated affidavit and other documents were taken at the police station and marked for urgent attention. No action was taken by the police to investigate the incident or notify the domestic violence coordinator. The documents joined the papers concerning the glued locks which were in the process of being archived.

[12] Julia's Affidavit 17 September 2002: application for Injunction Reading County Court

3.15 On 19 May Julia contacted William's school as he was due to take exams and she was concerned that the marital breakdown and his father's behaviour including his threats to kill her and himself were having an affect on him; she sent a letter to the school to alert the examination board. Julia told the school that she had advised the police; the school did not contact the police or social services.

3.16 On 28 May Alan delivered a further copy of the annotated affidavit together with a letter addressed to William, in which he described his anger and hatred for Julia because of what she had done in breaking up their marriage. It is evident from telephone records that during May and June Julia tried to engage the assistance of the police over this incident but without success.

3.17 In her consultation with the GP on 8 May, Julia told him that William was distressed and on 5 June she expressed concern for her own and her family's safety and that she was in contact with the police and her solicitor. The GP did not contact the police or social services.

3.18 In June Julia also contacted the domestic violence coordinator to request the installation of a panic alarm; she was concerned about her safety because she was due to return to court for the renewal of the injunction and would have to come into contact with Alan. She was anxious that the injunction would not be renewed. An alarm was installed and Julia was advised that in an emergency she should dial 999 for the police. On 19 June she told the GP that the stress at home was more relaxed and a panic alarm had been installed.

3.19 On 7 July at the hearing, following negotiations between the parties, the injunction was not renewed. Alan gave an undertaking not to enter the matrimonial home and was granted permission to park on the driveway at the family home if he was collecting William or C19 for contact. The judge ordered that the house should be sold. Julia told the GP that she was relieved by the court hearing.

3.20 During the summer, Alan took William and C19 on holiday before going on holiday with a friend to America. Following William's seventeenth birthday on 13 October his father collected him on Tuesday evening each week for a driving lesson. Alan wrote to Julia at the beginning of November asking her to retract allegations that she had made in her Affidavit in

September 2002 and giving her a deadline by which to contact him or the situation would have to stand. Julia told her brother again that she was convinced that Alan would kill her.

3.21 On 18 November following an exchange of mobile telephone calls and text messages with his son Alan arrived to collect William for his driving lesson. Julia was on the telephone to a friend but concerned about something that had happened, interrupted the call and suggested that her friend ring back later. At 1911hrs Julia dialled 999 and requested urgent help from the police, saying that her husband was on the drive with a gun and had let off some shots. Continuing to speak with the call operator, Julia was advised to keep hidden and that police officers were on their way. Having shot William five times, Alan then shot at the windows and doors of the house, gained entry, shot Julia four times and then himself. Julia's call lasted over fifteen minutes

3.22 Plain clothes police officers in an unmarked police car were dispatched to make an initial assessment and found William's body on the driveway approximately forty minutes after Julia made her phone call at 1911 hours. Armed police did not reach the outside of the house for about an hour after Julia called 999 and did not enter the house until 0148 hours the next day, over six hours after Julia made the call. At 0153 hours police found the bodies of Alan and Julia.

Key messages

3.23 The review panel has considered the appropriateness of the actions taken by agencies and professionals and has made a number of recommendations. It has taken account of the development of national policy and changes in local practice that have addressed many of the lessons highlighted during the events of 2002 – 2003. However, there are still important areas for reflection and improvement. We consider that the recommendations if implemented will inform strong leadership, meaningful policy, focused service delivery and critically a multi-agency risk management mechanism. In our view such measures will provide a platform from which families living under the threat of domestic violence can be better safeguarded.

3.24 In keeping with our terms of reference, we have also considered the ways in which the agencies, their staff and their systems engaged and managed the needs and expectations of the family in the aftermath of the murders.

3.25 The review found that of the three agencies involved in the review - Thames Valley Police (TVP); Berkshire West PCT (formerly Newbury and Community PCT) and West Berkshire Council - TVP in particular had significant responsibility for responding to requests for help from Julia Pemberton between September 2002 and her death in November 2003, and subsequently for liaising with her family.

3.26 Thames Valley Police have responsibilities for policing incidents of domestic violence. In September 2002, April and May 2003 Julia Pemberton and her family reported three domestic violence incidents to the local police station in Newbury and she sought help from the domestic violence coordinator in September 2002 and June 2003. On 18 November 2003 Julia made a 999 call requesting urgent police assistance because Alan was at the family home with a shot gun and she was frightened for her own and William's safety. The review has considered in detail the response of Thames Valley Police to Julia Pemberton during that fourteen month period. It has also considered the communication between TVP and Julia's family in the period leading up to the agreement by WBSCP in 2005 to commission a domestic homicide review.

3.27 Newbury and Community PCT had no direct referrals in relation to the family. Julia consulted the GP, an independent contractor within the NHS, on eleven occasions and Alan consulted him on five. Alan saw a private mental health consultant on three occasions. A review of the involvement of the medical practitioners is included in the report. Julia was employed by the PCT as a part-time health visitor; the PCT was unaware of her home situation.

3.28 West Berkshire Council had no direct involvement with either Julia or William. William attended a West Berkshire Council school where staff had knowledge of William's home situation. We have considered the involvement of the school. William had routine contact with the Connexions service, the partnership agency responsible for providing careers advice and guidance to young people. In the period prior to September 2002, Julia was known to some council staff as a member of the interagency Domestic Violence Forum which was supported by the council; they were unaware of her domestic situation.

3.29 Following William's death, the council as the lead agency for the Area Child Protection Committee had a responsibility under Working Together to Safeguard Children 1999

(Department of Health) to consider the circumstances of the death of a child where abuse is known or suspected. A Serious Case Review was not undertaken. This is considered in Chapter 12.

3.30 This report considers the preparedness of the council and the PCT alongside Thames Valley Police in their capacity as strategic commissioners, to provide guidance and leadership through West Berkshire Safer Communities Partnership to the local community and to professionals in dealing with individual cases and in coordinating action to reduce the incidence of and harm from domestic violence.

Thames Valley Police

3.31 The police deliver a diverse and complex service ranging from the management of routine public safety functions such as roads policing and public order, to the detection and prevention of acquisitive crime, offences involving property and ultimately extreme acts or threats of violence. They are the organisation the public will turn to in times of crisis and face on a daily basis the challenge of categorising and prioritising activities against often limited resources. The complexity of the challenges they face demands strong leadership, clear lines of accountability, the development, delivery and supervision of relevant policies and practices and critically the ability to reflect, review, learn lessons and adapt. Their role is not a simple one and we recognise and respect the difficult jobs they have chosen to do.

Leadership and Strategic Direction

3.32 Whilst the Thames Valley Police Management Service Review highlights a number of key learning points, none are more relevant than the procedural void created by what the Review highlighted as a lack of strategic direction. In our view this is an issue of organisational leadership and collective responsibility. The absence of policy for such a significant period of time undermined Thames Valley Police's ability to create a system that developed uniform understanding of the nature of domestic violence, highlighted roles and responsibilities and ensured support and training for those required to deliver a competent service.

3.33 Chief Officers and their senior management teams have a huge responsibility. Their decisions will influence the focus of force resources and the performance culture that drives activity. The power of their commitment to and investment or lack of it in particular policies should not be under estimated. 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. Balanced overall policy development is critical and we acknowledge the principle that TVP attempted to make sensible links when constructing a framework for Domestic Violence policy development. Nevertheless, a three year void is unacceptable and we have found it difficult to understand why in light of the comprehensive nature of the Home Office circular 19/2000 no interim policy was adopted. This lack of strategic direction manifested itself in an inconsistent service approach dependent upon individual officers often ill-informed, isolated and poorly supervised or supported.

3.34 Leadership demands clear lines of accountability and whilst we acknowledge the distance the force have come with regard to applying policy and practice following the murders of Julia and William Pemberton, we note that Her Majesty's Inspectorate of Constabulary's report of 2007 still highlighted that:

> '*The force does not have a written accountability document which details the accountability structure for DV investigations.'*
>
> And goes on to add:
>
> *'an accountability framework should be developed which outlines the structure through to the ACPO portfolio holder and it should also show the links to the HQ strategic lead.'*

Reflection and Learning

3.35 The passage of time undoubtedly diminishes the ability to accurately reflect upon what has happened, why, and how things might be improved for future service delivery. It is therefore critically important that reviews are carried out at the earliest sensible opportunity and that any evidence or information that might inform such a process is captured immediately.

3.36 In our view on the basis of its own policy[13] and requests from at least one of its senior officers,[14] the Force should have carried out a critical incident review or at the very least a focused and comprehensive overarching debrief of their engagement/s with the victims and perpetrator.

3.37 We recognise the professional commitment and honest endeavour of the Thames Valley Police Management Services Review. It is clear however that this review was inhibited by a number of factors. The passage of time made accessing critical information difficult for them and from their submissions it is clear that their methodology[15] did not include the remit to question officers to establish some of the important issues, for example - why didn't police attend the scene (referring to the threat to kill and the super-glued locks)? What was prioritised above the calls on the weekend of 14 and 15 of September and what did that say about officers' attitudes to this crime? Bearing in mind the limits placed on the Thames Valley Police Review team, we wish to stress that none of our conclusions or comments on the Management Service Review is directed at the Review Team. We consider that they approached all our requests for additional information in a conscientious and thorough manner.

3.38 It is our view that engaging in this exercise was made all the more difficult for them as they could not identify some key personnel, e.g. the officer who received the annotated affidavit or compel others to communicate with them. Ironically some of the information was ultimately accessed by them on our behalf. Future reviews need to have the ability to capture information from key contemporary sources and whilst we accept fully the need to protect the rights of serving officers, we believe this can be met by appropriate representation and that it is reasonable for the public to expect members of their police service to constructively engage with reviews of this type.[16]

3.39 Reviews involving policy development and leadership issues would benefit from the participation of a Chief Officer independent of the force. It would provide the opportunity to

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[13] Thames Valley Police *'Critical Incident Definition/ Standard Operating Procedure – 2003 and 2004'*
[14] Superintendent Crime and Operations on the West Berkshire Basic Command Unit
[15] Chapter 12 section: Analysis of internal agency management reviews paragraph 12.196 Thames Valley Police Management Service Review
[16] Reference Recommendation 19 of this report

ensure that learning is sufficiently focused at all levels and that an appropriate emphasis is placed on matters related to lessons for the senior command team.

Managing Risk

3.40 We recognise that domestic abuse often manifests itself through the power and control exercised by the perpetrator and that whilst in many cases it is enforced by the application of violence, in other cases threats and explicit or implicit coercion dominate the victim's life. Identifying the various elements and interpreting the risk an individual represents is a complicated endeavour and one that was not well understood in 2003. In our view the threat to those most vulnerable in such relationships is best managed as a shared activity. It has been clear throughout the review that even in the absence of a sophisticated risk assessment or management model, had all the information available to the family, friends and agencies been joined up, the true nature of the threat posed by Alan would have been apparent.

3.41 It is our view therefore that all agencies (including police, criminal justice and civil justice agencies, health, education and social care agencies) should work together towards agreeing a single multi-agency framework for identifying, assessing and managing risk in domestic violence cases. This should build on learning nationally on the model of Multi-Agency Risk Assessment Conferences (MARACs) and other single and multi-agency initiatives relating to domestic violence. This multi-agency framework for the identification, assessment and management of risk should not be based purely on information from one source or agency or on the circumstances at one particular stage of a case. The framework and process should be based on a shared understanding of domestic violence and risk, should recognise the dynamic nature of risk in domestic violence cases and the need to base decisions on information from a range of sources.

3.42 We have found Sir Ian Magee's concept of public protection networks (ppn), articulated in his Review of Criminality Information (ROCI) to be particularly helpful and whilst his review dealt with a much broader public protection remit his assertion is very relevant:

'it became clear that some catalyst is required to drive greater connectivity across the ppn, to provide a strategic direction for public protection as a whole, to draw attention to effective practice and challenge developments, process and behaviours that inhibit the appropriate sharing of information across the public protection network.'

Information Sharing

3.43 Whilst the police service by virtue of their role have opportunities to access information and should have the skills, ability and experience to translate that into intelligence or evidence, they are often unaware or unable to access critical material held by other agencies, family and friends. Information is the fuel which drives a risk management approach. Ensuring that all relevant information from the various agencies and individuals is harvested provides a number of challenges. Any system for sharing information must also acknowledge the potential implications and consequences with regard to both the victim of domestic violence as well as for the people providing support.

3.44 Whilst both public and professionals are often told that the Data Protection Act does not inhibit agencies from sharing information, it does not positively encourage or require it, nor critically does it explicitly offer protection to those charged with making the judgements about sharing sensitive personal data in cases of suspected risk. If we are to develop a multi-agency system with the confidence to share information, this situation is not tenable. In this regard we acknowledge and support the current work being carried out by the ACPO Domestic Violence working group which recognises that *'any prevention-based risk management strategy should have as a core requirement effective, information sharing within and between agencies*.' (ACPO lead Domestic Violence strategy paper 2008)

Berkshire West Primary Care Trust

3.45 The important role of the NHS in providing services that respond to the range of needs of victims of domestic violence and their families has been acknowledged in national

guidance.[17] Primary Care Trusts (as commissioners through contractual arrangements with GPs and in their role as providers of health services) in local communities have a significant responsibility for providing strategic direction with regard to domestic violence and the health community. In the absence of such leadership the ability of frontline staff to improve services is seriously undermined.

3.46 Primary Care Trusts, professional bodies, and representative organisations all have important contributions to make in developing the knowledge of medical professionals regarding domestic violence. Domestic Violence Fora and Partnerships in local communities provide opportunities to develop shared understanding about domestic violence, its presentation, identification and the most relevant and readily accessible ways to provide help. Primary Care Trusts need to become fully involved in these fora and take shared responsibility for promoting their effectiveness. We consider Primary Care Trusts have an important role, as commissioners of health care, in developing arrangements for multi-agency risk assessments with other agencies and ensuring that the contribution of GPs and other health professionals to these assessments can be made effectively.

3.47 In reviewing the Pemberton case, we have become increasingly aware of the importance of the role of general practitioners. As well as being providers of primary care they represent the doorway to secondary health care and other services. For victims and their children, like Julia and her children, who have limited involvement with other health or care services, the GP may have a pivotal role. They are in a key position to signpost patients to other sources of help and to alert appropriate agencies such as police and children's services when there are concerns about risk.

3.48 In circumstances such as the Pemberton case, where the GP has been the family doctor over many years, this may present a dilemma for the GP and their patients when both parties are registered with the same GP. This is a complex matter which involves issues of patient confidentiality and objectivity in the context of the management of risk and is an area on which Primary Care Trusts within their commissioning contracts, need to work with local GPs and their professional bodies.

[17] Department of Health (2005): *Responding to domestic abuse: a handbook for health professionals;* RCGP (1998) *Domestic violence: the general practitioners role Dr. Iona Heath MRCP FRCGP*

3.49 Patients place great trust in their GPs and have a right to expect that their consultations will remain confidential. We consider however, that patients need to recognise the conflicts that may arise from the GP's position at the centre of family health care and be aware that occasions may arise where there is a compelling reason for their confidentiality to be subordinated to the need to prevent harm to themselves or others. The doctor-patient relationship is at its most effective and powerful when it operates in an environment of mutual trust.

3.50 Later in this report we have noted that in 2002/03 Newbury and Community Primary Care Trust did provide strategic leadership with regard to child protection, but not specifically domestic violence. We are reassured by the current commitment given at a senior level by Berkshire West Primary Care Trust to ensuring representation on bodies where these issues will be discussed. Investment in developing and supporting all primary care services, through contractual arrangements, notably with general practitioners, with regard to responding to the needs of domestic violence victims and their children will help to address the impact on their mental and physical well being.

West Berkshire Council

3.51 Local councils have a key strategic role as community leaders in addressing domestic violence; this is an element of their statutory responsibility. They also have a specific statutory duty[18] to promote partnerships to reduce crime and disorder in their local area within which domestic violence accounts for a fifth of all recorded violent crime.

3.52 As the lead agency in developing Local Strategic Partnerships[19]councils are in a position to encourage partners to give priority to addressing domestic violence and can use the framework of Local Area Agreements to coordinate multi agency action around agreed local priorities. In providing leadership to their Crime and Disorder or Community Safety Partnership and Domestic Violence Forum, they are in a position to challenge when necessary the contribution and performance of other agencies and ensure that these partnerships are functioning effectively.

[18] Crime and Disorder Act 1998
[19] Local Government and Public Involvement in Health Act 2007

3.53 Councils have a statutory responsibility to safeguard children and support vulnerable adults through services such as housing and adult social care.[20] Councils have a responsibility to ensure at a corporate level that all council services have appropriate policy, procedure and training to meet the needs of victims of domestic violence and their children.[21] This includes the requirement to have suitable arrangements to link their responsibilities for vulnerable adults with those for safeguarding children.

3.54 In reviewing the Pemberton case we have been aware of the needs of families who may have limited contact with most council services. In those circumstances schools are able to provide for victims and their children an opportunity to access help. It is important that at the earliest opportunity the impact of domestic violence on children and young people and their different needs are identified. Schools are in a key position to ensure that this happens because of their link with parents and the council's children's services. Where necessary this may include consideration of a referral under the interagency child protection procedures.

3.55 The contribution of information from all relevant agencies is fundamental to the assessment and management of risk in safeguarding and promoting the welfare of children and young people where there is domestic violence. Developing understanding in a local community of this principle between all agencies including schools needs to be an ongoing process. Councils alongside the police service have a key role in developing multi-agency risk assessments for those experiencing domestic violence and making plans to manage the risks identified and support the victim.

3.56 The council through its statutory role is able to provide leadership in taking forward initiatives that promote understanding of domestic violence in the wider community. An example of how this can be achieved is the leaflet produced by the Greater London Authority, which provides accessible information about ways in which friends and family members can help victims of domestic violence and their children. [22]

3.57 The Local Safeguarding Children Board for each council area has responsibility to ensure that a serious case review is carried out when a child dies and abuse or neglect is

[20] Children Act 2004; Adoption and Children Act 2002
[21] Local Government Association: Local Government's role in tackling domestic violence: January 2006; Checklist for local authorities on domestic violence and partnership working: 2005
[22] If someone you know is experiencing domestic violence… Greater London Authority: November 2006

known or suspected to be a factor in the child's death, irrespective of whether the council's children's social care service is or has been involved with the child or family.[23] This includes domestic homicide where a child or young person is involved. In the case of a domestic homicide review, consideration should be given to how a coordinated review process can address all the questions in the most effective way.

Conclusions 2002 - 2005

3.58 The focus of this review has been on the response of agencies and professionals to the requests of Julia Pemberton and her family for help in the period September 2002 to November 2003 and their response to the family in the aftermath of her death and those of William and Alan Pemberton. Our conclusions are therefore about the past performance of those agencies and do not reflect the current response of agencies and professionals to requests for help from victims of domestic violence in 2008. We have been told about many improvements in the provision of services and these are referred to in chapter 14 of this report.

Thames Valley Police September 2002 – November 2005

3.59 Thames Valley Police had a primary duty to provide a service to Julia, William and C19, as victims of domestic abuse between September 2002 and November 2003. On the night of 18 November they had a primary duty when responding to the spontaneous firearms incident to protect members of the Pemberton family, the general public, and of course their own officers.

3.60 In this section we have brought together issues concerning Thames Valley Police performance under the following headings; crime investigation; domestic violence services; internal systems; emergency response; airwave communication; firearms response 18 November; Review of the Pemberton Case; information provided with regard to the Inquest. At the end of this section we have drawn overall conclusions about the service provided by Thames Valley Police.

[23] Working together to Safeguard Children HM Government 2006

- *Crime Investigation*

3.61 It is our view that 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. There is evidence of instances when police officers did not attend the scene, thoroughly investigate or link incidents or crimes which were reported on:

- 14 and 15 September 2002 - Threat to kill
- 20 September – Alan missing person
- 20 April 2003 - Glued locks
- 15 May 2003- annotated affidavit.

3.62 We have been provided with evidence that Julia and members of her family made a significant number of contacts with the police in relation to each of these incidents. Opportunities were missed to collect evidence in the first or 'golden hour' after the complaint regarding when an incident occurred. Thames Valley Police had policies and systems in relation to the investigation of crime other than domestic violence and we have identified issues in relation to supervisors and officers dealing with each of the three incidents where a crime was reported.

3.63 Officers did not identify or link the significance within the context of domestic violence of the four incidents, including Alan's behaviour in going missing and his threat of self harm. We attribute this lack of direction and focus to the absence in 2002 and 2003 of a Force-wide policy, procedures and training on domestic violence.

3.64 We have concluded that had the threat to kill been investigated as a serious crime in September 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 lead to a more informed police response at a critical time.

3.65 Thames Valley Police 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.

As a consequence, Alan Pemberton was not interviewed in relation to the alleged crimes reported and significant opportunities were missed to inform the police response.

3.66 We have concluded that positive intervention by Thames Valley Police in response to reported crime in the preceding fourteen months may have altered the course of events. It is not possible to know whether positive intervention ultimately could have prevented the deaths of William and Julia.

- *Domestic Violence Services 2002/2003*

3.67 We have concluded that in 2002/2003, Thames Valley Police's failure to implement HO 19/2000 had significant consequences for the standard of the police response to Julia, William and C19 as victims of domestic violence. Furthermore, Thames Valley Police had an obligation under child protection procedures to identify potential risk with regard to William; there is no evidence that this was ever addressed.

3.68 We learned that members of the Force's senior management team were aware there was no Force-wide domestic violence policy, procedure or training. We consider the failure to develop a policy and disseminate it in a timely way to be significant. This was not remedied until 2004.

3.69 In 2002/2003 Thames Valley Police was a highly devolved force. In the absence of a Force-wide Domestic Violence Policy the service to the victims of domestic violence and their children was left to the interpretation of the Local Police Area. We consider 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.

3.70 In 2002 in West Berkshire the Domestic Violence Coordinator (DVC) had received neither formal training, nor apparently a formal job description and received no specialist supervision in her role. These omissions are symptomatic of the absence of a Domestic Violence Policy and related service framework.

3.71 At that time not unlike other Forces, Thames Valley Police had no formal procedures for risk assessment, risk management and victim safety planning. The DVC undertook an

implicit rather than explicit risk assessment identifying risks with Julia and offering advice and some options for her to consider.

3.72 The focus of the DVC's role was on support to victims, interagency representation and in ensuring follow up on reported domestic violence which had been flagged to her by police officers. We have concluded that within the limitations of her role and in the absence of a Force wide policy, procedure and service framework including training, the DVC used her best endeavours to support Julia.

3.73 Crime investigation was not included with the DVC's responsibilities. In Thames Valley Police this was in the context that frontline police officers and supervisors with such responsibilities were not trained in the identification of or response to domestic violence.

3.74 We have seen evidence that although incidents were reported to Thames Valley Police by Julia and her brother, officers failed to investigate or to arrest and/or interview Alan in September 2002 and April and May 2003. During this period, in our view, there were reasonable grounds to suspect the commission of a number of criminal offences including harassment, and Alan was in breach of an Injunction, non-molestation and occupation order with a Power of arrest granted in September 2002.

3.75 We have identified a disparity between what might reasonably have been expected of the Force's domestic violence services and what was available to Julia Pemberton and her family in West Berkshire at that time.

3.76 We have concluded that the provision of a domestic violence service to Julia Pemberton and her family by Thames Valley Police was flawed because of the lack of a Force wide policy and procedural framework to advise, focus and support police officers engaged in this important work.

- *Internal systems*

3.77 The identification, flagging and response to domestic violence related incidents was the responsibility of call takers and police officers investigating crime; they were operating without a policy framework, procedures or training in the identification of domestic violence.

When the call taker on 20 April saw that a case was flagged on the Command & Control log, he/she needed to be able to identify the potential link between that incident and domestic violence.

3.78 Training was not provided in the use of the system that enabled call takers to access the information on the domestic violence marker and/or cut and paste that into the current log for the attention of officers dealing with an incident.

3.79 The information on domestic violence victims was held by the DVC on individual paper files at Newbury Police station. Police officers based at Pangbourne and Thatcham responding to Julia and her family would not have had access to the DVC paper file.

3.80 We have concluded in relation to the incidents on 20 April and 15 May there were failures in the internal communication technology and systems which resulted in the DVC not being informed of incidents by officers with responsibility for call taking and crime investigation.

3.81 On 18 November although there had been a number of incidents at the house the address was still imprecisely recorded on the Street Index Gazetteer. 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.

- *Emergency response*

3.82 We have concluded that the DVC's advice to Julia in an emergency to dial 999 was the correct advice; however her reference on the flagging application form with regard to the response to silent 999 calls was incorrect as this facility was not available at that time.

3.83 On 18 November it took eleven minutes and repeated questioning of Julia before the call taker was able to identify the correct location of Julia's house.

3.84 The directions to the house were not included with the flagged information; these would only have been available though the information relating to the Sovereign Call centre and would have been immediately available if Julia had activated the alarm.

- *Airwave communication on 18 November*

3.85 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.

3.86 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.

3.87 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.

3.88 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.

- *Firearms Response 18 November*

3.89 At the time that Julia and William were murdered, Operation Saladin was Thames Valley Police's policy for dealing with firearms incidents. The strategic aim in firearms situations was to '*identify, locate and contain and thereby neutralise the threat posed*.' This led to a focus on locating the offender, in this case Alan Pemberton.

3.90 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 Hallowes. It should be noted that during that time the status of Julia and Alan was unknown.

3.91 There were also a number of contributory factors including: 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.

3.92 We have concluded that the length of time taken for the firearms intervention following Julia's 999 call was unacceptable.

3.93 We consider that it is probable that William was killed by his father shortly after Julia dialed 999. From the pathologist's report and information made available to us it would appear that William tried to protect his mother. [24] We have concluded that his life could not have been saved on 18 November.

3.94 We consider that there is less certainty about the exact time of Julia's death on 18 November.

3.95 The time at which officers could reasonably have been expected to attend the scene is therefore of particular significance. Julia made a 999 call at 1911hrs and her last words were recorded at approximately 1925 hrs and 31 seconds (14 minutes and 31 seconds into the call). Alan's voice can be heard on the recording of the call at 1925 and 55 seconds. The sound of Julia's voice was recorded for the last time 15 minutes four seconds into the call: there was no discernable diction. The evidence provided by a neighbour at the Inquest indicated that the last shots were heard at approximately 1940hrs. This information suggests that Alan shot Julia and then himself between 1926hrs and 1940hrs.[25]

3.96 The window of opportunity for police to intervene to prevent Julia's death was therefore between 1911hrs and 1940 hrs. Information subsequently provided to the family by

[24] Post mortem report to Inquest – William Pemberton Dr N.C. Hunt and Preliminary Scene Report 19/11/03

[25] Post mortem report to Inquest - Julia Pemberton 26 November 2003- Dr N.C. Hunt included in his report reference to '*two apparently relatively close range gunshot discharges to her left lower back …associated with extensive disruption of the intra- abdominal viscera including the left kidney, the liver, the aorta and the inferior vena cava*' and he noted '*The injury associated with the disruption of the aorta and inferior vena cava would have itself been a fatal injury and I would not expect this injury to have been amenable to medical intervention even with the most prompt response.*'

Thames Valley Police estimated that, given the changes to the firearms policy and improved communications systems, an armed response to Hermitage would take approximately twenty minutes. Further tactical decisions would then need to be taken before entry to the house was made.

3.97 We have concluded in the context of the firearms policy and communications systems that were in operation in Thames Valley Police in 2003, it would not have been possible for an armed entry to have been made before Alan murdered Julia.

3.98 We have also concluded that on the balance of probability, in the context of the changes to policy and practice that have taken place since 2003, it would be unlikely that an armed response would be able to effect an entry and prevent Julia's death in the time that was available between her 999 call and the time that the last gunshot was heard by a neighbour.

3.99 We were provided with a copy of what we understand to be the Firearms Operational (tactical) Debrief concerning Thames Valley Police's response on 18 November 2003. We have been advised that Thames Valley Police consider that such a debrief was a proportionate response to the management of the incident. We have concluded that, given the range of difficulties encountered during the firearms deployment, the historic engagement with Julia and the tragic outcome, TVP could reasonably have been expected to carry out an overarching review of their relevant policies and practices.

3.100 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. The recommendations of the Highmoor Cross Review included the following:

> *'the policy in relation to spontaneous firearms incidents needs to be replaced. The new policy must provide clear direction and guidance on dynamic risk assessment, to respond to situations where people are believed to be hurt. It should include a presumption that unless there are good reasons for not doing so, the command*

function must take place near the scene. These policies need to be supported by new and better training.'

- *Review of the Pemberton Case*

3.101 We have concluded that Thames Valley Police did not give due consideration to the need for an overarching strategic review in relation to the Pemberton case. Prior to the 18 November 2003, Julia Pemberton, family and friends had sought help from the Force with regard to four domestic violence related incidents and Julia had contact with the Domestic Violence Coordinator on six separate occasions.

3.102 We have concluded that the Pemberton case warranted a review in relation to the potential for organisational learning. In our view the case met the terms specified in the *'Critical Incident Definition/ Standard Operating Procedure - 2003'* which, we have been informed, applied in 2003 and 2004.

3.103 Prior to and after the Inquest, there were a number of meetings when the Force could have elicited information from the family which could have informed an overarching review of Thames Valley Police's engagement. An overarching review was not undertaken. The Thames Valley Police Management Service Review was commissioned in 2006; the Terms of Reference were set by ACC B prior to the confirmation in January 2007 by WBSCP of the Terms of Reference for the Pemberton Domestic Homicide Review. Relevant information regarding the contact between Julia, her family and the Force in the period 2002/3 has come to light in the latter stages of the Pemberton Domestic Homicide Review.

3.104 The panel find the current ACPO Practical Advice on the Management of Critical incidents to be helpful in this regard and the definition developed by the MPS and now adopted as part of the ACPO practice advice provides a meaningful template:

'There are two main facets to Critical Incident Management:

- *Identifying and dealing with incidents where the effectiveness of the police response may have a significant impact on the confidence of the victim, their family or the community;*

- *Taking proactive steps to restore public confidence after a critical incident has been identified.'*[26]

3.105 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 Julia and William.

- *Information provided with regard to the Inquest*

3.106 A primary focus of Thames Valley Police in the aftermath of 18/19 November was the management of the Force presentation at the Inquest in the context of a murder inquiry.

3.107 It is our view that due consideration was not given to the fact that Julia Pemberton, her family and friends had sought help from Thames Valley Police with regard to four incidents and that Julia had contact with the Domestic Violence Coordinator on six occasions in the fourteen months leading up to the murders. This was not reflected in the level of information provided to the Coroner in Thames Valley Police's report dated 3 December 2003.

3.108 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 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.

3.109 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. The Coroner was provided with an edited version of Julia's 999 telephone call on 18 November.

[26] Practical Advice on Critical Incident Management (2007) National Policing Improvement Agency

3.110 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.

3.111 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.

Panel's overall conclusion with regard to Thames Valley Police

The panel have concluded that:

- 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.

- 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.

- On the basis of information we have received concerning the Firearms response on 18 November 2003 the unacceptable delay in responding to Julia's 999 call was in our view a result of technical and practical difficulties encountered on the night and complicated by the over cautious approach of Operation Saladin, the Force Firearms policy.

- On the basis of the extensive information provided to us we consider 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.

- Notwithstanding our conclusions it would be wrong to attribute the deaths of William and Julia to anyone other than Alan Pemberton.

Domestic Violence Services in 2008

3.112 The situation in Thames Valley Police today is very different from that in 2002/2003. The force has a clear domestic violence policy which incorporates Association of Chief Police Officers' guidance and is reviewed yearly and monitored by the force Public Protection Steering Group (PPSG). The PPSG is chaired by an Assistant Chief Constable with the strategic lead for Domestic Violence investigations. The Force's performance group, chaired by the Deputy Chief Constable and attended by all chief officers, sets priorities and actively monitors performance.

3.113 A strategic level multi-agency Domestic Violence group has been developed across the force area and monitoring of domestic violence incidents is audited on the Force CEDAR[27] system. In an audit commission inspection against National Crime Recording Statistics in May 2007 they were graded as 'Good' with a 93% compliance rate. Multi-Agency Risk Assessment Conferences have been established and the Her Majesty's Inspectorate of Constabulary inspection report of 2007 tells us that *'All operational officers have received a briefing on risk identification.'* Tactically, a supervised positive intervention policy is in place and if an arrest is not made, officers must justify the reasons to their Inspector or Sergeant. The duty Sergeant is responsible for monitoring initial scene attendance and investigations by the first responding officers and each Basic Command Unit has a nominated individual to proactively review incidents and check that standards are being met. We are told that staff in the control room have received training and this is supported by the Her Majesty's Inspectorate (HMIC) inspection of 2007 which gives examples of staff responses to crimes that could be indicative of, or related to domestic violence.

[27] Crime Evaluation, Data Analysis and Recording

3.114 We note that *'Critical incidents are managed through a robust gold group system which leads to debriefs and recommendations* (reference HMIC 2007)'.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.

3.115 Thames Valley Police have provided us with access to their response and ongoing actions to address all of the above issues. They also provided us with a comprehensive presentation and gave us access to current practitioners, highlighting the distance they have travelled and the improvements made since the murders in 2003.

Berkshire West Primary Care Trust formerly Newbury and Community Primary Care Trust

3.116 Newbury and Community Primary Care Trust were involved only through the family's GP, an independent contractor to the NHS. Julia was employed as a Health Visitor by the Primary Care Trust. We learnt that there were no opportunities from this relationship to enable the Primary Care Trust to assist Julia or her son.

3.117 In 2002/3 there is limited evidence of strategic leadership by the PCT in relation to domestic violence policy, procedure or practice. Apart from the interagency child protection procedures and distribution of the Department of Health Resource manual there was no specific framework or guidance provided by the Primary Care Trust in relation to domestic violence for health professionals whether contracted or directly managed. The Primary Care Trust was not represented on the Domestic Violence Forum; Julia Pemberton represented health visitors. We have been advised that the agreement of senior PCT managers for health visitor representation on the Forum would have been in the expectation that there would have been ongoing communication with regard to domestic violence.

3.118 There is no evidence that the PCT provided GPs in 2002/3 with specific guidance with regard to domestic violence; as is likely to have been the position elsewhere in 2002/3. In 1996 the Domestic Violence Forum had put together a leaflet which was revised regularly, provided information on services and was widely distributed and available in GP surgeries. The GP told us he had limited experience of domestic violence amongst his patients. We were advised by the Primary Care Trust that the only local training available was that linked with child protection. The GP provided Julia and Alan with considerable support during this period.

3.119 The GP was the Pemberton family's doctor for fifteen years; he and members of his family had personal contact with members of the Pemberton family and he had worked with Julia in her professional capacity as a health visitor. He had ongoing involvement as the family's GP from September 2002 to September 2003, receiving information from Julia and Alan about their respective views and experiences of the breakdown in their marriage. During that period Julia consulted the GP on 11 occasions and between March and July 2003 Alan consulted him on five occasions. The GP was the one professional who had direct contact with both Julia and Alan during this period.

3.120 The GP acknowledged when acting as GP to both parties the potential conflict of interest which might arise. In this case the GP was confronted with a complex set of issues as a result of his various relationships with members of the Pemberton family as outlined in 3.119 above. Our attention has been drawn to guidance issued in 2002 by the Royal College of General Practitioners with regard to domestic violence in families with children. This guidance acknowledges the potential for a conflict of interest; the need for each situation to be considered independently; and for the GP to make an explicit decision about whether to care for both parties. The GP advised us that he had discussed the case with his partners in the practice. There is no record as to whether he discussed with either Julia or Alan their option to transfer to another partner in the practice.

3.121 The GP acknowledged the potential risks for Julia in the situation but relied on the fact that Julia had communicated her concerns to the police, the domestic violence unit and her solicitor. In doing this he acted on the reasonable assumption that the police were responding appropriately to the information provided to them by Julia and that the Injunction she obtained in September 2002 afforded her protection.

3.122 The GP, in his referral letter on 2 May to the private psychiatrist requesting his help in assessing Alan's depression and risk of suicide, noted that Julia had left after more than 20 years of marriage and that both parties were embroiled in divorce proceedings. In the concluding paragraph of the letter the GP stated that he did not feel there was an immediate risk that Alan would harm his wife or himself. In the electronic record of consultations the designation is given as marital disharmony and separation.

3.123 We acknowledge that in line with the requirement to respect Julia's right to confidentiality, he did not provide the psychiatrist with ongoing information when she drew her concerns to his attention with regard to her own and William's safety arising from Alan's threats concerning his own and her life. At the time the General Medical Council Guidance would have permitted the GP to disclose without her consent Julia's concerns to the police in the interest of public safety (if this had not already been done by the patient); but would have prevented the GP in the absence of patient consent, from sharing this with another health professional.[28]

3.124 Following Julia's consultation with the GP on 5 June when she told him of her concerns for her own and her family's safety, the GP on the basis of his assessment did not arrange to see William himself or contact the police or social services (with or without Julia's consent). In Julia's next consultation with the GP on 19 June she advised him that the stress at home was more relaxed and that a panic alarm had been fitted.[29] As in September 2002 the GP responded to Julia on the assumption that Julia's contact with Thames Valley Police meant that they would be dealing with her concerns appropriately.

3.125 This case illustrates the limitations of relying on the assumption that other professionals and agencies are acting appropriately. In the event that the GP had made contact with either of the agencies, it is possible that initial enquiries under Section 47 of the Children Act 1989 may have been initiated. This may also have led to a refocusing by Thames Valley Police of their response to the risks faced by Julia and William; potentially also to the opportunity for William to share his views and feelings with others who were in a position to help and protect him.

[28] Confidentiality: Protecting and Providing Information; General Medical Council 2000
[29] Berkshire Area Child Protection Procedures 2001

Panel's overall conclusions with regard to Berkshire West Primary Care Trust formerly Newbury and Community Primary Care Trust and medical professionals

The panel has concluded that:

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

- In 2002/3 there is limited evidence of Newbury and Community Primary Care Trust providing strategic leadership to support professionals dealing with domestic violence beyond its work in relation to child protection, the distribution of information and support for health visitor representation on the Domestic Violence Forum.

- The GP provided considerable healthcare support to both Julia and Alan Pemberton and took appropriate steps to refer Alan to a psychiatrist for an assessment with regard to his risk of suicide.

- The GP acknowledged the potential conflict arising in a domestic violence situation of continuing as the GP for both Julia and Alan and acted in accordance with the advice available from the Royal College of General Practitioners.

- We acknowledge the issues raised with regard to patient confidentiality, but identify that the issue of information sharing in the assessment and management of evidence based risk is an important area for further consideration by professional organisations.[30]

- The case illustrates the need for ongoing work by professional organisations with regard to issues of confidentiality and information sharing in the context of child protection concerns or risk involving the potential commission of a serious crime.

- The GP took Julia's concerns in September 2002 and June 2003 seriously. It is acknowledged that the GP's assessment of the risk to Julia and William's safety based on

[30] Information sharing; Guidance for practitioners and managers (October 2008) www.everychildmatters.gov.uk/informationsharing

the information she provided then and subsequently on 19 June and 31 July did not result in him arranging to see William nor did he consider it necessary (with or without Julia's consent) to make contact with the police or social services. He relied on Julia's assurance that the police were involved and that they would act appropriately with regard to her concerns and that the stress at home had relaxed.

- This case illustrates the limitations of relying on the assumption that other agencies are acting appropriately. Neither the police nor social services had direct contact with William and he did not have the opportunity to share his views and feelings with them.

- The GP and the private consultant psychiatrist could not have predicted that Alan would murder William or Julia and were not in a position to have prevented the eventual outcome.

Domestic Violence Services in 2008

3.126 We were advised that there is now a strategic lead for domestic violence and that the Director of Clinical Services is responsible for progressing the strategic development and implementation of a Domestic Violence Policy, procedures and practice and training for health professionals. The Director is also responsible for providing the strategic link for health professionals on the three domestic violence forums - West Berkshire, Wokingham and Reading - within the area and on the Multi-Agency Risk Assessment Conferences. The Primary Care Trust is also working with the Thames Valley Partnership to agree a Domestic Violence policy for the whole of the area covered by Thames Valley Police.

West Berkshire Council

3.127 West Berkshire Council had limited involvement with Julia and William Pemberton prior to November 2003; this was through William's school and the Connexions service. Neither William's limited involvement with the Connexions service nor Julia's membership as the health visitor representative on the Domestic Violence Forum provided any opportunity for the council to assist the Pemberton family.

3.128 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. We consider because of the limited contact the family had with council services, this did not have any bearing on the outcome of the Pemberton case. Interagency child protection procedures did provide guidance to staff in relation to children affected by domestic violence.

3.129 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.

3.130 The primary involvement was through William's school. We were unable to ascertain how well informed the school was about William's experiences of the threats made by his father to his mother and his fears for his own safety. 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 enquiries[31] to be made which may have linked information held by the school and GP with that held by the police.

3.131 The school gave priority to Julia's wishes that William should not be made aware of her call. As a consequence William did not have the opportunity to express his own views. The school appears to have been influenced by the fact that Julia had told them the police were

[31] Children Act 1989 Sec 47

involved and that William was continuing to be a high achiever whose behaviour was not showing outward signs of the impact the situation at home was having on his ability to cope. However we agree with the views expressed by the current West Berkshire Children's services that the school should have notified the police or social services.

3.132 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.

Panel's overall conclusion with regard to West Berkshire Council

The panel has concluded that

- 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.

- 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.

- 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.

- The school acting as a single agency could not have predicted or prevented the eventual outcome.

- 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.

Domestic Violence Services in 2008

3.133 During the review we interviewed key staff concerned with domestic violence and were provided with a substantial body of evidence to demonstrate that the council was addressing domestic violence through the Safer Communities Partnership. Domestic Violence was agreed as a continuing priority for the Community Safety Strategy and targets associated with domestic violence had been included as one of the council's first Local Public Service Agreements (LPSA). As a result of the LPSA the council has recently been able to appoint a part-time Domestic Violence Reduction Coordinator to focus on the implementation of the Domestic Abuse Forum's action plan.

3.134 Revised Child Protection Policies and Procedures are in place across the six Berkshire Local Safeguarding Children Boards which strengthen the guidance to staff on domestic violence. The council is also working with the Thames Valley Partnership to agree a domestic violence policy for the whole of the area covered by Thames Valley Police.

3.135 The Joint Area Review of Children's services 2007[32] made favourable comment about the provision of services through the domestic violence forum to support children affected by Domestic Violence.

<u>Learning for the future – 2008 onwards</u>

3.136 In the following section we have drawn together the key themes which we have identified during the review and which we consider need to inform future service development:

[32] The Joint Area Review (JAR) is part of the integrated inspections of Children Services carried out at a local authority area level

Victims and their families

- Victims, their children, family and friends should be encouraged to report all concerns with regard to safety to police/other agencies and the information should be recorded (covered by guidance and advice facility on National Domestic Violence Helpline).

- Children and young people should be given opportunities to have their experience heard directly and to contribute to the assessment of risk.

For HM Government and all agencies and professionals

- Whilst both public and professionals are often told that the Data Protection Act does not inhibit agencies from sharing information it does not positively encourage or require it, nor, critically does it explicitly offer protection to those charged with making the judgments about sharing sensitive personnel data in cases of suspected risk. Any system for sharing information must also acknowledge the potential implications and consequences with regard to both the victim of domestic violence as well as for the people providing support.

- If we are to develop a multi-agency system with the confidence to share information, the current situation is not tenable. Attempts to deal with this matter by better training and clarification have not worked and it is therefore our opinion that the government needs to amend the DPA to reflect a positive duty to share information in cases where a potential threat or risk is exposed. In this regard, we acknowledge and support the current work being carried out by the ACPO Domestic Violence working group which recognizes that *'Any prevention-based risk management strategy should have as a core requirement, effective information sharing within and between agencies.'* (ACPO lead Domestic Violence strategy paper 2008).

For all agencies and professionals

- Agencies and individual professionals need to develop their understanding about the emotional and psychological affect on victims and their children of living with a partner

who has been coercively controlling; especially the kind of support they may need in relation to ongoing contact after the relationship has ended. This needs to be supported by awareness raising, to help family and friends better understand the dynamics of such coercive relationships.

- Professionals and front line staff need to make the link between domestic violence and child protection in order to safeguard children and young people (see respective national and local guidance which makes clear connections).

- All agencies need to contribute to developing and implementing an integrated local strategy for domestic violence.

- All agencies (including police, criminal justice and civil justice agencies and health and social care agencies) should work together towards agreeing a single multi-agency framework for identifying, assessing and managing risk in domestic violence cases. This should build on learning nationally from Multi- Agency Risk Assessment Conferences (MARACs) and other single and multi-agency initiatives relating to domestic violence.

This multi-agency framework for the identification, assessment and management of risk should not be based purely on information from one source or agency or on the circumstances at one particular stage of a case. The framework and process should be based on a shared understanding of domestic violence and risk, should recognise the dynamic nature of risk in domestic abuse cases and the need to base decisions on information from a range of sources.

For the police service

Chief Constables have an extensive range of responsibilities to discharge and it is appropriate that they will devolve responsibility for the development of key force policies to individual members of their Chief Officer team. Demonstrable leadership and direction is critically important and individuals must accept the responsibility of their role and rank. Chief Officer training and development programmes should highlight the importance of policy development and create opportunities for senior officers in training environments to review cases and consider links between policy and practice. The ACPO Practice advice on Critical Incident Management highlights that – '*Ineffective and/or inconsistent implementation of force*

protocols, policies and procedures have been identified as one of the main reasons why critical incidents develop.'

- It should ensure that Chief Officers evidence their knowledge of key policies and critical incident management relevant to domestic abuse. Ensuring that they understand and can articulate the implications poor management holds for the service and the damage it can do to public confidence. This should be supported and linked to experiential training in realistic practical scenarios.

- Senior Officers review/performance development programmes should audit their engagement in developing, delivering or reviewing key service policies and evidence their 'grip' on the initiatives devolved to them.

- Chief Officers should routinely demonstrate their values and the ethos of a service configured to protect the vulnerable by frequently engaging with those charged with delivering the practical implications of the policy developed under their leadership. This should include briefing key junior front line staff on their commitment to delivering meaningful policy on their behalf. Such engagements should enable front line officers to test and question their leadership team. Such an approach would ensure that the needs of practitioners and the communities they engage are not lost on those responsible for leading.

- In local Domestic Violence Fora the Chief Officer responsible for the policy should attend a set number of meetings (twice yearly) to allow the forum to test their understanding and delivery of leadership in such areas.

- The provision of a police response to the victims of domestic violence needs to be embedded in a framework based on a force–wide policy, procedures and training for all officers and staff.

- Domestic Violence Incidents should be attended to as a priority (now covered in Guidance 2004 and 2008).

- Threats in cases of domestic violence should be investigated (now covered in guidance).

- Record Domestic Violence incidents/crimes and flag systems (now covered in guidance and will be part of Police national database functions).

- Threats to kill/suicide should always be viewed as high risk (covered in guidance and work being carried out on single assessment model by ACPO lead on domestic violence).

- Update victims of crime appropriately (Code of Practice).

- Investigation should be reviewed at every stage and linked to risk assessment.

- Firearms debriefs related to complex scenarios, and all firearms incidents involving police deployments resulting in death, should be centrally maintained so that best practice can be captured and debriefs measured against a calibrated system - a potential role for the National Police Improvement Agency (NPIA).

- Recognition that where there are children and young people involved separate consideration must be given to their needs in line with Local Safeguarding Children Board procedures.

For PCT and health professionals

- PCTs as commissioners of health care services have the opportunity through their contractual arrangements e.g. with GPs, to include requirements with regard to domestic violence.

- PCTs as commissioners of health care services need to be engaged in their local areas in the development of multi-agency strategies, to reduce the harm caused by domestic violence to the health of victims and participate appropriately in relevant multi-agency fora for this purpose.

- As a primary health care service available to everyone, general practitioners are in a key position to provide support and access to help for victims of domestic abuse and their children. This role may cause problems in maintaining objectivity as GPs may be privy to information not available to other parties in complex cases and should in accordance with their professional guidance report, child protection concerns and information regarding risk involving the potential commission of a serious crime to all relevant agencies.

- Training is required for general practitioners and health professionals with regard to domestic abuse; to include the emotional and psychological implications for victims and their children both during and after leaving an abusive relationship and in managing ongoing relationships.

- Training provided for GPs and other health professionals about domestic abuse should identify risk indicators associated with the perpetrator's behaviour e.g. threatening suicide.

- GPs and health professionals in contact with victims and perpetrators should in accordance with their professional guidance report child protection concerns and information regarding risk involving the potential commission of a serious crime to police/other agencies and these should be recorded (covered by guidance and advice facility on National Domestic Violence Helpline).

For councils

- Should provide leadership in the local community with regard to the response to domestic violence.

- Should ensure that it has relevant policies, procedures and practice guidance with regard to domestic violence which cover all council services.

- In line with the Children Act 2004 should support local agencies, including health and schools to identify at the earliest opportunity the needs of children and young people as a consequence of domestic violence.

- Local Safeguarding Children Boards need to ensure policy, procedures and practice guidance in relation to domestic violence recognize the many different forms that domestic violence can take.

- Local Safeguarding Children Boards need to ensure that when a child or young person dies or is seriously injured in the context of domestic violence, proper consideration is given to the requirement for a Serious Case Review.

Recommendations

3.137 We have analysed the events of the Pemberton case and the actions of the responsible agencies, and our conclusions have been set out above. On the basis of our analysis and conclusions, we make the following a) recommendations about this case and its handling and b) about domestic violence reviews generally:

a) Recommendations in relation to the Pemberton case:

R1 It is recommended that agencies acknowledge the difficulties facing victims, their families and friends through the provision of support and guidance for them and for the wider community, including faith leaders, to help them understand the most effective ways to help victims of domestic abuse.

R2 It is recommended that agencies provide information to the public about the appropriate action to take if a fear is held about an individual. They should be encouraged to report such fears; the police can only positively intervene or develop a risk management plan when they have the information to inform it.

R3 It is recommended that agencies recognise the importance of leadership from senior staff in relation to the development of policy and strategy, giving direction to and control of standards in the delivery of front line services to the victims of domestic violence and their families and ensure that they have relevant strategy, policy and services in place.

R4 It is recommended that local councils recognise the need to exercise their strategic role as community leaders in relation to domestic violence

R5 Each agency should ensure that it contributes positively to the development of multi agency strategy, services and practice.

R6 It is recommended that agencies ensure that their representatives on the Crime and Disorder Partnership, Domestic Violence Forum and MARACs are experienced and at an appropriate level of seniority within each agency and are allocated the required amount of time to make an effective contribution.

R7 It is recommended that agencies better recognise the need to monitor and appropriately challenge, through the Crime and Disorder Partnership and the Domestic Violence Forum, the performance of constituent agencies in relation to the level of service provided to victims of domestic violence and their families.

R8 It is recommended that the Local Safeguarding Children Board and partner agencies for child protection ensure that staff fully recognise the many forms domestic violence can take, the impact of domestic violence on parenting and the need to ensure that children and young people are given the opportunity to have their own voice heard.

R9 It is recommended that when training professionals in relation to both domestic violence as well as child protection staff, are reminded of the importance of not assuming that other professionals are aware and taking appropriate action.

R10 It is recommended that agencies should undertake an internal management review immediately following a domestic violence homicide so that learning can inform changes to policy and practice at the earliest opportunity; in the event of the death or serious injury of a child, evidenced consideration must be given to the requirement for a Serious Case Review.

R11 It is recommended that Primary Care Trusts through their contractual arrangements with GPs recognise the important role of GPs in relation to victims of domestic abuse and their families and that appropriate training, guidance and support is provided by commissioners and professional bodies, to include identifying the risk indicators associated with perpetrator behaviour.

R12 It is recommended that all agencies and professionals (including police, criminal justice and civil justice agencies and health, including general practitioners and social care agencies) work together to agree a single multi-agency framework for identifying, assessing and managing risk in domestic abuse cases. This should build on learning nationally from MARACs and other single and multi-agency initiatives relating to domestic abuse.

This multi-agency framework for the identification, assessment and management of risk should not be based purely on information from one source or agency or on the circumstances at one particular stage of a case. The framework and process should be based on a shared

understanding of domestic abuse and risk, should recognise the dynamic nature of risk in domestic abuse cases and the need to base decisions on information from a range of sources. Any system for sharing information must also acknowledge the potential implications and consequences with regard to both the victim of domestic violence as well as for the people providing support.

From a police perspective we suggest that recommendation R12 is adopted under the current work being carried out by the ACPO Domestic Violence working group with regard to information sharing in the context of developing a multi-agency domestic violence system.

R13 It is recommended that domestic violence training is made available to criminal justice and civil justice agencies to ensure their full understanding with regard to domestic violence cases coming to their attention.

b) Recommendations in relation to Domestic Homicide Reviews:

3.138 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[33] rather than a template for future Domestic Homicide Reviews. This is due to the length of time, almost five years since the tragedies and the circumstances surrounding the setting up of the review including the Judicial Review by Lord Justice Moses.[34]

3.139 We consider, however, there are a number of learning points that could be usefully applied in the conduct of domestic homicide reviews, and we make the following recommendations:

R14 It is recommended that section 9 of the Domestic Violence, Crime and Victims Act 2004 is enacted.

[33] *Guidance for Domestic Homicide Reviews under the Domestic Violence, Crime and Victims Act 2004.* Home Office Consultation Document June 2006.
[34] See chapter 12

R15 It is recommended that in the event of the death or serious injury of a child due consideration must be given to the requirement for a Serious Case Review.

R16 It is recommended that agencies need to undertake an internal management review as soon as is sensibly possible following a domestic homicide, so that learning can inform changes to policy and practice at the earliest opportunity.

R17 It is recommended in all cases a Chief Officer/Directorate level staff member from outside the force or agency is involved to ensure appropriate examination and consideration of leadership issues.

R18 It is recommended that such reviews should operate on the presumption that they can access all personnel and issues relevant to the incident or identify and capture them as soon as appropriate given regard to other investigations. Such matters should be explicitly addressed in the commissioning terms of reference.

R19 It is recommended that, given the potentially important contribution of family and friends to the review process, the nature and scope of family involvement needs to be clearly established at the earliest opportunity and at all stages of the process.

R20 It is recommended that the methodology for internal management reviews needs to address matters relating to staff welfare, potential discipline and subsequent civil proceedings.

R21 It is recommended that the term 'light touch' should not be used as a description of an approach in the context of domestic homicide reviews.

R22 It is recommended that the issue of resourcing for the review process (internal and external) needs to be fully considered.

R23 It is recommended that an appropriate degree of independence and challenge needs to be incorporated into the review process.

R24 It is recommended that legal advice should be made available to reviews both internal and external.

4. Methodology

4.1 This review has been undertaken in private. With the exception of Julia, William and Alan, we have not used names but initials which are anonymous; we have used job title and in some cases an initial which is anonymous for staff. The review comprised:

- Thirty six formal interviews (appendix G) including members and friends of the family and the family's solicitor; staff from the three agencies; individual professionals and three expert witnesses regarding domestic violence.

- a thorough examination of all available relevant documentation including that provided by the family and friends; the family's solicitor; the agencies; individual professionals, expert witnesses; and the Treasury Solicitor (appendix G for reference source of information).

4.2 We requested Internal Management Reviews from Thames Valley Police, Berkshire West PCT and West Berkshire Council. Following examination of the internal management reviews and additional information submitted from each of the agencies, interviews with staff and individual professionals were undertaken as necessary to address the requirements of our Terms of Reference.

4.3 Our views and conclusions are based on findings from both documentary evidence and interview testimony and have been formed to the best of our knowledge and belief. We have sought the expert advice of an experienced general practitioner and former medical director of a PCT and of a consultant psychiatrist, the medical director of a mental health teaching NHS trust.

4.4 The review has used the following definition of domestic violence:

> *'Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality'*[35]

[35] Guidance for Domestic Homicide Reviews under the domestic violence, Crime and victims Act 2004: Home Office June 2006

We refer in the report to domestic violence covering all these behaviours. We regard the terms domestic violence and domestic abuse as interchangeable but recognise that there are some situations where one or other may be more relevant or appropriate.

4.5 The review has been concerned with events that happened more than four years before it commenced and we recognise that a number of local and national initiatives have now been put in place to address many of the lessons that the we have identified.

4.6 We have attempted to view the case and its circumstances as it would have been seen by the individuals at the time. It would be foolhardy not to recognise that a review of this type will undoubtedly lend itself to the application of hindsight and also that looking back to learn lessons often benefits from that very practice. We have, however, made every effort to avoid such an approach where possible.

4.7 A significant amount of the information concerning the events which took place between September 2002 and November 2003 was obtained from contemporary sources; including Julia's diary and Affidavit, Alan's Affidavit and telephone records from their home at Old Hallowes. Contemporary records provided by TVP and the medical practitioners were a valuable source of material. We were able to triangulate information from written and oral testimony.

4.8 We drew up a draft chronology based on this information and this was shared in confidence with members of Julia's family and close friends who had contributed information; the family solicitor; the chair of Thames Valley Police Authority; the Chief Constable of TVP, the lead officer for Berkshire West PCT internal management review and the lead officer for West Berkshire Council. This was to enable all parties to provide amendments and/or additional factual information.

4.9 Chapters 6 to 11 each cover a specific period of time and include a brief summary of events and incidents. Under the heading analysis of agency intervention we have considered the way in which agencies or individual professionals responded to Julia, William and Alan Pemberton in the context of the services for victims of domestic violence, their children and families might have expected to receive in 2002/2003.

4.10 Included in appendices A and B is information about the national policy and legislation available with regard to Domestic Violence and the delivery of services in local communities in 2002 – 2003. This information was compiled prior to the review and before circumstances relating to the case were known. In essence this reflects the information contained in the Home Office circular of 19/2000.

4.11 We have included relevant extracts from the individual internal management reviews together with comments on how far we consider they offer an accurate evaluation of the individual agency's intervention.

4.12 At the end of each chapter we have drawn overall conclusions about the response of agencies and medical practitioners to Julia, William and their family and also to Alan Pemberton in order identify learning for the future.

4.13 In chapter 12 - Aftermath - we have considered the response of agencies following the deaths of Julia, William and Alan on 18/19 November 2003; including their response to requests for information by Julia's family.

4.14 In chapter 13 - conclusions 2002-2005 - we have drawn together the key conclusions from our review of the involvement of agencies and professionals in the period 2002- 2005. We have also reflected on the provision of Domestic Violence Services in West Berkshire in 2008 and identified the overarching themes that we consider need to inform future service development and provision from the Review.

4.15 We recognise that there have been significant developments in local and national policy as well as local services in relation to domestic violence and abuse which have led to changes and improvements in the provision of the services to victims, their children and families beyond those that existed in 2002/2003. The recommendations we have identified are intended to help services build on those developments.

5. Background prior to September 2002

5.1 The information included in this section was provided by Julia's family and friends.

5.2 Julia was born on 17 January 1956 and Alan on 20 January 1955. They met whilst Alan was at university and Julia was at teacher training college in Southampton and they were married on 26 July 1980.

5.3 In September 2002 their children, C19 and William, were aged 18 and 15. William was born on 13 October 1986. All the evidence made available to us portrays them as two highly successful and talented children. William has been described as a loving son, a popular young man, academically able, a fine sportsman and a talented musician.

5.4 It is apparent from the information that we have received from members of the family and their friends, that Julia and Alan Pemberton and their two children were ostensibly the 'perfect family'. In 1997 Julia, Alan, C19 and William moved into an old house with four acres of land on Slanting Hill, a road in the village of Hermitage, near Newbury, West Berkshire. Over two years they built a large multi-storey detached house which they named 'Old Hallowes'; the house was staggered over six levels on a steep slope backing on to woodland.

5.5 Julia has been described to us as kind, loving and attentive, held in high regard by her family, friends and colleagues. She was employed as a part- time health visitor by Newbury and Community PCT and was the health visitor representative on the local Domestic Violence Forum. Julia contributed in 2001 to a leaflet on domestic violence for primary care staff.

5.6 Alan has been described[36] as a father who loved his children and demonstrated his affection for them by investing time and money in their education and interests. He was a chartered accountant, a successful businessman and managing director of a financial management company.

[36] C4, C5,and C8 Information to PDHR

5.7 We were told that in the summer of 2002 Julia had described to members of her family and a close friend, for the first time, how unhappy her marriage had been and that Alan's behaviour was unpredictable, demanding and controlling.[37] Julia had hoped to hold their marriage together until William reached eighteen. She had tried to leave previously[38] but Alan's behaviour would fluctuate between threatening and contrite; if he could not have her nobody else would. Julia told them that she believed that meant Alan would kill her, particularly as he had made death threats before.

5.8 On 18 July 2002 Julia found a breast lump which she learnt on 24 July was cancer. On 1 August she had a mastectomy.

5.9 Julia described in her Affidavit[39] that a few days after her return from hospital Alan had become '*very cold*' and had not spoken to her for seventeen days. She said that on 29 August when she had returned home from visiting a close friend, [40] Alan had been angry with her and accused her of ignoring him; he had shouted and screamed at her in a very threatening manner. Alan had then become very upset, crying and wanting to know where he stood and Julia told him that she wanted time to think.

5.10 On 30 August while Alan was away with William and C19 for a few days with family friends Julia told her brother[41] (C5) that she had decided to seek a separation and how frightened she was about Alan's likely reaction.

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[37] *'Coercive control is a model of abuse that attempts to encompass the range of strategies employed to dominate individual women in personal life.'* Coercive Control: How men entrap women in personal life– Evan Stark: Oxford University Press 2007

[38] In her Affidavit 17/9/02 Julia refers to such an incident when her children were aged 7 and 5; C5 information to PDHR

[39] Affidavit JP 17/09/02 and letter from C13 to PDHR

[40] Affidavit JP 17/09/02

[41] C5 information to PDHR

6. September 1 – 30, 2002

Summary of events

3 September

On his return home from holiday Julia told Alan her feelings and that their marriage was over; in her subsequent Affidavit[42] Julia stated that Alan had been tearful, had begged forgiveness and admitted that he was *'evil'*. Julia told him that it was too late; they talked in a rational way about a separation.

Over the next few days Alan told C8 that Julia wanted a separation and admitted to another friend that he knew that whilst he had been a good father that he had been a 'terrible' husband and wanted a chance to rectify this.[43]

From 4 to 10 September

Julia described how Alan had been '*very civilised*'.[44]

7 September

Alan reported to the police that a mountain bike had been stolen and on 9 September two officers made a visit to Old Hallowes.[45]

11 September

According to Julia's Affidavit Alan's behaviour became more and more aggressive. He told Julia that he did not want the relationship to end and that she could not walk out.[46] She had been very scared by his verbally aggressive behaviour. Alan had kept a record of what she had said on reams of paper in his study. Julia asked him to remove remarks he had written on a

[42] Affidavit JP 17/09/02 - application in relation to non- molestation and occupation orders
[43] C8 information to PDHR
[44] JP Affidavit 17/09/02
[45] Information to PDHR from TVP
[46] JP Affidavit 17/09/02

whiteboard in the study because they might alarm William and C19, they included references to '*she says she hates me'* and '*Alan is* evil'.[47] He had also left on his desk a piece of paper on which he had written '*911'*.

12 September

Julia described in her Affidavit how Alan had acted as if nothing was wrong.[48]

13 September

Julia stated in her Affidavit that on the night of 13 September before going on a business trip to Spain Alan had presented her with an ultimatum. He had told her she was to give them a chance to live as man and wife for a specified time, at the end of which he would decide if it was working or not, or:

> '*This is fact. I will take my life. I will take your life. You are not going to mess up my life. You can't do this to me.'*

Julia stated that she had shouted out: *'I can't believe that you are threatening to murder me'* and had asked Alan how C19 and William would cope. Alan replied, *'They'll survive.'* [49]

When Alan briefly left Old Hallowes Julia had tried without success to contact her brother (C5). Julia described how terrified she was she might die that night; she had gone to the separate bedroom she had occupied since her mastectomy.

Subsequently Alan admitted [50] he had decided the night before what he was going to say to Julia and the threat to kill her had not been said in the heat of the moment.

[47] JP Affidavit 17/09/02
[48] JP Affidavit 17/09/02
[49] JP Affidavit 17/09/02
[50] Written information to PDHR from C11

14 September – Julia's first contact with TVP (C&C log)

At about 6.30am[51] Julia had drifted off to sleep and woken up to find Alan stroking her face – Julia stated in her Affidavit that she had thought that he was going to strangle her.[52] Pretending at first to be asleep she had then made out that she needed to go to the toilet and left the room.

When Alan left the house telling her that he loved her, she was not sure whether he was in fact going to Spain or that he would return to kill her.[53]

Alan had left a card on her pillow, messages on the whiteboard in the study and both their wills on the desk with instructions for the children in the event of his own or Julia's death.[54]

Julia telephoned C3 one of her sisters and described how frightened she had been by Alan's threat to kill her. Julia also telephoned her brother (C5) in great distress; she described Alan's manner as cold, unemotional and chilling and that she was in no doubt that he would kill her.[55] C5 drove immediately to Old Hallowes. Julia told him that while Alan had been so close she had been petrified and unable to call for help or to leave the house as only C19 was with her and she felt William would be vulnerable.

Julia also telephoned her friend C12 who described how she was incoherent and paralysed with fear; C12 drove down immediately to the house from London.[56]

At 1644hrs[57] C5 telephoned the police and reported that Alan had threatened to kill Julia who was petrified; he feared for the safety of his sister. He said William and C19 were also at the house frightened by what Alan had said to Julia.

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[51] JP Affidavit 17/09/02
[52] During the review it was suggested to the panel that Alan attempted to strangle Julia; and the panel have received conflicting evidence from different people about how Julia described the incident. However in her Affidavit Julia stated that she thought that he was going to strangle her.
[53] JP Affidavit 17/09/02
[54] JP Affidavit 17/09/02
[55] Information from C3 & C4, C5, Statement (1) C5 to PDHR
[56] Information from C12 to PDHR
[57] TVP C&C log: URN 1364 for information regarding calls to TVP made on 14/09/02 & 15/09/02; URN is the Unique Reference Number given to a 'call for service' that is logged on the Thames Valley Command and Control (C & C) system. Command and Control log is a computerised call- logging and

C5 asked the police to visit Old Hallowes[58] and to 'triangulate' Alan's mobile phone because the family were uncertain of his whereabouts.[59]

At 1701hrs C5 stressed that his sister had managed to find the courage to report this to the police and action should be taken.[60]

At 1732hrs C5 was advised that the circumstances at this time were unlikely to justify an attempt to locate Alan by means of auto-triangulation of his mobile phone. It was noted in the Command and Control log (C&C log) for URN 1364 that Julia was undecided as to whether she wished to make a complaint; at 1741hrs Julia and her brother are recorded as wanting to be seen about domestic violence and that C5 had found two air rifles. At 2029 hours he called the police station again to check that however late, a visit would be made.

At 2326hrs, Sgt A telephoned to apologise for the delay and explained that the day shift would visit on the Sunday morning; if this was not possible before 1600hrs he said he would attend personally.

During the weekend Julia, William, C19 and C5 had slept in the same room; at one point C5 and William slept in the hall behind the front door in case Alan returned to prevent him from gaining entry to the house.[61]

15 September – Julia's second contact with TVP (C&C log)

At 0915hrs on the Sunday morning the commitment to respond to Julia's request for help was deferred by officers to 1600hrs when Sgt A was due to come on duty.

At 1646hrs it was recorded on the C&C log that Sgt A had been unable to attend because of other commitments and he advised Julia's brother C5 at 1658hrs. C5 was recorded as having

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tasking system used by Thames Valley Police to manage calls for service. Each commitment is logged as an incident.

[58] C5 statement (1)to PDHR

[59] TVP information to PDHR '*this was not possible as TVP could not meet the RIPA threshold*'

[60] Information from TVP C&C log

[61] C5, C12 & C16 information and C5 Statement(1) to PDHR

asked for police to visit before 2200hrs and failing that he had said Julia would phone on Monday after she had seen a solicitor about an injunction.

At 1755hrs Julia and C5 called the police again wanting to see a police officer to make a statement; C5 was adamant about pressing charges as his sister had received text messages from Alan that evening, and that C5 believed Alan might be coming to the house that evening. The police gave advice about calling 999 if Alan turned up.

At 1920hrs it was recorded that the local beat officer was committed that evening taking other statements.

At 1929hrs, Sgt A was recorded as having spoken to Julia who had said that at no time had she been assaulted; she had decided to leave her husband who was away until 19 September; on the 16 September she would be seeking solicitor's advice about an injunction and was fine with that arrangement.

Sgt A advised C5 that he could not make allegations on behalf of his sister and that reports had to come from Julia. Sgt A noted on the log that although C5 might contact police again that evening '*incidents do not need to be dealt with fast time.*'[62] Sgt A also asked for the URN to be flagged for the Domestic Violence Unit (DVU).

At 2147hrs C5 spoke to a Police Enquiry Centre (PEC) Operator and challenged what had been recorded at 1929hrs by Sgt A concerning his conversation with Julia. The same PEC operator spoke to Julia who was insistent on seeing an officer and stated that Sgt A's comments about her previous conversation with him (see detail above at 1929hrs) were incorrect.[63] C5 came back on the phone and confirmed with the PEC Operator that he was expecting police to attend by 2200hrs.

At 2154hrs it was recorded on the C & C log that in a conversation with Sgt A, Julia changed her mind again about police attendance and she would contact the DVU on her return from the solicitor the following day. C5 was recorded as complaining about the lack of police assistance and requested attendance so that they would know the location of Old Hallowes;

[62] TVP C&C log
[63] TVP C&C log

he was told about the police knowledge of the area. At 2156hrs it was recorded that C5 and Julia said they were *'leaving it'* and that they would contact the DVU in the morning.

16 September – Julia's third contact with TVP; her first meeting with the Domestic Violence Coordinator (DVC records)

On Monday 16 September, Julia and C5 met with the Domestic Violence Coordinator (DVC) at Newbury Police Station. The DVC opened a domestic violence file and noted *'Years of abuse. Told of end of marriage. A threatened to kill J.'*[64] The DVC recorded on the Advice Form using a check list that she had discussed a number of options with Julia; changing her telephone number; incoming caller ID barring; solicitors including injunctions and advice concerning possessions, housing, financial matters and children; support via Berkshire Women's Aid and victim support; a community alarm; notification in an emergency; flagging the address; moving house; counselling; visiting her GP; criminal proceedings and positive intervention in the event that police were called to Old Hallowes. On the checklist the DVC noted *'none'* against the item '*Injuries'* and that Julia declined support from Berkshire Women's Aid and the installation of a community alarm.[65]

The DVC advised Julia to call 999 if she was at all in fear. [66]

The DVC arranged an urgent appointment for Julia with a local law firm and provided a written report to the solicitor '*to quantify getting a power of arrest on an injunction.'*[67] She wrote:

> *'Alan's mood swings said to last a few days- sometimes as much as 10 days. Julia has said the only way she can bring these mood swings to an end is to offer herself to him. She has also said that on several occasions she has not been a willing sexual-partner with him…, I feel it is sexual abuse. This in itself is I feel akin to violence towards an individual.'*[68]

[64] TVP DVC file
[65] DVC Witness Statement to Inquest 02/03/04
[66] DVC Witness Statement to Inquest 02/03/04
[67] TVP DVC Witness Statement to Inquest 02/03/04
[68] TVP DVC report to solicitor 16/09/02

In the letter the DVC also referred to Alan's threat to kill Julia:

> *'In all my experience as a DVC I have not come across such a cruel act. As a result of our conversation I have 'flagged' Julia's address, to the effect that any incidents from or to the house are to be treated urgently. This does not happen to every person I talk to. I have done this as I believe the perceived threat level to Julia has escalated.'*

On the flagging application[69] the DVC noted that there were threats to kill the occupant, Julia Pemberton by her husband Alan; there were two children aged 18 and 15 also at the address; Julia had suffered years of emotional, financial and sexual abuse; the perceived level of threat had escalated during the previous ten days and that after Julia had told Alan that the marriage was finished, he had said he would kill her and then himself. The DVC also noted that *'Any calls even silent 999 calls to be treated as urgent. Perceived threat level to victim very high. Positive intervention required.'*

At 1213hrs URN 1364 for the 13 and 14 September, was closed after Julia's meeting with the DVC at Newbury Police station.

URN 871 was created by the DVC as an interim flagging system and was closed at 1526hrs. [70]

Julia met with a solicitor to complete an affidavit in relation to an application for a non-molestation and occupation order.[71] In her Affidavit she described the events of the 13 September and the problems in her marriage; the trigger for Alan's outbursts had been if she refused sexual intercourse when Alan would *'turn into a state of cold seething anger. He would then move into the spare room.'* She stated that he would take her credit cards away which left her in a position where she was unable to buy food or petrol *'I was completely at his mercy.'* The situation would only be resolved when Julia said sorry, begged forgiveness and resumed sexual relations. In relation to Alan's threat to kill her she stated that:

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[69] TVP C&C SIG Flagging Application 16/09/02
[70] TVP Information to PDHR this was to address the delay in obtaining a full SIG flag attached to a location and would be available to any operator (using the correct code) should an incident occur at the address
[71] JP Affidavit 17/09/02

'I believe he has the potential to kill me. He has said that if ever I try to leave him he will kill me. He is ruthless and vengeful in business and always has to win at any cost. Nobody can cross him.'

On her return from seeing the solicitor Julia collected William from a friend's house and was described as very distraught saying Alan was trying to kill her.[72]

Later at 2109hrs,[73] C5 contacted the police from a telephone call box to report a suspicious Ford Mondeo near to Old Hallowes. The police completed an unsuccessful area search and made one call to C5. In the URN it was noted *'unfortunately wrong number called back.'*[74] At 2305hrs not having heard from the police, C5 called back and said he would check the area himself and call 999 if he saw anything.

17 September – Julia's first consultation with the GP

Julia consulted the GP, for the first time since Alan's threat to kill her.

'Husband has given her two choices; either to live together for undetermined length trial and 'he' will decide if marriage viable or he will kill both himself and her. Police, domestic violence unit and solicitor all involved. He was initially distressed and tearful. Has kept notes of all conversations and white board in study with jottings all family can read. Never any physical violence. But long standing verbal abuse/posturing, has taken credit cards in past, recently moved money around. Similar situation 12 years ago. JP attributes weight loss to grieving for her brother's death and domestic situation-denies depression. See again in 1-2 weeks.'[75]

Julia told the GP that Alan had kept a gun at the house and the GP checked with her that it had been removed.[76]

[72] Letter to PDHR from C10
[73] TVP C&C log URN 1544:16/09/02; C5 information to PDHR
[74] Information from TVP to PDHR is that it is not clear what number was called.
[75] Berkshire West PCT Internal Management Report
[76] Berkshire West PCT Internal Management Report

Julia was successful in her application at Reading County Court for an emergency Injunction, non-molestation and occupation order with a Power of Arrest.

The items handed in at Newbury Police Station by C5 were recorded on TVP's Crime Property Register including an air rifle, an air pistol, a dagger, two kitchen knives and a meat cleaver.[77]

18 September

Julia told C8 (a mutual family friend) and his family about Alan's threat and the Injunction. Julia asked C8 if he would provide support to Alan, as when he returned from Spain he was to be served with the Injunction.[78] Julia, William and C19 went to stay with her sister and brother-in-law C3 and C4 in Dorset while this was going on.[79]

19 September

Alan returned from the golfing holiday/business trip in Spain.

20 September

0230hrs when Alan arrived at Old Hallowes he was served with the injunction and spent the rest of the night at a hotel with C8.[80] C5 also spent some hours with Alan at the hotel during the day as C8 had to go to a business appointment.

In the evening, Alan did not meet up as arranged with C8 and was not answering his mobile phone. C5 had called Alan's business partner as C19 and William were concerned that Alan might commit suicide.[81]

[77] Thames Valley Police Crime Property Register 17/09/02
[78] Information from C8 to PDHR
[79] Information from C3 and C4 to PDHR
[80] C5 and C8 information to PDHR
[81] Information from C5 to PDHR

2328hrs C8 called in at Newbury Police station and reported he was

> '*concerned for the welfare of his friend Alan Pemberton who was supposed to meet him tonight Alan had an injunction served on him last night to stay from his wife and children and home and did not take the news well.*'[82]

21 September

1034hrs C8 telephoned Newbury Police Station to say he had still not heard from Alan and was becoming increasingly concerned; he had been in contact with the phone company for Alan's mobile who had said they were unable to give details of the location as it had been ringing with no answer; they had told C8 to contact the police.

C8 gave a description of Alan and explained it was very unlike him and believed he was going through a stressful situation; there were problems between Alan and his wife and his state of mind at the time was possibly total confusion. C8 had last seen Alan at 1745hrs on 20 September. C8 said that he was very worried as were all Alan's family and friends to whom he had spoken and who also had not heard or seen anything of him.

It is recorded on the log that C8 called Newbury Police station at 1224hrs and reported that Alan was still missing and that he was becoming increasingly worried. He said that Julia was ill and was staying in Dorset; that Alan had planned to meet his daughter half way to Dorset but that too had not happened. Alan's daughter had been trying to contact Alan by text and had left messages on his mobile and had not received a reply until forty five minutes earlier when the telephone where she was staying had rung once and stopped; when she dialled 1471 it gave her father's number.

At 1244hrs noted on the C&C log in relation to the previous incidents was *'Hallowes include domestic dispute burglary and request for assistance.'*[83]

The log recorded that the police called Alan's mobile and having got the answer phone they did not leave a message. They contacted the phone company who advised that they were not

[82] TVP URN 1970 C & C log 20/09/02
[83] TVP URN 1970 C&C log 20/09/08

in a position to do anything without the necessary authorisation. Cell site analysis could only be undertaken where there was a very real fear regarding the preservation of life and would need authorisation from an Assistant Chief Constable. A precise location could not be obtained if the phone was switched off; cell site analysis with regard to the last usage could be undertaken but that might be some distance away as the phone would look around for the nearest signal from a mast.[84]

22 September

At 1803hrs C8 notified the police Alan had returned at 1500hrs and was well, he was said to have contemplated self-harm. Alan had tried to contact the police sergeant, initially the phone had been switched off, but they had spoken since and he had agreed to report to a police station.

Alan told C8 he had spent a night during the weekend in his car in the New Forest.[85]

Members of Julia's family thought they might have seen Alan near where Julia, William and C19 were staying at C3 and C4's house in Dorset. On 22 September, C4 took C19 and William to meet Alan in the local park after Alan had contacted the house requesting to see the children. It became apparent that Alan had gone to Dorset probably Friday evening and he offered that he had been looking through the hedge into C3 and C4's garden at some point during the weekend.[86]

24 September

1440hrs it was recorded on the police log that Alan had been '*sighted safe and well at Crowthorne*' [police station].[87]

[84] Cell site analysis is the geographical locating of a mobile phone or data device at the time a call or SMS are made or received, either live or historically.
[85] Information from C8 to PDHR
[86] Information from C4 to PDHR
[87] TVP URN 1970 C&C log 20/09/08

25 September - Julia's fourth contact with TVP (DVC records)

The DVC telephoned Julia and left a message and Julia phoned her back. The DVC recorded on the Advice Form that Julia had an Injunction to run to 26 March 2003.[88]

26 September

Julia accompanied by C16 one of her sisters, attended Reading Court for the injunction hearing. She was very distressed as she had to sit in the same waiting room as Alan. He made proposals to the Judge about how Old Hallowes could be divided so that he could live downstairs. Julia was successful in pleading with the Judge to exclude Alan from Old Hallowes so that she could return there with William and C19.[89] The emergency Injunction with a non-molestation and occupation order and a Power of Arrest was extended and remained in place until July 2003.

27 to 30 September

On 29 September C4 and C8 acting as mediators met with Julia and Alan to discuss practical and financial matters.[90] Over the following five days Alan sent Julia flowers and was tearful.

On 30 September, Julia absented herself from Old Hallowes so that Alan could spend time there with William and C19; subsequently Alan phoned her on occasions up to three times a day and was verbally aggressive.[91]

September

C5 advised the panel that during a telephone conversation with a police officer he was 'promised' a ten minute response to even a silent 999 call from Old Hallowes.[92]

[88] TVP DVC records & Witness Statement 02/03/04 to Inquest
[89] Information from C16 to PDHR
[90] Information from C8 and C4 to PDHR
[91] JP Affidavit 13/03/03 for extension of non- molestation and occupation order
[92] C5 information to PDHR

Analysis of agency intervention

Thames Valley Police

(i) 14 and 15 – Julia's first and second contact with Police; 20 September associated contact with Police regarding Alan as missing person.

6.1 On 14 and 15 September, TVP had two opportunities to positively intervene; to collect evidence and undertake a proper investigation including an assessment of the risk to Julia, William and C19.

6.2 Julia made a difficult decision to involve the police, which took courage because it could have exacerbated the situation with Alan. Julia was very frightened but initially she and her family believed that the police would act to protect them.[93]

6.3 On the Saturday afternoon the police were presented with the following information; a threat to murder, a woman who had been very frightened by events over the preceding 24 hours, an imprecise location for the person representing the threat and concern that he might be in the vicinity, two young people in the house who were very alarmed and frightened by recent events and the woman's brother who was conveying in strong terms the degree of fear and the pressure they all felt under.

6.4 We consider that officers from TVP did not take Julia's allegation of a threat to kill seriously and that the situation was compounded by a lack of policy or supervision to direct and ensure minimum standards. By not visiting the scene, they lost the 'golden hour' opportunity to capture evidence of the alleged crime or to gather information which subject to appropriate analysis, could have better informed their assessment of the risk faced by Julia and her children.

6.5 In the C&C log it is recorded by Sgt A that at times Julia equivocated;[94] we consider that as a victim of coercive psychological and emotional abuse this was understandable and should not have influenced the police response. It is apparent that Sgt A did not recognise

[93] Reference C5 Statements 1 &2 also transcripts
[94] TVP C&C Log 15/09/02

that a crime had been committed, nor indeed the need to investigate the circumstances further. In the absence of any attempt to capture evidence or of any active consideration of the veracity of the potential threat posed by Alan and the risk faced by Julia, Sgt A advised his colleagues on 15 September that if C5 contacted the police again incidents did not need to be dealt with *'fast time'*[95].

6.6 It is fair to say that formal risk assessment processes were in their infancy at this stage. The Metropolitan Police Service and South Wales were using risk identification models but ACPO[96] had not yet published the Guidance on Risk and the Home Office Circular 19/2000 makes no explicit reference to risk factors. However, even in the absence of an updated policy reflecting the new Home Office guidance the 'positive intervention' approach should have been well understood.

6.7 Officers decided not to triangulate Alan's mobile to locate his whereabouts before assessing the risk to Julia. There was an implicit assumption, without evidence, that Alan had left the country and that they were justified in not visiting the house.

6.8 In light of the references in the C&C log to resourcing issues we have looked into the demands on police time on 14 and 15 September[97]. We have reached the view that there was no evidence that demands on police time prevented attendance. The day shift made a decision at 0915hrs on Sunday morning to defer the matter until after 1600hrs when Sgt A was due on duty. Julia and C5 were not informed about this decision and were not spoken to until 1658hrs when they were advised that officers were committed.

6.9 From their first call to the police at 1644hrs on 14 September, throughout the weekend Julia and her family waited for the police to visit Old Hallowes. Between 1700hrs and 2330 hrs on Saturday and from 0900hrs until 2200hrs on Sunday this is borne out by the police log. This indicates that the family waited patiently for an officer to become available. It is evident that C5 and Julia called the police at times, when on the basis of information from the police, they would reasonably have expected a visit to have occurred; when no contact had been made or when texts from Alan raised the level of their anxiety. The

[95] TVP C&C log 15/09/02
[96] ACPO - Association of Chief Police Officers
[97] TVP Pemberton Timeline Officer Deployment 0700hrs 14/09/02 – 1000hrs 16/09/02

circumstances at Old Hallowes over that weekend have been described as like being under siege,[98] made worse by the fact that a visit from the police was anticipated but never occurred.

6.10 There was a clear allegation of a 'threat to kill' by Alan, a serious criminal offence. This should have been properly investigated. We do not accept that C5 could not report the crime on behalf of Julia. Allegations can be made by third parties and whilst we accept a prosecution might be difficult in such circumstances, a third party allegation should not inhibit an investigation. Had the police visited the scene they could have adduced evidence of criminal intent, namely that Alan's threat was a premeditated act. Further, they could have recovered significant circumstantial evidence; writing on the whiteboard, documents and wills that were left out with instructions in the event of Alan or Julia's death and indeed direct evidence from Julia about the history of domestic abuse. Such a proactive and positive approach might also have sign-posted the information disclosed by Julia with her close friend and members of her family in June, August and September.

6.11 We consider that had a positive intervention and proactive investigation taken place, the police could have begun a process of identifying the threat posed by Alan and working with other statutory partners to assist Julia to manage the risks.

6.12 Even in the event that positive action and a proactive investigation had been initiated, we accept that Julia may have gone on to meet with the DVC and might still have pursued a civil injunction. We have also concluded that the police would have been much better informed and therefore more likely to have interviewed Alan, better established the risk he posed and potentially held him to account for his criminal conduct. There is evidence that criminal justice sanctions in some cases do reduce offending and also change offending patterns.

16 September – C5 report of suspicious car

6.13 On the evening of 16 September police officers having followed up C5's report of a suspicious car called a "*wrong number*"[99] and did not persist in trying to contact C5 to advise

[98] T C5,C12,C16 information and C5 Statements 1&2 to PDHR

him of their actions in relation to his call. They therefore did not demonstrate that they had responded and to Julia and her family, this was a further example of the police not responding to their requests for help.

20 September - C8 report of Alan's failure to make contact

6.14 TVP provided us with a copy of the C&C log concerning Alan's failure to make contact on the 20 September, after it came to our attention in July 2008.

6.15 The panel was informed that the Command and Control Log was the only record available because in accordance with TVP Force Policy the GEN35 (missing persons report and enquiry forms) were destroyed after two years in January 2005. We were informed that:

> *'Whilst it is not possible, in the absence of the GEN 35, to ascertain what actions were or were not taken, there is no indication in the summary URN from the archive database that this concern for welfare following the service of a domestic- based injunction was notified to the DVC.'*[100]

6.16 Alan would have been aware when he presented himself at Crowthorne Police station on 24 September of the grounds on which Julia had been granted an Injunction with a Power of Arrest on 17 September. We noted the reference in the C& C log was to *'domestic dispute'*; there is no evidence to indicate that the police considered the domestic abuse allegation, linked the incident or took the opportunity to investigate the alleged threat to kill.

6.17 The panel considers TVP's failure in September 2002 to link this information with the URN concerning Julia's request for help on 14 and 15 September (threat to kill) and to notify the DVC, representative of a serious failure.

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[99] Information from TVP to PDHR is that it is not clear what number was called *'unfortunately wrong number called back'* noted on URN for 22/09/02

[100] TVP information to PDHR 14/07/08

TVP Management Service Review

Extracts with reference to TVP responses on 14, 15 and 16 September:

> Review Comment 1:
>
> *In 2002 this* [triangulation of Alan's mobile phone] *was based on the immediacy of the 'threat to life'. Mobile telephone service providers were not obliged to supply such information until the relevant section of RIPA*[101] *was invoked in January 2004 and requests were considered on a case by case basis and acquired under the provisions of the Data Protection Act.*
>
> *Given the constraints on the use of cell site analysis and the available legislation at that time, it is the opinion of the reviewing officers that the decision [not to triangulate] was correct.*
>
> Review Comment 3:
>
> *The repeated efforts of Julia and* [C5] *to report their concerns to police failed. The review has been unable to establish why officers were not dispatched sooner but the passage of time on the memory of the officers has clouded our ability to identify what the other commitments that prevented their attendance were.*
>
> *It is clear that at 09.13hrs on the Sunday, the decision to defer the incident for the Sergeant to deal after 16.00hrs was taken. There was no apparent attempt to resource the commitment, this was an error as it did not allow us the opportunity to consider the deployment of officers throughout the day and may have built in an unnecessary delay. It appears that there may be some discrepancies in what the officers recollect saying and what is recorded in the Command and Control Log. For example, although a positive step, the Sergeant does not recall asking for the log to be flagged to the DVU.*

[101] Regulation of Investigatory Powers Act 2000 C 23

Review Comment 4:

No crime was recorded or investigated, no written statement was obtained and no explicit threat was recorded on the file.

It is apparent that both Julia and [C5] *believed that Alan had threatened to kill Julia and there was an expectation that some form of investigation would follow.'*

Review Comment 5:

The effect of the National Crime Recording Standard was to focus the recording of crime on a victim based approach.

It is the opinion of the Force Business Information unit that with the clarity that we now have around the standards[102], the incident should have been recorded as a threat to kill.

Review Comment 9:

The failure to update Julia and [C5] *on the progress of our search appears to have had the effect of them believing that we did little or nothing, and reduced their confidence in our ability to respond to their concerns.*

Panel comments

We note and agree with the MSR comments in relation to TVP's responses on 14,15,16 September, but consider that the reviewers should have acknowledged the effect of the absence of a domestic violence policy, procedure, and training as a contributory factor in the failure of officers to intervene positively during this key period. Home Office Circular 19/2000 required that forces had policies which had been developed in full consultation with the CPS.

[102]The Home Office Counting Rules for recorded crime and National Crime Recording Standard, adopted by TVP in April 2002

It should be noted that the National Training Programme was not released in October 2002 so any training prior to that would have been locally developed.

We are of the view that had the threat to kill been taken seriously by police, cell site analysis would have been a legitimate and proportionate option to consider. It was accepted by senior TVP representatives that the process could have been applied and indeed had been in other situations concerning threats to life.[103] The fact that no consideration was given for a cell site request supports the view that the allegation was not taken seriously. We therefore differ from the TVP MSR in so far as there is no evidence that such an application was appropriately considered.

We are concerned that when the TVP MSR was undertaken in 2006/2007, information concerning C8's report of Alan as a missing person on 20 September was not identified from internal records by the TVP review team and therefore the implications and potential lessons for the future were not considered by them. The fact that police could and should have made the link to Alan's part in the domestic violence report, his threat to kill and the opportunity to ensure the DVC was informed of his subsequent behaviour was deeply concerning. All the more so given the fact that the injunction is clearly referred to in the police logs. The evidence of the positive police approach with regard to Alan's status as a potential missing adult contrasts in almost every sense with the service Julia and her children experienced on her first and second contacts with TVP.

(ii) Domestic Violence Policy

6.18 We were informed that TVP did not have a domestic violence policy in 2002/3. In October 1999 TVP in a report DCI (1) noted that there was virtually no Force Policy in respect of domestic violence. In early 2000 DCI (2) at Force HQ was tasked with formulating a policy to be commenced following publication of Home Office Guidelines in May 2000.[104] A new draft policy was produced in 2000 with a view to replacing area policy where it existed. This draft was not progressed.

[103] TVP reviewers information to PDHR
[104] Home Office Circular 19/2000

6.19 A second draft was produced by DCI (3) who published a review of the draft policy in April 2001 to be presented to the Crime and Operations Superintendents.

6.20 The work regarding a domestic violence policy was subsumed into the Best Value Review of Violent Crime which in May 2002 noted '*There is no existing policy on Domestic Violence.'*[105]

6.21 A brief outline of the progress until a draft was implemented by the Force project in June 2004 is as follows:

- 21 June 2002 - a report on Crime Investigation incorporating violent crime and domestic violence was submitted to Thames Valley Police Authority Best Value Working Group with a recommendation that it was referred for adoption to the 31 July 2002 Audit and Performance Review Committee. The Committee considered the report and it was adopted on behalf of the Police Authority.

- The Review resulted in a set of recommendations for improvements to response to domestic violence including additional funds for staffing the Crime Policy Unit:

    - 2003-04 additional money included in budget for recruitment from September 2003
    - Corporate project approved to include recommendations for improvement.

- December 2002 a corporate project brief was drafted with a planned start date of April 2003 and a completion date of September 2003 (the project did not commence as planned due to resourcing difficulties).

- September 2003 – a project manager was appointed.

[105] Best Value Review (BVR): By virtue of Section1(1)(d) of the Local Government Act 1999 all police authorities in England and Wales are required to make arrangements to secure continuous improvement in the way in which the function of policing is exercised within their force area, having regard to a combination of economy, efficiency and effectiveness. Her Majesty's Inspectorate of Constabulary (HMIC) is charged with the responsibility for inspecting all BVRs within the police service. The resulting reports are 'public' documents, and in every case a copy will be forwarded to the Secretary of State, the chair of the police authority and chief constable or commissioner of the force concerned.

- September 2003 – HMIC[106] Best Value Review Report on Crime Investigation recommended '*pending outcome of the domestic violence project interim guidance should be published.'*

- January 2004 – new strategic approach and corporate policy agreed by Chief Constable's Management Team; a full Training Needs Analysis report was submitted to the training prioritisation Board and a Domestic Violence Training programme was agreed.

- February 2004 interim guidance was circulated for consultation.

- June 2004 – A Domestic Violence Policy and new operational guidelines for officers and staff was published.

6.22 The panel have learnt that in 2002 in the West Berkshire Police Area, it was not clear on the area who was responsible for 'managing' domestic violence issues. The TVP Management Service Review found that Inspector(1) who was the DVC's line manager did not consider himself responsible and that responsibility rested with the Superintendent Crime and Operations. The Area Crime and Operations Superintendent although agreeing it was his ultimate responsibility believed that management fell to Inspector (1) and DI V. There was a lack of clarity and no-one owned Domestic Violence Policy on the area.

6.23 The only guidance document on the area was an 'area' policy on responding to domestic violence that was written by DI V in response to a decrease in detection rates pertaining to domestic violence. It was approved by the area management team on 30 June 2003 and circulated to all supervisors and included in the area's training inputs.[107] The TVP reviewers noted that this was apparently the only guidance document available to staff and officers on the area *' not a holistic policy for DV, but rather an interim approach advocating a positive intervention to fast- time incidents.'*[108]

[106] HMIC: Her Majesty's Inspectorate of Constabulary
[107] This was after TVP's last recorded contact with Julia on 10/06/03; the DVC, whilst on leave, met Julia on 8 July. This information was made available at the inquest.
[108] TVP MSR

6.24 The TVP reviewers commented that;

'Other documents produced by the DV Coordinator, suggest that she was repeatedly engaging with managers on the Police Area to raise the profile of domestic abuse issues, including the telephone resolution of domestic incidents by control rooms. The apparent failed development of the issues flagged by the DVC has not been further examined by the review team, although it is considered highly indicative of management engagement with these issues at the time.'[109]

TVP Management Service Review

Extract with reference to the Domestic Violence Policy:

Review Comment 37:

[Reference Review of Draft DV Policy 11 April 2001]
Reviewing officers are unable to find any evidence of the document progressing beyond this stage.'

Review Comment 39:

There is clearly much to be learned from the manner in which domestic violence policy evolved. There have been several attempts to produce a Force policy over a number of years, all of which floundered in the face of competing demands, changes in key personnel and a rapidly altering national picture as we 'waited' for the next report or guidance document.

The analysis of the evolution of the policy does not make for comfortable reading. A number of false starts and lack of strategic direction resulted in a procedural void that was filled by the development of ad-hoc local interpretations of national guidance.

[109] TVP MSR

Panel comments

We note the comments of the MSR and agree that the lack of strategic direction resulted in a procedural void.

The majority of police services had a policy in place at this time. Most were almost entirely based upon the Home Office Circular with some additional local information.

We have concluded that the absence of a Force-wide domestic violence policy led to a service failure. This resulted in little or no consistent direction and support for the front line services, which would respond to Julia and her family over the following fourteen months.

The absence of a Force policy or interim guidance over such a period of time was in our view a significant omission.

(iii) The DVC – Julia's third (16 September) and fourth contact (25 September) with TVP (DVC records)

6.25 We were informed that prior to her appointment in July 2000, the DVC had been away from frontline operational duties for at least three years including working on animal rights protests. At the time of her appointment as a part-time DVC (4 days per week) for West Berkshire she received no formal training or induction.[110] At a later unspecified date she attended a week-long pilot course for DVUs; we understand that the feedback from those attending[111] including the DVC was that the course was not considered fit for purpose. [112]

6.26 The Home Office Circular 19/2000 required that staff had job descriptions and clear line management arrangements. TVP reviewers have provided us with a DVC job description which it was not possible to accurately date, an estimated date of 2001-2 has been suggested; its status is unclear. The DVC prepared a list of tasks for herself and her colleagues providing cover in her absence which she had on her office wall.

[110] TVP additional information for PDHR – March 2008
[111] TVP information to PDHR February 2008
[112] TVP additional information February 2008

6.27 The DVC supported Julia on the basis of the extent of the threat that she perceived; made an appointment for Julia with a local solicitor and used the material she had been given by Julia to secure her safety. She wanted protection for Julia who she assessed was pre-disposed towards a civil outcome.[113] We have learnt that whilst staying with her sister and brother-in-law in Dorset possibly during the weekend of 22/23 September, Julia expressed concerns in the event that Alan were to be arrested about the implications and the affect this might have on C19 and William.[114]

6.28 We have learnt that although the DVC noted on the flagging that an urgent response was required even to silent 999 calls made from Old Hallowes, in fact at that time it was not technically possible to identify the address from which a silent 999 call was made nor therefore information flagged at that address.[115]

6.29 We were told that the DVC did not seek advice from CID or the duty Sgt about Alan's threat to kill Julia. In the absence of evidence to the contrary we must therefore conclude that the DVC accepted the position adopted over the weekend by other officers. We are however surprised that having captured the serious nature of Julia's situation in very strong descriptive language, the DVC did not look into whether the matter had been dealt with appropriately over the preceding weekend. As a result a third opportunity was missed to appropriately investigate the threat to kill.

6.30 We were advised by the TVP reviewers that in other cases there was evidence of the DVC adopting a positive intervention approach; the DVC's approach in this case may therefore be a reflection of Julia's preference. It may also have been informed by the fact that Sgt A, having failed to positively intervene and or investigate the allegation of crime over the weekend had referred the matter to the DVC for her attention. We recognise that whilst a serving police officer, the primary focus of DVC's at this time was engaging victims of domestic abuse to provide support and advice. We consider that such a position may have unhelpfully diverted individuals undertaking the DVC role from focusing on crime and their principal occupation as an officer of the law. We would expect a police officer to follow up such a serious allegation with CID colleagues.

[113] TVP additional information for PDHR March 2008
[114] C4 Information to PDHR
[115] TVP information to PDHR

6.31 We were informed that there is no evidence that the DVC was aware of the events concerning Alan on the weekend of 21 September. Following what was a short- term intervention with Julia, the DVC's follow-up call on 25 September to establish the outcome of the application for an injunction was an example of good practice.

TVP Management Service Review

Extract with reference to the DVC:

> Review Comment 6:
>
> *The approach to the selection and training of specialist DVC is now significantly different. DVCs sit within the Public Protection Units, work in a structured environment and are subject to close supervision.*
>
> Review Comment 7:
>
> *In many ways the DVC dealt with the case as if it had been more formally identified in current terms as 'high risk' although it is clear that 'high risk' was not defined at that time.*
>
> Review Comment 8:
>
> *The reviewing officers commend the pro-active action taken by the DVC but there does not appear to be any selection process for referral to a Solicitor specialising in family issues. We recommend that consideration is given to a structured referral 'list' of accredited and available lawyers.*

Panel comments

The MSR would have benefitted from an explicit acknowledgement of the implications for victims and the post holder of TVP's failure to provide the DVC with adequate training, supervision and support.

Whilst referring to the level of risk assessed by the DVC in the Pemberton case, the MSR does not identify the significance of the absence of a domestic violence policy, systems and training for police officers in the Local Police Area expected to respond to Julia when she reported a serious crime in September 2002.

Berkshire West PCT

6.32 The GP had been in practice for just over twenty years; had a list of approximately 2000 individual patients and was a principal of the local practice. He had been the family doctor since Julia and Alan's registration with him on 26 November 1987. He had contact with Julia in her professional capacity as a health visitor. The GP and members of his family were also acquainted socially with the Pemberton family; he said that he was always consciously aware of the boundary between the professional and the personal relationship. We understand that he discussed the case informally with other partners in the practice.

6.33 We acknowledge that in her contact with her GP Julia was primarily seeking help, support and guidance with her health care needs. The GP told us that in many years of general practice he had come across very few cases of domestic violence and at that time had not received training or identifiable support from the PCT or elsewhere in this regard.

6.34 The GP relied on Julia's reassurance that she had informed the police, the domestic violence unit and a solicitor that Alan had threatened to kill her. She told him that the guns had been taken to the police station and that she had obtained an injunction. He did not feel it necessary to make direct contact with the police.[116]

6.35 He was aware of the Refuge and discussed Julia leaving Old Hallowes but she had declined. Julia told him that she had good support from her family and friends. He told the panel although not recorded in his notes, he would have recommended Relate. He was aware that Julia had been part of the West Berkshire Domestic Violence Forum.

6.36 A leaflet 'Domestic Violence for Primary Care', of which Julia Pemberton had been a co-author with a senior midwife and GP, had been prepared by a sub group of the Domestic

[116] Transcript GP & BWPCT IMR

Violence Forum and was available in GP surgeries. It focused on the recognition of physical abuse and did not point practitioners to the issue of psychological or emotional abuse.

6.37 Berkshire West PCT subsequently advised the panel that copies of *A Resource Manual for Health Care Professionals* (Department of Health 2000) were distributed in 2002/3 and that there had been training opportunities for primary care staff linked to child protection training.

6.38 During this period Alan did not consult the GP.

Berkshire West PCT Internal Management Review (IMR)

> *'This report* [IMR] *is based on actions taken by [the GP] in a professional capacity but notes that his family were acquainted with the Pemberton's socially.*[117]
>
> [GP] *was aware that there was a gun in the house and checked with* [Julia] *that it had been removed.'*

Panel comments

The IMR does not comment on:

- **the content of the consultation with Julia in September**
- **or include reference to the possible implications of the social relationship between the GP, members of his family and the Pemberton family**
- **or include reference to the possible implications of continuing to act as the family doctor in particular with regard to Julia and Alan**
- **the fact that a long standing GP had only come across a few cases of Domestic Violence and the implications for knowledge and understanding of the impact of the emotional and psychological abuse on Julia's capacity and ability to protect herself and her children**

[117] Berkshire West PCT IMR

- **the fact that in such cases health practitioners need to pro-actively take steps to ensure that 'all' relevant information is appropriately shared.**

The IMR does note that having been informed about a gun in the house the GP checked with Julia that it had been removed.

<u>Panel's overall conclusions September 1 – 30, 2002</u>

The panel have concluded that:

6.39 In 2002 Thames Valley Police did not have a Domestic Violence Policy, procedure, practice framework or training for officers and staff.

6.40 Police officers dealing with the events of the weekend of 14 and 15 September appeared to have had very limited, if any, terms of reference for dealing with domestic violence and inadequate supervision As a result an opportunity to positively intervene was lost. They failed to investigate a serious crime, to interview Alan and critically to gather information that would have assisted the agencies involved to identify and manage risk.

6.41 Julia and her family's confidence in the police to help her as a victim of domestic violence was seriously undermined as a consequence.

6.42 On Monday 16 September in her contact with the DVC, Julia engaged with a police officer who took her case seriously; who reviewed a range of options with her; captured significant evidence of historic abuse and provided support in relation to her application for an injunction.

6.43 In a largely unsupported and ill-defined role the DVC positively engaged Julia, established an early understanding of the threat and worked with and supported her attempt to mitigate the risk by a civil injunction. On the basis of the standards of the day and in the context of a system that seems to have largely separated the criminal investigation and victim support functions, it would be unfair not to recognise the DVC's individual efforts - albeit we consider that she should have discussed the case with her

supervisor and police colleagues. It is apparent that the advice regarding making a silent 999 call was made by the DVC without a full understanding of the limitations of the system at the time.

6.44 TVP officers did not inform the DVC when Alan was reported as a missing person and there was concern about him as a suicide risk. This was not recognised as relevant to an assessment of risk with regard to Julia's situation.

6.45 The GP responded to Julia's information on the understanding that she had informed the police, including the domestic violence unit and her solicitor; she had family support that the guns had been removed from the house and she had obtained an injunction.

Learning for the future – 2008 onwards

For the police service

- **Demonstrable leadership and direction is critically important and individuals must accept the responsibility of their role and rank.**

- **The provision of a police response to the victims of domestic violence needs to be embedded in a framework based on a force-wide policy, procedures and training for all officers and staff.**

- **Domestic Violence Incidents should be attended to as a priority (now covered in Guidance 2004 and 2008).**

- **Threats in cases of domestic violence should be investigated (now covered in guidance).**

- **Record Domestic Violence incidents/crimes and flag systems (now covered in guidance and will be part of Police national database functions).**

- **Threats to kill/suicide should always be viewed as high risk covered in guidance and work being carried out on single assessment model by ACPO lead on domestic violence.**

- **Update victims of crime appropriately (Code of Practice).**

- **Investigation should be reviewed at every stage and linked to risk assessment.**

- **Recognition that where there are children and young people involved separate consideration must be given to their needs in line with Local Safeguarding Children Board procedures.**

For PCT and health professionals

- **PCTs as commissioners of health care services have the opportunity through their contractual arrangements e.g. with GPs, to include requirements with regard to domestic violence.**

- **As a primary health care service available to everyone, general practitioners are in a key position to provide support and access to help for victims of domestic abuse and their children. This role may cause problems in maintaining objectivity as GPs may be privy to information not available to other parties in complex cases and should in accordance with their professional guidance report, child protection concerns and information regarding risk involving the potential commission of a serious crime to all relevant agencies.**

- **Training is required for general practitioners and health professionals with regard to domestic abuse; to include the emotional and psychological implications for victims and their children both during and after leaving an abusive relationship and in managing ongoing relationships**

7. October 1 – December 31, 2002

Summary of events

At the beginning of October Alan met C14 who was later to become his new partner.[118]

In October, Julia recorded in her diary that she had received forty six telephone calls from Alan and on some occasions up to three times a day.[119] She noted that the content of the calls varied from Alan being depressed and threatening, that he would commit suicide to being verbally aggressive towards her. Alan was also seen to drive slowly past Old Hallowes on more than one occasion.[120]

2 and 3 October - Julia went with Alan and an estate agent to view potential properties for him to rent.

6 October - Julia recorded in her diary she left Old Hallowes from 1000 hrs to 1800hrs whilst Alan visited to collect some possessions and spend time with C19 and William. He telephoned Julia afterwards and she recorded in her diary that he was quite verbally aggressive.[121]

8 October - Alan wrote to Julia saying that he could not live without her and that he would never threaten her life again.[122]

9 October – Julia's fifth contact with TVP (DVC records)

The DVC recorded that she had spoken to Julia and that there were no current problems 'aio [all in order] …*peaceful…no probs* (sic) *from Alan.'*[123]

11 October - having sprained his ankle Alan drove to Old Hallowes and when he asked Julia to take him to hospital, she refused. Julia recorded in her diary that Alan had said to William later 'She's *f**king evil for not taking me to hospital- things are going to go f**king ballistic*.'

[118] C14 evidence at Inquest
[119] JP diary
[120] C12 information to PDHR
[121] In Alan's Affidavit 19/06/03 he denied that he telephoned afterwards and was verbally aggressive.
[122] AP Affidavit 19/06/03
[123] TVP DVC Advice form

16 October - in a letter to Julia Alan wrote that he hoped that Julia would let him keep Old Hallowes.[124]

17 October - Julia and Alan attended the funeral of C8's mother together.[125]

20 October - when spending a day at Old Hallowes on his own with William and C19, Alan was angry and told them he was going to kill himself. William was so distressed by what had happened that he did not go to school the following day.[126]

22 October - (Julia's second consultation with GP since September 2002) Julia told the GP that she had obtained an injunction for six months and that Alan was tearful and had been threatening suicide; the GP arranged to see her again in four weeks.[127]

23 October - Julia told Alan that she was not happy with the financial proposals and that she needed to take advice; he was unhappy, the house would have to be sold and there was only one answer and that he wanted to distance himself from the children in order to prepare them.[128]

25 October - Alan informed the payroll manager at work that he wanted to alter the arrangements for payment of his monthly salary; for the following five months to be split between a joint account with Julia and a new personal account and thereafter the full salary to be paid into the new personal account.[129]

28 October - Julia met a friend and told her the cancer had brought the situation with Alan to a head; previously she had kept the mental cruelty a secret from her children, family and friends but now she wanted to be free of an unhappy life.[130]

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[124] Exhibit with Alan's Affidavit 19/06/03
[125] C8 information to PDHR
[126] JP Affidavit 19/06/03 and diary
[127] Berkshire West PCT IMR
[128] JP diary
[129] C11 Information to PDHR
[130] C15 letter to PDHR

4 November - Alan telephoned Julia and asked her to change her mind; when she saw him at the supermarket he was begging and tearful; he telephoned C19 threatening suicide and she was very upset.[131]

5 November - the GP wrote to Julia's employer to say that she was fit to return to work. Alan took C19 to an exhibition in London and made further threats about committing suicide.[132]

6 November - Alan commenced the lease on a local property.

10 November - Julia and Alan had a further meeting with C4 and C8 and discussed a settlement that would allow Alan to remain in Old Hallowes and for funding for Julia to buy another property; Alan agreed to Julia choosing a solicitor, to whom C8 would introduce her, in order to ratify the arrangement.[133]

13 November – In her Affidavit, Julia stated that she had refused to travel in the same car with Alan to a parents' evening at William's school. Alan had been very angry and told Julia that something terrible would happen. During the parents' evening Alan had begged her to go for a drink with him afterwards and she had gone because she was afraid to refuse. Alan continued to make threats towards Julia and she left.[134]

21 November - Julia recorded in her diary '*Telephone call - tearful, threatening suicide - call the police*'. [135]

25 November - Alan telephoned Julia and said that he had to have her and that he would not tolerate 'it'.[136]

26 November - Alan telephoned Julia *'very difficult phone call - threats'*[137]

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[131] JP Affidavit 13/03/03 and diary
[132] JP Affidavit 13/03/03 and diary
[133] C8 Information to PDHR
[134] JP Affidavit 13/03/03 and diary
[135] TVP information to PDHR is that they were unable to trace any record of a call on the DV file or on C&C log from either Old Hallowes or Alan's new address.
[136] JP diary
[137] JP diary

28 November - (Julia's third consultation with the GP since September 2002) Julia told him that she was coping well; work and finances were fine; Alan was living in the village. The GP arranged to see her again in three months.

29 November - Julia's sister C16 received a call from Alan saying that he would do something not very nice to Julia.[138] C16 asked him did he mean that he was going to kill her and Alan replied *'I've got to do this'*. Her sister called Julia and told her, Julia asked her sister to tell someone else because she felt nobody believed her. C16 called C8 and asked whether he thought the police needed to be told, C8 did not feel Alan was serious and that '*it was all talk.'*[139]

30 November - Julia recorded in her diary that Alan had made a specific threat '*You have ruined my life, you will have to face the consequences.*'

4 December - Julia recorded in her diary a threatening telephone call from Alan *'I will take my revenge; it will devastate L+W. I will not tolerate this.'*

6 December - Alan made a further threatening telephone call to Julia which she recorded in her diary *'You can't do this. You have destroyed my life.'*

13 December - Alan attended William's prize giving and sat next to Julia and throughout the evening whispered compliments. Julia recorded in her diary '*threats- something is going to happen, you'd better stop this – this will be the biggest mistake of your life.'* On her return home Julia found two threatening messages on her answer phone.[140] Alan subsequently denied that he had acted in this way.[141]

15 December - Alan called Julia and she recorded in her diary: *'Why are you doing this? I'm just going to have to do it-* [C19] *+W are going to be f**king orphans and its all your fault.'*

19, 20 and 21 December - Julia recorded in her diary further calls from Alan in which he referred to ending his life and that Julia had achieved what she wanted.

[138] C16 information to PDHR
[139] C8 did not recall this conversation when questioned about it at the Inquest.
[140] JP Affidavit 13/03/03
[141] AP Affidavit 19/06/03

23 December – lock barrels were changed at Old Hallowes.[142]

24 December - Julia recorded in her diary that William and C19 had visited Alan at his invitation. When they arrived he had not been there and they had found a bottle of wine, a bottle of gin and three boxes of paracetamol on the coffee table with a note marked '*24hours to go.'* He had crossed off the numbers 24 down to 5, indicating there were 4 remaining. Julia recorded in her diary *'C19+W to Alan's – suicide set up C19 very upset.'*[143]

25 December - William received a text message from his father wishing him *'Merry Christmas from Bristol Airport.'*

During December Julia told C8 on a couple of occasions that '*if Alan ever committed suicide he would kill me first.'*[144]

Analysis of Agency Intervention

(a)TVP

7.1 On 9 October the DVC telephoned Julia who reported that there were no current problems with Alan. There was no other engagement with TVP.

TVP Management Services Review

> Review Comment 10:
>
> *'It is significant that Julia's diary entries indicate an increase in the frequency of the contact from Alan and demonstrate some escalation in the level of threat both to harm himself and Julia. However, the police remained unaware of the escalation and the DVC reports that there was no discussion about this after her meeting with Julia on 16 September 2002.'*

[142] C17 information to PDHR
[143] JP Affidavit 13/03/03 and diary
[144] C8 Information to PDHR

Panel comments

The MSR did consider in *Review Comment 9* that the failure to update Julia and C5 on the progress of the search on 22 September 2002 may well have resulted in their loss of confidence in TVP. However, the MSR does not consider the possibility that the failure of TVP officers to respond appropriately on the weekend of 14 and 15 September to the report of Alan's threat to kill Julia may well have resulted in Julia losing confidence that they would take any action if she contacted them. We consider this may have been the case given Julia's response in her conversation with her sister on 29 November.

(b) Berkshire West PCT

7.2 Julia consulted the GP for the second and third time during this period; she said that she was coping well. This is at a time when there is substantial evidence from her diary of Alan's mounting emotional and psychological pressure on her.

7.3 She referred in the second consultation with the GP to Alan's threats of suicide; this was not referred to in the third consultation although there is evidence that at this time these threats were happening continuously. Alan was also telling William and C19 that he intended to take his own life. He had not consulted the GP. There is no evidence during this period that Julia told the GP about Alan's threats towards her.

7.4 At this stage the GP did not make a connection between Alan's threats of suicide and potential risk to Julia. He accepted Julia's self assessment that she was managing the situation.

Berkshire West PCT IMR comments - none regarding this period

Panel comments

It is our view that the IMR should have considered the possible significance of the information provided by Julia concerning Alan's threats to kill himself in the context of an assessment of the overall risk to Julia.

Panel's overall conclusions 01 October to 31 December 2002

The panel have concluded that:

7.5 During this period, there were occasions when Alan telephoned Julia two and more times a day threatening to commit suicide or making threats against her. He told his son and daughter that he intended to commit suicide without regard for the emotional impact on them. Alan appeared to go along with the financial proposals discussed in the meetings with C8 and C4, however he had begun to make arrangements to reduce payments into the joint bank account.

7.6 The GP received information from Julia about Alan's threats with regard to taking his own life; Alan did not consult the GP. On the basis of information during that period from Julia that she was coping well the GP acted appropriately.

7.7 Alan set up the 'mock suicide' on 24 December with no apparent regard for the extreme emotional distress he would cause William and C19. It was not until Christmas Day that Alan contacted his son. The impact of his actions on William, C19 and Julia cannot be over estimated. It is clear to us that Alan's objective to get Julia to change her mind overrode his consideration for the needs of his children at this time.

7.8 Alan's threats in December about suicide became ambiguous and could be interpreted as further threats to kill Julia. She told C8 that if Alan was planning to commit suicide he would also kill her. Julia's family and friends witnessed a deteriorating situation between Julia and Alan.

7.9 Individuals inside and outside the family circle held information that was not made available in a contemporary sense to the police; this information concerning threats to Julia and about his threats of suicide may well have informed a better understanding of the risk posed by Alan.

7.10 In Julia's response to her sister, there is evidence of her lack of confidence that she would be believed if she reported the threat to the police. This was understandable

given the absence of an appropriate police response to Alan's threat to kill her on the weekend of 14 and 15 September.

7.11 Trust in the police is critically important if people are to feel sufficiently confident to come forward and share information they believe may not be relevant or worse still, think the police will not take seriously.

7.12 There are a number of complex issues affecting how victims, families and friends respond to a situation such as that facing Julia in the autumn of 2002. During this period, Alan tried to regain control over Julia in order to get her to change her mind about the breakdown in their marriage; he threatened to commit suicide, threatened to harm her and involved C19 and William with regard to both.

7.13 Julia's contact with Alan may have created the impression to those outside her immediate family circle that her relationship with him was 'normalising'. However, her presentation in this respect is similar to that of many victims of domestic violence, who having experienced many years of a controlling relationship seek to meet the needs and feelings of their children whilst dealing with their own fears and feelings about the abusive partner. Julia's commitment to her children meant that she took responsibility for trying to maintain the relationships between Alan and his son and daughter. This involved finding new accommodation for Alan that would facilitate contact with them; attending events with Alan at William's school and separately maintaining friendships with people who had previously been friends of theirs as a couple and who continued to offer support to her and her children.

7.14 Where domestic violence has occurred members of an extended family and friends will continue to be presented with challenging and difficult situations particularly where they are in contact with both parties. In some cases, they may not recognise the significance of the information they are receiving; may feel they have to respect the wishes of the victim in relation to confidentiality or that with the passage of time and separation from the abuser, the safety of the victim will improve. We consider that there needs to be information and support available to families and friends to promote understanding and awareness that concerns about the safety of the victim and their children need to be reported to the police.

Learning for the future – 2008 onwards

For all:

- **Agencies and individual professionals need to develop their understanding about the emotional and psychological affect on victims and their children of living with a partner who has been coercively controlling; especially after the relationship has ended. What kind of support do they need in relation to ongoing contact after the relationship has ended? This needs to be supported by awareness raising to help family and friends better understand the dynamics of such coercive relationships.**

- **Victims, their children, family and friends should be encouraged to report all concerns about safety to police/other agencies and the information should be recorded (covered by guidance and advice facility on National Domestic Violence Helpline).**

For PCT and health professionals

- **PCTs as commissioners of health care services have the opportunity through their contractual arrangements e.g. with GPs, to include requirements with regard to domestic violence**

- **As a primary health care service available to everyone, general practitioners are in a key position to provide support and access to help for victims of domestic abuse and their children. This role may cause problems in maintaining objectivity as GPs may be privy to information not available to other parties in complex cases and should in accordance with their professional guidance report, child protection concerns and information regarding risk involving the potential commission of a serious crime to all relevant agencies.**

- **Training provided for GPs and other health professionals about domestic abuse should identify risk indicators associated with the perpetrator's behaviour e.g. threatening suicide.**

8. January 1 - March 31, 2003

Summary of events

In early January 2003 Alan started seeing C14[145]

During the first half of 2003 Alan and Julia exchanged letters and notes about their financial arrangements. Alan's meetings with William became more distressing.[146]

4 January - Julia wrote to Alan about wanting to go ahead with a divorce and negotiate a settlement without fighting through solicitors. She suggested that she stayed at Old Hallowes until William had taken his GCSEs; and that she would use an independent solicitor identified by C8.[147]

13 January - Julia told Alan that she was consulting a solicitor and was commencing divorce proceedings.

20 January - Julia did not send a birthday card to Alan who was very upset, when C19 stood up for her mother Alan was very angry with her.[148]

21 January - Alan wrote to C19 who was going to South America before going up to Cambridge, saying that he was sorry that their relationship should have ended in that way.[149]

26 January - Alan left on the doorstep at Old Hallowes, a family portrait and an eleven page document entitled: *'The Pemberton family - 27 years to develop and 1 day to destroy'*. It contained references to his hatred for Julia, for what she had done and the way that she had done it. He refuted the information contained in Julia's affidavit and the reference to sexual abuse. Alan admitted that he had threatened to kill her if she divorced him, but claimed that he had said this in the heat of the moment:

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[145] C14 evidence at Inquest
[146] C8 information to PDHR
[147] AP Affidavit 19/06/03
[148] JP Affidavit 13/03/03
[149] JP Affidavit 13/03/03- Alan subsequently refuted this in his Affidavit of 19/06/03 and said it was a reference to not being able to find a bon voyage card and apologised for involving C19 in the matrimonial dispute.

'my love for her is rapidly matched by hatred for her, not just because of what she has done but more the way in which she did it and her subsequent actions.'[150]

28 January - Alan asked Julia to sign a letter to the mortgagee to get ownership of Old Hallowes returned to him; he had transferred it from their joint ownership to Julia in May 2002 to avoid it being part of a compensation claim associated with a court case involving an ex-business partner. It was only possible for it to revert to joint names.[151] Later that day, Alan met William and questioned him about his views regarding his parent's marriage. Alan told William that it would be his last meal with him and that he was changing his will and was leaving him £30,000 and his sports car. Alan sent twenty-one text messages to William and a text to C19 referring to the damage that Julia had caused to her and her brother.[152]

30 January - Alan met with C19 an hour before she was due to leave for South America and she returned very upset because he had implied that he would not be around when she was due to go up to Cambridge in the autumn.[153]

4 February - Julia told Alan that she was consulting a solicitor and that they would deal with all financial affairs. Her solicitor wrote to Alan and told him that Julia was intending to commence divorce proceedings and asked him to prepare his financial disclosure.[154]

7 February - Alan advised Julia that that he would be withdrawing maintenance payments and proposed that Julia took out a credit card that he would settle on a monthly basis. In her statement for interim maintenance in May 2003, Julia stated that she did not accept Alan's proposal because it would have given him financial control over her and she was afraid he would not pay the monthly credit card bill.[155] Julia told C17 that she was very worried as all household bills were in her name including the mortgage. C17 offered to support her financially if she needed it. Without Julia's knowledge, Alan had cancelled the insurance on C19's car and Julia had continued to drive it.[156]

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[150] JP Affidavit 13/03/03
[151] JP Affidavit 13/03/03; AP Affidavit 19/06/03
[152] JP Affidavit 13/03/03
[153] JP Affidavit 13/03/03
[154] JP Affidavit 13/03/03
[155] JP Statement for Interim Maintenance 1/05/03
[156] C17 information to PDHR

7 February - Alan sent C8 an email telling him that his anger had grown towards Julia because she had refused to retract the allegation of sexual abuse in her Affidavit (17/09/02).

25 February - Julia noted in her diary that Alan had emptied the joint bank account of a large sum of money. Alan wrote to her saying that without communication it was not possible to control the joint account; he would cease maintenance payments from March; that Julia should use her personal bank account into which he would pass money on a monthly basis. [157] C5 advised us '*Thereafter he steadfastly refused to give Julia any financial assistance either for her benefit or for C19 or William. He did however give many gifts to C19 and William.*'[158]

26 February - Alan sent C8 an email in which he said that having lost his wife, his children, his family, future plans and wealth, the only possible best that he could hope for was to keep the house, without that he had nothing and therefore nothing to lose and therefore would fight that one to the death.[159]

26 February - Alan went to Alabama on holiday for thirteen days, returning on 9 March.[160]

4 March - Alan informed his business partners by email that he was signed off work and on medication for depression. He asked if he could have his monthly draw converted to a loan in order to gain advantage in his negotiations with Julia – his request was declined.[161]

5 March - Julia lodged her petition for a divorce.

17 March - (Julia's fourth consultation with the GP since September 2002) She advised him that Alan was still making threats but that she was not concerned that he would act on them; she was applying for a further injunction.[162]

18 March - William was distressed by his father who had said that he would be involved in injunction hearings.[163]

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[157] JP diary, AP Affidavit19/06/03
[158] C5 para: (1) of supplementary statement to Coroner 27 /09/04
[159] Email AP to C8
[160] JP diary
[161] Email exchange between AP and business partners
[162] Berkshire West PCT IMR

20 March - the Injunction Hearing was postponed to 7July 2003 and all previous conditions continued in place.

24 March - Alan saw the GP for his first consultation since September 2002 and told him that he had felt low over the six months since the separation from Julia. He had not expected the separation. He also told the GP about the writ of £10m from his ex-partner. He said that he had experienced insomnia and had written suicide notes, considered an overdose and given some consideration to arranging his affairs. Alan said that he could not understand why his marriage had broken up. He reported feeling hopeless; loss of self esteem/self confidence and feeling some hatred and anger; he had been accused of sexual abuse. The GP prescribed an anti-depressant and arranged to see Alan in two weeks or earlier if necessary.[164]

26 March - Alan went on holiday to Jersey for a week, returning on 1 April.[165]

28 March - Julia's solicitor wrote to Alan requesting interim maintenance.[166]

From the end of March Alan was living more or less fulltime at C14's house in Herefordshire.[167]

Analysis of agency intervention

(a) TVP

8.1 When, in January, Alan left the letter and photograph at Old Hallowes he contravened the terms of the injunction. Julia did not report this or the contents of the letter which amounted to harassment, to the DVC or her other police colleagues. This would have represented another opportunity for police intervention and for Alan to have been investigated and possibly arrested and interviewed.

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[163] JP Affidavit 19/06/03
[164] Berkshire West PCT IMR
[165] JP diary
[166] JP Statement for Interim Maintenance 1/05/03
[167] C14 Evidence at Inquest

(b) Berkshire West PCT

8.2 We acknowledge that in his contact with the GP, Alan was seeking help, support and guidance with his health care needs. During this period the GP received information directly from Alan as well as Julia.

8.3 When Julia consulted the GP in March it was unclear to us from the GP record whether she was referring to Alan's threats as being in relation to hers or to his own life; the GP recorded that Julia, at that time, was not concerned that Alan would act on them.

8.4 Alan consulted the GP for the first time on 24 March. He told the GP his views about the breakdown in his marriage but that he would never harm Julia. The GP told us that he considered Alan's reaction showed his despair about what to do regarding the marital situation; although Alan showed symptoms of depression he was not actively suicidal.[168]

8.5 Alan's appointment with the GP coincided with withdrawing his maintenance payments from Julia and being off sick from work. Alan's first consultation with the GP occurred between taking holidays in Alabama and Jersey.

8.6 The GP provided Alan with medication and a sick note for a fortnight.

Berkshire West PCT IMR Comments with reference to period up to August 31 2003

> '[The GP] *was seeing both Julia and Alan on a regular basis and was privy to both sides of the marital dispute. He acknowledges that the substance of one consultation would be mirrored in a subsequent consultation with the other party.*
>
> *A detailed review of the medical records will note, on occasion, that when the GP suggested that either* [Alan] *or* [Julia] *should return with in a short timescale (e.g.2/3weeks) the next consultation was often later than this timescale, indicating that the family were not wholly reliant on support from their GP.'*

[168] GP information to PDHR

Panel comment

We consider that the explanation offered by the PCT in relation to the pattern of Alan and Julia's visits to the GP is supposition, and its relevance to the review is not explored.

Although noting that the GP was privy to both Julia and Alan's views about the marital situation, the IMR does not consider either the implications for the GP's role nor the possible strategies available to him to address the implications.

<u>Panel's overall conclusions 1 January to March 31 2003</u>

The panel have concluded that:

8.7 In the period between January to the end of March Alan demonstrated increasing anger towards Julia, expressed directly to her, to William and to C19. Alan had emptied the joint bank account and withdrew maintenance payments which made Julia very anxious. This was at the time when Julia was making application for extension of the injunction and was commencing the legal processes to obtain a divorce.

8.8 No request for help was made to the police although Julia was continuing to be harassed by Alan. It is apparent that Julia had no confidence that she would be believed. In March the postponement of the hearing meant that there was no opportunity for the issues regarding Alan's ongoing harassment of Julia to be considered in the civil court.

8.9 In continuing to act as the family's doctor, the GP received information from both Julia and Alan about what was happening and each would have been aware that he continued to be the GP of the other. He acknowledged when acting as GP to both parties the potential conflict of interest which might arise and his actions are in line with the accepted professional guidance at the time provided by the Royal College of General Practitioners. The GP advised us that he had discussed the case with his partners in the practice. There is no record as to whether he discussed with either Julia or Alan their option to transfer to another partner in the practice.

Learning for the future - 2008 onwards

For all:

- **Victims, their children, family and friends should be encouraged to report all concerns about safety to police/other agencies and the information should be recorded (covered by guidance and advice facility on National Domestic Violence Helpline).**

9. April 1 – August 31, 2003

Summary of Events

April

2 April - Alan telephoned William and said that he would have to choose with whom he was going to live.[169]

3 April - Alan failed to file his statement in relation to the injunction hearing in July.

7 April - Alan's solicitors applied for a fourteen day extension[170].

8 April - Alan wrote to the GP and said that he had felt a little nauseous after the first couple of days of treatment so had come off the tablets for a couple of days, but was now back on them. He wrote that he was still feeling very stressed and depressed and unable to face work. Alan had a sick note from 24/03/2003 and requested a sick note for a further period. The GP issued certificate for one calendar week.[171]

11 April - Alan in an email to his solicitor, noted that he had made one threat to kill Julia for which he had apologised.[172]

13 April - Julia and William went on holiday with C8 and his family to Mallorca.[173]

20 April - Julia and William returned from holiday. Accompanied by C8's wife and son they arrived back at Old Hallowes between 1430hrs and 1500hrs to find the front and side door locks had been super-glued. William and C8's son eventually dislodged the superglue in the side door and gained entry. C8's wife checked to see if Alan was there. Julia concluded that

[169] JP diary
[170] JP Affidavit 19/06/03
[171] Berkshire West PCT IMR
[172] Email AP to solicitor
[173] C8 information to PDHR

Alan had done it. We were told that William defended his father saying that Julia always assumed it was Alan but that anyone could have done it. [174]

Julia's sixth contact with TVP (TVP Crime Report)

20 April 1855hrs (5 mins and 10 secs) telephone call made to Newbury Police Station from Old Hallowes, 1900hrs (15 mins 55 seconds) telephone call made to Newbury Police Station from Old Hallowes. [175]

Julia's call was taken by a Police Enquiry Operator at Kidlington who recorded that at 1911hrs she had telephoned and reported to the police that the front and side door locks at Old Hallowes had been super glued.[176] The operator recorded that Julia had explained she had an injunction against her husband with a power of arrest and she thought Alan might have done it but was not in position to provide any evidence. The operator established Julia was safe and Alan was not present.

The operator input details on the C&C log and saw the address was 'flagged' with a domestic violence marker that had been created in September 2002. The operator did not believe Julia was in any danger at that time and did not view the flagged marker; she did view whether there were reported incidents in the preceding three months; there were none. She informed Julia a colleague would call her back to take necessary details. The operator did not inform the DVC.[177]

At 1929hrs Julia was contacted by a Police Enquiry Centre and the crime recorded as criminal damage. Alan was included in the crime report as a suspect. The Crime Report domestic flag was set to '*No*'.

Julia telephoned her brother C5 crying and distraught. C5 tried to reassure her, promising to call the police in order to support her earlier call to them.[178]

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[174] C8 Information to PDHR
[175] Telephone records from Old Hallowes provided by C5 to PDHR C5
[176] TVP MSR
[177] TVP MSR
[178] C5 information and Statement (1) to PDHR; C17 information to PDHR

C5 telephoned Newbury Police Station numerous times to ensure the police were aware of the significance of what had happened and referred to Sgt A by name because of his knowledge of the situation [reference to 14 and 15 September 2002]. C5 received confirmation that Alan would be interviewed and told the police about the historical, continuing and escalating threats and the injunction with Power of Arrest.[179] C5 and C17 informed us that Julia had hoped that the incident would be investigated.

21 April - Crime desk at Newbury Police Station faxed a hard copy of the crime report to Pangbourne Police Station, the station with geographic responsibility for Hermitage for allocation.[180]

24 April - Alan's solicitor wrote to Julia's advising that Alan was suffering from depression, was not working and had no income. Alan returned an oil bill to Julia saying he could not pay it. A friend of Julia's gave her £5,000 and offered to continue to support her financially when she needed it.[181]

25 April - Alan asked William what his intentions were with regard to living with him half time as he wanted to know whether to buy a house or to go and live in France; he would be taking a loan for £600,000 to buy a house.[182]

28 April - 2046 hrs (14minutes 20 secs) telephone call made to Newbury Police Station from Old Hallowes.[183] TVP have no record of this call.

May

During May Alan visited the howtomurder.com and murder.com websites using the computer at his office.[184]

[179] C5 Statement (1) and information to PDHR
[180] TVP MSR
[181] JP statement for Interim Maintenance 1/05/03; C17 information to PDHR
[182] JP diary
[183] Telephone records from Old Hallowes provided by C5
[184] Printout from AP's computer; C5 Statement (2) to PDHR

1 May - Alan was locked out of his office by his business partners. Alan was off sick but had been going into the office out of hours and on several occasions left the door unlocked and on one occasion the burglar alarm had not been set.[185]

Julia submitted an application for interim maintenance based on advice from C5. In the statement, she noted that between October and January all the money, a large sum, had been withdrawn from a bank account in her name, using her password to which she did not have access but to which Alan did. She noted also a nil balance in the joint account and that Alan had ceased maintenance payments in March.[186]

1 May - (Alan's third consultation with GP since September 2002) the GP recorded the following:

> *'Depressive disorder'* [Alan] *reported still low mood; lost wife/business/house. Anger towards wife, increasing legal cost re divorce, 'now detests wife', unable to gain pleasure from usual pastimes, tries golf, difficulty contributing at office, High Court case re business partner March 2004.* [Alan] *tearful.'*[187]

2 May - the GP referred Alan to a private consultant psychiatrist by phone and letter:

> *'I do not feel that there is an immediate risk that he will harm his wife or himself but despite an apparently good pre-morbid personality, he is having great difficulty in losing, in his own words, 'my wife, my business and my house' and it is of concern that he is not improving on medication'.*

The letter contained information about potential risk indicators of suicide with regard to Alan.[188]

2 May - at Pangbourne Police Station Sgt B allocated to PC C the glued locks crime report. It was described as follows:

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[185] C11 information to PDHR; C14 evidence at Inquest
[186] JP statement for Interim Maintenance 1/05/03
[187] Berkshire West PCT IMR
[188] GP letter to private consultant psychiatrist

> '*This was un-witnessed. The only reason there is a named suspect is the fact that the agg.* [aggrieved] *Has an injunction against the suspect. There is no evidence to suggest the suspect actually caused the damage.'*[189]

The hard copy was reviewed by a Sgt who had responsibility for checking where the offence occurred and to reallocate the crime to the relevant shift. PC C made telephone contact with Julia.[190]

2 May - Julia received a letter ostensibly from Alan's company cancelling her private health cover on the basis of her intended divorce. Julia was still receiving treatment for breast cancer.[191]

2 May – Alan's company received a letter from BUPA requesting confirmation that the private health care for Julia was to be cancelled. It emerged Alan had sent a letter to BUPA on company headed paper and signed it from the directors, none of whom were aware of what he had done. Alan was angry when they put a stop to his attempt to cancel Julia's health cover.[192]

5 May - Julia wrote to the company group secretary who confirmed he had been unaware of the letter to BUPA and her health cover would not be cancelled[193].

8 May - (Julia's fifth consultation with the GP since September 2002) the GP recorded:

> '*Insomnia, initial and delayed, 6 weeks, no low mood, worries, financial worries, aware husband off work, maintenance request not forthcoming, son distressed. Sleeping tablets prescribed for insomnia. Vasovagal attacks – once standing after breakfast the second standing from sitting.'*[194]

[189] TVP Crime Report Notes
[190] TVP MSR
[191] Letter to JP from Alan's company; JP Affidavit 19/06/03
[192] C11 information to PDHR
[193] JP letter to Company Secretary
[194] Berkshire West PCT IMR – Zoplicore is a sleeping tablet

10 May - Alan finished work.[195]

13 May - Julia recorded in her diary William had told her on returning from a meal with Alan:

> *'Dad will never let us lead a normal life all this will end up with you being killed dad could even kill me.'*

The next day Julia took William out of school for the afternoon.

15 May – Alan delivered to Old Hallowes in an envelope addressed to William, a copy of Julia's Affidavit dated 17 September 2002. Alan had annotated Julia's Affidavit with expletives and angry and abusive comments which Julia believed to be death threats; in her Affidavit (19 June 2003) she stated '*took me back to how I felt when he first made threats against my life.'*[196]

Julia intercepted the envelope and called her solicitor who advised her to report the matter to the police.

Julia's seventh contact with TVP (note handwritten by TVP officer)

Julia in some distress and her brother C5 went to Newbury Police Station to report Alan had delivered an annotated copy of Julia's Affidavit to Old Hallowes.

They met a uniformed officer described by C5 as '*antipodean'*[197] who promised to help. C5 told him about the seriousness of the development, the context, the Injunction with a Power of Arrest and the history of continuing death threats. *'Between us we did our best to ensure that the police could be under no illusion as to the seriousness of this development.'*[198]

The Officer gave C5 his mobile phone number. C5 asked the officer to alert Sgt A (who was involved over the weekend of 14 &15 September 2002 and to whom C5 had directed police

[195] Consultant psychiatrist statement for Inquest
[196] JP Affidavit 19/06/03 for extension of Injunction
[197] C5 Statement (1) to PDHR
[198] C5 Statement (2) appendix A to PDHR

officer's attention on 20 April 2003) and the officer agreed to do so. When C5 phoned the officer later at least twice he assured C5 that the matter was in hand.[199]

The annotated affidavit together with other correspondence including Julia and Alan's wills, instructions to executors, handwritten notes from Alan etc were received at Pangbourne Police Station by PS G. Attached to the papers was an unsigned and undated handwritten note addressed to PC C that referred to the Crime Report number for the super glued locks on which was written '*Copy of Injunction & correspondence between Pembertons. Please call ASAP!'*[200]

PS G forwarded the papers to PS B to be allocated to PC C.[201]

At 1928hrs (1 min 2 secs)and at 2051hrs (1 min 29 secs)telephone calls were made from Old Hallowes to a police mobile, one of a batch allocated for collective use at Thatcham Police Station; TVP have no record of these calls. [202]

15 May - Alan went on holiday to the Maldives.[203]

16 May - at 19:28hrs (3 mins 33 secs) a telephone call was made to the same police mobile as on 15 May from Old Hallowes.[204] TVP have no record of this call.

17 May - TVP Crime Report regarding glued locks as follows:

> *'17/05/03: 'Spoke to Mrs Pemberton she said that she had not expected any action she just wanted it recorded. I explained that without further evidence we could not take this any further. PCW I therefore suggest that this is filed. PC D'*

[199] C5 Statements (1)&(2) to PDHR
[200] TVP MSR – TVP were not able to identify the date when the documents were received at Pangbourne Police Station.
[201] TVP MSR states that PS B, PC C and PC D did not recollect receiving the papers. The annotated affidavit and other papers were found with the closed glued locks crime report by the TVP reviewers with the note but without a copy of the injunction. The date the papers had joined the closed glued locks crime report is not known.
[202] BT Telephone record for Old Hallowes; TVP information to PDHR
[203] JP diary
[204] TVP have no record of who was using the mobile phone or what information if any was exchanged between Julia and a police officer on 15 and 16 May

17 May – Julia's eighth contact with TVP (TVP Crime Report)
Julia recorded in her diary that she had received a telephone call from Newbury Police Station: *'Tel call from Newbury Police- re locks incident- no evidence ∴ can't take any further.'*

18 May – TVP Crime Report record regarding glued locks as follows:

> '*OIC* [Officer in charge] *has spoken to agg.* [aggrieved] *She was surprised police were investigating. She only notified police for recording purposes. She fully accepts that without any evidence police action is limited. All lines of enquiry complete. PCW please file papers sent 18/05/03.'*

19 May - Julia's GP wrote to her solicitor advising that she was signed off work until 19 June.

19 May - Julia telephoned the examination tutor at William's school and wrote a follow up letter to alert the examinations board to the potential impact of the *'huge pressure'* he was experiencing which she believed would have an impact on his performance in his forthcoming GCSEs:

> *'he is having to deal with our marital breakdown which began in 2002 but which has become increasingly ugly in the past weeks, making it more difficult for him to deal with, he is extremely worried about me as I have been subject to death threats and William has had to endure suicide threats and very difficult behaviour from his father.'*[205]

22 May - (Julia's sixth consultation with the GP since September 2002) the GP recorded:

> '*Insomnia some benefit only, feels weak, tired but denies depression, not catnapping, no physical symptoms; review two weeks.'*[206]

28 May - Alan returned from his holiday in the Maldives.[207] He gave William a letter and a copy of the annotated affidavit. In the letter (dated 14 May) Alan described over four sides of

[205] WBC IMR
[206] Berkshire West PCT IMR

A4 his anger towards Julia because of the contents of her first Affidavit which he noted he had sent to William previously. Alan referred to four court cases; the injunction, divorce, financial settlement and the split of financial assets. He referred to a suggestion William had made about acting as a go-between:

> *'…I will not accept that your mother can undertake such a heinous act and get away with it…I can't describe the anger I have for your mother… I absolutely hate the one who has destroyed my life in the past several months…I advised her not to take legal action and that if she did I would fight it to the death I have nothing to lose now…*
>
> *You asked what I would accept now. The most sensible solution would be for Mum to apologise and for me to accept her back - I don't think she'll do that.*
>
> *…The only acceptable solution to me now is if she were to disappear and give me back my children, home and wealth - I don't think she'll do that either in which case we're heading towards a disaster and the end of the Pemberton family that I was so proud of having jointly achieved with your Mum.*
>
> *…You know what my objective is-it's quite simple-it will however be a pyrrhic victory!'* [208]

28 May to 2 June - Alan was golfing in France.[209]

29 May - Julia noted in her diary that she had discussed Alan's letter and the annotated affidavit with William as well as her real fears. At 2049hrs (7 mins 5 secs) a telephone call was made from Old Hallowes to Newbury Police Station and at 2111hrs (2mins) a further telephone call was made from Old Hallowes to the same police mobile phone as on 15 May; TVP have no record of these calls. [210]

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[207] JP diary
[208] JP Affidavit 19/0/6/03 ; extracts from letter to William which was included as exhibit
[209] C5 to PDHR Information from JP records
[210] BT Telephone record for Old Hallowes C5 information to PDHR; TVP information to PDHR

June

2 June - 0937hrs (1min 3 secs) a telephone call was made from Old Hallowes to the DVC extension at Newbury Police Station; TVP have no record of this call.[211]

3 June - at 1213hrs (53 secs) a telephone call was made from Old Hallowes to the DVC extension at Newbury Police Station; TVP have no record of this call.[212]

3 June - (Alan's fourth consultation since September 2002) GP recorded:

> *'Remains deeply unhappy re divorce proceedings, allegations, tearful, seeing psychiatrist next week, difficulty tolerating medication (fluoxetine 40mg) because of nausea reduced to 20mg occasional fizzy sensation in left leg, lasts 30 seconds, still thoughts of suicide-encouraged to discuss with* [private consultant psychiatrist] *review 1 week later.'*[213]

4 June – at 1029hrs (2mins 14 secs) a telephone call was made from Old Hallowes to the DVC extension Newbury Police Station; TVP have no record of this call. [214]

5 June - (Julia's seventh consultation with the GP since September 2002) GP recorded:

> *'some anxiety symptoms, mentions distressing letter from husband to William over 4 sides A4, concerned about safety self and family, seeing police support and solicitor, good family help, denies depression review in 2 weeks Insomnia, Zoplicore* [*sleeping tablet*] *helps for 4 hours.'*[215]

5 June - Julia wrote in her Financial Statement[216] she was intending to seek an order for sale of the house and required a sufficient share of the proceeds to re-house herself, William and C19. She wished to take full control of finances and not to be dependent on Alan; she was

[211] BT telephone records Old Hallowes C5 information to PDHR; TVP information to PDHR
[212] BT telephone records Old Hallowes C5 information to PDHR; TVP information to PDHR
[213] Berkshire West PCT IMR
[214] BT telephone records Old Hallowes C5 information to PDHR; TVP information to PDHR
[215] Berkshire West PCT IMR
[216] Extract from Financial Statement (Form E) prepared by Julia dated 5/06/03

concerned about the control and manipulation he had exhibited in the past and was continuing to exhibit:

> *'He* [Alan] *has recently made veiled threats to kill me via our son William…he has threatened to 'play dirty' and 'take me all the way to the High Court.'*

9 June - Julia meeting with the DVC ninth contact with TVP (DVC record)

At the meeting (between 1030 and 1130hrs) the DVC completed a further Advice Form; including directions to Old Hallowes. The DVC noted that Julia was 'concerned *for her safety for 7/7/03, advised personal safety'* [date of Hearing for extension of the Injunction]. The DVC recorded on the Form she had discussed with Julia changing her telephone number; civil solicitor matter and that Julia did not want support form Berkshire Women's Aid. In relation to moving house, Julia had said if the Injunction was declined she might have to. On the Advice Form the DVC noted '*VTSE'* [violence to secure entry] against the item criminal proceedings. The DVC advised Julia to phone 999.[217] The DVC also advised Julia about relaxation and supported Julia's wish for a community alarm.[218]

9 June - Julia noted in her diary that PC C left a message on her answer-phone '*ref statement'*. Julia telephoned PC C and left a message '*on answer-phone'*. At 1314hrs (2 mins 20 secs) a telephone call made to Pangbourne Police station from Old Hallowes; TVP have no record of this call. [219]

10 June – Julia's tenth contact with TVP (DVC record)
The DVC opened a URN log whilst she was visiting Old Hallowes for the fitting of the alarm giving Alan as the offender and requesting *'any calls treat as urgent.'*[220] She met Julia with the person from the safety alarm company and an alarm was installed and tested; explicit instructions were included by the DVC on the notification to the Alarms Administrator

[217] DVC Witness Statement 02/03/04 for Inquest
[218] DVC Advice Form [incorrect date given as 9/05/03 on the Form] and DVC Witness Statement 02/03/04 to Inquest.
[219] BT telephone records Old Hallowes C5 information to PDHR; TVP information to PDHR
[220] TVP advised PDHR this was a routine procedure when DVC made such visits

regarding the directions to Old Hallowes.[221] The log was closed when the DVC returned to the police station.

11 June - Julia recorded in her diary that she had phoned PC C and when there was no reply she had left a message on the answer phone. Telephone records for Old Hallowes show that at 1610hrs (28secs) a telephone call was made to Pangbourne Police station and again at 1611hrs (1 min 6 secs); TVP have no record of these calls. [222]

11 June - Alan had his first consultation with the private consultant psychiatrist who noted the following:

> *'Not seen as major suicide risk'*, no evidence of major depressive illness, no psychotic symptoms, no evidence of pathological jealousy, no evidence of psychotic process- '*Obviously only got one side-probably not an easy man, possibly egocentric? Narcissistic to some degree, materialistic.'*[223]

12 June - Alan made his final will and wrote a letter to his bank to cease payments from his account in the event of his death.[224]

13 June - the psychiatrist wrote to the GP referring to the information Alan had given concerning the break up of his marriage

> *'She has accused him of being abusive to her throughout the marriage and has even apparently suggested that he could be a risk to his children.'*

The psychiatrist noted in the early stages of the break up Alan had lost his temper and threatened to kill himself and Julia and *'I do not have the impression that she was ever in significant danger from him.'* He went on to note that Alan had *'no psychotic features or evidence of pathological jealousy and I did not think he represented any danger to his wife.'*[225]

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[221] TVP Alarms Admin form 10/06/03
[222] BT telephone records Old Hallowes C5 information to PDHR; TVP information to PDHR
[223] Information from psychiatrist to PDHR
[224] TVP MSR
[225] Letter from psychiatrist to GP

15 June - Julia noted in her diary that PC C had telephoned her. TVP have no record of this call.

16 June - the GP wrote to Julia's solicitor:

> *'Julia is suffering from considerable stress as a reaction to her circumstances, both recent and long term. She feels that there has been disharmony throughout her marriage as a result of psychological and verbal abuse from her husband and since her separation this has become more acute with concerns about her own personal safety and that of her children. She feels affected by the various threats which her husband has evidently made both to kill himself and her and has sought support both of family and friends and Domestic Violence Unit and legal counselling.'*

Letter refers to various threats evidently made by [Alan] both to kill himself and her and emphasises the need for a swift and fair settlement in the interests of [Julia's] state of mind.[226]

19 June - Julia wrote her Affidavit for the Injunction hearing giving as evidence the incidents concerning the glued locks; the alleged letter from Alan's company concerning her removal from the BUPA scheme; William's expressed fears that Alan would try to kill her; Alan's hand delivery of an envelope addressed to William containing a further copy of the annotated affidavit and his letter to William:

> *'I sincerely believe that the threats are there and that he is capable of doing me serious harm. William is also very worried about the contents of the letter.'*

19 June - (Julia's eighth consultation with the GP since September 2002) Julia was given a sick certificate for three weeks by the GP:

> *'-stress at home more relaxed; has panic button to remote alarm centre, impending court appearance, worried that injunction may not be continued.'*[227]

[226] Berkshire West PCT
[227] Berkshire West PCT IMR

19 June - In his Affidavit Alan wrote he felt a '*mixture of extreme anger and distress*' at Julia's decision to end their marriage and on 13 September 2002 he had threatened to kill both Julia and himself. He apologised for making such a threat:

> '*There was never any intention on my part to carry it out. I love my family and would do nothing to harm them.*'

He referred to Julia's decision as coming at a '*particularly low time for both of us*' in the context of the instigation of court proceedings by a former colleague against the company and himself; Julia's brother's suicide three days later; his diagnosis of melanoma in January 2002 for the second time and Julia's mastectomy. Alan set out a detailed response to Julia's Affidavits of 17 September 2002 and 13 March 2003. He asked the Court to accept he was not a threat to Julia; they could live separately at Old Hallowes and asked to be allowed to return to restricted parts of the property.[228]

24 June - Alan had a second appointment with the private consultant psychiatrist. In his letter to the GP of the same date, the psychiatrist noted that Alan remained:

> 'very *troubled and preoccupied with the various allegations that his wife has made via her solicitor, about him and the quality of their marriage.*'

The psychiatrist noted that he had tried to get Alan to see what Julia had said might have been meant less literally than Alan had understood. He wrote that he had also discussed with Alan how he risked making the situation worse for himself in a number of ways; including in his relationships with his business partners which Alan attributed to their feeling he was not pulling his weight and getting back to work. He noted Alan had spoken of challenging Julia through the courts even if it ended in financial ruin for both of them; Alan's main pre-occupation was with the break-up of his marriage; his communication with Julia was now only via solicitors and this was becoming increasingly antagonistic. He did not think that Alan represented any danger to Julia and was due to see him again in July.[229]

[228] AP Affidavit 19/06/03
[229] Letter from psychiatrist to GP 24/06/03

The same day Alan had his fifth and last consultation with the GP since September 2002[230] the GP recorded:

> *'Depressive disorder. Unable to face clients, pops into office in evenings to collect papers, two remaining partners unhappy with his depression, relationship tense, court case 07/07 to again return to house, hatred for JP "growing" review 2 weeks.'*[231]

July

7 July - One of Julia's sisters, C18 went with Julia to Reading Court for the adjourned Hearing for the extension of the Injunction.[232] In her Affidavit (19/06/03) Julia had given details of the incidents which had occurred and referred to the ongoing threats that Alan had made. Alan and Julia's Barristers had been in negotiations before the Hearing and had reached an agreement. Alan gave an Undertaking to the Court promising:

> '(1) *not to enter or attempt to enter the former matrimonial home known as "Old Hallowes", Slanting Hill, Hermitage, Berkshire, or it's curtilege save that he may enter on and use the driveway in the event that he is collecting William or* [C19] *for contact.'*[233]

Alan was warned by the District Judge that if he was found to be in breach of the Undertaking that it was an imprisonable offence. The Judge made an order that the house was to go on the market as soon as possible and Julia was to deal with the sale. The Orders dated 26 September 2002 and 20 March 2003 were discharged and no Power of Arrest was granted.

8 July – Julia met with her solicitor and told her she had been happy to accept the Undertaking because it had meant that she did not have to go through with a full Hearing.

[230] Alan was seen by a partner at the GP practice on 4/11/03
[231] Berkshire West PCT IMR
[232] Information from C18 to PDHR
[233] General Form of Undertaking in Reading County Court 7 July 2003 Claim no:RG020F01734

Julia said she had learnt from mutual friends that Alan had been surprised that the Judge had a made an order that the house be placed on the market. The solicitor noted Julia *'said that she is always on the alert any way and she still has her panic alarm.'*[234]

8 July – Julia's eleventh and last contact with TVP until 18 November 2003 (DVC Witness Statement to Inquest)

Julia met by chance in Newbury the DVC who was off duty. The DVC has stated Julia told her the Injunction had been renewed [see entry above for 7 July] and that she was a lot happier. The DVC advised her there were other staff to whom to refer in her absence.[235]

10 July – (Julia's ninth consultation with the GP since September 2002) the GP recorded:

> '*separated husband made undertaking not to visit house, judge ordered house to be sold. Relieved by initial court hearing, husband ordered to answer questions re finances,* [Julia] *still taking hypnotics.'*[236]

14 July - DVC commenced sick leave.

15 July - Alan's third consultation with the psychiatrist; Alan told him Julia remained *'intransigent'*; he was planning a final holiday with William and he talked of breaking off contact afterwards '*Too painful to continue they don't need me*.' The psychiatrist noted Alan had set up obstacles for himself in relation to his business partners by asking for a key to the office. Alan had said the staff at work knew Julia had accused him of abuse and he could not go back to work unless she retracted her allegation. It was left Alan would fix a further appointment with the psychiatrist.[237]

23 July - C19 returned from South America.[238]

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[234] Attendance Note 08 July 2003 provided to PDHR by solicitor (2)
[235] TVP MSR; DVC Witness Statement to Inquest 02/03/04
[236] Berkshire West PCT IMR
[237] Information from psychiatrist to PDHR
[238] C8 Information to PDHR

25 July - Alan wrote in an email to the GP which he recorded as follows:

> *'matters have deteriorated, regularly encountering funny turns and collapsed/ fainted on a few occasions. Current comforts alcohol and sleep. Requests sick note extension and gives permission for a medical note to be sent to* [Julia] *solicitors and work colleagues on request. "Thanks for all your help over the years".'*[239]

In his record of a telephone conversation with Alan the same day in response to the email, the GP noted:

> *'discussed, low mood still, further follow-up psychiatry, financial concerns as sole significant asset (house) changed to his wife's name 2 months before she told him of proposed separation, still intermittent tingling in upper left leg, compliance with medication was not good.'*

31 July - (Julia's tenth consultation with GP since September 2002) GP recorded:

> *'Separated stopped taking medication 1 week ago, returns to court 01/10, Husband plans to move away, injunction* [sic] *extended 6 months, house being sold, relieved that divorce not being contested, hopes to return to work 2 days/week.'*[240]

August

5 August - Alan vacated the house he was renting locally and moved to live with C14 in Herefordshire; he changed his will and signed over to her two life policies valued at a total of £300,000.[241]

7 August - C8 saw Alan for the last time and told him to stop using William and C19 as emotional pawns.[242]

7 August - The GP wrote to Alan's solicitors:

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[239] Berkshire West PCT IMR
[240] Berkshire West PCT IMR
[241] C14 Evidence at Inquest
[242] C8 Information to PDHR

'The diagnosis is one of clinical depression and clearly the particular circumstances have been both a significant precipitating and perpetuating factor. Once the divorce proceedings are complete, the High Court case involving his business partnership is resolved and he has sorted his personal, social and financial position, one has to be optimistic about his future prognosis and ability to return to work in the medium to long term. However, with any clinically significant episode of depression there is risk of recurrence.'[243]

12 August - From evidence at the Inquest it is apparent that Alan wrote letters to his bank and Barclaycard.[244]

12 August - Alan went on holiday to Greece with C19 and William until 20 August.

26 August - Julia whilst out with a friend, is reported to have said that she was ready to meet with other mutual friends; was pleased and relieved that Alan had moved away from Newbury and had a girlfriend.[245]

Analysis of agency intervention

(a)Thames Valley Police

9.1 During this period TVP had three further crucial opportunities to intervene positively. Whilst between October and April there had been no contact from Julia or family with TVP, this was not the case in April, May and June.

- 20 April - super-glued Locks
- Annotated affidavit
- Julia's meeting with the DVC and installation of the alarm

[243] Berkshire West PCT
[244] Letters found posthumously on 25/11/03 by C14
[245] C15 letter to PDHR

9.2 The incident concerning the super gluing of the locks is the fifth police engagement with Julia and an opportunity to positively intervene.

9.3 When the operator input the details on to the Command and Control log, she became aware that it was previously flagged as domestic violence. Because Julia told her that Alan was no longer at the address, she did not deal with it as domestic violence and she diverted it into a crime (criminal damage) report.[246]

9.4 The Crime Report in respect of the criminal damage on 20 April was not acted on until 2 May, eleven days after Julia telephoned the police. It was allocated to PC C who at that time had only been an operational officer for ten weeks. He was under the constant supervision of PC D his tutor constable. Initially PC C decided that he was going to follow up with house-to-house enquiries and take a statement from Julia. PC C made telephone contact with Julia. In his statement to the TVP reviewers he wrote that during the phone call with Julia.

> '*She seemed very surprised to hear from him and said that she had not expected any investigation. She said that she had reported the incident for information only as she was aware there was no evidence to link the damage to her husband. She told me she was going through a divorce and had an injunction against her husband but she said nothing about domestic violence and did not seem in the least bit concerned.'*

9.5 There was a motivated suspect and a crime scene, whereby it would have been possible to have carried out an investigation to establish whether or not there were any fingerprints or other evidence linking Alan or any other individual for that matter to the scene and various criminal acts – criminal damage, harassment or breach of the injunction. There appeared to be an operating assumption on the part of the officers dealing that because of where it was there would be no likelihood of being able to prove that it was Alan, in any event non attendance ensured that no evidence would be collected and no potential suspect identified.

[246] Information on TVP response to glued locks incident from TVP MSR and Crime Report

9.6 This was another opportunity, where a potential crime was disclosed, where Alan was a credible suspect. Julia had an Injunction with a Power of Arrest and TVP should have undertaken an investigation; given, in the event that Alan had glued the locks, he would have breached the terms of the Injunction and presented further evidence of his harassment of Julia. No attempt was made to recover evidence from the scene, no demonstrable thought went into the means by which this could be addressed and no effort was made to interview Alan as a suspect.

9.7 Had the police gone to the scene, they may have collected further evidence and capitalised on the significant opportunity to gather more information in respect of the increasing threats Julia and William were experiencing.

9.8 In the period between the DVC speaking to Julia in October, when she was reassured that everything was peaceful, and the glued locks incident, there had been an escalation of Alan's threatening behaviour as noted in previous sections of this report. If information had been obtained from Julia and her family in the process of investigating the incidents in April and May and documented by the police, this would have provided a full profile of Alan's ongoing criminal harassment of Julia and informed an assessment of the risk that Alan represented to her.

9.9 The operator made the first error by not connecting the crime with domestic violence. Notwithstanding the fact that PC C, the investigating police officer, was told by Julia about the injunction and Power of Arrest he also did not identify that a domestic violence incident or linked crime had been committed. As a result no contact was made with the DVC and no action taken by TVP.

9.10 We noted on 17 May the telephone call to Julia made by PC D regarding the glued locks was recorded in both her diary and on the Crime Report. The police record states that during the call Julia conveyed that she had not expected any action but had just wanted the incident recorded. PC D recorded that he explained that without evidence no further action could be taken; we consider it was this aspect of PC D's record that was reflected in his

conversation with Julia and noted in her diary.[247] We consider that an investigation should have been undertaken by Thames Valley Police and the DVC notified of the incident.

TVP Management Service Review

Extracts with reference to super-glued locks Incident:

> Review Comment 11:
>
> *'It is the opinion of the reviewing officers that the 'failure' to make the link between this report of criminal damage, the 'unrecorded' threat to kill and the domestic violence file constrained subsequent police activity and prevented the officers from taking a more holistic view of the circumstances that Julia was facing.*
>
> Review Comment 13:
>
> *It is apparent that PC C did give some consideration to the attendance of the Forensics Investigations Unit to the house but this was discounted. As a frequent and legitimate visitor to the address it would be expected that Alan Pemberton's finger marks or DNA would be present and would offer little or no evidential value.*
>
> Review Comment 14:
>
> *'This philosophy of 'active investigation management now runs throughout the organisation driven by a Detective Superintendent. In this context there were some failings in the original investigation.*
>
> *The length of time it took to allocate and investigate the incident following the recording of the crime.*
>
> *Our failure to actively investigate the report which in possibly reducing Julia's faith in the police contributed to:*

[247] Julia's diary

A failure to identify the escalation in Mr Pemberton's behaviour which was unknown to the Police but may have become apparent if the links to the ongoing domestic situation had been made.'[248]

Review Comment 34:

In Julia's case, the decision had been made at the point of recording the criminal damage to the locks that the incident was not related to domestic violence, this would not be acceptable under current policy.

Review Comment 36:

The ability to look across different databases with a single search would have enabled the links between the domestic violence file and the crime complaint to have been made.

Panel comments

The panel question the reference in the MSR to Alan '*as a frequent and legitimate visitor*' to Old Hallowes, as this does not take account of the Injunction with the Power of Arrest; we understand that the barrels of the locks were changed in December 2002 after Alan had left the family home in September 2002.[249]

The MSR did not identify the significance of the absence of a domestic violence policy, procedure and training on the performance of officers, civilian staff and supervisors and on the delivery of a service to Julia and William at a time when there was evidence of an escalation of risk.

[248] Underlined as in TVP MSR
[249] C5 information to PDHR

- Annotated affidavit

9.11 This was the sixth engagement between Julia and TVP. It was another opportunity for TVP officers to have adduced the evidence of an escalating and deteriorating situation and to have investigated and potentially interviewed and arrested Alan for breach of the Injunction.

9.12 During the review, we asked TVP to identify the '*antipodean officer*' and how the papers came to be filed; TVP have not been able to identify either the officer or how the papers came to be filed. We consider that the content of the note addressed to PC C indicates that Julia and C5 had conveyed the urgency of the information to the '*antipodean*'; nevertheless it was not logged as an incident and no recorded action was taken as a result at the time by TVP officers.

9.13 The panel have noted that the conversation with PC D about the glued locks incident took place only two days after Julia and C5 had taken the annotated affidavit to Newbury Police Station and given information to the 'antipodean officer' about their concerns regarding the escalating threats. We consider on the balance of probability that Julia would have made reference to this in her conversation with PC D (PC C's tutor constable).

9.14 C5 provided us with telephone records for Old Hallowes that show a number of calls of different duration were made in this period to TVP telephone numbers. TVP have confirmed that the telephone calls made on the evenings of 15 and 16 May were to a mobile phone allocated for use to Thatcham Police Station.[250] These calls were made on the same day and the day after Julia had handed the annotated affidavit in at Newbury Police Station. On 29 May, the day after Alan gave William the letter and a further copy of the annotated affidavit, a call was also made to Newbury Police Station. TVP have no information regarding the mobile phone user, the content of those calls or the ones made to Newbury and Pangbourne Police Stations. TVP have not been able to provide any records regarding the receipt of the annotated affidavit at Newbury Police station other than the A4 paper with handwriting on it.

[250] One of a corporate block of numbers used by TVP prior to personal issue of mobile phones: TVP information to PDHR June 2008

9.15 The telephone records for Old Hallowes provided by the family show that calls were also made to Pangbourne Police Station on 9 and 11 June. TVP have been unable to ascertain the purpose of PC C's call to Julia on 9 June; her diary entry records that it was '*ref statement*'. Julia recorded in her diary on 15 June that PC C had spoken on the telephone to her. TVP have no record of that call either.

9.16 The papers concerning the glued locks had been closed on 17 May and archived on the 25 May. TVP were not able to confirm when the annotated affidavit and other papers were filed. In the circumstances we have concluded that it is probable that the telephone calls made from Old Hallowes on 29 May and 9 and 11 June concerned the annotated affidavit.

9.17 Following our requests for further information concerning the individual officer likely to have been involved and the handling of the annotated affidavit and other documents, TVP have undertaken additional investigations but without success.[251]

9.18 The incident involving the annotated affidavit was not recorded at Newbury Police Station and not flagged to the DVC.

9.19 Julia and C5 made concerted efforts to get help from TVP at a time when there was evidence of Julia and William's increasing anxiety about what Alan might do to harm them and officers failed to respond appropriately.

TVP Management Service Review

Extract with reference to the annotated affidavit Incident:

> Review Comment 16:
>
> *'This has puzzled the reviewing officers who have been unable to establish the full continuity of the papers between their delivery at Newbury and the subsequent filing. The accounts of the officers are not supported by the facts.*

[251] TVP information to PDHR 13/06/08

It is clear that the papers 'signposted' the domestic situation and warranted further investigation. None was carried out and the papers were just filed with the crime complaint, they were not referred to the DVC and no connection was made with the domestic situation. These were significant errors.'

Panel comments

In relation to the annotated affidavit we do not consider that the significance of this incident was recognised in 2003, nor was it given due regard by the TVP reviewers in 2006; there was information available from the contact between the family and TVP and obtained in meetings in 2004 and 2005 indicating the significance of this document. It is apparent from telephone records at Old Hallowes that calls were made to TVP police stations during a key period when Julia was also expressing her concern for her own and William's safety to the GP, family and friends.

In delivering the annotated affidavit to Old Hallowes, Alan had breached the Injunction and provided further evidence of criminal harassment. It would therefore be reasonable at least to expect the police to have questioned him.

- Julia's meeting with the DVC and installation of the alarm (Julia's eighth contact with TVP)

9.20 In late April 2003, the DVC reported sick with stress citing *'excessive workload'* and from early May 2003 another police officer provided additional support in the DVU on Monday and Friday per week; the DVC worked Monday to Thursday. TVP do not have information concerning the content of the calls received from Old Hallowes to the direct dial number in the DVC office on Monday 2, Tuesday 3, and Wednesday 4 June.

9.21 Julia met with the DVC on 9 June. This engagement overlapped with PC C's contact with Julia. From the DVC record of the 9 June it is apparent that there had been discussion between Julia and the DVC about VTSE (violence to secure entry).

9.22 The DVC's advice to Julia regarding the importance of relaxation and the benefit to be gained from aromatherapy has been criticised. We do not share this view; we consider this

advice to Julia as a victim of domestic violence was intended to help her in regaining her mental and emotional equilibrium. The DVC's supportive advice to Julia came at a time when other police colleagues were failing to respond appropriately to Julia's reports of Alan's continuing harassment and threats. We do however fully understand that when taken in isolation and within the context of the quality of the broader TVP response that it could appear inappropriate.

9.23 On 10 June the DVC visited Old Hallowes to supervise the fitting of the alarm. TVP reviewers advised us that, as was the case during the DVC's visit to Old Hallowes, it was a standard operating procedure for the address to be flagged for immediate response when the DVC was visiting an address. The visit was the only one made to the house by a TVP officer other than on 9 September 2002 in response to the stolen mountain bike reported by Alan. There is no evidence to establish whether or not during the DVC's visit on 10 June consideration was given to Julia's options in relation to the layout of the house and grounds in the event of violence to secure entry by Alan. We were told that Julia was seen on some occasions to wear the alarm whilst in the extensive grounds at Old Hallowes.[252]

9.24 The only elements of a domestic violence system in the West Berkshire Basic Command Unit of TVP were a flagging system which required officers to flag incidents so that the DVC could follow them up. The incident on 20 April was not flagged as domestic violence at the point of referral. The report of the annotated affidavit on 15 May was not properly recorded as a separate incident. The system in so far as it did exist to protect domestic violence victims, relied entirely on the knowledge and competence of individual officers. We have already noted the absence of policy, procedure and training with regard to domestic violence for civilian, uniformed officers and supervisors. The fact that the incidents on 20 April and 15 May were not flagged meant that the system, in so far as it did exist to protect victims of domestic violence, failed to protect Julia.

9.25 The DVC would not have therefore known about the two incidents unless Julia or PC C told her. At the Inquest the DVC acknowledged that she knew about both incidents but could not recall when she became aware. We consider that through the telephone contact between Julia and the DVU on 2 and 4 June and direct contact on 9 and 10 June there were

[252] C17 Information to PDHR

opportunities for Julia to have shared with the DVC the events of the preceding six weeks. If this had been the case we consider that in her coordinating role the DVC could reasonably have been expected to link with her fellow officers to find out what action had been taken to protect Julia and to have consulted her supervising officer. The DVC's information to the TVP Management Service Review sheds no further light on this matter.[253]

9.26 As previously stated we are aware that the note attached to the annotated affidavit was addressed to PC C and that according to Julia's diary she was still in contact with him.

9.27 We have been advised by TVP that the DVC would not have been expected to investigate the crime reports herself; it was not a DVC responsibility. We have sought to ascertain from TVP how frequently the DVC initiated any criminal prosecutions and/or referred to uniformed colleagues for further investigation.

9.28 We have been informed by the TVP reviewers of evidence of the DVC's positive intervention approach particularly with regard to DV prosecution cases; in other cases where officers had dealt with 'single' incidents, the DVC's collation of incidents had resulted in admissions in interview and charges made on the offender.[254] However there is no evidence of this being the case in relation to the incidents in September 2002, April or May 2003 concerning Julia.

9.29 The DVC took sick leave from 14 July to 5 October 2003.

TVP Management Service Review

Extract with reference to the DVC:

> Review Comment 17:
>
> [DVC advice regarding aromatherapy]

[253] TVP MSR additional information to PDHR March 2008
[254] TVP Information to PDHR June 2008

'This advice has been subject to some criticism but in the context of all the advice given by the DVC it appears that this was a genuine attempt to empathise with Julia'

Review Comment 19

[Contact between DVC and Julia]:
'The DVC stress- related sick leave may have contributed to the lack of communication and there was no further contact from Julia or anyone on her behalf until 18 November.

In respect of any arrangements for continued contact the DVC reports 'None as I recall. Due to the volume of work I generally tell people to call me. I used to try to keep in contact with clients if there was something specific to tell them, but there was just too many. I had to rely on them calling me or 999. They were advised about both which was normal practice.'

Contact with Julia ceased and there was no structured communication plan. It is the opinion of the reviewing officers that this absence of contact with Julia resulted in her having to take the lead in any communication with the police.

The lack of communication and Julia's experience of dealing with the police had possibly resulted in a lack of confidence in our ability to deal with her concerns and a reluctance to report the ongoing domestic situation.

We would recommend that there needs to be a more structured review of contact between a victim of domestic violence and the police. This would need to be based on the perceived risk to the victim and may take the form of a 'managed' contact agreement'. The frequency, nature and incremental reduction of contact reached in agreement between the victim and the officer dealing.'

Panel comments

The MSR acknowledges the lack of a structured plan for follow-up of cases, the workload of the DVC and her sick leave, left the responsibility with Julia to make contact. We agree with the MSR reviewers that this combined with her experience of dealing with the police may have resulted in a lack of confidence in TVP's ability to deal with her concerns and a reluctance to report ongoing concerns.

Julia had acted in accordance with the DVC's advice to report any matters of concern by calling 999 or direct to the police station. In the incidents in April and May, Julia notified Newbury Police Station but did not receive an appropriate level of response.

(b) Berkshire West PCT including the consultant psychiatrist

In this period Julia consulted the GP on six occasions. Alan consulted the GP on three occasions, once in person and once by letter; he emailed the GP on the third and final occasion and the GP responded by telephone. Alan saw a private psychiatrist on three occasions.

- Julia's contact with the GP

9.30 The GP believed that Julia had police and family support. In his referral letter to the psychiatrist concerning Alan the GP had noted *'I do not feel that there is an immediate risk that he will harm his wife or himself.'*[255]

9.31 The GP had made an assessment that Julia was not at immediate risk of harm; he advised us that he believed that in the long run the risk assessment of threatened harm was outside his expertise and more within the expertise of the police. He did not contact the police himself when Julia expressed her concerns about safety but relied on Julia's report that she had done so and that the police would act appropriately.

[255] GP's letter to consultant psychiatrist

9.32 On 8 May, Julia told the GP specifically of her son's distress and on 5 June her concern for her own and her family's safety. On the basis of his assessment of Julia's information the GP did not arrange to see William himself or contact the police or social services.[256] As in September 2002 the GP responded to Julia on the assumption that Julia's contact with Thames Valley Police meant that they would be dealing with her concerns appropriately.

9.33 In the event that he had contacted either of these agencies, and thereby contributed to a multi-agency gathering of information, initial enquiries under section 47 of the Children Act 1989 may have been initiated. [257] These may have led to a refocusing by Thames Valley Police of their response to the risks faced by Julia and William. Potentially also to the opportunity for William to share his views and feelings with others who were in a position to help and protect him.

9.34 We note that in her next consultations with the GP on the 19 June and 31 July, Julia advised him that stress at home was more relaxed and that a panic alarm had been installed.

- Alan's contact with the GP and private consultant psychiatrist.

9.35 Alan was not interviewed by the police about the two incidents reported by Julia and her family. The GP and the psychiatrist were the only professionals who had with direct contact with Alan resulting in the opportunity to share information with each other to inform an assessment of the risk he presented to Julia or himself.

9.36 In responding to Alan's expressed suicidal thoughts the GP acted appropriately in referring him to a psychiatrist; he also briefed the partners in his practice.

9.37 The GP referred Alan by letter and telephone to the psychiatrist; in the letter the GP stated *'I do not feel that there is an immediate risk that he will harm his wife or himself.'*

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[256] Berkshire Area Child Protection Procedures 2001

[257] Berkshire Area Child Protection Committee - Child Protection Procedures 2001 page 17 also 76 par: 16.14.2 *'Where there is evidence of domestic violence the implications for any children in the household should be considered including the possibility that children themselves may be subject to violence or other harm.*
16.14.5 Where there are concerns regarding possible or actual domestic violence all professional workers should consider the need for the safety for the alleged victim as well as any children.

The GP does not, however, describe how he had arrived at that conclusion. The GP told us that he would have sought Alan's views of the threats reported by Julia in September 2002, but acknowledged that he did not see Alan until March 2003. We have not seen a record of such a discussion. The GP's referral letter is primarily concerned with Alan's depressive symptoms and potential suicide risk.

9.38 Alan's contacts with the GP and with the private consultant psychiatrist in May, June and July were in a key period. Alan told the GP on 1 May he was angry with Julia and detested her but on 3 June was having thoughts of suicide and was unhappy about Julia's allegations.

9.39 Alan told the psychiatrist that he had made a threat to kill himself and his wife and when asked to clarify what he meant Alan said he was sure he had not meant it.

9.40 The psychiatrist wrote to the GP a letter which arrived on 16 June in which in stated that:

> *'I do not have the impression she was ever in significant danger from him, but she took out an Injunction, the police were involved and he is not allowed to see her or visit the house'.*

9.41 The psychiatrist told us he offered Alan alternative strategies for dealing with the break–up of his marriage and the difficulties with his business partners; Alan demonstrated an unwillingness to explore any of these further in his discussion with the psychiatrist.

9.42 The psychiatrist confirmed he had not found evidence of mental illness nor considered Alan to be a serious risk to either Julia or William. The psychiatrist told the panel that looking back he could not connect Alan's presentation in June with what he had done in November 2003.

9.43 The psychiatrist told us that his recourse if concerned about risk in an individual case would be to contact the patient's GP. In Alan's case he did not consider there were grounds to do so.

9.44 We accept that on the basis of the evidence made available to him the psychiatrist was not in a position to have predicted Alan's subsequent actions.

9.45 We note that on 24 June both the GP and the psychiatrist separately saw Alan. To the GP, Alan referred to growing hatred towards Julia and to the psychiatrist that he felt so betrayed by her that he was willing to risk financial ruin. Neither doctor considered on the basis of information available to them that there was a need to contact the other.

9.46 We understand the role of the psychiatrist in dealing with a potential perpetrator is to address the risk to others and to take steps accordingly, based largely on historical indicators. The GP's referral did not include information of this kind (reference paragraph 9.40 above)

9.47 In our meeting with the consultant psychiatrist he told us he had limited or no immediate professional experience or specific knowledge about domestic violence.

Berkshire West PCT IMR

[In relation to Alan]

> [GP] *'offered Alan a referral to the NHS Mental Health Services' Team, however Alan made a clear choice that he wished to see a private consultant adult psychiatrist and so did not benefit from the support of a wider team……at no stage did he feel that there was sufficient concern to justify calling for a Mental Health Act Assessment with a view to compulsory admission to a psychiatric hospital.*[258]

We agree with this comment

> *From discussions and an overview of the medical records, it is apparent that there was considerable medical input given to members of the Pemberton family, when they wished to access it, in terms of emotional support, general advice and guidance. From the notes it is possible to pick up indicators that, with hindsight,*

[258] WBPCT IMR

could have heightened concerns but these were not sufficient at the time to escalate treatment of [Alan] *or security for* [Julia].

[GP] *felt that a referral to the Community Mental Health Crisis Team could have been helpful to* [Alan] *had it been available in 2003...it is believed unlikely that he would have accepted this referral.*

We agree that it is unlikely that he would have accepted a referral to the Community Mental Health Team; however the IMR should have been clearer as to whether this was the view of the GP or the psychiatrist or a conclusion reached by the IMR; having introduced this opinion it should also have concluded whether this had any bearing on the course of events; we have concluded that it did not.

It is felt significant that, in order to maintain continuity of care for his patient, [GP] *kept* [Alan] *on the practice list even though he had moved, within Berkshire, just outside the practice area, and then, after* [Alan] *had moved to Hereford, the final email was accepted as a not unexpected "over and out" moving on, thank you note. At the time, there was little to suggest that there were any underlying circumstances that could turn a life crisis into such tragic circumstances.'*[259]

We acknowledge the GP's positive action in following up on Alan's email. We agree that on the basis of the conversation with Alan there were no grounds for the GP to take any further action at that time with regard to his mental health.

[In relation to Julia]

A further considered decision was taken in not referring [Julia] *to a psychiatrist. Her insomnia/stress related symptoms could be clearly attributed to an adjustment reaction to her separation which would have been in conflict with her strong religious faith. It was also made clear that* [Julia] *had support from her family. Her brother stayed regularly in the house when necessary,* [Julia's] *solicitor and the*

[259] WBPCT IMR

Thames Valley police, including their domestic violence unit, were aware of the situation.

We agree with the GP's assessment that Julia did not require referral to a psychiatrist but consider given her experiences of domestic abuse the option of referral to another healthcare professional with whom she was not professionally connected could have been explored.

[In relation to William]

Berkshire West PCT IMR

'The marital problems between Julia and her husband were discussed in consultations with the GP from 2002 and she raised concerns for her and her and her children's safety in June 2003.

'At the time of the incident William was just seventeen. He had been living in a house of considerable tension and the question has to be raised as to whether Child Protection should have been involved. Both parents referred separately to his distress in consultations with the GP but the anecdotal evidence is that William was an extrovert, an active member of his school who showed no outward signs of being affected by the situation.'

Panel comment

William was aged fifteen when Alan threatened to kill Julia. The IMR subsumed Julia's report of her concerns for her family's safety into a general reference to William's distress. The IMR does not make it clear whether the conclusion regarding William is referring to the GP's use of his own contemporary 'anecdotal' information or that of the reviewers. In either case in our view the IMR should not have relied on unsourced anecdotal information.

We consider that the IMR should have reached a conclusion about whether or not the GP should have notified the police or social services in accordance with the West Berkshire

Child Protection Procedures 2001.[260] The IMR should have acknowledged that William did not have the opportunity to express directly his own views and wishes about his situation.

Thames Valley Police Management Services Review

[Reference the psychiatrist's assessment of Alan]

> Review Comment 18:
>
> *'Whilst the consultant's assessment of Alan Pemberton was that he did not present danger to Julia, this information, when taken in context of what police did know at the time, may have resulted in a re-assessment of the risk to her.*
>
> *Information sharing between agencies is currently subject to much discussion with the Home Office.*
>
> *The reviewing officers have spoken to the police representative in these negotiations to ensure that the proper weight is given to the necessity to share information between partners engaged in the care and support of victims of domestic violence.*
>
> *Thames Valley Police have also changed the Force process on the assessment of potentially dangerous people and managing the risk they pose, through the Multi-Agency Public Protection Panel process, to enable inclusion of high risk individuals such as DV offenders. This good practice is believed to be in line with new ACPO guidance on the subject due in Spring 2007.'*

Panel comments

We consider that there is an urgent need to build on the MARAC process; to resolve the issues concerning information sharing and reach agreement on a single multi-agency framework for identifying, assessing and managing risk in domestic abuse cases.

[260] See footnote 257

(c) West Berkshire Council

9.48 There was no relevant contact between the Pemberton family and West Berkshire Council's directly managed services between September 2002 and November 2003.

9.49 The only recorded contacts were between Julia and William's school and William's routine contact with the Connexion service. There was nothing of note in his contact with Connexions which was a one hour, year eleven session in a group of five young people.

9.50 Julia wrote to William's school on 19 May with reference to his forthcoming examinations. The IMR stated that the letter was passed on to the examination board and that no other action was taken. The information to the IMR from the school was provided by the current head teacher who is new to the school; the school report for the IMR noted that there was no suggestion of domestic violence as far as the school was concerned and that there was not deemed to be a child protection issue.

9.51 The IMR summary noted that whilst there was no written evidence in any of the school records the former head teacher, now retired, had confirmed with a senior council officer that the school had already been aware of the difficulties between Julia and Alan and of Alan's threats. The former head teacher had also stated that the school were aware that Julia had reported to the police the threats and harassment that she was experiencing and that William had spoken to his school tutor about the threats and the stress at home.

9.52 In the absence of contemporary records about the information held by the school concerning the home situation the panel chair contacted the former head teacher who initially confirmed the understanding at the school at the time to be that contained in the school's report to the IMR. Subsequently, he advised us that he had not been personally aware of the situation regarding Alan's threat to kill Julia or the ongoing situation. Apart from the information in 9.50 above, due to the passage of time and the fact that other key personnel involved with William in 2003 are no longer working at the school, it has not been possible to clarify further the extent of the school's knowledge.

9.53 The school took no advice from the Children and Young Peoples Directorate (CYPD) or the police. It is our view that the information contained in the letter alone referring to death

threats and suicide threats should have led to the school notifying the CYPD and/or the police. Officers with current responsibility for child protection in West Berkshire Council agreed with this view. The IMR did not contain a view on this matter. We consider that the school should not have assumed at that time that Julia was in a position to be able to protect herself and her son.

9.54 It is apparent to us that the school addressed the presenting request from Julia and did not pursue a better understanding of the risks she was facing in May 2003 and to which she was drawing their attention. Had the school done so, they could have obtained information from William about what was happening both at home and with regard to his father's behaviour and in so doing assessed the risk to William. By engaging with William, someone other than Julia and members of his family would have had the opportunity to have verified with William his views and feelings about the risk to himself and to his mother.

9.55 Taking into account the standards of child protection practice at the time, had there been contact from the school with the police and/or social services this may have resulted in a more rounded assessment of the information which had been given by C5 and Julia on 15 May when they handed in the annotated affidavit and accompanying documents at Newbury Police Station.

9.56 We considered there was an ambiguity in the IMR's presentation of the school's position, in that it was unclear whether the view expressed related to the school's position in 2003 or represented the school's current understanding of domestic violence and child protection. In order to clarify the position we interviewed a senior council officer from the council's Children's Services.

9.57 The officer advised us that his understanding was that the school acknowledged that they had not worded their response to the request for information as they might have done; their intended meaning was that there had been no indication that violence had occurred. The officer confirmed that currently both the council's Children's Services and the school believed that Julia and William's circumstances fell within the definition of domestic violence. Subsequently he confirmed that in 2003 the school would have been expected to notify Children's Services or the police in line with the Child Protection Procedures 2001 even if it was reported to the school by the mother that she had already reported it to the police.

West Berkshire Council IMR comment

The IMR repeated the information from the school and from the former head teacher:

> *'In addition there was no suggestion of domestic violence as far as the school was concerned (8-30) …' In particular the schools Child Protection policy was in place however there was not deemed to be a child protection issue'.*

Panel Comment

We are critical of the IMR for failing to clarify the school's contemporary and current understanding of this as domestic violence with implications for child protection. We accept the subsequent assurance given by a senior officer of the council in interview that both the council and the school accept that this was domestic violence and that the school's submission to the IMR was poorly worded.

The senior officer whom we interviewed offered as explanation that the IMR had not made an evaluation of the school's response to William and Julia because it was their view that they were merely providing us with information on which to make a judgement; we consider that this did not meet the requirements of the Terms of Reference which require IMR's to analyse their agency performance and is not consistent with the following statements in the IMR which offer such evaluation [261]

IMR finding

> *'It is possible to confirm that the engagement with the family in this case is consistent with policies and procedures for safeguarding and promoting the welfare of children and wider professional standards'…*

[261] West Berkshire Council Management Review

Panel comment

We agree with the view expressed by the council's senior officer that in 2003 in line with the Child Protection Procedures 2001, even if Julia had told the school that she had already reported to the police her concerns and fears for her own and her family's safety, the school would have been expected to notify Children's Services or the police direct.

IMR finding

> *'We find there was limited contact with most services* [Council] *involved with this review but that all services had in place policies, procedures and practice guidance to ensure that an appropriate response would have been given to any member of the family if contact had been made.'*

Panel comment

We acknowledge that West Berkshire Council's involvement with Julia and her family prior to November 2003 was limited to that relating to William's school; this supports the IMR's overall conclusion that there was limited contact. We sought evidence about policies and procedures.

West Berkshire Council IMR provided reference documents in connection with specific service areas such as Housing and Child Protection. We sought clarification as to whether there was a Domestic Violence Policy supported by training and guidance across the council to support the IMR's positive conclusion. We were advised that this was not consistently the case across the council's services. We consider that the IMR conclusion lacked a rigorous evidence base and whilst some policies were in place, its generalisation was unsubstantiated.

West Berkshire Council IMR comment

> *'Where contact was made with a service an appropriate response was given.'*

Panel Comment

We have commented on the inappropriateness of this conclusion in relation to the school response in 2003.

West Berkshire Council IMR comment

> *'All services have recognised that there is good practice and learning opportunities to be taken from conducting this review and there have been some changes to policies, procedures and practice guidance as a result.'*

Panel Comment

We were advised that in 2007 the Joint Area Review Assessment of Children's Services commented favourably.

> *'The West Berkshire Domestic Violence Forum also runs an effective service, helping to prevent domestic violence from affecting children. Good group and individual work with families takes place in a variety of locations across West Berkshire, including in rural areas. Good inter-agency child protection procedures and protocols are in place and these are reinforced by effective child protection training. There are good arrangements for staff supervision in children's social care and within other agencies. The Local Safeguarding Children Board monitors the impact of multi-agency work on a regular basis.'*

<u>Panel's overall conclusions April 1- August 31 2003</u>

The panel has concluded that:

9.58 This was the significant period for potential interagency intervention. Julia informed the police, the GP and the school of her concerns for her own and William's safety. The agencies and professionals did not share information although there were grounds to have done so.

9.59 During this period there was contemporary evidence of Alan's increasing hatred for Julia, of his emotional abuse of William and that William feared for his own safety.

9.60 Julia sought help from TVP by phone on 20 April and in person on 15 May. Telephone records for Old Hallowes show that there were a number of contacts made with the police including after 28 May, when Alan gave a letter to William together with a further copy of the annotated affidavit; there is no record of the content of those conversations. The police did not investigate.

9.61 The school and GP did not identify any potential child protection concerns with regard to William arising from his father's ongoing domestic abuse. This may be a reflection of the understanding about the child protection implications of domestic violence in cases of this nature in 2002/03. In the event that either the GP or the school had contacted Social Services or the police, this may have caused initial enquiries to be made (Children Act 1989 sec 47). In those circumstances the bringing together of information held by each agency may or may not have re-focused the police response to Julia's requests for help.

9.62 As a high achieving young person it appears to have been assumed that William did not need the opportunity to share his views and feelings with others who were in a position to protect him.

9.63 This case illustrates the limitations of relying on the assumption that other agencies are acting appropriately.

9.64 Neither the GP nor the school on the information available separately to them could have predicted that Alan would kill William and Julia, nor could they have prevented the eventual outcome.

9.65 From the information available about Alan's consultations with the psychiatrist, there were no predictors of Alan's subsequent fatal shooting of his wife and son.

9.66 Information was shared with us by the GP and psychiatrist about the limited extent of their specific experience and knowledge with regard to domestic violence. We

consider this to be indicative of the position with regard to the limited availability of specific policy, training and awareness for and amongst health professionals at that time with regard to domestic violence.

9.67 In reviewing all the information that has been made available by the family it is evident that the family did make considerable efforts to engage the help of TVP in April, May and June.

9.68 Julia and her family believed that the information they had provided was being held on record by the police and would be accessed in the event that she needed help; this was not the case.

9.69 Significant opportunities for the police to positively intervene were missed in April and May. On 15 May, in delivering the annotated affidavit to the house Alan had breached the conditions of the Injunction. There was evidence that he had continued to harass Julia and he could have been arrested and interviewed.

9.70 In the event that the police had interviewed Julia and William and taken statements they may have obtained a full story of the ongoing threats and harassment since September 2002. From this information the police could have ascertained the extent of the current emotional and psychological abuse. They would have learnt:

- **From Julia of the escalation in Alan's controlling and intimidating behaviour, the threats of suicide, threats to her life, financial abuse and her concerns for her own and William's safety.**

- **From William direct and corroborative evidence about his distressing experience of emotional abuse from his father and his fears for his own and his mother's safety which should have triggered child protection procedures.**

9.71 In the event that Alan had been interviewed at any time in the period April to June, the police would have had access to information and written evidence of his ongoing harassment of Julia and William. Such an interview may have revealed Allan's expressed hatred of Julia and the risk he posed to her and William. Alan's behaviour

continued unchecked and his anger and resentment increased and inflamed his distorted view of reality.

9.72 In the period April to June in relation to the Pemberton case, there is evidence of failures in all the TVP systems for crime recording, crime investigation and internal communication. Opportunities were missed to intervene positively to protect Julia and William Pemberton.

9.73 Whilst accepting that sometimes murders occur with little or no escalation or warning, this period provided a real opportunity to identify the escalation of events and potentially manage the threat which ultimately lead to the deaths of Julia and William.

9.74 TVP's Management Service Review in considering separately each of the engagements in April, May and June did not provide a comprehensive analysis and commentary on Force performance during a significant period. In this respect TVP did not at the time nor when undertaking the MSR recognise the significance of the information reported by Julia and her family.

9.75 There is evidence that the performance of individual officers fell short of what could reasonably be expected; they were operating in a Force that had no policy and apparently no system for effectively dealing with cases of domestic abuse. There was evidence of service and systems failures which required urgent attention.

Learning for the future – 2008 onwards

For all:

- **Professionals and front line staff need to make the link between domestic violence and child protection in order to safeguard children and young people (see respective national and local guidance which makes clear connections)**

- **Children and young people should be given opportunities to have their experience heard directly and to contribute to the assessment of risk**

- **GPs and health professionals in contact with victims and perpetrators should in accordance with their professional guidance report child protection concerns and information regarding risk involving the potential commission of a serious crime to police/other agencies and these should recorded (covered by guidance and advice facility on National Domestic Violence Helpline)**

- **All agencies (including police, criminal justice and civil justice agencies and health and social care agencies) should work together towards agreeing a single multi-agency framework for identifying, assessing and managing risk in domestic violence cases. This should build on learning nationally from MARACs and other single and multi-agency initiatives relating to domestic violence.**

This multi-agency framework for the identification, assessment and management of risk should not be based purely on information from one source or agency or on the circumstances at one particular stage of a case. The framework and process should be based on a shared understanding of domestic violence and risk, should recognise the dynamic nature of risk in domestic abuse cases, and the need to base decisions on information from a range of sources.

For the police:

- **Criminal damage should be viewed as a risk indicator (this is included within the single risk model by the ACPO lead and in the update to the Practice Advice on Harassment).**

- **Importance of record- keeping and continuity of evidence (MoPI).**[262]

- **Recognition that where there are children and young people involved separate consideration must be given to their needs in line with Local Safeguarding Children Board procedures.**

[262] Management of Police Information: helps forces to meet common standards for police information management through a statutory Code of Practice and associated guidance

For PCT and health professionals

- **PCTs as commissioners of health care services have the opportunity through their contractual arrangements e.g. with GPs, to include requirements with regard to domestic violence.**

- **PCTs as commissioners of health care services need to be engaged in their local areas in the development of multi-agency strategies to reduce the harm caused by domestic violence to the health of victims and participate appropriately in relevant multi-agency fora for this purpose.**

- **As a primary health care service available to everyone, general practitioners are in a key position to provide support and access to help for victims of domestic abuse and their children. This role may cause problems in maintaining objectivity as GPs may be privy to information not available to other parties in complex cases and should in accordance with their professional guidance, report child protection concerns and information regarding risk involving the potential commission of a serious crime to all agencies.**

- **Training is required for general practitioners and health professionals with regard to domestic abuse; to include the emotional and psychological implications for victims and their children both during and after leaving an abusive relationship and in managing ongoing relationships.**

Training provided for GPs and other health professionals about domestic abuse should identify risk indicators associated with the perpetrator's behaviour e.g. threatening suicide.

- **GPs and health professionals in contact with victims and perpetrators should be encouraged to report all concerns to police/other agencies and these should be recorded (covered by guidance and advice facility on National Domestic Violence Helpline).**

For councils

- **Should provide leadership in the local community with regard to the response to domestic violence.**

- **Should ensure that it has relevant policies, procedures and practice guidance with regard to domestic violence which cover all council services.**

- **In line with the Children Act 2004 should support local agencies, including health and schools to identify at the earliest opportunity the needs of children and young people as a consequence of domestic violence.**

- **Local Safeguarding Children Boards need to ensure policy, procedures and practice guidance in relation to domestic violence recognize the many different forms that domestic violence can take.**

10. September 1 – November 17, 2003

Summary of events

September

9 September - (Julia's eleventh and final consultation with GP since September 2002) the GP recorded

> *'improving, slow legal process, house on market next week, keen to return to work, seen by occupational health see again 2 months'*[263]

10 September - the GP wrote to Alan's company expressing optimism about Alan's ability to return to work in the medium to long term.[264]

11 September - Alan - went on holiday with a friend to California until 28 September.[265]

18 September - the GP wrote for the second time to Alan's company confirming that Alan was unfit to work during the period of sick certification for short periods or part time.[266]

26 September - the psychiatrist wrote to the GP advising that he was no longer seeing Alan and had no contact from him since the end of July.[267]

28 September - Alan retuned from holiday; the friend who had accompanied Alan on holiday was sufficiently concerned to telephone Julia to alert her about his behaviour whilst on holiday.[268] At the Inquest C14 said that Alan had been a lot quieter on his return from holiday, had not slept well, getting up in the night, had stomach pains and indigestion.[269]

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[263] Berkshire West PCT IMR
[264] GP Information to PDHR
[265] C5 information to PDHR
[266] GP Information to PDHR
[267] Consultant psychiatrist information to PDHR
[268] C17 information to PDHR
[269] C14 information to Inquest

October

1 October - C19 went up to Cambridge. As Julia's car was too small C17 took C19, William and Julia in her car. It had been anticipated that Alan would arrive independently but he did not do so.[270]

3 October - C8 received a handwritten note from Alan in which he referred to the death threat he had made to Julia in September 2002:

> *'In total desperation I resorted to my final resort of threatening to kill her…I am desperately trying to keep my sanity, if only to get through the court case* [reference Alan's company]*in March 2004.'*

Alan also emailed a letter to C8 in which he referred to his feelings about his marriage to Julia and what he alleged to be her lies concerning their relationship and events since September 2002. He referred to the arrangements for C19 going up to Cambridge and his anger towards Julia in relation to them; the contents of her Affidavits and the proposed financial divorce settlement. [271]

5 October - the DVC returned from sick leave.

9, 10 and 11 October - Alan and C8 exchanged emails. C8 asked Alan to consider how much his behaviour was upsetting William and C19. In his last email to C8 Alan stated:

> *'Sadly putting my anger behind me is not yet possible because of its severity. Things will only ever start to recover if and when Julie starts retracting the lies* [reference to allegations of sexual abuse]. *'*[272]

13 October - William's seventeenth birthday.

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[270] C17 Information to PDHR
[271] C8 Information to PDHR
[272] C8 Information to PDHR

14 October - William's first driving lesson. Alan did not come to the door, but contacted William by mobile phone to say he was outside, then parked his car on the drive and used C19's car for the driving lesson.[273]

21 October - papers which Alan sent to C8 that arrived posthumously included a cheque for £10,000.00 which had been made out on 21 October.

21 October - William had a driving lesson and meal with Alan.[274]

28 October - C17 visited Julia; William had a driving lesson with Alan.[275]

November

1 November - Julia told C12 that William had said to her *'Mum I do not know why we bother with dad, he is going to kill us anyway.'* Whilst working on financial papers for the court hearing Julia and C12 discovered that large sums of money had been withdrawn by Alan.[276] Julia asked C5 why Alan was disposing of all his assets and C5 said that he thought it was so he could make a financial claim against Julia.'[277]

4 November - Alan was seen by a partner at the GP practice;

> *'Anxiety with depression. No real benefit from medication. Now drinking a bottle of wine a night-given advice. Not coping/emotional liability, stay off work, and to see again in 3 weeks.'*[278]

8 November - Alan wrote to Julia [approximately 10 days before 18/11/03] asking her to retract her allegations about sexual abuse and gave her a deadline by which to make contact with him:

[273] C17 Information to PDHR
[274] C1 Letter to PDHR
[275] C17 Information to PDHR
[276] C12 Information to PDHR
[277] C5 Information to PDHR
[278] Berkshire West PCT IMR

'Please have the decency to respond -I'm sure you don't want to talk but please send me a text message or get William to do so. If I do not hear from you by the end of the weekend I will accept the current situation will have to stand.'

Following receipt of the letter Julia reminded her brother, C5 that she was convinced Alan would kill her *'I just want to remind you that Alan is coming for me'* C5 replied that he thought Alan would not do it while he (C5) was alive.[279]

11 November - William had a driving lesson with Alan; his school friend visited as usual and was dropped off at his father's house in Newbury by Alan and William.

14 November - Julia showed the letter from Alan to C17 and said she could not let him do it to her. C17 and Julia had a good evening together and Julia left in a good mood.[280]
Julia sent copy of Alan's letter to her solicitor where it arrived posthumously.

When later that evening C8 brought William back home with his son who was staying the night at Old Hallowes, Julia showed him Alan's letter.[281]

15 and 16 November - Alan gave two cars to C14 (one of which a Caterham had a personalised number plate W111 PEM) and gave her £2,500 in expenses as he had not been contributing to the running of her house.[282]

16 November - Julia told C8 and C17 that Alan alleged there were some irregularities in the planning permission. As the house was in her name and being sold Julia was very worried she had somehow broken the law.[283] C4 checked with a local authority planning office and on the information he provided was advised there ought not to be a planning issue and the matter could be resolved by an exchange of letters with the relevant planning authority. C4 relayed the information to Julia the same day.

[279] C5 Statement (1) to PDHR
[280] C17 Information to PDHR
[281] C8 Information to PDHR
[282] C14 Evidence at Inquest
[283] C18 & C17 Information to PDHR

17 November - Julia went to the planning office with C17.[284]

Analysis of Agency Intervention

(a) Thames Valley Police

During this period there was no contact with the police.

(b) Berkshire West PCT

10.1 In September Julia had her last consultation with the GP who noted that she was improving and considering returning to work.

10.2 In this period Alan had no direct contact with the two professionals with whom he had consulted between May and July. The GP informed us that he had discussed Alan's presentation with his GP colleagues in the event that whilst he was on leave Alan made contact with the practice.

10.3 The psychiatrist wrote to the GP to inform him that Alan was no longer seeing him.

(c) West Berkshire Council

During this period Julia did not contact the school or any other council service.

Panel's overall conclusions September 1- November 17 2003

The panel have concluded that:

10.4 TVP had no further opportunity to intervene positively during this period. There were no new specific incidents which might have caused Julia to seek further support from TVP.

[284] C17 Information/ transcript

10.5 There is some evidence that after the Hearing in July, with Alan's agreement to sell the house and his move to Herefordshire, Julia felt there was the potential for her life to go forward. There is limited evidence of interaction between Alan and Julia apart from disagreement over arrangements for C19 to go up to Cambridge. At the same time there is evidence that Julia continued to believe that Alan posed a very real threat to her.

10.6 The content of Alan's letter to Julia in November was ambiguous. Julia did not tell the police about the letter but sent this to her solicitor. She told C5 that she was convinced that Alan would kill her.

10.7 During the weeks after his return from holiday Alan's anger about what he referred to as Julia's allegations persisted. In much the same way as he had tried to use William to influence Julia, at this point he tried unsuccessfully to use C8 in a similar way.

10.8 We do not know the circumstances in early November that had caused William to say to Julia, with reference to wondering why they bothered with his father that he thought his father would kill them anyway; but this highlights the impact of the overall situation on William.

Learning for the Future – 2008 onwards

For All:

- **Victims, their children, family and friends should be encouraged to report all concerns about safety to police/other agencies and the information should be recorded (covered by guidance and also note advice facility on National Domestic Violence Helpline.**

11. November 18 and 19, 2003

Summary of Events

18 November[285] - In the morning Julia followed up on concerns arising the previous day relating to planning consent in relation to Old Hallowes.

Alan left Ross-on-Wye mid-morning and drove to the golf and country club.

1230hrs - Alan seen at the golf club

1400hrs - Alan teed off alone.

1614hrs - Text from Alan to William *'Do you want to eat first or drive first dad xxx'*

1615hrs - Text William to Alan *'Don't mind I'll drive to where we eat if that ok wit u? Im looking forward to seeing u. Did u have a gd weekend?' Love wil xx'* This was followed by an exchange of texts anticipating that evening's driving lesson.

1630hrs - C7 telephoned to speak to Julia and advised to call back at about 1700hrs

1730hrs and 1830/45hrs - Alan was in the club bar where he drank half a glass of cider and engaged in conversation with bar staff before leaving the golf course.

1842hrs - William telephoned Alan. There was no record of the content of that call. This was followed by two missed calls from William to his father.

1848hrs - William sent a text his father *'Are you still coming at seven? '*

1849hrs - Alan called his son and the call was connected.

[285] Information concerning the events on 18 and 19 November has been obtained from TVP C&C log, TVP MSR; Witness Statements to the Inquest; the record of mobile telephone and texts between AP and WP provided by TVP

1900hrs - C7 called Julia again and they were engaged in conversation for approximately five minutes. The conversation was interrupted by Julia, her friend heard noise in the background and Julia said *'Excuse me something has happened, I've got to go Oh my God ring me later.'*

A note containing Julia and William's handwriting was found by the police in the kitchen on a telephone pad after William and Julia's murder. It contains a written exchange that may have occurred around this time between William and Julia set off by Alan making a remark to William about the allegation of sexual abuse and using William to relay his comments to Julia and includes Julia's response to William.

Any attempt by us to reconstruct the context of this written exchange between William and his mother would inevitably be conjecture. The exchange may have taken place whilst Julia was on the telephone to her friend at 1900hrs or whilst William was on the telephone to his father at 1907hrs and 1908hrs (see below). It is not possible to know what exactly happened.

We consider from the evidence available that at that moment Julia did not realise that Alan had come with the purpose of carrying out his threat to kill her.

We reviewed the information on the C & C log for the evening of the 18 November in conjunction with the transcript of Julia's 999 call and evidence from neighbours provided at the Inquest. We acknowledge that the recollection of witnesses with regard to precise timings in circumstances such as those on the night of 18 November will be subject to a number of factors including stress and anxiety arising from the events that were unfolding. The precision of the timings of witnesses may therefore not be exact.

The TVP MSR contained the following explanation with reference to the C&C log:

> '*timings are in blocks of one minute intervals and will only be recorded when the operator either refreshes the screen or uses the return key to move to a new line. therefore if the operator listens to the caller for a few minutes before typing in the summary of what was said there will be a difference in real time to the time recorded within the Command and Control system.'*[286]

[286] TVP MSR

1900hrs - At about the same time as Julia's call from C7 a neighbour (N3) heard gun shots.

1906hrs - William's mobile phone records show a missed call to Alan followed by two calls at 1907hrs and 1908hrs which connected.

1910hrs - Neighbour (N2) reported he heard a gunshot, voices and breaking glass.

Also at about 1910 Neighbour (N1) was upstairs in his house and saw someone whom he thought might be Alan banging on the front door. After a minute or two the man walked back to his car and sat in the driver's seat, leaving the door open and the tailgate up.

At 1912hrs another neighbour (N4) heard 4 bangs from the rear of her house.

At about 1915hrs N2 and his daughter also heard shouts which sounded like *'Don't go McKenna'* and N2 reported that his daughter said *'That's Will.'*

From the pathologist's report and information made available to us it would appear that William tried to protect his mother.[287]

N2 called 999, logged at 1919hrs. He also called the local police number at around 1940hrs. At about the same time N2's wife stated in her Witness Statement to TVP on 19 November 2003, that she heard a female voice coming from the direction of Old Hallowes '*not shrieking or hysterical but sounding as though she was reasoning desperately and urgently*,' followed by the sounds of two further gun shots and a series of bangs and then a third gun shot.

1911 – 1926hrs

1911hrs - Julia dialled 999.

1911hrs + 13 seconds - Julia clearly very distressed gives her address to the call taker at Kidlington who found it difficult to discern in detail what she was saying. She told the call taker that Alan was outside with a gun and had let off some shots. Gun shot audible.

[287] Post mortem report to Inquest – William Pemberton - Dr N.C. Hunt and Preliminary Scene Report 19/11/03

1911hrs + 54 seconds - After being asked twice by the call taker Julia repeated her address. Scream and bang audible in background.

1912hrs + 8 seconds - Julia tells the call taker that Alan has come through the window with the glass and in answer to the call taker that her son is 16. Gun shot audible

1912hrs + 22 seconds - Loud scream and inaudible shout in background - the call taker asked Julia again for her address, corrected himself and asked for her name; Julia repeated her address and then gave her name in answer to his question. Julia said at that point referring to her address *'I have given it to you two times'*.

1912hrs + 39 seconds - The call taker told Julia *'I've got officers on the way Julia'*.

1912hrs + 44 seconds - The call taker asked Julia to keep hold of the phone. Loud scream and shout.

1914/15hrs - The call taker checked Julia's address with her and the location of the house on Slanting Hill and Julia offered information about a for sale sign outside the door.

1915hrs - Julia told the call taker she was in a storeroom, and in answer to the call taker's question about whether police had been to the house before, she told him that the police had been alerted and that she had an injunction.

1915/16hrs - The call-taker's log was picked up in Wantage control room by the relevant radio operator who immediately (timed 1916hrs) searched for resources to deploy.

1916hrs - Julia told the call taker that she thought Alan was running around the house trying to find her and that she could still hear shooting. Gun shot audible.

1917hrs - Julia told the call taker that she had heard at least a dozen shots.

1917hrs - The supervisor at Wantage noted the log and provided initial direction in the URN including seeking further information via the call taker from Julia. He advised that no units

were to attend at that time and notified both the duty inspector in Milton Keynes (as silver) and local response inspector in West Berkshire (as bronze).

1919hrs - The Force Control Room Inspector (HBI) located in Milton Keynes was notified and took command.

1920hrs + 12 seconds - Julia reported that she had heard another bang and that Alan was banging down the front door

1920hrs + 23 seconds - The call taker told Julia '*We've got people coming up there now*' and Julia asked if they were nearly there. She said *'I've got about one minute before I die if you don't get here in time.'*

1920hrs + 56 seconds - The call taker told Julia to stay where she was and to keep hidden. Sounds of bangs.

1921hrs - Julia reported that she could hear Alan coming into the house, glass breaking and that she was going to die.

1922hrs - The correct location of Old Hallowes, flagging information reference domestic violence, the injunction and the alarm were identified – (11 minutes into call).

1923hrs - Decision made to establish a rendezvous point; no unit was to go to the scene [Old Hallowes] at that time.

1923hrs +26 seconds - Julia responding to a question from the call taker about whether she was upstairs, told him that she was not and was hiding in the storeroom and said *'Here he comes now.'*

1924hrs - HBI dispatched an Armed Response Vehicle (ARV)

1924hrs +33 seconds - Julia referring to the police *'Why aren't they here? Please come.'*

1924hrs +39 seconds - The call taker told Julia *'There are police officers coming there. We, I mean they're just trying to approach carefully. If he's wandering about with a loaded gun…'*

1925hrs + 06 seconds - The call taker learnt from Julia she could not lock the door of the storeroom from the inside

1925hrs +07 seconds - Julia told the call taker that Alan was coming *'He'll be here in a minute. He's coming.'*

1925hr +28 seconds - The call taker asked Julia had she heard her son at all. Julia said *'No I haven't, no. He's there.'*

1925hrs + 55 seconds - A male voice, presumed to be Alan, was heard.

1926hrs - The dial tones were depressed and sounds from Julia were heard and then the line went down (15 minutes and 4 seconds into the call).

1930hrs – 0224hrs 18 November

1930hrs - Decision to establish rendezvous point at Downe House School

1930hrs - The call taker recorded that there were no sounds of gunshots at all and very little background noise all the time Julia had been on the line.

1930hrs - The Firearms Tactical advisor (TAC) Inspector L was contacted by HBI. TAC asked that contact be made with Julia if possible and a second caller who had reported hearing gunfire should be 'de-briefed'. Inspector L advised that an unmarked vehicle with plain clothed officers should attend the address to make an initial assessment and seek to establish an observation point.

1934hrs - Ambulance went to the rendezvous point.

1935hrs - Three plain clothes officers left Newbury Police Station in unmarked police car, deployed by the local inspector to locate an address where domestic incident reportedly involving a firearm had taken place.

1937hrs - TAC also advised that an Ambulance should be placed on standby, that the Silver commander should be contacted. The TAC deployed himself, with HBI consent to the forward RVP. The HBI dispatched two more ARVs to the RVP.

1940hrs - [timing imprecise] N2 heard loud but more muffled '*bangs', slamming of doors and there were noises for quite some time.'* He had heard 6-7 shots up to that point.

1940hrs - Another neighbour drove past.

1940hrs - Air Support was requested but reported that they were unable to fly due to low cloud base.

1942hrs - N2 called the police again whilst he was on the phone his wife heard a woman's voice which she described was not hysterical or shrieking but sounded as if the woman was desperately reasoning with somebody. She then heard two further gun shots, with a short break between them of about 30 seconds and then a series of bangs not gunshots, followed by one gunshot and thereafter no more noise from Old Hallowes.

1949hrs - Ambulance arrived at Downe House School.

1950/55hrs - Three unarmed officers located the house and saw a male casualty on drive, PC G was unable to find signs of life; PC F requested an ambulance. An estate vehicle was on the drive, tail gate open. Ambulance at rendezvous point.

1956hrs - According to radio logs information was imparted regarding male body on drive. Also at approximately this time ARV6 and ARV5 arrived at the rendezvous point.

1959hrs - ARV directed by HBI to location to make safe.

2000hrs - N3 went out to garage and saw lights outside in the road, heard *'armed police, armed police, get back in house'*.

2001hrs - Road closure in progress.

2005hrs - PCs E, F G took cover in hedges either side of Old Hallowes maintaining a watch on the premises. House lights were on, front door closed and lamp post on drive was lit, no movement seen or heard from house.

2005hrs - Call made to Superintendent M to brief on serious incident in his role as the Local Policing Area Commander for West Berkshire.

2015hrs - By 2015hrs Superintendent M notified Superintendent F at home.[288] He was unable to take command at that time as there was no facility to fully brief him on the rapidly changing information and intelligence and his access to tactical advice was limited.

Superintendent F made the decision to travel to the rendezvous point so he could be fully briefed and assume command of the incident. This required a 45/60 minute drive during which communication by mobile telephone was severely constrained by poor signal coverage.

2020hrs - Second ambulance at Downe House School – moved from front to back of school as too close to incident

2030hrs - N2 looked out of curtains and saw all lights at Old Hallowes were on as well as external lights. Heard noise of a car.

2058hrs - Superintendent F arrived at the rendezvous point [Downe House School] at approximately 20.58hrs and met with the Duty Detective Inspector, the Firearms Tactical Advisor and Sergeant N (his 'loggist'). It was rapidly established that the location was unsuitable for command of an incident such as this as it was a boarding school.

[288] Supt F was the Silver Commander on 18/11/03

2100hrs - N2 called police again and was advised that armed police were in the vicinity, to stay down and police would contact.

2118hrs - Superintendent F and Tactical Advisor arrived at the Newbury 'Silver suite' where they had access to the police command and control, helicopter television (although this was now known to be unavailable), police databases, telephones, maps and information to support the operation.

2122hrs - Tactical Advisors noted records from member of public that a body of a male was seen at Hatchgate Close with something in his hand.

2125hrs - Briefing reference the matrimonial home commenced at 2125 hours with Sergeant N detailing the conversation and briefing in the Log.

2127hrs - One ARV was despatched to find the male at Hatchgate Close, although no one was found.

2130hrs - Officers report because of poor quality light visibility not good.

2145hrs - Tactical Advisor log reads *"witness to body in Hatchgate Close…is attending area in a red Fiesta…to liaise with ARV"*.

2146hrs - Superintendent F was still at Newbury and was awaiting radio communications to provide the necessary coverage for the location whilst he did not formally have 'command' at this point he was engaged in quality assuring the decisions being made. The local units had no communications until this link was established.

2157hrs - ARV report "no trace of body at Hatchgate Close despite assistance…"

2220hrs - First tactical plan prepared by Superintendent F is rejected by the Gold Commander as it had not incorporated the use of negotiators. The subsequent callout and set up of the negotiating cell and their equipment placed significant delay on the entry to the address.

2230hrs - Attempted to secure services of Air Support frustrated, still not available due to low cloud.

2230hrs - N3 received a call from police to say there was somebody with a gun - time uncertain: between 22.30 - 23.00hrs

2237hrs - Superintendent F, although he was still not having access to effective communications himself had growing concerns that de facto command was being defaulted to Inspector L, tactical advisor, took command from Newbury Police Station in the dedicated Silver suite.

2331hrs - The Gold Commander was updated on the plan but a further problem was identified: the use of negotiators would slow down the tactical plan and the need for dynamic action should the negotiation strategy fail required the presence of a fully trained dynamic entry team which necessitated a further callout.

2338hrs - Full containment established at the matrimonial home [Old Hallowes]. The resources returning from the report of the man in the ditch at Hatchgate close allowed for the Firearms Team to set up a visual containment of the scene with 6 armed officers.

19 November

0032hrs - Superintendent F agreed to the surrender plan and updated the Gold Commander.

0054hrs - Superintendent F was given authority for the plan to proceed. The negotiators were to stay at Newbury Police Station and the armoured Land Rover was to approach the front door. Once in a position the negotiators were to initiate a landline call to the address. If there was a reply they were negotiate surrender as a strategy. If it failed, armed officers in the armoured land rover were to use the PA in the vehicle to attempt communication. If this failed the armed officers were to force the front door and affect a partial entry and conduct a slow methodical search room by room using a tactical plan.

0119hrs - Superintendent F made the decision that the plan could not be delayed any further.

0131hrs - Contact was made by Cambridgeshire Police with C19.

0148hrs - Entry to house made.

0153hrs - Bodies of Julia and Alan found.

0224hrs - C19 was informed by Cambridgeshire Police.

0400hrs - C19 telephoned and told her aunt, C16 who telephoned family and Alan's parents.

Analysis of agency intervention

(a) Thames Valley Police

11.1 We have used the following headings in this section:

- Address and directions to Old Hallowes
- Call taker response
- TVP Firearms response.

- Address and directions to Old Hallowes

11.2 Julia was advised in September 2002 and June 2003 by the DVC to dial 999 in an emergency and did so on 18 November.

11.3 We have sought information from TVP as to whether on 18 November 2003 there were directions on the location file for Old Hallowes. We were advised:

> *'The address of 'Old Hallowes' has a location file and reference number. It is to this location address (with variations of the spelling of the name), any SIG flags, any alarm records, any previous incidents or any directions are "filed".'*[289]

[289] TVP information to PDHR 14/07/08

11.4 We were informed that at the date of the response to our enquiry (July 2008), there were four variations of the name/spellings of the house recorded in the location file; '*Hallowes, Old Hallows/Olde Hallows/Old Hallowe's* and that these were all input after the homicides. In September 2002 we noted that there were two different variations of the address given on the C &C Log; *'Hallowes'* and *'Old Hallows'* and in April 2003 the address was given in the police records as '*Hallowes'*.

11.5 We were also advised by TVP that directions were included in the location file (as at July 2008) but as there is no audit trail within the location folders to track any changes to the direction, flags or alarm accounts TVP were unable to confirm when directions were added to the location file. It was therefore not possible to ascertain whether once the correct address had been identified when Julia phoned 999 on 18 November 2003 directions would have been accessible.

11.6 Potential difficulties in locating the house had clearly been anticipated by C5 on 15 September 2002 when he requested that '*they* [officers] *just attend the address to show we* [TVP] *know where it is.*'[290] A visit was not made to the house on that occasion.[291]

11.7 We have identified two specific areas of concern; firstly the difference in names/ spellings for the house which would have made difficulties for the call operator in identifying Julia's address and secondly that the police do not appear to have had immediate access on the location file to directions to the house.

11.8 The DVC visited Old Hallowes on 10 June for the fitting of the alarm and included on the *'Alarm Admin'* form the correct address and explicit instructions about how to reach Old Hallowes. These would have been accessed immediately if the alarm had been activated although the advice the DVC gave Julia was to call 999.

11.9 It is apparent from the recording of Julia's call that she expected the police to provide immediate help in response to her 999 call. In line with the call taker's advice she

[290] C&C log 2156hrs on 14/15 September 2002
[291] A visit had been made with regard to the report of a stolen mountain bike on 7 September 2002 by Alan

remained hidden, kept her voice down and waited in the expectation that police were on the way to help her.

11.10 In the event that Julia had pressed the alarm it would have immediately identified her correct address as Old Hallowes as well as provided directions to the location. In those circumstances unarmed police officers responding on the basis of information from sovereign alarm may have gone to the house and with the discovery of William's body on the drive in all likelihood would have acted in accordance with TVP's Firearms Policy.

- Call taker response

11.11 Although the family have acknowledged the difficulty facing the call taker there are a number of aspects of the call which they have contested.

11.12 We acknowledge that for the call taker, Julia's call on the 18 November would have presented a significant challenge. For Julia experiencing fear and panic, there was a desperate need to make her situation known and to obtain help. For the call taker there was an urgent need to obtain information about Julia's location and as much as possible about the circumstances she was facing and the events as they were unfolding in order to inform the police response.

11.13 Our purpose in looking at the interaction between Julia and the call taker is to consider how far their differing objectives were irreconcilable; whether or not this was inevitable; and to identify possible future learning.

11.14 There are three written records of Julia's call which we have considered. (i) An edited version prepared by TVP for the Coroner; (ii) a transcript prepared by the family solicitor after the Inquest; (iii) one prepared by TVP in 2005 for their Management Service Review. We understand that the differences between (ii) and (iii) may be related to the technical capabilities of the play back facility.

11.15 We have also listened on a number of occasions to the recording of the call which was provided to the family solicitor prior to the Inquest. We do not know how well Julia or the call taker were able to hear each other during the call. We recognise that the call taker had

difficulty in understanding what Julia said at the beginning of the call. Using a CD player with a review and rewind facility (a process unavailable to the call taker) we were able to listen to and understand the interaction between Julia and the call taker. We were aware of Julia's intense fear; her sense of imminent danger and her belief that help was on its way.

11.16 In relation to the call taker's response we considered the following specific issues:

- The repeated questioning of Julia about her address
- The misinformation to Julia about the imminence of the police response
- The advice to Julia to stay on the line and to remain hidden.

11.17 It is clear from the recording of the 999 call that repeated questioning about her address added to Julia's distress. Once the address was identified, the apparent lack of directions on the flagging system also potentially affected the initial police response time.

11.18 The time taken to identify and locate Julia's address was time during which she could have been considering the possibility of escaping from the house and from Alan. The call taker did not discuss this option with Julia.

11.19 The call taker told Julia on three occasions that the police were on their way; at 1.39 minutes into call *'We're on our way'*; at 9.23 minutes into call '*We've got people coming up there now'*; and at 13.39 minutes into the call '*Police officers trying to approach carefully*'. [292] This was not in fact the case.

11.20 In keeping Julia on the line in order to obtain information, including Alan's location we understand from the TVP MSR that the call taker was acting in line with TVP's Firearms Policy consistent with ACPO Firearms Policy (see 11.22 below TVP MSR Review Comment 24).

11.21 At 1923hrs as noted on the C &C Log the decision was made to locate the rendezvous point at Downe House School; at that time no unit was directed to go to Old Hallowes.

11.22 On the C&C log the call taker noted at 1925hrs that there were no sounds of gunshots

[292] TVP transcript of 999 call included in TVP MSR and Transcript of call provided to PDHR by Julia's family

at all and very little background noise all the time that Julia was on the line. When we listened to the recording we noted what sounded like gunshots and bangs at intervals during the call.

TVP Management Service Review

The call taker's response

Review Comment 24:

Operators were trained and issued with Basic Firearms Awareness guidance, consistent with ACPO Firearms Policy that the operator should 'try to keep the caller on the line in order to obtain the fullest facts possible and the latest developments. The operator will bring the incident to the immediate attention of the control room supervisor who will, in turn, inform HBI'.

This guidance remains the current ACPO advice to call-takers.

Current guidance to TVP call takers prompts:

'Can the caller remain on the line without putting themselves in danger? If the caller is in any danger get them to move to a safe location but try to retain them on the line whilst they do so. Obtain as much of the following (not included here) information as possible. Ensure C&C log is updated.'

The difficulties faced by [the call taker] should not be underestimated. At the time of the call he was dealing with a 'precise' location with Julia providing a commentary on what was happening. Had he advised Julia to flee from the address the incident would have become' imprecise' and Julia may have been pursued by Alan without us knowing where they were'

Review Comment 25:

When asked for his rationale for telling Julia the police were en-route the

call-taker says:

'My intention in telling Julia police were on their way was to try and reassure her and keep her calm as possible whilst questioning her to gain as much intelligence as possible for others to use in responding to the incident'

There has been some criticism of the assurances given by [the call operator] *that the police were on their way. If Julia was aware that the police were not responding directly to her address, she may have decided to flee from her home.*

We can never know if Julia would have survived had she escaped from the address and sought sanctuary elsewhere.

It appears to the reviewing officers that the operator was in need of support in developing his questioning 'strategy'. It was clear within the first few seconds of the call that something terrible had happened.

'my husband is out there with a gun. My son's dead.[293] *I…'*

and ' My husband's outside with a gun, he's let off some shots. My son's outside there with him, he's [inaudible].'

The operator was complying with ACPO policy but with hindsight he should have sought the support of a supervisor or another operator to eavesdrop the call and assist or prompt his questioning.

This activity does not appear to have been considered by the Supervisor.

This was within the functionality of ICCS[294] *at the time, but it is unclear whether this operational need is met within the current network technology, in use within*

[293] When we listened to the tape of Julia's call we concluded Julia may have said 'there' not 'dead'
[294] Integrated Communication Control System

CRED.[295]*This technical capability and its operational benefit needs to be re-publicised within the department.'*

Review Comment 26:

'There was no discussion during the call with Julia about possible escape routes and there seems to have been no consideration given to the immediacy of the threat and the length of time it would take the police to attend.

If these factors had been considered then in these circumstances, it may be that the appropriate response would have been for Julia to attempt escape. The police should offer information that would inform such a decision but it appears to the reviewing officers that we can never make that decision for someone.

What is clear to the reviewing officers is that by this time Will had been murdered by his father outside the house. No advice that we could offer in response to the 999 call would have saved him. Testimony from the Pathologist to the Coroner's Inquest was that Will would have died almost immediately after being shot.

In respect of the decision to tell Julia the police were on their way and to stay on the phone, the reviewing officers are loath to make recommendations that would constrain what must be, with reference to all the circumstances, a subjective decision. However, these decisions must be based on the availability of potential escape routes, the immediacy of the threat and the availability of police support.

Incorporated into current practice in medium and high risk DV cases is the need to develop a 'victim safety plan' which includes discussions around possible escape routes.

We would recommend that this is adopted as best practice and where an escape plan exists that this is included or referred to in the SIG warning flag.'

[295] Control Rooms and Enquiries Department

Panel comments

We agree with the MSR comments regarding support for the call taker during the call. We also note that his response to Julia was informed by the policy requirements of Thames Valley Police's firearms policy. We support the recommendation concerning the inclusion or reference in the SIG warning to an escape plan where this exists.

- TVP Firearms response

11.23 In reviewing events on the night of 18/19 November we have taken into consideration the information contained in the C&C log, the findings of a Firearms Operational (tactical) Debrief conducted in December 2003 and information received from meetings with the Gold and Silver Commanders including their individual Logs and TVP's MSR. Although we have looked in detail at all the information provided we have focussed on four aspects; the information available concerning the location and condition of Julia and Alan Pemberton after Julia's 999 call terminated; Operation Saladin; communication difficulties; and delays encountered during the incident.

11.24 We have considered information contained in the C&C log and that received from the Silver and Gold Commanders on the night. This indicates that the TVP Firearms response was based on the premise that:

- William had been found on the drive by the three unarmed police officers and was known to be dead.
- After Julia's call ended there was no information concerning the location or condition of either Julia and/or Alan.

11.25 The decision was finally made at 0119hrs by the Silver Commander to enter the house. The police entered Old Hallowes at 0148hrs and at 0153 hours, six hours and forty two minutes after Julia called 999 that police, discovered the bodies of Julia and Alan.

11.26 The Coroner determined the time at which Alan shot Julia and then himself from information provided in Witness Statements given by the neighbours concerning the timing of gun shots which were heard between 1926hrs and 1940hrs. The pathologist's report stated

that Julia had been shot four times by Alan and that her injuries were such that she would have died almost immediately and that it would not have been possible to have saved her.[296]

11.27 The MSR refers to TVP's 'strategic aim' in all firearms situations at that time as that stated in Operation Saladin:

- Minimise injuries to all persons
- Prevent the subject from causing harm
- Use no more force that is absolutely necessary and in appropriate circumstances arrest the offender and secure evidence
- This may best be achieved by identifying, locating and containing the subject thereby neutralising the threat posed.

11.28 The MSR confirms:

> *'It is the duty of the police to Safeguard the public. While there is no hierarchy of life, the protection of the public is the priority in every spontaneous firearms incident. The Police Service cannot be reckless in its response to such incidents but it must respond.'*[297]

11.29 The Firearms Debrief of December 2003 identified a number of delays during the incident. Full transfer of command from the HBI to the Silver Commander did not take place for three hours. The Silver Commander was contacted at home and initially briefed at 2015hrs. During the 45 minute drive to the rendezvous point he was out of communication because of poor mobile coverage.

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[296] Post mortem report to Inquest - Julia Pemberton 26 November 2003 - Dr N.C. Hunt included in his report reference to '*two apparently relatively close range gunshot discharges to her left lower back …associated with extensive disruption of the intra- abdominal viscera including the left kidney, the liver, the aorta and the inferior vena cava'* and he noted *' The injury associated with the disruption of the aorta and inferior vena cava would have itself been a fatal injury and I would not expect this injury to have been amenable to medical intervention even with the most prompt response.'*

[297] TVP MSR

11.30 Following contact from the HBI at 1930 hrs TAC went to the Downes' School and established a rendezvous point. Having joined TAC at 2058hrs, the Silver Commander made a decision to relocate to Newbury Police Station because he considered he could not command the incident from the rendezvous point without a means of communication, with no access to other information systems and because of proximity to the scene. At 2125hrs the briefing of the Silver Commander began at Newbury Police Station. The delay associated with the transfer of the rendezvous point had a detrimental effect on the speed of initial deployment of resources and the time taken to resolve the incident.

11.31 The Debrief identified further delays in the mobilisation of TVP's second tier firearms response. Once this was mobilised, a further delay was experienced in the on call firearms instructor[298] who happened to live in the south of the force having to drive to the HQ at Kidlington to collect the Armoury vehicle [Land Rover] and then drive it back south to the location of the incident.[299] There was only one of the two armoured Land Rovers in the Force at the time: the other was out of the Force being refurbished.

11.32 We learnt that this was the first day that Airwave radio had gone live in the Force. The only people able to use Airwave on the night were the HBI, TAC and the firearms team. Contact with the Silver Commander was either by VHF radio or through TAC which had an impact on the role he subsequently carried. There were also problems experienced by the officers in the armed response vehicles arising from unsuitable clothing for working at night (white shirts) and insufficient night vision equipment.

11.33 TVP received Information from a member of the public concerning the body of a male with something in his hand at Hatchgate Close which resulted in one of the ARVs being despatched at 2127 to follow this up. At 2157hrs the ARV reported there was no trace of a body.

11.34 The Debrief noted that there were also delays in terms of decision making about the tactics to be deployed and the resourcing required to achieve them. At 2220hrs, the Silver Commander's first tactical plan was rejected by the Gold Commander as it did not include the

[298] TVP Firearms Debrief December 2003
[299] TVP Firearms Debrief December 2003

use of negotiators; time taken to make the necessary arrangements contributed to the delay in entry being made to the house.

11.35 Air support had been requested earlier and at 2230hrs was not available because of low cloud; this presented difficulties to the Silver Commander in determining his response to the incident because of the wooded and sloping area around the house.

11.36 Although still without access to effective communications the Silver Commander took command at 2237hrs from Newbury Police Station.

11.37 The Gold Commander was updated at 2331hrs. Full containment on the house was achieved at 2338 hours. On the 19 November the surrender plan was agreed at 0032hrs and authority to proceed given by the Gold Commander at 0054hrs. The decision was finally made by the Silver Commander at 0119hours to enter the house. Entry was made to the house at 0148hrs.

Thames Valley Police MSR Comments

Extracts from references to Firearms' incident

Review Comment 29:

There were historic problems with the UHF and VHF radio frequencies which meant that communication with officers on the ground was difficult, the introduction of the 'Airwave Radio' was designed to overcome these difficulties as it is a digital system.

Because of the introduction on that day of the new Airwave radio system, the presence of unarmed officers at the scene was unknown by the firearms team. This later resulted in the unarmed officers being challenged by the armed colleagues.

This circumstance is unlikely to repeat itself now that Airwave has been fully 'rolled out' with the resultant functionality allowing for the patching of talk groups

together to allow responding officers to hear what is happening across the force area.

Review Comment 31:

[Reference notification of Silver Commander at 2015hrs]

It is the opinion of the reviewing officers that given all the circumstances, he could not be expected to assume command and that this was the correct decision at that time

Review Comment 32

The operational needs of commanders seem to have been overlooked in the planned roll-out of the Airwave system, to force roamers[300] and then BCUs.

The introduction of Airwave was a huge step forward in securing adequate radio communication and sought to eliminate the difficulties encountered with the legacy UHF and VHF radios. The introduction of airwave on the day of the shootings did provide a level of communication that would not have been present previously but the firearms commander had not been issued with an Airwave radio set.

The firearms commander on the night whilst not wishing to take formal command from the Newbury Silver Suite until sufficient communications had been made available to him(in accordance with ACPO principles) recognised that the inability of HBI to access his hand- held Airwave radio, presumably due to other pressures and the Tactical Advisor's continued Airwave communication with the Firearms Responders, were inadvertently undermining his role.

This prompted him to take command sooner than he may otherwise have wished on the rigid interpretation of ACPO guidance (see Firearms Command & policy analysis).

[300] TVP terminology for a force resource not based geographically on an area

The implications of the Airwave rollout are not likely to be repeated in the near future, with the system now in widespread use, but we recommend that operational/ command needs are fully considered in other strategic programmes in future.

Panel Comments

The MSR also provides an analysis of the Firearms Response noting that there has been a fundamental change in the way that Thames Valley Police deal with incidents involving firearms. It goes on to state that all those directly involved on the night of the murders.

'genuinely believed that the decisions they had made were in accordance with the ACPO Manual of Guidance on the Police Use of Firearms (ACPO Manual), Thames Valley firearms policy (Operation Saladin) and the training they had received.

Our delay in containing and searching Old Hallowes following the call from Julia seems to be as a result of failings in our Policy in place at that time.'

The MSR goes on to consider issues related to Command and Policy. Under Policy it notes with regard to Operation Saladin:

'*It was satisfactory for dealing with pre-planned operations or events that were prolonged and therefore needed a wide range of services and support.*

It was subsequently identified as inadequate as a policy to deal with spontaneous firearms incidents. It had the potential to build unnecessary delays into incidents which required immediate firearms deployments. The policy attempted to eliminate risk rather than manage it.'

The MSR draws attention to the *'strategic aim'* as stated in Operation Saladin as being *'standard'* and that:

'there was a tendency not to articulate what the aim was during a specific firearms operation. It was also one of the reasons that the activity was focused on locating

Alan Pemberton who may have been at large; and insufficient consideration given to Julia following the discovery of Will's body.'

We note that no direct reference is made in the MSR to the recommendations of the Highmoor Cross Review[301] which was published in October 2004 regarding Operation Saladin. The Highmoor Cross review was referred to in meetings between TVP officers and the family in 2004 and 2005.

We found recommendations from the Highmoor Review to be of relevance in our consideration of TVP's response on 18/19 November:

'Operation Saladin should be withdrawn and replaced with a new policy to provide clear guidance to commanders dealing with spontaneous firearms incidents, especially where people have been, or are suspected to have been injured. The policy must highlight the roles and responsibilities of commanders and also provide clear guidance in relation to the transfer of command. It should also stipulate that the command function must, unless there are good reasons for not doing so, be performed near to the scene of the incident. Policy and training needs to provide clear direction and guidance to all firearms commanders in relation to dynamic risk and threat assessing and the making of command decisions under extreme pressure and with limited information or intelligence.'[302]

<u>Panel's overall conclusions 18 and 19 November 2003</u>

The panel have concluded that:

11.38 It would not have been possible from the information available prior to 18 November to have predicted that Alan would murder William and Julia on 18 November. On previous Tuesdays in October and November when Alan was due to collect William from Old Hallowes for a driving lesson, other people had been present. Alan came on 18 November fully equipped with shotgun and ammunition and an affidavit for Julia to sign

[301] Appendix D The murders at Highmoor Cross occurred on 6 June 2004
[302] Reference Highmoor Review

with William as witness, retracting the allegations she had made in September 2002. We do not know whether he came similarly equipped on the previous Tuesdays.

11.39 Within a few minutes of Julia's 999 call at 1911hrs, Alan fatally shot William and it would not have been possible for a police response to reach Old Hallowes in the time required to have saved him.

11.40 It has not been possible to ascertain from TVP whether prior to 18 November 2003 directions to Old Hallowes were included on the location file.

11.41 The failure of officers to update Julia's address on the Street Index Gazetteer when dealing with the incidents in April and May was poor practice which ultimately undermined TVP's ability to locate Julia in a timely manner.

11.42 The call taker should have sought the assistance of his supervisor or another colleague in responding to Julia.

11.43 The call taker, although acting in accordance with Operation Saladin, did not consider with Julia the option of attempting to escape.

11.44 It is not possible to know whether Julia would have been able to escape to safety from Old Hallowes and from Alan but this was an option that she should have been given.

11.45 The location and physical conditions of Julia and Alan Pemberton were not known until 0153hrs after entry was made to Old Hallowes at 0119hrs.

11.46 Based on the findings of the post mortem report Julia's condition would not have been amenable to medical intervention even if this had been available immediately after 1940hrs when the last gun shot was heard by a neighbour.

11.47 The delay in entering Old Hallowes can be attributed to the failings embedded in Thames Valley Police policy and training in responding to firearms incidents; a number of factors on the evening in question, including technical difficulties and most notably an over cautious approach.

11.48 In the absence of a review of the firearms response on the night of 18/19 November 2003 TVP's Firearms Policy, Operation Saladin was not reviewed, the learning identified and the policy not withdrawn until after the Highmoor Cross Review.

Learning for the future – 2008 onwards

- **Firearms debriefs related to complex scenarios and all firearms incidents involving police deployments resulting in death should be centrally maintained so that best practice can be captured and debriefs measured against a calibrated system - a potential role for the National Police Improvement Agency (NPIA).**

12. Aftermath

This chapter concerns a number of issues and events following the death of William, Julia and Alan and is set out in the following sections:

- Postscript
- West Berkshire Area Child Protection Committee
- Communication between Thames Valley Police and Julia's family Part 1 (January 2004 – September 28 2004)
- Inquest
- Communication between Thames Valley Police and Julia's family Part 2 (1 October 2004 – October 2005)
- Internal Management Reviews.

- **Postscript**

12.1 After 18 November 2003, a number of Alan's actions over the preceding months can be understood in a different context. In the letter he wrote to Julia which she received on or around 8 November 2003, Alan referred to it being 400 days since 3 September 2002 when Julia had told him of her wish for their marriage to end and he gave her until 16 November to contact him or *'the situation would remain the same'*. It is therefore possible that Alan wrote the letter to Julia on 7 October (400 days from 3 September 2002).

12.2 Letters written and actions taken by Alan that came to light after the murders provide evidence of how pre-meditated his plan to murder Julia had been. The reference in the letters which Alan made to different numbers of days since 3 September 2002 has been interpreted subsequently by family members as indicating that Alan had planned to murder Julia on previous Tuesdays in October when he was collecting William for a driving lesson from Old Hallowes but on those days there had been friends of Julia or William present at the house. This was also the case in November.

12.3 On 19 November a letter from Alan was found in his car in which he wrote:

'Dear All,

By the time you read this note, the ghastly news will have hit you. I only hope that William did nothing stupid!

…It was exactly 420 days from the day she dropped her bombshell to the day of reckoning.'[303]

12.4 In fact 18 November was 442 days after 3 September; on the preceding Tuesday a school friend had been visiting William. In the letter found posthumously Alan had written that if he failed, he had paid a substantial amount of money to have Julia killed with instructions, she was to suffer for at least 420 days and that there was to be an element of surprise with bonus payments for key dates that she would recognise. He wrote that money had also been paid to destroy *'those who I feel have conspired with her through the past year or so.'*[304] The police were contacted by TVP in the areas where the individuals lived to whom this was likely to refer and advice provided at the local level.

12.5 Amongst other items also found in his car was £36,000 in cash, a bottle of Jack Daniels, two Dictaphones, duct tape, cable ties, scissors, bicycle type rope chain and lock, golf bag and equipment; four small plastic soft drink bottles (subsequently found by the family to contain petrol). There was also a newspaper article concerning a domestic homicide which had been committed by a former local publican.

12.6 C8 and Alan's solicitor both received letters which he may have posted during the 18 November. In the letter to his solicitor Alan appointed him as joint executor with C8 enclosed a will and schedule of his financial position. His residual estate was to be divided into equal shares between C19 and William. In the accompanying undated letter Alan explained how life:

[303] C5 Statement (1) PDHR
[304] C5 copy letter provided to PDHR

'…had become intolerable with Julie's cancer (following my two cancers) and her bombshell decision to divorce and her subsequent decisions and actions. I apologise for what I have done but she drove me to insanity.' [305]

12.7 In his letter to C8, referring to 405 days, Alan enclosed an amended will dated 12 August and a copy of a final draft affidavit he had written in Julia's name, retracting statements she had made which he intended her to sign before he killed her. Alan asked C8 in the letter to '*take care of the children*' and that he was hoping '*to get Julie to tell William the truth on her death bed.*'[306]

Panel's Overall Conclusion

12.8 We have concluded that it is probable that following William's birthday, Alan had planned to kill Julia when collecting William for a driving lesson and the opportunity presented itself.

- **West Berkshire Area Child Protection Committee (WBACPC)**

12.9 The WBACPC did not commission a Serious Case Review (SCR) following the murder of William by his father Alan Pemberton. The requirement to hold Serious Case Reviews is set out in the statutory guidance Working Together to Safeguard Children 1999 Paragraph 8.5: [307]

'An ACPC should always undertake a case review when a child dies (including death by suicide), and abuse or neglect is known or suspected to be a factor in the child's death.'

12.10 We have established that there was no written contemporary record of a discussion by the WBACPC in the minutes of meetings in 2003 about the holding of a SCR.

[305] C8 Information to PDHR
[306] C8 Information to PDHR
[307] Working Together to Safeguard Children(DoH, DfEE & Home Office 1999)

12.11 In March 2005, contemporaneously with the Adjournment debate in the House of Commons, it was noted in email exchanges between a senior officer of the Commission for Social Care Inspection (CSCI) and a senior WBC officer that the Local Safeguarding Board had given consideration previously to this matter (no date given):

> *'We haven't undertaken a serious case review following this incident. At the time, when we considered it, the Local Safeguarding Board was clear that:*
>
> *a) we had no prior knowledge of this family;*
> *b) the circumstances did not concern abuse, as per Working Together guidelines, but a criminal act which merited a police investigation;*
> *c) whilst we received information from the police after the event, this was regarding some prior intimidation by Mr Pemberton in respect of his wife following their separation – which would not normally trigger a case review.'*[308]

12.12 We do not consider that this was a correct interpretation of the guidance and was based on incomplete information from the agencies. We made enquiries regarding the timing of this decision and the basis upon which it had been made and were unable to ascertain any further information on either matter.

12.13 In the email exchange in March 2005 with CSCI, a senior WBC officer offered to reconsider the decision.

12.14 On 13 June 2005 there is a record in the minutes of the Local Safeguarding Board under the heading domestic violence noting, that the Safer Communities Partnership was to undertake a domestic homicide review:

> '[The Chair of the ACPC] *said that the Board should be made aware that the Safer Communities Partnership is reviewing the Pemberton case. This will address a number of issues in relation to domestic violence. It should link into the Highmoor Cross Incident.'*

[308] Email from West Berkshire Director of Children Services 22/03/05 to CSCI

There was no reference to consideration being given to a Serious Case Review in relation to William's death.

12.15 In May 2006 there was an exchange of e mails between C5 and the council's Chief Executive (WBCE); on 7 May C5 requested that a SCR be undertaken and following a response by the WBCE on the 31 May C5[309] requested copies of the minutes of WBACPC discussions regarding the matter.[310]

12.16 On 25 May 2006 the Local Safeguarding Children Board's Executive considered the family's request for a SCR:

> *'It was noted that a previous ACPC consideration of this issue had been conducted by* [the ACPC chair], *in consultation with the Chief Executive.*
>
> *Summary of discussion*
>
> *1. Terms of reference of a proposed Domestic Violence Homicide Review closely match those that a Part 8 review is likely to involve Serious risk of duplication, which could be unhelpful, and also inefficient use of resources, which is contrary to Working Together Guidance.*
>
> *2. There is no record of request for involvement of any statutory children's services, with William and no such involvement.*
>
> *3. There is no record of a history of prior abuse or neglect of William, so this aspect of the guidance criteria is not met.*
>
> *4. The family have raised concerns about the way the police report responded at the time of this event. These include technical matters about speed and means of responding that the LSCB is not best placed to judge. These would be addressed*

[309] Correspondence 28 June 2006 WBC to C5

more appropriately by the Police contribution to the Domestic Violence Homicide Review.

5. In the light of these points it was decided that this request for a serious case review would not be supported. [A senior officer] *for West Berkshire Council agreed to investigate how the LSCB can be fully informed of the outcomes of the Domestic Violence Homicide Review so that any necessary actions can be addressed.'*[311]

12.17 On 13 June 2006 the LSCB supported the decision and reasons for not carrying out a SCR. It noted that there was to be a homicide review into the case with very similar terms of reference, a SCR would therefore involve duplication. It also noted that the family had sought a judicial review of the proposed homicide review involving its terms of reference. It noted that there were no records of requests for involvement of Children's Services (education, social care or health) with William prior to his death, nor any record of prior abuse or neglect of William. Issues of concern raised by the family involved police procedures for dealing with firearms incidents that would be more appropriately dealt with in the scope of the Homicide Review.

12.18 On 28 June 2006 a senior WBC officer wrote to C5 in response to C5's requests for minutes of ACPC discussions and for a SCR to be held. HCCQ advised that there were no such minutes in relation to the earlier decision as, contrary to WBCE's email to C5 on 31 May 2006, the decision had been made by the Chair of WBACPC after consultation with the former WBCE and there had been no discussion at any WBACPC meeting. No date was provided for the discussion with the former CE, but we were advised by HCCQ that the discussion did not take place until after the possibility of a DHR had been raised; the purpose of the conversation had been to advise the former WBCE that there were no plans to carry out a SCR. The letter also responded to the family's 2006 request to carry out a SCR. Extracts from the LSCB minutes of 16 June 2005, the LSCB Executive 25 May 2006 and the LSCB of the 13 June 2006 quoted above were enclosed.

[311] Letter from chair of LSCB to C5 28/06/06

Panel's overall conclusions about the WBACPC decision-making with regard to holding a Serious Case Review

The panel has concluded that:

12.19 A Serious Case Review should have taken place in the immediate aftermath of 18 November 2003. When a decision was made in June 2005 to hold a Domestic Homicide Review, it was appropriate that the child protection issues were incorporated in the Domestic Homicide Review.

12.20 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.

12.21 In the event that a Serious Case Review had been carried out following William's death, consideration could have been given to the circumstances and lessons applied.

- **Communication between Thames Valley Police and Julia's family**

Introduction

12.22 We have addressed in the earlier sections of this report our review of TVP's engagement with Julia and her family in the period September 2002 to November 2003. We have considered issues upon which the family subsequently sought information from TVP between November 2003 and June 2005. In this section we do not comment on the accuracy of the information that was provided to the family and their supporters in meetings and correspondence during that period but consider the process of TVP's communication with the family.

- Part 1, January 2004 - September 28 2004 covers the period prior to the Inquest;

- Part 2, 1 October 2004 – October 2005 covers the period after the Inquest and prior to the family's application to the High Court[312]

The information contained in these sections is based on documentation provided by the family, the family solicitor, Julia Drown (formerly MP for South Swindon), the Treasury Solicitor and by TVP.

12.23 We were advised by Supt F, Area Commander for West Berkshire and the Silver Commander on the night of 18/19 that he approached Assistant Chief Constable A (ACC A) at Headquarters on the 19 November to raise the need for a Critical Incident Review of the Pemberton Case; he told us that he was advised that the case did not meet the criteria for holding such a review.

12.24 We sought information from TVP regarding the criteria that would have been applied in November 2003 and March 2004[313] and were advised as follows:

> *'Work on a policy defining and setting out the response to a critical incident commenced on 8th April 2003.*
>
> *Versions 1 and 2 were never agreed and published. TVP do not hold hard copies of Versions 1, 2 or 3.*
>
> *Whilst Version 3 has not been retained in force, recent analysis of the Force Policy Unit files suggest that this version was approved by ACC A on 17 November and published on 20th November 2003.*
>
> *Version 4 is the earliest complete copy that TVP has retained and it is this definition which has been supplied to the panel. Version 4 was last updated on 25th November*

[312] Their application was to have WBSCP's decision to commence a domestic homicide review quashed and for an order requiring WBSCP to set up and organise an enquiry after consultation with the family
[313] Additional information supplied by TVP to PDHR March/April 2004

and published on 23rd December 2003. Version 4 was thus the 'current' document in March 2004.'

12.25 The categories set out in the Critical Incident Definition Standard Operating Procedure 2003 and included in the Current Critical Incident Definition 2004 are as follows:

> *1.4 Often the incident itself may have an actual (or potential) element of seriousness about it and examples could include* [in italics in original] *the following scenarios:*
>
> - *a homicide*
> - *a serous assault*
> - *a vulnerable missing person*
> - *an operation involving the police use of firearms, which results in death or injury*
> - *an incident of a type that has been subject to heightened media attention, e.g. paedophile activity or a series of racist or homophobic attacks.'*

12.26 We consider that the Pemberton case met elements of this criteria, both in relation to the Firearms response on 18 November as a critical incident and in the context of TVP's response to Julia Pemberton as a victim of domestic violence during the preceding fourteen months.

Part 1 January 2004 to Inquest September 28 2004

12.27 In January 2004 C5, acting on behalf of the family, wrote to DI V the Officer who was responsible for the murder investigation and for reporting to the Coroner seeking answers to a number of questions. DI V also had been responsible for the production of the local domestic violence policy in 2003 and had been involved on 18/19 November in his capacity as Senior Investigating Officer. [314]

12.28 On 20 January 2004 C5 sent a schedule containing 133 questions to which he was seeking answers. The questions were set out under the following headings; History Leading to

[314] DI V evidence at Inquest

the Incident; Panic Alarm; 999 Calls; Julia and Will's Death; Siege; Alan's Car; Police Reports; Rights/access to information/inquest; Post Event Searches/tracking.

12.29 C5 wrote further letters on the 3 and 13 February[315] in which he requested additional information including the Command and Control logs for all contact with the police involving Julia, William and Alan Pemberton and also himself; TVP's interpretation of the Home Office Guidelines in dealing with Domestic Violence and the TVP policy on liaising with and taking advice from the Crown Prosecution Service.

12.30 On 3 and 13 February and 3 March 2004 the family through their solicitor challenged Coroner (1) for West Berkshire regarding a potential conflict of interest in conducting the Inquest which was due to be held on 15 March 2004. This was on the basis that he was a partner in the firm of solicitors which had acted for Alan Pemberton in the matrimonial proceedings and for Alan's company and was also, they believed, a personal friend of Alan's. The family were concerned that this would cause unease amongst members of the public. The family advised us that Coroner (1) had replied saying that he noted their comments but could not imagine that the public would be aware of the matters and therefore did not understand why anyone would have feelings of unease. While the family did not consider the issues they had raised would prevent him from acting as Coroner, they felt he was insensitive in resisting their requests to stand down.[316]

12.31 DI V replied on 16 February advising that the Command and Control logs and other Policy logs were subject to Public Interest Immunity and therefore not available; he provided a copy of the Home Office Guidelines, the CPS Guidelines and West Berkshire Police Area's interpretation. DI V advised the force was currently in the process of reviewing its policy on dealing with Domestic Violence and he confirmed a meeting with the family and their solicitor for the 21 February. He also provided a written response to each of the 133 questions; in many instances these amounted to one word answers. The family was not satisfied with a significant number of the answers provided by DI V.

12.32 On 21 February a meeting was held between the family, TVP officers and the Coroner's officer and was attended by C9, the family's solicitor. The family understood from

[315] C5 information to PDHR
[316] C5 information to PDHR including correspondence with Coroner (1)

the meeting that the request for the Command & Control Log was refused on the grounds that if disclosed it might prejudice the safety of officers; DI V had taken advice from the force solicitor on this matter. The current position regarding the force DV policy was also discussed. The family were advised by the Coroner's officer that the Coroner wanted to list the inquest and that it would take a half day.

12.33 On 5 March 2004 Coroner (1) in his reply to the family's solicitor stated that he did not accept the family's challenge regarding a potential conflict of interest. He had decided to adjourn, the Inquest since enquiries were still taking place in relation to the domestic violence unit file. As a consequence of the adjournment he advised that the case would be taken by the Coroner (2) for East Berkshire who had been appointed from 1 April 2004 to cover the County of Berkshire.

12.34 We were advised by Coroner (2) that he understood from Coroner (1) that the family had in Coroner (1)'s view unfairly challenged his handling of the case. Coroner (1) had hoped to deal with the case but it was agreed at a meeting with Coroner (2) that in the context of the family's challenge and Coroner (2)'s appointment to cover the County of Berkshire, that Coroner (2) would accept the case.

12.35 We were told by Supt F that on the 19 November he had the question with ACC C of whether the incident was considered to be a critical incident and was advised that it did not meet the then current criteria, as the impact of the firearms response was localised to Newbury. Supt F advised us that he raised the matter again on 5 March 2004 with Chief Superintendent (CS D) and was advised that it did not meet the criteria. [317] We understood from our discussion that in the event that an incident was defined as critical a 'Gold Group' would be convened chaired by an ACPO member including all the relevant people involved to discuss the case, identify potential issues and actions which could include undertaking a review.

12.36 A meeting of senior officers in TVP referred to as the 'Pemberton Gold Meeting' was held on 9 March with the requirement identified as

[317] Supt F information to PDHR

'The need for the force to ensure that it was properly and correctly prepared to manage the response to the forthcoming coroner's inquest'

12.37 The meeting considered a brief history of the domestic violence in relation to Julia; a synopsis of the police contact with her and a brief outline of the tactical response to the firearms incident on 18/19 November. Amongst other matters discussed the meeting noted no official complaint had been received from the family but this might follow the inquest proceedings. Further to this it was agreed that the Professional Standards Department would meet the family and pre-empt a complaint by commencing an enquiry.

12.38 Following the Gold meeting a number of attempts were made to arrange a meeting with C5 and the family's solicitor regarding a possible complaint against the police or civil action. Included in the notes of the meeting is reference to an agreement post-meeting that the Performance Standards Department (PSD) would meet the family and pre-empt a complaint by commencing an 'enquiry' and that a date for that meeting was set for 13 April 2004.[318] From information provided by TVP it is apparent that the family subsequently declined to meet with the officer from PSD on the basis that they did not wish to make a complaint as their concern was to obtain a copy of the DVC's file. No enquiry was initiated by TVP.

12.39 On 24 March 2004, C9 the family's solicitor wrote to the Coroner (2) for East Berkshire advising that the family were considering invoking Article 2[319] at the forthcoming Inquest Hearing on the basis of the involvement of TVP through its Domestic Violence Unit. C9 also noted his Client wished the Coroner (2) to consider whether or not he would be willing to accept that Section 8 (3) (d)[320] applied. The family's solicitor pointed out:

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[318] Notes of Gold Meeting 9 March 2004 provided to PDHR by TVP

[319] Article 2 RIGHT TO LIFE Human Rights Act 1998 Chapter 42
1. Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.
2. Deprivation of life shall not be regarded as inflicted in contravention of this Article when it results from the use of force which is no more than absolutely necessary:
(a) in defence of any person from unlawful violence;
(b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained;
(c) in action lawfully taken for the purpose of quelling a riot or insurrection.

[320] Coroners Act 1988 Section 8 (3) If it appears to a coroner, either before he proceeds to hold an inquest or in the course of an inquest begun without a jury, that there is reason to suspect— (d) that the death occurred in circumstances the continuance or possible recurrence of which is prejudicial to

'Our Client's argument is comparatively simple. His suspicions are that the policy adopted by Thames Valley Police in response to the Home Office guidelines did not provide for a system which would ensure that those in need of protection obtained such protection.'

12.40 C9, the family's solicitor referred to the DVC's memorandum and to the documentary evidence that had been '*lodged not logged.*' He concluded:

'As we understand it provided that the circumstances suggest a failing of the system, the condition will be satisfied and the jury obligation triggered.'

12.41 The Coroner for East Berkshire replied also on 24 March advising he would be taking up the post as Coroner for the County of Berkshire on 1 April. He had not received the papers or had a chance to read them and until he had the opportunity to consider the papers he would not be able to respond to the points made. He anticipated that he would wish to hold a preliminary hearing in which, along with other matters he would invite representations as to whether Article 2 was engaged and would determine the future conduct of the Inquest.

12.42 At a meeting held on 21 April[321] requested by TVP with the Coroner to discuss the conduct of the case, officers noted the family was *'targeting'* a number of issues; the policy of the TVP Domestic Violence Unit; Thames Valley Police had yet to issue a published Domestic Violence Policy; there was a local West Berkshire policy; the issue of the duty of care/depth of responsibility of TVP in such circumstances.

12.43 On 27 April the Coroner advised the family's solicitor that a Preliminary Hearing was to take place on the 26 May.

12.44 A further Gold Meeting[322] was held on 28 April based on the same requirement as the March meeting but with the following additional overall objectives:

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the health or safety of the public or any section of the public, he shall proceed to summon a jury in the manner required by subsection (2) above.

[321] Reference Attendance Note 21.04.04 provided to PDHR by TVP
[322] Notes of Gold Meeting 28 April provided to panel by TVP

- *To ensure that Thames Valley Police provides an effective and professional response to the incident at all stages;*

- *To provide support, reassurance and timely information to family, witnesses and TVP staff;*

- *To provide reassurance to the community and the public acknowledging the impact the incident may have on community confidence;*

- *To identify areas of good and bad practice with a view to improving future police performance;*

- *To ensure that the interests, integrity and reputation of Thames Valley Police and its staff are maintained and safeguarded.*

12.45 At this meeting the key areas of dissatisfaction from the family were noted as being the handling of Julia's 999 call; the firearms response and the Domestic Violence Unit response. It was recorded there was no indication the family were intending to make a complaint; they just wanted access to the Domestic Violence Unit file. It was noted that the Heap trial[323] was due to recommence on 10 May and the Faruqui re-trial[324] on 12 July. The meeting with the Coroner with regard to the Pemberton Inquest and the Force's preparation for the Inquest were also included in the matters discussed.

12.46 On 4 May the family's solicitor wrote to the Coroner referring to the House of Lords judgement in Middleton[325] pointing out;

> *'Having looked at the judgement in its entirety it seems to us that the judgement does not limit the broader 'how' approach to those situations in which the state article 2 obligation has been engaged'*

[323] On 26 April 2003 Yvonne Heap was stabbed to death by her partner Naheed Akhter in her car outside Cowley Police Station, Oxfordshire.
[324] On 2 August 2003 Rana Faruqui was stabbed to death by her ex- boyfriend Stephen Griffiths at Burnham Buckinghamshire.
[325] Regina v Her Majesty's Coroner for the Western District of Somerset (Respondent) and other (Appellant) ex parte Middleton (FC) (Respondent 11 March 2004).

12.47 The DV file was subsequently given to C9 the family's solicitor on the 17 May at a meeting with DI V. C9 recorded in his attendance note the information concerning the DVC file and related issues that he received; the DVC worked within a chain of command accountable to and under supervision of a line manager; it would not have been necessary for the DVC to consult the line manager because the allegations were of an historic nature and it would not be normal practice to refer the file following an initial contact with the potential complainant. C9 understood from DIV that in his view the DVC's memorandum to the solicitor on 16/09/02 had to some extent exaggerated the seriousness of the position on the basis that the DVC would have been anxious to ensure that every assistance was afforded to Julia in her pursuit of a Non- Molestation Order to include a Power of Arrest. C9 was advised that the DVC had no knowledge of the incident in April 2003 with regard to the super-glued locks; she had also not seen the annotated affidavit and associated paperwork which had been added to the crime file concerning the super-glued locks. The DVC meeting on 9/06/03 with Julia had come about because of Julia's concern that the original Non- Molestation Order was about to expire as the Order was needing to be extended. DIV confirmed that a new Domestic Violence Policy was in the course of being piloted and when adopted, each complaint would be made the subject of a Risk Assessment.[326]

12.48 On 26 May at the Preliminary Hearing [327] it was noted that C9 acting on the instruction of the family advised '*the family now acknowledge that it is not an Article2 scope Inquest.'* The Coroner '*ruled that in those circumstances it will be the narrower form of Inquest.'* In the notes of the meeting it was also recorded that:

> *'as it was accepted that this is not a wider scope Article 2 Inquest, presumably Section 8 of the Coroner's rules do not apply and therefore no jury is required.' The family solicitor confirmed that he and the family accepted that it is not a jury case.'*

The Inquest was set for 28 and 29 September 2004.

12.49 On June 9 the Chief Constable of TVP in relation to the domestic homicide case involving Vicky Horgan and Emma Walton:

[326] C9 information to PDHR – Attendance Note 17/05/04
[327] Notes of Preliminary Hearing 26/05/04 provided to panel by family solicitor

'…commissioned a review of the practices and procedures adopted by Thames Valley Police in connection with the fatal shootings at Highmoor Cross on Sunday 6th June 2004,[328] to facilitate organisational learning.'

12.50 In June the family's solicitor, on request to TVP was provided with a copy of the tape of the 999 call which was neither transcribed nor listened to until after the Inquest had taken place.[329]

12.51 On 28 July 2004 Julia Drown, the then Labour MP for Swindon South wrote to the Chief Constable.[330] She explained that she was writing on behalf of Julia's brother and family and with the knowledge and support of David Rendel the then MP for Newbury. Julia Drown referring to the meeting between DI V and the family in February 2004 noted that it had not fully resolved the concerns and questions voiced by the family.

12.52 She advised the Chief Constable that notwithstanding their decision regarding Article 2, the family wanted senior officers on the night of 18/19 November to be at the Coroner's Hearing, so that they might have the opportunity to ask questions of them. David Rendel MP had approached Supt F, who subject to the views of the Chief Constable, had said that he would be willing to attend as an observer. Julia Drown urged the Chief Constable to volunteer his officers to the Coroner. She added:

'I am asked to stress that the family are not seeking to find fault. They merely wish to be able to see the situation in the round.'

12.53 Julia Drown also requested the opportunity for the family to have an early meeting with the Chief Constable, preferably before the Inquest *'to better understand what happened in the time coming up to the 18 November and on the night itself.'*

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[328] Highmoor Cross Review published 6 October 2004 – Stuart Horgan had a long history of domestic abuse towards his wife; had been registered as a dangerous offender and was the subject of the Multi-Agency Public Protection and Panel arrangements, whose risk was managed through the Multi-Agency Risk management process. Stuart Horgan the estranged husband of Vicky fatally shot her and her sister Emma Walton and severely wounded their mother.
[329] Information from notes of meeting between family and TVP 20/12/04
[330] Letter to Chief Constable provided to PDHR by J Drown

12.54 Over the following eight weeks Julia Drown and/or her office, on four occasions made enquiries regarding a reply and on two occasions were asked by the Chief Constable's office to fax a copy of the letter as it could not be located.

12.55 A customer satisfaction questionnaire dated the 22 September was sent from TVP HQ addressed to Julia at Old Hallowes.[331]

12.56 The Deputy Chief Constable (DCC) replied on 24 September apologising that a personal reply had not been sent previously; she referred to a conversation which had taken place between Supt F and David Rendel and Supt F and C5 regarding a meeting to discuss the circumstances. The meeting was to take place after the Inquest as *'it would be inappropriate to do so until the Inquest has been concluded.'*[332]

12.57 The DCC noted on behalf of Thames Valley Police that she was anxious to do all that could be done to help the family deal with the tragedy and to come to terms with the tragic events:

> *'I know you will appreciate the importance of ensuring that the Inquest deals only with matters relevant to the Coroner's inquiry. However I would wish to emphasise that, outside the confines of that formal process, we remain committed to engaging with the family on any wider issues relating to the incident'*

- **Pemberton Inquest 28 and 29 September 2004**

Introduction

12.58 The Terms of Reference (appendix A) included as matters for consideration by this review '*the nature, outcomes and findings of the inquests in this case'*; in this section we have set out our findings and conclusions.

12.59 We met with the Coroner for Berkshire who heard the Pemberton Inquest on 28 and 29 September 2004 in order to consider these matters. He told us that as an Independent

[331] C5 information to PDHR
[332] Letter from Deputy Chief Constable to Julia Drown dated 24 September 2004

Judicial Officer he was constrained in discussing evidence and decisions after a hearing had been concluded.[333] He pointed out that in the course of an inquest he was obliged to make administrative decisions which were only challengeable by a higher court and that no such challenge had been made. He referred us to the comments of LJ Moses at the hearing, by way of a judicial review of the scope of the Pemberton Domestic Homicide Review:

> *'It would be quite wrong and inappropriate to seek to impugn or attack the Coroner in any way…I shall record that I can see no ground for any criticism whatever of the approach of the Coroner to the bereaved, or his conduct of the inquest once representations were not pursued and there was no application that there should be an enhanced Middleton – type inquest'*[334]

12.60 The *'nature, outcomes and findings'* of the Pemberton Inquest have been contested by the family and friends of Julia and William Pemberton and on their behalf by Julia Drown MP. Julia Drown presented their combined views on the Inquest and the conduct of the Coroner in correspondence with the Minister of State for Department of Constitutional Affairs, the Secretary of State for the Home Office and in correspondence with the Coroner's Unit at the Home Office; and in the Adjournment debate in the House of Commons. The family met with Baroness Scotland Minister of State for the Home Office and corresponded with her and with the Head of the Domestic Violence at the Home Office.

12.61 The family's views about the Inquest were also central to the application made in October 2005 by C5 for a Judicial Review with regard to the setting up the domestic homicide review in 2005; the family were concerned that the state's obligations to institute an investigation pursuant to Article 2 of the European Convention on Human Rights would not be fulfilled by the proposed review, this was in the context that the Inquest had been the narrower form. The family sought an order to quash the Partnership's decision and to require them to set up a domestic homicide review after consultation with the family.

[333] Coroner information to PDHR
[334] Transcript of the Judgement of LORD JUSTICE MOSES: THE QUEEN ON THE APPLICATION OF MULLANE CLAIMANT v WEST BERKSHIRE SAFER COMMUNITIES PARTNERSHIP and Others DEFENDANT Monday, 31 July 2006.

12.62 We are aware that in those cases where it is shown that the state's duty is to initiate an investigation in order to fulfill its Article 2 obligation, that duty will generally be met by an inquest. At the Hearing on 31 July 2006, LJ Moses stated that:

> *'If, therefore, a claimant contends that the state is under a duty to initiate an investigation and if an inquest is to be held, it is open to a claimant, both before and if necessary at the opening of the hearing of the inquest, so to contend. The result is that the coroner will be given an opportunity to consider and rule on the nature and extent of the inquest, whether it be an enhanced Middleton inquest or something more limited. If the coroner takes the view that an enhanced inquest is not required, then it is incumbent on those adversely affected to challenge the coroner's inquest and the conduct of the inquest by way of judicial review.'*

12.63 As stated earlier in this report initially the family through their legal representative advised the Coroner that they wished him to consider whether it was an Article 2 case. We were advised by C5 that as the family were unable to ensure they all had the same level of understanding at the same time, necessary for reaching a consensus, their solicitor was instructed not to pursue the matter of Article 2.[335] C5 told us that he believed that consideration of Article 2 should not have been left to the family and that through the matters raised in his Supplementary Statement to the Inquest he had believed the Coroner would consider whether an Article 2 scope enquiry was required.

> *'Whilst it is true that we as a family will not pursue system neglect, we all hope that the coroner accepts that if during the course of the inquest evidence is given which may support such a proposition, then we rely upon him to consider that very issue.'*

12.64 After the Inquest the family did not seek to challenge the Coroner's inquest and the conduct of it by way of a judicial review; a recourse which would have been open to them in the three months after the Inquest.[336] C5 explained to us the family, still coping with the tragic loss of Julia and William, exhausted from trying to get answers from TVP during the preceding twelve months, distressed by the experience of the Inquest and denied critical

[335] C5 email to chair PDHR 1/04/08
[336] Pre-Action Protocol for Judicial Review : Civil Procedure Rules; Ministry of Justice

information on the Command and Control log which was not made available to them until January 2005, did not feel able to pursue an application within the required timescale. They had decided with the help of Julia Drown to get agreement from Ministers, in advance of the legislation, to a domestic homicide review to assess whether everything was done to try and prevent the deaths of William and Julia Pemberton.

Inquest 28 – 29 September 2004

12.65 The Coroner explained to us it was for the individual Coroner to assess the evidence and decide upon the appropriateness of the inquiry he would conduct. In the Pemberton case the Coroner's focus was how Julia, William and Alan lost their lives.

12.66 We understand that the police prepare and present the evidence to the Coroner; they provide the reports, statements that they have obtained and documents and material available. The Coroner also has officers available to gather evidence.

12.67 We learnt that the scope of an Inquest is dealt with, as occurred in this case, by a letter from the Coroner to the interested parties' representatives advising them of the papers which he believed to represent the evidence available to him, the witnesses he proposed to call, and those witnesses he proposed to read out; by that stage an appropriate bundle of documents would be prepared and shared. As in the Pemberton case the Coroner then holds a preliminary hearing and hears applications and submissions on the scope of the inquest.

12.68 The Coroner confirmed that all the evidence that he had that was relevant to his enquiry and that was introduced at the Inquest was set out in the transcript of the Hearing.

12.69 If in the process of an inquest information comes to light that the Coroner considers warrants it being opened up, the discretion is available to him, as it is to any of the legal representatives, to make application in the course of the Inquest for the Coroner to review the situation. In relation to the Pemberton Inquest the Coroner confirmed that at no point had he considered that stage to have been reached and at no time had any applications been made of that kind by the legal representatives.

12.70 We took the opportunity to consider with the Coroner various aspects of the evidence in relation to the outcome of the Inquest.

12.71 The Coroner confirmed that he was not aware that the transcript of the Julia's 999 call with which he was provided by TVP had in fact been edited without his knowledge. He informed us that he would have expected a full record of Julia's telephone conversation

12.72 He had not been provided with the C & C log but had received information about what was on it relevant to his inquiry from DI V who he recalled he was offered by TVP on the basis that he was a senior officer who would be able to deal with all the relevant surrounding issues. He had not received any requests from either the legal representative for the family or TVP for access to documents.

12.73 The Coroner outlined the information concerning the incidents about which he had received evidence at the Inquest; the threat to kill; the glued locks and the annotated affidavit. He had understood that Julia did not share information during the autumn of 2002 about ongoing threats with police. He had received evidence in relation to the glued locks that Julia had been surprised that police were still involved and that she appreciated they could do nothing about it. He had been unable to find any direct reference by Alan to a death threat in the annotated affidavit. He was also aware that Julia had seen the DVC.

12.74 He was not aware that the terms of the injunction had been varied and his understanding had been that it continued in place. Nor had he been aware that the DVC had specifically advised Julia to call 999 rather than use the alarm. The Coroner acknowledged that he had not been given a clear understanding about whether directions to Old Hallowes were included with the flagging of Julia's address.

12.75 The Coroner confirmed that from evidence at the Inquest he had concluded that the three victims were tragically dead by 1940hrs and in that context therefore it had made no difference to his inquiry that it had taken a further six hours for TVP to enter the house. He had not seen the firearms debrief undertaken by TVP in December 2003 and did not see the Highmoor Cross Report until after the Pemberton Inquest; he noted in general terms that he considered the Highmoor Cross Incident to have been a very different set of circumstances from his inquiry.

12.76 The Coroner said that he was extremely apologetic for not expressing his best wishes to C19 for her future. He had extended his sympathy to the bereaved; and had not been aware at the time that Julia's mother was at the Inquest. In relation to the exchange with C5 he commented that the remark he had made was in the context that he had been in conversation with an advocate; and someone who was not entitled to speak at that point, had made a remark and he had sought to prevent this happening again by the strength of the comment he had then made. He was clear about his intention in the remarks he made in his summing up concerning William's death and it was not that which had been subsequently interpreted by members of the family.

Post Inquest

12.77 On 8 November 2004[337] Julia Drown wrote to the Minister of State for Constitutional Affairs asking him to investigate the conduct of the Coroner. She enclosed the family's records from the tapes of the Coroner's summing up which she had marked and commented upon. She said that she considered that the Coroner had:

- Appeared to exonerate the police in relation to the firearms response - she noted that although the Highmoor Report had been about to be published and the police would have known of the system failures they had not alerted the Coroner

- Accepted too lightly the police delays in taking action

- Shown a lack of understanding of domestic violence and failed to deal adequately with the domestic violence issues

- Not considered widening the scope of the Inquest although the police had been culpable of not doing everything possible to prevent the murders[338]

- Been insensitive towards C19 and towards Julia's mother

[337] Letter to Lord Falconer of Thoroton QC Minister of State for Constitutional Affairs from Julia Drown 4/11/04 provided to PDHR by Julia Drown.
[338] Article 2 scope inquest: to consider causation of death not only "by what means" but "by what means and in what circumstances."

- Not acknowledged Julia or William's courage and bravery

- Suggested by default that William did something wrong or got in the way and therefore may have deserved being shot or not and thereby implied that Julia definitely did something to deserve it.

12.78 Julia Drown concluded her letter by hoping that the Minster of State would review the Coroner's behaviour with a view to providing training in domestic violence issues and a refresher on his responsibilities towards article 2 and *'preferably more serious action to show all Coroners that the public deserve better than this treatment.'*

12.79 Julia Drown's letter was passed by the Coroners Unit to the Coroner, his response is summarised as follows:[339]

- At the time of his Inquest the Highmoor report had not been published and that he understood that the circumstances of the deaths at Highmoor were significantly different to the circumstances of Julia William and Alan Pemberton; he did not understand how the Highmoor deaths were in anyway relevant to his enquiry.

- When he had reviewed the papers initially before the Inquest he had not considered it was an Article 2 case; having received correspondence from the solicitors representing the family indicating that they wished him to consider it was an Article 2 engaged case, he had conducted a preliminary hearing at which the family's legal representative and the Counsel for the Police attended. Coroner had invited submissions from the family's legal representative but he had declined and when pressed given his earlier correspondence had accepted that it was not an Article 2 inquiry, a view shared by the Counsel for the Police.

  'The possibility that the State's discharge of its protective duty under Article 2 had to be considered but was not central to causation in this particular Inquest on the evidence.'

[339] Letter from coroner (2) to Coroners Unit provided by Treasury Solicitor to PDHR

- The family's legal representative had not raised the matter immediately prior to the Inquest and invited him to reconsider the position

- From the evidence there were only 15 months of domestic violence after the first most serious incident of the threat to kill followed by the discovery of the glued locks and the affidavit annotated by Alan. Julia Pemberton had negated the effect of the Injunction by allowing Alan to collect William for driving lessons. The solicitors acting for Julia did not appear to have received any instructions to obtain a committal against Alan for any suggested breach of that Injunction.

- Julia had not referred to any ongoing difficulties with Alan at the '*Informal and probably coincidental meetings*' with the DVC.

- At the point when Julia's call was logged Alan was already at the house and may have already killed William. The 16 minute call had ended at a point where it was 'reasonable to conclude that Alan had shot Julia dead and himself very soon after. However quickly the police response had been it would not have been possible to prevent the deaths.

- He was concerned that Julia Drown's letter had given an incomplete picture of the evidence heard at the Inquest.

- It was a police decision not to arrest Alan following the allegations made against him but there had been a significant period of time between the third event and the murders of his wife and son; he had moved away, started a new relationship which apparently had lessened any potential risk of domestic violence.

- Whatever her opinion of the police, it appeared that Julia had not told the police of her fears and concerns. After the glued locks it was clear that the police had spoken to Julia and she had expressed surprise that they were following the matter up as she had accepted there was no evidence to justify the police approaching her husband about it.

- He did not condone Alan Pemberton's actions but had attempted to put them from Alan's perspective - the observation of unlawful killing being one of the gravest about conduct that a Coroner could make.

- His remark about what William Pemberton could have done to justify his father's behaviour he felt was a view shared by everyone at the Inquest.

- His comments at the Inquest were a summary based on the facts and evidence that he had heard –'*I believe that Alan Pemberton was a cunning and evil man who prepared his plans over long period of time'*.

- He was sorry to hear that the family felt that he was in any way insensitive towards them and that he had failed to display courtesy, compassion or respect for them. It had not been his intention and he apologised if that was how they felt.

- He apologised that he had missed the opportunity to give his best wishes to C19 Pemberton for her future and to acknowledge her bravery in the course of the Inquest, but noted that he had commented at the beginning of the Inquest that it would be a very difficult occasion especially for members of the family.

- He said he had not been aware that Julia's mother had been present and noted that in the course of an Inquest the Coroner's review of evidence may be distressing to one aspect of the family- he had not intended any lack of courtesy to anybody.

- He commented that he had also seen Julia Drown's letter to the Home Secretary, she had criticised him without having been present at the Inquest; and he did not accept her criticisms for the reasons he had stated in his letter to the Coroners Unit.

- He noted that a personal friend of both Julia and William Pemberton had approached him quite unsolicited and thanked him for the fair and reasonable way he had conducted the Inquest.

Panel findings

12.80 We are not qualified and have therefore not sought to comment on the implications of our findings, merely to report on them; it is for others who are qualified to determine whether there are any implications.

12.81 We have identified the following points from the oral and written information received in relation to the Pemberton Inquest:

- The Coroner was provided with evidence by the police on the basis of which he decided that it was to be a narrow inquest i.e. concerning the causation of the deaths of Julia, William and Alan Pemberton.

- The Coroner invited submissions at the preliminary hearing regarding the scope of the Inquest; the family through their legal representative had the opportunity to request that the scope of the inquest was widened, they did not do so.

- The Coroner advised us that during the Inquest he did not receive evidence that would have caused him to widen the scope; nor did he receive any requests from advocates to do so.

12.82 TVP provided evidence to the Inquest in relation to Julia and William's deaths and Alan's suicide on the basis of a murder inquiry. They provided information and Witnesses at the Inquest in line with the Coroner's determination that it would be a narrow scope Inquest.

12.83 We are concerned that TVP, without the Coroner's prior knowledge,[340] provided him with an edited transcript of Julia's 999 call. This was not known to the family at the Inquest. In subsequent meetings with the family in response to questions raised by them about the edited transcript, the point was made by TVP officers that a full recording of the call had been given to the family solicitor prior to the Inquest. This does not address the fact that at the Inquest the family were unaware that the Coroner had an edited transcript.

[340] Coroner information to PDHR

12.84 Individual officers representing the police provided evidence of their knowledge of TVP's involvement with Julia without the benefit of a comprehensive review by TVP of the handling of the case. Information was not available to the Inquest about the absence of a force-wide domestic violence policy; the failure to investigate reported crimes, to positively intervene and to link incidents; or about the delays in the Firearms response on 18/19 November.[341]

12.85 In the Conclusions section of this report we have identified those matters with regard to TVP's response to the Pemberton case which have in our view a bearing on the nature, outcomes and findings of the Inquest.[342]

12.86 The family had an advocate present to draw matters out and to challenge the evidence available; they did not have access before or during the Inquest to the level of information that could have informed their judgement about challenging the scope of the Inquest; or could have enabled them to focus on specific areas in relation to the police engagement with Julia in the preceding months or the response on the night of 18 November. After the Inquest access to that information may or may not have informed their decision making regarding an application for a judicial review. The have advised us that the Command and Control logs were not made available to them until January.

12.87 Had this information been available at the time of the Inquest the Coroner may or may not have widened the scope.

12.88 We discussed with the Coroner a proposal that the police in domestic violence cases be asked to provide a report to the Coroner of their involvement. The Coroner advised that if in other cases e.g. concerning an untoward incident in a hospital, he was aware that a review had been conducted it was his policy to request a copy of it and that it could assist in deciding what kind of evidence to call. We consider that access to a domestic homicide review report could in a similar way be of assistance to a Coroner in determining the scope of an Inquest.

[341] Chapter 13
[342] Chapter 13

Panel's overall conclusions with regard to the Inquest

The panel has concluded that:

12.89 There was information that, had it been available to the Coroner, may have influenced his decision regarding the scope of the Inquest;

12.90 The family decided not to request an Article 2 scope Inquest prior to or during the Inquest or to challenge the decision during or after the Inquest by way of judicial review; they did not have access before or during the Inquest to the level of information that could have informed their judgement about challenging the scope of the Inquest.

12.91 In a domestic homicide case, it would be appropriate for the police who have responsibilities in delivering key aspects of a domestic violence service, to provide the Coroner with a report of their involvement with regard to the individual case and for that to be included with the information provided to the Coroner.

12.92 Domestic violence training should be made available for Coroners.

- **Communication between TVP and Julia's family Part 2, October 2004 – June 2005**

12.93 On 6 October 2004 the Highmoor Cross Review was published; the recommendations of which are set out in appendix D to this Report

12.94 On 16 October a meeting was held between Supt F and the members of the family and friends which was attended by Julia Drown. Questions presented by the family at this and a subsequent meeting included; the absence of a Force Domestic Violence Policy; the role, training, and supervision of the DVC; the investigation of the incidents in September 2002, April and May 2003; the panic alarm; flagging; the call taker's response to Julia's 999 call on 18/19 November; the firearms response on 18/19 November; access to the Command and Control logs for each of the incidents.

12.95 The family have shared with us their recollection and understanding of the discussion with Supt F. A number of matters detailed in 12.94 were covered. In summary the family

concluded that at the meeting Supt F conceded there had been a number of failures including the calling out of the wrong Silver Commander on 18/11/03; and that the firearms response had been over cautious. They understood from the meeting that the DVC did not have a line manager or supervision; advice with regard to the use of the panic alarm and 999 could have been better; that there were differences between the two with regard to the flagging up of information. Basic investigative skills needed to be improved along with training and supervision; there were information management problems. The family understood from Supt F he considered the officer dealing with the glued locks should have been told about the annotated affidavit and it had not been logged nor was it referred to in the DVC file. The placing of the annotated affidavit on the closed glued locks file had been at best a mistake; had he seen the document it would have significantly increased the risk.[343]

November

12.96 Julia Drown wrote on behalf of the family to the DCC on 1 November, further to an earlier letter concerning the Command and Control log for 18/19 November, requesting access to the logs for the other incidents that Julia had reported to TVP. The DCC responded on 3 November pointing out that such logs were not routinely available because they usually contained confidential personal details or sensitive operational tactics and police methods. She went on to say that:

> *'Also the Command and Control system is a resource and incident management tool, not an information recording tool- such logs do not purport to be a comprehensive and accurate evidential record. Read in isolation, the logs can be extremely misleading as a record of what was happening, They are full of highly specialised terminology and codes which, to be frank, are not readily understandable without translation except by those police officers or police staff with particular expertise.'*

12.97 The DCC agreed '*exceptionally*' to make available the logs and a specialist police expert to provide explanations. She confirmed that she was taking a personal interest as was the Chief Constable and that Supt F had discussed the possibility of the family meeting with one or other of them.

[343] C5 information to PDHR

12.98 On 8 November Julia Drown wrote to David Blunkett the Secretary of State to the Home Office requesting a homicide review of the case in advance of the legislation and for a meeting to discuss it. She said that the family were dissatisfied with what they felt was complacency on the part of Thames Valley Police both in their attitude to the family and to the inquest of Julia's and William's death. Julia Drown referred to the length of time taken, over six hours, to get into Julia's house and that Julia had been told that the police were on their way. She referred to the findings of the Highmoor Report in particular *'that the police's policy had not assisted the person seeking assistance; which means system failure.'*[344] and went on to say that '*System failure was clear in both firearms response, and in their domestic violence policy which seems to be a shambles'*.

12.99 Julia Drown wrote that TVP had already admitted basic investigative skills were lacking. She pointed out that *'Despite at least three strong episodes of domestic violence reported to the police, the assailant* [Alan] *was never arrested or questioned'*. She noted what she considered to be inconsistencies in the TVP officers' reports to the Coroner concerning police procedure.

12.100 On 13 November 2004, Supt F met for the second time with members of the family, friends, Julia Drown and David Rendel MP. The Command and Control logs had by then been identified for the 14/09/02, 16/09/02 (2), 20/04/03, 10/06/03 and 18/11/03.[345] The family provided us with a list of sixty- nine questions which they took to the meeting concerning a range of issues which included; the withholding of information from the family; the 999 call; silent 999 calls; the flagging and directions to Old Hallowes; the call operator's advice to Julia; Firearms response and policy [and following Highmoor], the transcript of Julia's 999 call; cover for the DVC and training, supervision; the DV policy; Alan's threat to kill; the annotated affidavit and the absence of a Police Review into the case. The family also shared with us their file note of the meeting in which they recorded that from the information shared at the meeting they had concluded there had been a system failure and they considered that

[344] Letter from Julia Drown MP to the Rt Hon David Blunkett MP, Secretary of State Home Office 8/11/04

[345] C5 information to PDHR - the C&C log for 18/11/03 was not released to the family until January 2005 (see paragraph 12.64)

Supt F had also conceded this. The family had concluded that a review of TVP's involvement in relation to the case was required.[346]

12.101 Following the meeting C5 provided Supt F with a list of actions including requests to: establish routing of the annotated affidavit; deal with deficiencies of officers; explain delay of despatch of officers on 18/11/03; ascertain why Supt F had not been called until 2015hrs and information regarding his access to live information; provide information regarding the DVC absence from work, cover, training, knowledge of the incidents etc; answer questions regarding DI V's information at Inquest reference briefing of officers; explain why family had been told in February 2004 they could not have C&C log; receive a copy of the ambulance log. In the absence of a response from Supt F which he had said he would draw up by the end of November on 30 November C5 sent an email regarding the availability of a response in the context of the agenda for a meeting with the DCC.

12.102 In his response on 2 December Supt F noted that he was aware that Julia Drown was in contact with the DCC's office about a meeting with her. He also noted that:

> '*Some are controversial but as when we first met I will always be open and honest with you – even though that will not necessarily keep the waters smooth.*'[347]

Supt F provided a written response to the family's action list which is summarised as follows:

- <u>The annotated affidavit</u> -after extensive enquiries he had been unable to identify the officer to whom Julia and C5 had handed this; he had concluded that the document had been forwarded to the Crime Incident Management Unit and placed on the super-glued locks file. He noted that he had made the whole Police Area aware of the deficiencies that had occurred in the routing.

- <u>The delay of despatch between Julia's address coming up and 19.35 hrs when Sgt E had said he had been contacted</u> [348], Supt F said that he was unable to explain the apparent delay between the timings on the URN and Sgt E's statement. He went on

[346] Provided to PDHR by C5 on 3/02/08
[347] Email & response document provided to PDHR by TVP & C5 2008
[348] Sgt E's witness statement to Inquest

to say that TVP policy on the management of Firearms incidents had been acknowledged as overly cautious and he had explained the new policy to the family and Julia Drown MP

- Why he had not been called until 20.15 hrs on 18 November - Supt F referred to this being symptomatic of the overly cautious firearms policy that was operating at the time of the incident. He explained that the Control Room Inspector had commanded the incident until relieved by him.

- Why the Wantage control room had not forwarded all live information to him so that he could have heard the call taker's conversation with Julia - he apologised that he had been incorrect in giving the impression that it was possible at the time to do this – he referred also to the emphasis in the new Force policy on the need to take decisive action to protect the public.

- The DVC's time off, maternity leave and cover arrangements - Supt F advised that this had occurred during 2002 and that she had returned a few weeks prior to 18 November 2003; the DVC had also taken a further period of leave commencing in December 2003 and cover was provided by extremely experienced officers and the DVC provided a briefing and handover. He said that he had increased the supervisory ability for the Domestic Violence function.

- The training for DVCs – Supt F confirmed there was still no training for Domestic Violence Unit staff because it was a coordination role and that the new force policy which was being trialled in two Police Areas aimed to rectify this. This was more comprehensive and rigorous and he said what the force was proposing was a much more robust stance towards domestic violence. He noted that the West Berkshire Police Area had a good performance in positive action.

- When and what the DVC knew about all three serious crime incidents – he said that he that he had spoken to the DVC who believed that she saw the annotated affidavit but was not sure when or in what context. He explained that there had been some organisational issues resulting from a number of different experienced officers

undertaking the domestic violence coordination role up to 18 November. He noted that it was possible that the annotated affidavit arrived whilst the DVC was way and that she saw it later on prior to the incident. He said that he did not believe as an isolated piece of information it would have drastically altered the course of events given the policies that TVP had in place at the time.

- If Supt F and DI V had known about the three crime incidents they would have gone to see Alan Pemberton - Supt F noted that it was with hindsight that the incidents could be categorised as serious but acknowledged that as a senior police officer he believed had all three incidents been linked up under one officer Alan Pemberton would at the very least been spoken to. He confirmed that he did not believe that he would have been arrested for any one of the individual incidents.

- DI V had said that the briefing of officers had explained the delay between the 999 call and the despatch of officers but there was no record of this on the URN and the officers statements showed no briefing had taken place - Supt F explained that DI V had meant that the armed response vehicle officers before they attended an incident needed to be briefed- that they did not delay in attending an incident but were briefed on the way. There may have been a delay in updating the log which was not an accurate information recording tool.

- Why had DI V said that the family could not have the Command and Control log in February 2004 citing officer anonymity and safety as reasons-these could have been erased - holding back information seemed to be an attempt to mislead the Coroner – Supt F confirmed that DI V did not have authority to release the log; that the force was reluctant to release the URN because of the sensitive nature of the information. He advised that following Julia Drown's approach to the DCC arrangements had been made with the Force Solicitor for the personal details to be removed and the logs sent to the family.

- The availability of the ambulance log in order to see the times that they were called; they left the station; where routed; at what time and how many times they got to Old Hallowes - Supt F advised that he could not obtain the ambulance log and that an approach would need to be made to the Royal Berkshire Ambulance Service.

He was able to advise that the Ambulance Control Room received a 999 call from TVP requesting an ambulance at 1934 hrs and that a unit was dispatched from Newbury Ambulance Station and arrived at Down House School (the rendezvous point) at 1949hrs; a second unit had been dispatched at 20.09hrs and arrived at the same rendezvous point at 2020hrs. He noted that the Highmoor report was available on the IPCC and TVP websites made some comments about the ambulance service policy and procedures and that he was aware that the ambulance service had subsequently altered its policy and procedures with regard to responding to requests for assistance in connection with firearms incidents.

12.103 Julia Drown wrote on 7 December to the DCC regarding the meeting arranged for 20 December which was to include the family, David Rendel MP and her. She set out in detail the issues, including those that had been raised at meetings with Supt F, under the following headings: Domestic Violence Policy and Practice; Dealing with the Family and the Inquest; Firearms Policy; the need for a Review of this Case.

12.104 In her letter Julia Drown said TVP at a senior level needed to recognize the failures in the Domestic Violence Policy in the Pemberton Case. This was in relation to the lack of an appropriate response to Julia and C5's requests for help. She referred to:

> *'a catalogue of errors in terms of receiving information, processing it and the regular ignoring of Julia and* [C5]*'s calls and visits to the police station, which led Julia to believe that there was not any point in approaching the police for help.'*[349]

She identified a number of areas where improvements were required with regard to policy and practice in the police response to victims of domestic violence.

12.105 Julia Drown expressed her disappointment that the Chief Constable had been unwilling to meet with the family prior to the Inquest. She was critical of the delay in establishing what had happened and the adverse effect this had on the family's grieving process. She referred to the editing of the transcript of Julia's 999 call and considered that

[349] Letter from Julia Drown to PDHR

the refusal to release information prior to the Inquest had denied the family and the Coroner access to evidence that was relevant to consideration of Article 2 of the ECHR.

12.106 She referred to the Highmoor Cross Report and the changes to TVP Firearms Policy and raised questions about the time taken on the night to call Supt F; the call takers response to Julia; the expectations of the public in relation to the response from the police in such circumstance. In asking for a review of the case Julia Drown expressed the family's concern that they could not see any demonstrable evidence that TVP had tried to gather lessons from the Pemberton case. She acknowledged that Supt F had given considerable time to review the case and in meetings with the family, but in her view such meetings could not be regarded as a formal review with appropriate external oversight and accountability. In referring to the domestic violence legislation she called on TVP to agree to participate or initiate a homicide review of the case.

12.107 On 9 December C5 requested the return of Alan's computer which had been given by the police to C14. C5 explained that he was requesting this because of the threats contained in Alan's final letter and the need to check everything.

12.108 The DCC wrote on 13 December confirming the agenda as falling within five policy headings: Domestic Violence policy and practice; Firearms Policy; Call handling; Dealing with the family; and the Inquest and Reviews and Investigations.[350]

12.109 On 20 December 2004 the DCC, Supt F, Supt G (Tactical Firearms Support), Chief Supt H (Control Room) and DS J (Crime Support leading on domestic violence) met with family members, friends, Julia Drown (chair of meeting) and David Rendel. [351]

12.110 The discussion (0930hrs-1310hrs) covered each of the headings set out in the DCC's letter. The notes of the meeting record the DCC said TVP's position was that the handling of DV and Firearms issues fell short of the current standards, but the force did not accept that those shortfalls had led to the deaths. During the discussion she said TVP's Professional Standards Department had satisfied themselves that it was not a case for a misconduct

[350] Letter from DCC to C5 copied to Julia Drown 13/12/04 provided to PDHR by J Drown 2008
[351] TVP Notes from meeting 20/12/04 provided to PDHR 2008; Family's Notes of meeting provided to PDHR by C5

enquiry, there were shortfalls but not misconduct; there was insufficient evidence to carry out a complaint investigation and the family had not made a complaint; after discussion with the Independent Police Complaints Commissioner it had been agreed the better route was meetings between TVP and the family. TVP did not accept that Julia was in their care so the case did not fall within the new Coroner's system [Article 2 scope inquest]. The DCC accepted that there had been shortfalls and that changes had been made to improve systems.

12.111 The DCC and her TVP colleagues responded to the family's issues on Domestic Violence. In summary the family were advised that the management of the case was consistent with DV policy at the time; from April 2005 a Public Protection Unit was being set up to include Domestic Violence; there had been a change in crime recording standards and process in 2002/3; current systems meant that an investigation plan would be set up and all systems checked and links made with the DV records. In relation to the super-gluing of the locks it was accepted that the investigation was not as good as it should have been and TVP had been unable to track the route of the annotated affidavit. Domestic violence was not a single agency matter; the role of the DVC had been victim focused but this was no longer the case; the DVC had supported Julia's desire to obtain an injunction; there were not the resources to do risk assessments on every DV case; if risk assessment had been in place it may not have made any difference as Alan might not have been identified as high risk.

12.112 In relation to the issues about the 'Firearms Policy', the family and their supporters were advised that following the Highmoor Report firearms commanders had been re-trained and re-equipped and would go in as soon as possible to check for casualties; they were now able to act on information that was available to them at the time; the Human Rights Act said that everyone has a right to life, public and police alike; a response for Hermitage would come from Reading or Abingdon and the time taken would probably be reduced to 20 mins; the firearms response was now available 24/7 and an officer going straight to scene would in appropriate circumstances drop short and make a tactical approach approximately 200 yards from the scene; everyone working in the incident would be listening and working from the same radio channel.

12.113 In a general discussion on 'Call Handling' and which system should be used, either the panic alarm or 999 system it was confirmed that both the 999 and the alarm would now be activated at the same time -as a priority call. The alarm can be used as a secondary means of

contact if the victim is not able to get to the telephone. An explanation was given regarding the control room operation; the need to be specific about the advice given to victims; the control room were able to check systems to identify risk; there was a new training package for call takers and new technology which would enable support to be given to the call taker; they were trained and advised to keep a person on the phone and obtain as much information as possible; it was TVP policy to provide a summary of the 999 call for the Inquest not a verbatim transcript.

12.114 It was recorded that under 'Dealing with the Family and the Inquest' the DCC referred to the meeting with DI V held on 13 January 2004 at which the family had tabled 133 questions; a meeting had also been arranged for the family on 13 April 2004 with the Professional Standards Department but had been cancelled by C5. She apologised for the loss of Julia Drown's letter and explained that the meeting with family was offered for after the Inquest so as not to usurp role of Coroner. The logs had not been disclosed because of confidentiality and Data Protection, but subsequently they had been released. In January 2005 with the introduction of the Freedom of Information Act it would be possible to disclose logs, subject to the provision of the Act. The DCC said that she could not comment on the statements of officers at the Inquest without them present; different people would have had different recollections of incidents.

12.115 In response it is recorded that the family representatives commented that they would have been better informed before the Inquest if they had been given the Command and Control logs and possibly this could have saved lives. They considered that the review of the case required external scrutiny; they wondered how the Inquest could have reached the decision that without all the information available.

12.116 Finally under the agenda item 'Reviews and Investigations' it is recorded the DCC explained that the decision to review the Highmoor incident had been made by the Chief Constable and herself. The Pemberton case was different and TVP had agreed to meet with family and discuss their concerns. The DCC confirmed that there were shortfalls, not systematic failures, but this did not amount to causing the deaths; that TVP was committed to providing a service and to improving that service. She proposed going through the actions from the meeting with officers to ensure that the new policy reflected additional issues and for that to be shared with members of the meeting.

12.117 The notes of the meeting record that the family representatives confirmed that they believed an internal debrief was not a review; there should be a more formal review to ensure lessons were learnt and that external scrutiny was required; if TVP did not accept there had been a systems failures they had no confidence that changes would be made. Alan should have been interviewed and they considered the deaths could have been prevented.

12.118 The family have shared with us the notes they made following the meeting with regard to issues of concern which arose from the discussion and which included the following; they had not been given the C&C logs before the Inquest which denied them access to relevant information about system failures; the transcript of the 999 call had been portrayed at the Inquest as a complete record of Julia's call; they alleged that TVP had misled the Coroner; Alan had not been questioned by the police; the lack of DV policy and training; the absence at the meeting of a risk assessment concerning Alan; Alan's threats had not been taken seriously and not recorded by TVP as crime in September 2002; crimes in April and May had not been investigated; police systems were not linked up, escape and safety plans should have been made with Julia; call operators needed to be clear in their advice to victims including response times and TVP's failure to identify 'antipodean officer'. The family noted that debriefs were not reviews, an external review was needed and that TVP could not say that the shortfalls did not lead to the deaths. The family challenged the DCC on the basis that in the oil industry had there been three fatalities and the DTI/Health & Safety Executive subsequent investigation found such failures in leadership, communication, training and information management it would amount to system failure. The family noted that the DCC had preferred to call them shortfalls.

12.119 On 21 December Julia Drown received a letter from Hazel Blears, Minister of State, Home Office responding to her request for a domestic homicide review *'to be conducted to account for the murders of both Julia and William Pemberton.'*[352] Hazel Blears noted that some agencies were already conducting such reviews at a local level and gave as one example the Metropolitan Police Service. The letter also referred to the conclusions of the Highmoor Cross Review:

- *The review concludes that the delay in getting to the scene could not be justified*

[352] Letter Hazel Blears to Julia Drown – dated 21/12/04

- *The reasons for the delay are not due to the failings of individuals involved in the response. The failings are embedded in Thames Valley Police policy and training in responding to firearms incidents*
- *Essentially current policy seeks to eliminate risk rather than manage it. The direct result of this was that the police priority in response to the emergency calls was to locate the offender rather than get to the victims, and an overly cautious approach to the deployment of armed officers.*
- *The report recommends that the policy in relation to spontaneous firearms needs to be replaced, and supported by new and better training*
- *The review also identifies national issues for firearms policy and training and need for a revision of the Association of Chief Police Officers guidance.*

The letter referred to the rolling out, depending on available resources, of the Domestic Violence Crime & Victims Act 2004 from April 2005 and that therefore a call for a review to be conducted in the Pemberton case *'did not fall within the Act.'*

January 2005

12.120 On 4 January C5 sent further questions by email to the DCC and Supt F noting that these were the ones that in the DCC's letter of 13 December she had suggested would best be answered in writing. The questions covered a range of topics including a request for an inventory of property from Old Hallowes and Alan's car; information as to why it was thought Alan's computer belonged to C14; copies of the DVC's documents/records of meetings with Julia from the DVC file; the responsibilities of the DVC; the Domestic Violence Policy 2002 and 2002/3, subsequent and planned policies; the editing of the transcript of Julia's 999 call; a copy of risk assessments carried out re threats to the family; information as to whether William was included on an at risk register. He requested that the answers be sent in batches. He also sent a request for a copy of the actions from the meeting that the DCC had said that she would share for comment.[353]

12.121 Supt F replied on 5 January saying that he would endeavour to respond to C5's latest questions by 1 March 2005. The same day C5 replied saying that he did not think that 1 March

[353] Emails C5 provided by TVP to PDHR

was reasonable; he suggested that the questions could be answered in batches. He requested confirmation that he would receive answers as soon as possible and that all would be answered by the end of January.

12.122 Julia Drown replied to Hazel Blears on 6 January acknowledging that domestic homicide reviews were not legally enforceable but had hoped that in the sprit of the Domestic Violence, Crime and Victims Act 2004 Hazel Blears might be willing to ask the agencies to undertake such a review. She referred to the more than thirteen hours of meetings with the police but said that she remained concerned over what had happened in the case and whether all the lessons that needed to be learnt were being learnt. Julia Drown said that possibly the best way to take this forward was through an Adjournment Debate and hoped to have an opportunity to meet and discuss this with her. She had written to Lord Falconer regarding the conduct of the Coroner and understood it had been forwarded to the Home Office and she was also seeking a response on that aspect of the case.

12.123 On 10 January Supt F replied[354] to C5's email of 5 January saying that he would deal with C5's request as *'expeditiously'* as he was able but he understood that the family had chosen their 'option' and had made a complaint to the Independent Police Complaints Commission (IPCC) about TVP. He said that this changed how TVP could interact with C5. The IPCC had asked for certain information and he did not want to circumvent that process. Supt F said that in line with standard procedure he would not be communicating with C5 until the complaint had been dealt with. Supt F noted he did not want to jeopardise his position as he too was entitled to rights now that the family had chosen to complain. Once he was clear as to whether he was to be investigated for his role in the matter then he would be able to revise his decision accordingly.

12.124 On 11 January, C4, C5's brother in law replied to Supt F as C5 was off sick. He said that TVP had clearly misunderstood the family's position and offered some clarification. C4 had given a commitment to the Chief Executive of the IPCC to informally update her about the progress of their last meeting(s) with the DCC and Supt F. C4 confirmed that the family had not to date made a formal complaint; their position was unchanged as per the meeting in December. C4 was awaiting the outcome of a conversation between the Chief Executive and

[354] Email exchange Supt F and C5 provided by TVP to PDHR

the DCC to aid the way forward. C4 said that the DCC and Supt F had taken away a number of actions from the last meeting which could play an important part in how the family decided to proceed; they were looking forward to receiving information.

12.125 Supt F replied on the same day[355] and said that with the family continually reserving the right to keep all 'options' open, referring to C5's latest press release to the local paper, he had to protect both his own position and that of his officers. He said that the IPCC had asked for a considerable amount of information. He did not wish to comment or engage further until he knew the outcome of the IPCC's deliberations; *'In effect there is a complaint made.'* He said that all the staff at West Berkshire were fully committed to assisting the family with their requests for information but he could not do so whilst there was the possibility that some of his staff might well face potential disciplinary enquiries depending upon the outcome of the IPCC deliberations. He did not wish to appear obstructive and contended that he and his staff had been the reverse. He and they did not wish to communicate further until the position was clearer as determined by the IPCC; this was the advice given by the Police Federation (representing rank and file officers up to chief inspector) connected with the case. Supt F went on to say that if it was alleged or even suspected that he or his staff had acted wrongly then they would wish to have the correct safeguards afforded to them. He gave assurances of his very best intentions to assist the family again at a later more appropriate stage.

12.126 C5 also wrote to Supt F on 12 January and said that all 'options' were still open but none had been pursued yet. No complaint had been made but it remained an option. The family had agreed to tell the IPCC what they thought about the meeting on 20 December, which they had done, they knew that the DCC had also told the IPCC what she had thought. The DCC had said that she would share her actions from that meeting on 20 December with the family but as yet had not done so.

12.127 On the 12 January in the DCC's absence away from the Force, her personal assistant (PA) advised C5 by email[356] that Acting ACC A who was covering and *'fully briefed on the matter'* had contacted Supt F and advised him that no formal compliant had been made to

[355] Emails provided by TVP to PDHR
[356] Email exchange provided by TVP to PDHR

the IPCC. The PA said that should C5 have a need to be in touch further to contact Acting ACC A.

12.128 C5 replied requesting the information from the Acting ACC A that the DCC had offered at the meeting on 20 December. He received a reply on 13 January from Acting ACC A to say that he would forward her reply as soon as she was able to deal with the matter.

12.129 On the 19 January C5 wrote to the Acting ACC A requesting the various actions that the DCC had said she would circulate after the meeting and as it was a month asked why they were still waiting for them.

12.130 On the same day Acting ACC A sent C5 a Briefing note from the DCC dated the 7 January entitled '*Review of Force Policy on Domestic Violence.'*[357] The Briefing Note referred to the DCC's meeting with the family on 20 December. It was addressed to ACC K and stated that that many of the issues discussed were being addressed within the DV project and the work to incorporate the latest national guidance. The DCC had mentioned some of the issues to ACC K on 5 January but was recording them for the sake of completeness:

- An overview had been given on 20 December by DS J of the Risk Assessment pilots in Slough and Reading – there had been debate at the meeting about whether Alan Pemberton on the basis of information available would be considered high risk using the TVP model – it had been suggested that on the Metropolitan system he would have done so.

Action - Ensure new process quality assured run the facts known about Alan Pemberton through the risk criteria and make an assessment

- There had been discussion on 20 December about the method of contact with police that victims should use if they were subject to attack – the use of the 999 system was confirmed as the preferred contact and that any panic alarm was a secondary means.

Action - Ensure whatever corporate advice is developed for victims includes this information.

[357] Letter from Acting ACC A 19/01/04 to C5 and Briefing Note from DCC 7/01/04 provided by TVP to the PDHR

- Plans were being developed for a corporate gazetteer for all IT systems which would assist in dealing with any confusions over addresses that existed because of discrepancy between current gazetteers; this was a long term project. During discussion DCC had become aware of a software development 'caller line identification (CLI) in the ICT proposed work schedule for some while to enable automatic caller identification at least from landlines although it would not work with mobiles.

Action – Ensure CLI progressed as soon as practicable – in any case within the next 6 months.

- It would be sensible to test alarms when these were issued so that the control room could check there were no difficulties with addresses or any other factor and that victims could be reassured that the system worked.

Action - Ensure whatever corporate guidance is developed addressed this suggestion.

- Whilst there was an agreed operational response for Julia Pemberton (including use of a police dog to search the woodlands) it was not apparent that she had a personal escape plan taking into account lay out and location of her house – clearly this was a valuable process to have undertaken before the victim is under immediate threat.

Action - Ensure that whatever corporate guidance is developed for victims addressed the value of contingency planning.

- When Julia Pemberton was on the line to the control room she was told the ARV was on its way. Family were concerned that Julia was not given accurate information about likely time of arrival. While it cannot be the call handler who takes decision to provide such information – it could be an option for the silver commander to pass this information on. Changes to technology in control rooms and command vehicles had made this a possibility 'fast time'.

Action - Include consideration of this option in firearms training.

Summary – The DCC noted that she had a strong sense of the value of looking at the response to DV across the functions. In particular the need to ensure that changes in technology and call handling in the control rooms and in firearms response were understood by domestic violence officers so that advice & guidance is as up to date and as accurate as possible.

12.131 On the 19 January there was an exchange of emails between C5 and Supt F following on from the advice that Supt F would make contact with the family and in connection with the questions to which the family were awaiting answers. There were also some issues concerning the release of property that had been recovered by the police from Alan's car. Supt F confirmed that he would respond to the issues and questions as soon as he had all the answers. C5 requested that the answers be sent in batches. Supt F responded that he would answer the questions by 01.03.05 as some involved enquiries elsewhere; he noted that he had a *'huge range of other issues to deal with that I must also cover. If this is not acceptable to you please accept my apologies but it is a reality.'*[358]

12.132 C5 responded saying that he appreciated that Supt F had a whole range of issues to cover but said that there was no need to imply that the family were monopolising his time. *'We have asked a batch of questions with three supplementary e-mails spread over a few weeks. That is hardly exhaustive*.' C5 again requested that Supt F release answers in batches.

12.133 Supt F replied, repeating his commitment to helping the family and to continuing to provide answers but also saying he was becoming *'quite exhausted'* with their communication. He went on to suggest that he and C5 ceased communication and that he tried to work with another member of the family such as C4, acknowledging that C5 had the right to complain about this.

12.134 On 24 January members of the family met with the Commissioner for the IPCC. From the information provided by the IPCC, the family has advised us prior to the meeting they had understood that the IPCC would only become involved if the family raised a complaint against the actions of an individual or individuals within TVP but they had felt that this would not address what they believed to be a system failure. Subsequently they had understood that the IPCC were willing to be involved in a review of policy, by TVP. This had come at the time

[358] Emails C5 and Supt F provided by TVP to PDHR 2008

when the question of a possible complaint by the family had led to Supt F's writing to advise that he would be discontinuing communication with them. They advised us that at the meeting on 24 January they explored with the Commissioner other options with regard to taking their concerns forward which were as follows:

- IPCC to manage an investigation using TVP resources
- IPCC to agree the Terms of Reference for an investigation to be carried out by TVP
- TVP to undertake an investigation.

From the discussion at the meeting the family recollection was that the IPCC position was it was unlikely their case would meet the criteria for an Independent Investigation [the IPCC being unsure of their (IPCC) terms of reference at that time]. They also did not feel that the three options as set out would deal with their concerns about system failure. The family confirmed with us that the decision as to whether to pursue matters through the IPCC was overtaken as a result of the Adjournment debate on 16 March and the subsequent meeting with Baroness Scotland regarding a domestic homicide review.

12.135 On 27 January C5 wrote[359] to Acting ACC A. He referred to the email exchanges with Supt F regarding his proposed date of 010305 for responding to the family's questions and also to Supt F's request to deal with another member of the family. He noted that the DCC had given a commitment to provide written answers to questions that were not raised with her on 20 December. C5 explained that he acted as spokesperson for the family and that he would now deal direct with Acting ACC A and asked him to provide answers to all the questions he had posed to Supt F, releasing answers in batches if there were to be significant time gaps.

February

12.136 Supt F sent an email to C4 on 4 February 2005 referring to his having found it necessary to withdraw from working with C5. He confirmed that he would be answering the family's questions but asked the family to discuss the issue of spokesperson and get back to him. He also suggested that if she was in agreement he could work to their MP. He had briefed Acting ACC A.

[359] Letter from C5 to Acting ACC A provided by TVP to PDHR

12.137 Acting ACC A wrote on 4 February to C5 saying that he had spoken with Supt F who had confirmed that he felt it was not in anyone's best interests for him to communicate with the family through C5 at that time. Acting ACC A advised that Supt F was intending to approach C4 about becoming the family spokesperson. He confirmed the commitment of TVP to assisting the family and to personally reviewing the situation if matters could not be resolved. He said that he agreed with Supt F that the answers should be provided in one go; a number of the questions were inter-linked and he was conscious of the need to provide as full and in depth answers as was possible.

12.138 C5 replied[360] on 8 February saying that the family considered the correct way forward was to deal with Acting ACC A. He expressed the family's concern and anger that an officer representing a public body had tried to choose and influence with which member of the public he dealt; this had strengthened the family's resolve. C5 referred to the ongoing concerns of those who had been the subject of the death threats [contained in Alan's letter found after the murders]. He noted that it was nearly fifteen months since the murders and the family were still waiting for answers. He said that the police had admitted:

> *'We have listened to the Police admit to a number of serious failings which needed to be mended and to practices which desperately require improvement. Now we see a senior officer trying to deliberately deflect the answering of questions by instigating a diversion, namely challenging with whom he chooses to deal with* [sic].'

He said it was appropriate to release answers in batches and confirmed his request for answers to be provided as soon as they were available. He concluded by saying that the family would continue to pursue their rights in resolving why the tragedy had happened and to effect change.

12.139 On 8 and 9 February five members of Julia's family sent emails to Acting ACC A confirming C5 as the family spokesperson and asking him or the DCC to collate information and prepare responses. They expressed appreciation for the sensitive and courteous manner in which Supt F had worked with the family thus far and the need to negotiate a realistic and achievable timescale for answers to the family's questions and to move forward.

[360] Letter 8/02/05 from C5 to Acting ACC A copied to Chief Constable and DCC provided by TVP to PDHR

12.140 Acting ACC A replied to C5[361] acknowledging that the relationship with Supt F had become '*somewhat strained*'. He said that he was clear that Supt F had not intended to divide the family or deflect the answering of questions and had expressed concern that deterioration in the relationship would be detrimental to the family and to TVP. In light of this Acting ACC A advised that he had appointed DCI W from the Professional Standards Department, who was aware of the current position, to undertake a review of the answers to the questions the family had submitted.

12.141 He referred to C5's concerns regarding the death threats and that he had been informed that

> '*…we* [TVP] *have conducted a proportionate investigation, correctly and properly and have adequately risk assessed the threat to the Pemberton family.'*

He said that if there were concerns or further information required to advise him so that if needed a further investigation could take place. ACC A also responded to the statement in C5's letter concerning *'serious failings';* he had discussed this with Supt F and the DCC and had to state their position as articulated by the DCC:

> '*…that there were shortfalls' in some areas and not serious failings as you state in your correspondence. I know this is a sensitive matter and one which we all seek some form of resolution to, but I do feel it important that our position is not misrepresented in correspondence between us.'*

He said that DCI W would supply answers during the week commencing 21 February and would be available to discuss them with the family.

12.142 Supt F sent an email[362] on 14 February 2005 to members of the family, friends and Julia Drown copied to Acting ACC A, extracts from which are as follows;

> *'I apologise for any hurt caused and I do acknowledge that whilst that would have been reasonably foreseeable my motives for wanting a change were true and in my*

[361] Letter Acting ACC A 14/02/05 to C5
[362] Email 14/02/05 from Supt F to family provided by C5 to PDHR.

view necessary to continue to provide the open and honest dialogues with the family that I have, and will always maintain, to do.

I know that [Acting ACC A] *is writing to you to explain the force position but having discussed the matter with him it is right that I do acknowledge the feelings that my communication caused. I am genuinely sorry for that.*

I am aware that [Acting ACC A] *has now decided to remove me as* the *point of* contact for the family *for the future* and *in a sense I guess that is actually what I was seeking to achieve, only this way it is more acceptable for the family and allows what I fully endorse to continue- open and honest dialogue.*

...I have greatly admired your tenacity and belief to understand the factors surrounding this tragedy and no matter how trite it may seem I hope at some stage I was able to assist you.'

He noted that he hoped that the family would be able to obtain the answers they were looking for.

12.143 Acting ACC A also wrote[363] on 14 February to C4 advising that he was reviewing the issues around the TVP point of contact and provided the same response with regard to question of the death threats as he had to C5.

12.144 On 18 February Hazel Blears replied[364] to Julia Drown's letter of 6 January noting that as previously stated the measures in the Domestic Violence, Crime and Victims Act 2004 were not retrospective and that a domestic homicide review was not a legal obligation in the Pemberton case. She agreed to meet with Julia Drown to discuss the lessons that could be learnt from the Pemberton case.

12.145 C5 replied to Supt F's email on 18 February saying that Supt F had conceded serious failings on behalf of TVP. C5 stated that it was his duty to get answers and to do what he

[363] Letter from Acting ACC A to C4 14/02/05 provided by TVP to PDHR
[364] Letter from Hazel Blears to Julia Drown 18/02/05 provided by Julia Drown to PDHR

could to prevent such tragedies from happening again. He thanked Supt F for the answers he had provided so far.

12.146 DCI W wrote on 21 February to C5 enclosing a document, and suggested that it would be very useful if he could speak to C5 after he had considered the written material:[365]

> *'Response to questions asked in respect of the murder of Mrs Julia Pemberton and Mr William Pemberton.*
>
> *Contents:*
> *a. Written response to questions*
> *b. Property list*
> *c. Positive intervention policy for Newbury Area*
> *d. Domestic Violence policy for TVP*
> *e. Domestic Violence coordinator Job Description*
> *f. South Wales 'Best Practice' domestic violence document.'*

The written response to questions covered a range of issues; relevant extracts of which are tabled below:

[365] Letter and Response Document provided by TVP to PDHR

	Question	Answer
8	*Was Julia Pemberton ever placed on an at risk register? If so, please provide details*	*The description 'at risk' register normally applies to register held by Social Services in respect of children. However, whilst this was not a case which related to that type of registration, the case involving Julia and Alan Pemberton was recorded in a manner which relayed the increased risk revolving around their separation. This existed in the Command and Control Flagging which was set up to inform an enquirer (normally a control room operator) of the context in which any calls relating the address should be treated. The address was also provided with the alarm which linked with the alarm centre records which would be relayed in the event of activation.* *Finally there existed the Domestic Violence Officer's file which (and we accept that it did not capture all records of potentially relevant events) should have been a focal point for all domestic violence related issues reported to the police. This relied on;* *a) the recognition of the receiving officer that it was relevant to this type of recording (Domestic Violence) and;* *b) the submission of appropriate forms.* *Significant changes have been and continue to be made to improve the effectiveness of this system and subsequent risk assessment and management.*
9	*Was William Pemberton ever placed on an at risk register? If so, please provide details*	*William Pemberton would have been included in the provisions made by the systems described above insofar as he lived at the 'flagged' address. Should any event relating to him have been identified as having a connection with the Domestic Violence case involving Julia and Alan Pemberton a link should have been made provided sufficient*

		information was obtained to justify it. *For example; one would expect any threat made to William with the motive of influencing the outcome of any divorce proceedings to have been linked should it have been reported. No such matters were recorded. Please note that this is merely an example given to aid understanding. There is no suggestion that any such event was reported.*
10	*Please provide details of the results of your running this case via your new risk Assessment model, as agreed at our meeting 20 December 2004.*	*An assessment has been conducted and this provides a '<u>high risk'</u> rating under the new model at both stages of the assessment.* *There are three levels of risk; low, medium and high. Some more work is being conducted which will help me to explain to you how this process works and you may care to discuss this in more detail.*
11	*Please clarify ranking of priority – 999 v panic alarm.* [Supt F] *said he could help on this (meeting 20 December 2004)*	*Both types of call create an 'immediate response' requirement which then should link to the available data on the Command and Control system. This means that the 'flagging' of the address should link the data to either type of call.* *The '999' call is the preferred method of contact as it has the potential to provide much more data (verbally and audibly) than an alarm and is much less likely to be a false alarm.* *However, the alarm does provide a method of calling for assistance without the need for speech. This is clearly advantageous in some cases.*

		The Sovereign alarm installed at 'All Hallowes' [sic] *provided a link to a 24 hour monitoring station which would then have instigated a call for police assistance on the '999'system.* *In this case the alarm was installed and tested on 10.6.03 (i.e. it was tested activated).*
12	*Please confirm advice in victim's DV pack does/will include advice that they should not call 999 from a PAYG phone*	*The victim advice is still being refined in consultation with the two pilot areas but important practical advice such as this is highly likely to become a fixed feature.*
13	*Please confirm that the new policy will include the Police call handling Centre testing the victim's landline and/or mobile phone, to check if their number comes up in the police call handling Centre.*	*An action has been raised to introduce a software package which will allow some caller identification (dependent on the source of the call)* *The 'panic alarm' facility does carry the advantage of identifying the location of the alert.*
14	*Please answer other actions agreed at our meeting 20 December 2004 not specified above*	*The actions to which you refer have been passed to ACC K who is directing the development of Domestic Violence and Hate Crime Units and Public Protection issues. Please understand that the development of the new processes is recognised as a complex area of work and requires careful handling. Thames Valley Police seeks to learn from the experience gained from dealing with serious cases such as your own. These events have emphasised the need for a radical overhaul of our systems from time to time to adapt to demands and to benefit from improved tactics and technology.* *A standard operating procedure has been set up. This is classified as 'restricted' material, as it contains a description of police tactics. I would be willing to discuss the significance and content of the document.*

15	*Please provide a copy of the domestic violence policy in place at September 2002?*	*In 2002 the Thames Valley Police Areas, of which there were 10, were managed by the Area Commanders who were given a high degree of autonomy. There was no Force Domestic Policy in existence at the time. Significant changes have been introduced including the reformation of the Police Area into 5 Basic Command Units. In respect of the Newbury Police Area the historical information in respect of what policy applied when transferred, leaving only some hard copy information which does not appear to assist. There is reference to a policy document for police staff. The search for this information continues.*
16	*Please provide a copy of the Domestic violence policy in place between September 02 and November 03?*	*At request of Supt* [F], *D/Inspector* [V]*wrote a positive intervention policy for the Area and this was introduced in July 2003. A copy has already been provided to* [the family solicitor] *but another is enclosed for your perusal.* [not included with Review Report]
17	*Please provide a copy of the Domestic violence policy in place after the tragedy in November 2003?*	*The same situation existed until latest policy was drafted in December 2004.*
21	*Please provide details of the responsibilities of the Domestic Violence Coordinator as at September 02, between September 02 and November 03, after the tragedy in November 03, now and planned?*	*The sequence of events in this area is proving difficult to establish but work continues to establish the facts.* *This post was set up in 2000 with a general brief to concentrate on Domestic Violence issues and to ensure that an extra level of monitoring and activity was provided.* *A specific job description was introduced and a further degree of supervision and support were set up following the events in November 2003. This provides more definition to the role and a copy is attached.*

		The significant changes to those responsibilities have been introduced through the introduction of the Domestic Violence Policy and the Standard Operating Procedure. *However, there have been changes to the support and supervision of the Newbury Domestic Violence Coordinator and these were implemented following recommendations by D/Inspector V shortly after the events of November 2003.* *The planned changes include the role being integrated in a Domestic Violence and Hate Crime/Public Protection Unit with its own specialised supervision and resilience in terms of expertise and experience as well as staff numbers. This development will come with the changes to the Police Areas.*
22	*Please provide details (not in the DV log you have copied us) of the DV records kept on* [DVC] *first meeting with Julia Pemberton in September 02, after which,* [DVC] *wrote a detailed letter to*[the solicitor]	*The whole of the Domestic Violence file has been provided to you.* [The DVC] *has been asked to try to recall further detail about that meeting and cannot add anything at this stage.* *The record keeping has been scrutinised and does not include the sort of decision making and risk assessment records which best practice would now require.* *It is unclear whether you are missing any document and this can be clarified if you will discuss the documents you have available.*
23	*Please provide details of the meeting between* [DVC] *and Julia Pemberton in June 03, which will show* [DVC*] records of being told about the glued locks and annotated affidavit, as testified by* [DVC] *at the Inquest*	*There does not appear to be any written record of this meeting.*

	(not in DV records you have sent us)	
28	*Was a complete transcript of Julia Pemberton's 999 call ever made?*	*The only transcript made by the police was typed by a Detective Sergeant. This was done to avoid playing the tape in Coroner's court as the content is distressing. The Detective Sergeant made the transcript to avoid exposing a Police Staff typist to distressing material.*
29	*Who made the decision to provide an edited transcript to the coroner?*	*The decision to type what can be described as an 'edited version' of the call was made by Detective Sergeant who believed that he was providing sufficient information for the court and interested parties. It was not intended as an edited version with any purpose in mind other than to minimise distress. It is common practice to provide a Record of Taped Interview (ROTI) which is a summary, quoting direct speech. This process is routinely used in summarising interviews with suspects, by far the most common taped conversation. The transcription of traumatic recorded conversations will continue to be a matter of judgement in which the feelings of the affected parties will be considered but you have raised an important point in a case where the handling of such a call has been called into question. The points you have subsequently raised have put the omissions into a more important context but that was not known at the time.*
30	*Who approved the edited transcript?*	*The transcript was required by Detective Inspector V and completed by Detective Sergeant C. As the transcript was typed by the officer he felt no need to proof read it and neither did D/Inspector V*
31	*Was the Police legal team aware that the transcript provided to the Inquest was incomplete?*	*There is no indication that the Police Legal Team believed that they had less than a full transcript. Prior to the inquest, on 6th July, a copy of the tape was provided to* [your solicitor] *with the police transcript.* *The full information was therefore available to you prior to the inquest and one would*

		hope that this demonstrates to you that there was no attempt to deceive you or the Coroner (who read out a much smaller excerpt of the call as sufficient for his purpose). It is common practice to seek to minimise the distress caused by the provision of raw data at such hearings.

12.147 On 22 February C5 wrote[366] to Acting ACC A saying that the family were looking forward to receiving responses. He raised the request that had been put to Supt F for the files of the investigations into threats outstanding to the family and subject to reviewing these they would be in a better position to provide more details. C5 said that the family remained *'staggered'* by the DCC's assessment of '*such serious system failures as shortfalls*.' He referred to meetings at which TVP senior police officers had conceded much more; where numerous examples of system failures had been highlighted. C5 noted that whilst there were differences in opinion between senior officers in TVP and the DCC did not accept seriousness of the failings '*the public are on notice that their Police Force has a number of failings which need to be mended and practices requiring improvement*.'

12.148 Between 23 February and 14 March C5 exchanged emails with DCI W[367] in which he acknowledged receipt of the document [*Response to questions asked in respect of the murder of Mrs Julia Pemberton and Mr William Pemberton*] and accompanying letter and referred to supplementary questions he had drawn to the attention of Supt F, including a request for a copy of the glued locks file. He said that the family needed time to consider the information before arranging to meet.

March

12.149 On 17 March an Adjournment Debate[368] took place in the House of Commons concerning the murder of Julia and William Pemberton. Julia Drown asked the

> '*Home Secretary, via the Minister, to call for a homicide review, to ask for the conduct of the Coroner in the case, to be reviewed and we seek a review of the granting of injunctions in domestic violence cases*.'

12.150 Introducing the debate she gave a detailed account of the events prior and subsequent to the murders and stated that despite many hours of meetings with TVP she and the family *'remain hugely dissatisfied with their response.'* She also made reference to the family's concerns with regard to the Coroner(s) and the scope of the Inquest.

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366 Letter C5 to Acting ACC A 22/2/05 provided by TVP to PDHR
367 Email exchanges between C5 and DCI (4) 23/02/05 to 14/03/05
368 Copy of transcript of debate from Hansard provided by HM Treasury to PDHR

12.151 She explained that the family had decided not to pursue an Article 2 Inquest because they wanted to minimize their trauma and the police having refused to disclose the Command and Control Logs prior to the inquest they had not had access to all the information. The family had submitted a statement prior to the Inquest to the Coroner reminding him of his duty to consider Article 2. Julia Drown said that her and the family's view the Coroner had accepted the time delays in the police response far too lightly and failed to pick up contradictions in the testimony given by TVP officers. She commented on the total lack of compassion and sensitivity she and the family considered had been shown by the Coroner towards the family. She also requested that how injunctions were dealt with be looked at.

12.152 In his response the Parliamentary under-Secretary of State for the Home Department (Paul Goggins) referred to the Domestic Violence, Crime and Victims Act 2004. He said that during 2005, domestic homicide reviews would be introduced for all domestic violence-related homicides '*so that local agencies can learn lessons and adjust their policies and procedures accordingly.'* He went on to say;

> '*The reviews will not be mandatory. We want them to be light-touch investigations that improve practice, so that local agencies can make the necessary changes, but there will be a reserve power for the Secretary of State to order such a review if there is lack of willingness and it is considered necessary for that to take place.'*

12.153 He noted that reviews were taking place and made reference to London where agencies had voluntarily agreed to undertake a review. Mr Goggins advised that Baroness Scotland would be meeting with members of the family and that he hoped the question would be resolved by then of whether there were retrospective powers to require a review to be held. He advised that he would draw the attention of the Lord Chancellor to the comments made in relation to Coroners services as it was outside his authority to take a view on conduct of Coroners. The family were approached after the Debate and an arrangement made for them to meet Baroness Scotland.[369]

[369] C4 information to PDHR

12.154 On 24 March Baroness Scotland met with members of the family, friends, Sandra Horley from Refuge and Julia Drown.[370] The family and friends raised concerns in relation to each of the following areas; Homicide Reviews; Thames Valley Police; Response to non-physical violence; Risk assessment; Training; Firearms.

12.155 In relation to homicide reviews, Baroness Scotland pointed out that she had spoken to the Chief Constable but she had no power to force him to conduct a retrospective review; she agreed to contact him to discuss how to take the matter forward. She said she did not think that TVP would agree there had been a system failure. Baroness Scotland said that the family would have to be clear that the focus of the review was about lessons to be learnt not placing blame. On the matter of Thames Valley Police and training, she said that changes to recording of crime figures and sanction detections were improving the police response to domestic violence.

12.156 With regard to the police response to non-physical abuse Baroness Scotland referred to the changes in sanction detections putting pressure on forces to follow up on every reported incident. On the issue of risk assessment she said she thought that the Metropolitan Police had a good model that might be an area to look at if there was a review.

12.157 Baroness Scotland said in relation to police training all new police officers received domestic violence training and cited Devon and Cornwall as examples of good practice. She advised that all Judges and magistrates dealing with domestic violence cases received training and agreed to write to the Lord Chancellor regarding training for Coroners.

12.158 In relation to Firearms, C5 specifically stated that he considered TVP's firearms policy was flawed and Baroness Scotland agreed to raise the issue with Hazel Blears the Police minister.

[370] Notes of Meeting provided by Treasury Solicitor to PDHR

April

12.159 On 12 April 2005 Baroness Scotland wrote[371] to C5 advising him about measures that had been put in place which addressed his concerns regarding policing; including the new guidance on how to investigate domestic violence incidents, which had been issued in November 2004 by ACPO, and made it obligatory for every new recruit to be trained on the domestic violence module.

12.160 Baroness Scotland had written to the Chief Constable of Thames Valley thanking him for his cooperation in conducting a review and that a timetable would be agreed to take the process forward. She said that the matters concerning the Coroner would be taken forward with the relevant officials; that C5 would be contacted about that and about similar reviews that had been published to give the family an idea of what to expect from such a process.

12.161 DCI W sent an email[372] to C5 on 29 March referring to the media coverage on the adjournment debate to find out whether he wanted to discuss a way forward or preferred to wait for any decision in relation to the Homicide Review. He said he could see no reason not to continue to make some progress without prejudice but asked C5 to let him know whether he had any reservations. He noted that there was a property matter outstanding.

12.162 C5 replied on 1 April saying that the family were discussing the opportunity of meeting with TVP. He then referred to the matters concerning the return of property. There followed an exchange of emails over the next few days in which DCI W offered to meet in order to get an idea of how he could help to move matters forward. Correspondence was exchanged during April between C5 and DCI W regarding authorisation for and distribution of property. C5 advised that the family were considering meeting with DCI W; that he was seeking authorization from the executors of Julia's and Alan's estate to deal with property distributions and raised questions about items which had already been distributed by TVP.

12.163 On 5 April Julia Drown wrote to thank Baroness Scotland for the meeting on 29 March enclosing a letter dated 4 April signed from the family and friends of the Pemberton's thanking her for the meeting and for pursuing their request for a Homicide Review. The letter

[371] Letter from Baroness Scotland provided to PDHR by Treasury Solicitor
[372] Email correspondence between DCI W provided by TVP to PDHR

confirmed they considered that the purpose of the review should be to examine all aspects of the case, not just TVP's involvement and to establish what mistakes were made, details of the numerous system failures and the lessons to be learnt for the future. It stated that it would be essential for the family to be involved in the Review; establishing the Terms of Reference and in giving evidence. The family said they were encouraged that Baroness Scotland was prepared to take forward their issues with the Coroner.[373]

May

12.164 C5 met with DCI W on 7 May and correspondence continued between them concerning items of property during May. On 10 May, C5 confirmed that the family were awaiting the outcome of Baroness Scotland's meeting before arranging to meet DCI W. He confirmed that he wanted to deal with all the property matters in one go and was awaiting authorization from the executors of Julia's and Alan's estates.

12.165 On 18 May the Head of Domestic Violence (HDV) at the Home Office wrote[374] to C5 on a number of issues as promised at the meeting in March with Baroness Scotland and which had been raised in correspondence and in the adjournment debate concerning the murders of Julia and William: the Homicide Review; the Coroner; and the undertaking given at the Injunction Hearing in July 2003.

12.166 The HDV advised that TVP were seeking agreement from the Primary Care Trust, the Local Authority and others to consider holding a Homicide Review. He had met with and been assured by the Chief Constable that he wanted to see a full and transparent review.

12.167 The HDV explained that the Crime and Disorder Reduction Partnership[375] in West Berkshire would be meeting to take the matter forward, appointing a chair, agreeing terms of reference, points of procedure and the timetable.

12.168 He noted that the Homicide Reviews would be based on, and follow a similar pattern to that of the Part 8 Reviews which were required by the Department for Education and

[373] Letters from Julia Drown and family to Baroness Scotland provided by Julia Drown to PDHR
[374] Letter provided by HM Treasury Solicitor to PDHR
[375] In West Berkshire this is the West Berkshire Safer Communities Partnership

Schools in the case of the death or serious injury of a child. He enclosed a copy of the Q&A that had been drafted to accompany the Domestic Violence, Crime and Victims Act 2004 which set out the remit of the Homicide Reviews; there were still issues to be resolved by the government working party responsible for drafting the guidance.

12.169 The HDV explained that the involvement of local agencies and the taking of views from third parties, including members of the family would be a matter for the chair and the commissioners to decide. He gave assurances that *'all senior parties involved with the Review are mindful of the views and concerns of your family and will consider them at each stage of their deliberations.'*[376]

12.170 In relation to policing and the role of other agencies the HDV said that those which related to policy, procedure and the implementation of new guidance would be covered in the review. He acknowledged that other agencies like Health and Education could have had knowledge about the circumstances and could have a future role in sharing information or concerns to deal with cases more effectively.

12.171 He said that the several concerns raised about the way the Coroner made decisions regarding both the evidence taken at the inquest and about possible system failure had been considered carefully and checked with the Coroner to clarify what details were available to his investigation. He said that from what he had been able to establish, the question of Article 2 did not arise; before and during the inquest submissions on the question of Article 2 had been invited and no representations made by the family's solicitor, who had appeared to accept that article 2 was not relevant to the inquest. The HDV went on to say that there had been no suggestion that the inquiry was incomplete or inadequate, nor had the verdicts been challenged;

> *'This was never a case for a narrative verdict since the short form verdicts were entirely appropriate to the evidence heard at the inquest'.*

[376] Letter 18 May 2005 Head of Domestic Violence to C5 provided by HM Treasury Solicitor to PDHR

12.172 The HDV said that the understanding was that there were no indications of system failure in the sense that it had been set out in Julia Drown's speech at the adjournment debate.

> *'…the domestic violence unit and the firearms team were assessed by the Coroner on the evidence at the inquest as having done what would have been expected.'*

12.173 He referred to correspondence between the Coroner and the Home Office Coroner's Unit in November and December 2004, in which he had set out his responses to issues previously raised by Julia Drown regarding his conclusions that no system failure on the part of TVP had occurred and reason why Article 2 was not engaged. The HDV said that he assumed that C5 had copies of the letters but would provide copies if necessary.

12.174 The HDV referred to the points raised in Julia Drown's speech about repeat victimisation and what was reported to the police and how they responded and noted that they appeared

> *'…to be at odds with the evidence that was presented to the inquest and on which the Coroner based his findings. I can only assume that you are already aware of these discrepancies.'*

He provided the details of the Head of the Coroners Team at the Home Office in the event that C5 wished to pursue the matter further.

12.175 The HDV responded in the letter to a question that had been raised by a family friend in relation to the acceptance by the court [Injunction Hearing on 7 July 2003] of an undertaking instead of an injunction with a power of arrest. He said that an explanation about what that meant would have been given to Julia and that the solicitor should have understood the scope and limitations of an Undertaking.

12.176 The HDV said that the advice he had been given was that the court must have considered whether an undertaking would have provided adequate protection for Julia and whether or not she agreed to the terms of the undertaking, would have been relevant in the court's determination of adequate protection on the facts. He noted that it was fairly

common in cases where there was an acceptance that the threats had decreased for undertakings to replace orders. The HDV said that it was hard to comment on exactly what had been said in court and why an undertaking had been accepted by the Judge; he enclosed a statement of principle about undertakings for information and said that it was possible to make a complaint about a judge to the Department of Constitutional Affairs.

12.177 The HDV said that his letter was obviously not a comprehensive response to all the issues C5 had raised and that he hoped that the Review would provide further clarification of how matters had been taken forward at a local level.

June

12.178 DCI W sent an email[377] to C5 on 2 June advising that the DCC would be writing to him the following day to advise what would be happening regarding the Review. He said that he was conscious that C5 might not be aware that this would be discussed at the WBSCP meeting on 6 June. Emails were then exchanged concerning the venue, including Terms of Reference that was being submitted by the DCC requesting WBSCP to commission the Review. On 3 June, the DCC's letter was emailed by DCI W to C5; a copy of the paper was also sent to him at 1613hrs following the agreement WBSCP. The DCC's letter suggested that as C5 was in contact with the Home Office he would have been kept informed of progress in respect of establishing the Review.

12.179 C5 expressed strongly his concern in an email to DCI W on 3 June that the DCC's paper did not include reference to the annotated affidavit that he and Julia handed in at Newbury Police Station; that the reporting of the threat to kill in September 2002 and the police response were also incorrectly stated. C5 said that it gave him no confidence in TVP's ability to conduct a professional review. He also asked for information regarding attendees at the meeting.

12.180 Following the meeting on 6 June attended by C4 and C16, C5 requested minutes of the meeting from the chair of WBSCP. In an exchange of emails during June C5 noted the very short notice of the meeting of 6 June; requested information concerning the setting up

[377] Email exchange and letter from DCC provided by TVP & C5 to PDHR

of the Review including the selection and appointment of a review chair and consideration of individuals proposed by the family for the role.[378]

12.181 C5 drew our attention to a meeting which had been held on 29 July 2005 between Richard Benyon MP for Newbury and the DCC, DCI W and DS J. Richard Benyon MP in a letter to us advised that at the meeting a number of issues were discussed about which he had been concerned and had sought information from TVP officers; TVP's firearms response on 18 November; the management of Julia's 999 call and TVP's response to Julia as a victim of domestic violence. He said that he was aware that TVP's Firearm's policy including the management of an armed response had had been revised to reflect the concerns with regard to the Pemberton case and the incident at Highmoor Cross. TVP officers had also advised him that additional training was being given to call operators and supervisors involved earlier in the management of a 999 call like Julia's. He had learnt that TVP's approach to domestic violence had changed and that TVP's response to the incidents that had occurred would be different; under the new system Alan would have been categorised as 'high risk'.

12.182 The West Berkshire Safer Communities Partnership (WBSCP) agreed the proposal to commission a domestic violence homicide review on the terms set out in papers presented to the Partnership by the DCC. In chapter one of this review report we have recorded the events following this decision.

Panel's overall conclusions with regard to TVP's communication with the family

The panel have concluded that:

12.183 There would have been considerable benefit if TVP had undertaken a comprehensive review of the policy, procedure and practice adopted with regard to:

- **the firearms response on 18 November 2003**
- **their engagement with Julia Pemberton and her family from September 2002**
- **the policy, procedure and practice implications**
- **identifying future learning.**

[378] Information from C5 to PDHR

12.184 In the absence of a comprehensive review of their engagement with Julia Pemberton, TVP provided the family over the ensuing seventeen months with information in a manner which was at times confusing and contradictory.

12.185 This was not related to individual officer performance but rather to flawed decision making at Force HQ in November 2003 and March 2004 with regard to the need for a review.

12.186 It is regrettable that at the Gold meeting held on 9 March given the type and scope of the concerns raised by the family and reported to the meeting by DIV, a decision was not made at that stage to carry out a review

12.187 It is apparent from the notes of the meeting between the Coroner and TVP in April the information provided by TVP did not include the following:

- **TVP officers had failed to investigate the threat to kill on 14 and 15 September and therefore had not ascertained what evidence might have been available;**

- **When Julia allowed Alan to visit Old Hallowes in autumn 2002 for access to C19 and William she had not been present;**

- **The annotated affidavit which had been delivered to Old Hallowes by Alan had been handed in by Julia and her brother, not logged, the incident not investigated and the documents subsequently placed on the closed glued locks file at Newbury Police Station;**

- **The content of the call taker's response to Julia;**

- **The reasons for the undue length of time taken on 18 November for officers to arrive at the scene and/or to enter the property.**

12.188 TVP's decision in March 2004 that the commissioning of an enquiry was to be predicated on the family making a complaint resulted in a missed opportunity to engage

positively with the family; as a consequence the family were unable to gain satisfactory and comprehensive answers from TVP in a timely way prior to the Inquest.

12.189 The loss of Julia Drown's letter on two occasions and delay in replying represent unacceptable administrative failures.

12.190 In the period immediately following the Inquest TVP's approach to addressing the family's concerns and enquiries compounded the family's distress by not:

- **undertaking at that time a comprehensive review of the Pemberton case**
- **acknowledging a system and service failure at the meeting with the DCC in December 2004**
- **apologising for service failures in the period between September 2002 and 19 November 2003.**

- **Internal Management Reviews 2007**

12.191 Following the deaths of Julia, William and Alan Pemberton in November 2003, there were no contemporary internal investigations or reviews undertaken by TVP, the council or the PCT.

12.192 On 25 January 2007 the WBSCP confirmed the Terms of Reference for the DHR. Following consultation with members of WBSCP on the 23 January 2007, the WBSCP chair wrote on 30 January to the family solicitor and to the chair of the review panel confirming that the treatment of the bereaved family would be included in the review. On 1 February 2007 the chair wrote to TVP, West Berkshire Council and Berkshire West PCT requesting the individual agency's management review of involvement with the victims, Julia and William Pemberton and with Alan Pemberton, the perpetrator. The information requested was as follows:

- A management review of involvement with Julia, William and Alan Pemberton including a comprehensive chronology, analysis of involvement, good practice and recommendations for action

- A copy of the relevant policies, procedures and practice guidance which were in place in the period up to and including the 18 November 2003 and a copy of any subsequent revisions including implementation dates and processes

- Any other information which will assist the members of the Pemberton Domestic Homicide Review to meet the requirements of the Terms of Reference. In this context and in relation to number 1) of the Terms of Reference (quoted on page 2 of this letter) the panel will also be considering contact between the agencies and members of the family subsequent to the deaths of Julia and William Pemberton and Alan Pemberton.

12.193 During the course of the review, it has become clear to us that the term 'light touch' has proved to be misleading and counterproductive and has significantly and adversely affected the approach of individual agencies to the compilation of their internal management reviews. It is our view that such a term associated with a review relating to the murder of a human being is inappropriate.

12.194 As a consequence we have had to identify and obtain a substantial amount of additional oral and written information in order to address the requirements of the Terms of Reference.

12.195 We have a number of concerns about the scope and content of the internal management reviews which are set out below in relation to the three key agencies.

Analysis of agency IMRs

(a)Thames Valley Police

12.196 In this section we consider issues relating to TVP's Management Service Review (MSR) which was provided in February 2007.

12.197 Following the WBSCP decision in June 2005 to commission a domestic homicide review, TVP appointed a Detective Superintendent as a Review Officer. Protocols were agreed

between the Review Team, the Police Federation and UNISON and it is noted that these highlighted:

> *'The aim of the DVHR'* [Domestic Violence Homicide Review] *as being focussed on capturing organisational learning rather than individual culpability, and were consistent with Professional Standards' good practice at the time'* [379]

12.198 WBSCP appointed an independent chair for the DVHR and Terms of Reference were agreed with the agencies on 20 September 2005 represented on the Partnership. The MSR notes that as the independent chair would be liaising direct with members of the family, TVP released the two Family Liaison Officers from the Police Review Team.

12.199 TVP records and documents concerning both background and the events on 18/19 November were collated by members of TVP's Review Team as follows:

- *Command and Control Incidents at the (old) Hallowes location;*
- *CEDAR (Crime Recording) incidents either at the (Old) Hallowes location or involving any of the Pemberton family;*
- *The Investigation files for criminal damage to house locks;*
- *The Domestic Violence file;*
- *Command and Control administration records for the (Old) Hallowes location- e.g. for flags/warning markers/directions etc;*
- *Police Investigation file for HM Coroner;*
- *Command and Control Incident records on the night;*
- *Audio recordings of the 999 call from Julia;*
- *Audio recordings of all radio and inter- control intercom traffic;*
- *Firearms command and tactical advice logs/notes;*
- *Senior Investigating Officer policy, and;*
- *Force and BCU policies on Domestic Violence and Crime Investigation.*[380]

[379] TVP MSR, appendix A Methodology
[380] TVP MSR

12.200 HM Coroner also provided the TVP Review Team with access to his papers and audio recordings of the Inquest.

12.201 The MSR records that:

> *'Full interviews of all personnel who had some interaction with the Pemberton family was decided not to be proportionate with the Home Office Guidance that the DVHR should be 'light touch', focussed on organisational learning.'*

12.202 The MSR notes that it expected the following three themes -areas to be central to the WBSCP DVHR:

- The 999 call handling
- The investigations into historical DV allegations, and
- The Police response on the night.

12.203 Other potential areas were identified such as the introduction of Airwave.

12.204 Progress on the MSR was then delayed following the family's application for a judicial review into the Terms of Reference in October 2005. [381]

12.205 In April 2006 *'concerned that further delay would impact on the recollection of officers and staff and mindful of our duty to prevent other occurrences'*[382] an internal Service Management Review was commissioned by Assistant Chief Constable B (ACC B):

> '*Of the practices and procedures adopted by TVP in respect of the sequence of events which led to the fatal shootings of Julia, William and Alan Pemberton.*'

12.206 The MSR states that the observations contained in the report were reliant on paper records as the TVP reviewers were not able to speak to anyone outside TVP because of the ongoing judicial review process. It also acknowledges that following the judicial process TVP might be required to contribute to a Domestic Homicide Review that might '*seek to establish*

[381] Chapter 1 Introduction
[382] TVP MSR Introduction

whether all agency intervention was appropriate and whether agencies acted within their set procedures and guidelines.'

12.207 The Terms of Reference[383] for the MSR were set by ACC B and are included in the Management Service Review Report provided to the Pemberton Domestic Homicide Review in February 2007. The MSR states that it:

> '*…does not seek to pre judge the terms of reference or the findings of such a review* [DHR]*but will allow for a comprehensive and considered response to such a commission and an understanding of the scope of further work that may be necessary.'*

12.208 The Police Federation and their solicitors, Unison and the Superintendant's Association were briefed about the MSR. Lists of written questions were sent to staff and written responses were submitted via legal advisers as was felt necessary. We were advised by the reviewing officers from TVP that a number of the individual police officers they had wished to meet had declined to do so following advice from their staff representative**.** We found this also to be the case in relation to some officers with whom we had hoped to clarify information concerning events.

12.209 When we met with the TVP reviewers we were advised that they considered the Pemberton case was an '*unfolding story*'.[384] TVP officers acknowledged that there was a difference in the terms of reference between the MSR and the DHR:

> *'…the MSR work had a narrower, lighter focus and accordingly many of the papers and detail subsequently requested by the panel had never been previously sought.'*[385]

12.210 During an interview with the TVP lead officer, the panel were advised that because the MSR was compiled in the period after the family's application for Judicial Review in

[383] TVP MSR notes that these were agreed with the Association Chief Police Officers
[384] TVP information to PDHR
[385] TVP response to PDHR 22/04/08

October 2005 and before the judgement in July 2006 because of the judicial process TVP reviewers had not been able to have direct contact with members of the family. [386]

12.211 We consider in the contact between TVP and the family prior to and after the Inquest the Force obtained information from the family that could have informed an overarching and comprehensive of TVP's engagement with Julia and her family from September 2002 and including 18 November 2003. Other relevant information regarding the contact between Julia, her family and the Force in the period 2002/3 has only come to light in the latter stages of the PDHR e.g. the report of Alan as a missing person, the information concerning telephone calls made from Old Hallowes on key dates in 2003, the significance of the annotated affidavit.

12.212 The MSR states in appendix A:

> *'…the extended Judicial Review Process and instructions from a subsequent appointed independent chair for the DVHR prevented the Review Team from engaging with the Pemberton family for additional information or viewpoints.'*

12.213 On 3 November 2006 and subsequently on 3 January 2007 the chair was contacted by the chair of WBSCP on behalf of ACC B. On 3 November the chair of WBSCP advised that ACC B had informed him that:

- TVP had completed the MSR;
- The family had become aware of this;
- Various statements had been made in the public domain and ACC B wanted to meet with the family to discuss those statements.

12.214 The review chair advised the WBSCP chair that given the independent review was due to commence and we would be reviewing the internal management reviews at that stage she did not consider it was appropriate for the police to provide the family with a copy of their internal management review, or to discuss its contents with them at that stage. In November

[386] TVP information to PDHR

2006 the Terms of Reference for the review which would establish the scope of the internal management reviews had still had not been finalised.

12.215 Following a further enquiry on this matter from WBSCP chair on 3 January 2007 with reference to information from ACC B concerning a possible complaint by the family to the IPCC, the chair confirmed the response that she had given in November 2006. She also confirmed that she had not said that the police should not meet with the family; she pointed out that would not be hers or the review panel's decision to make.

12.216 The MSR notes that they were unable to access some audio recordings and records from the Control Rooms as a result of retention policies and the passage of time between the incident and the MSR. The MSR also notes that there were delays in completing the review relating to the process of obtaining legal advice.

12.217 Following clarification with TVP's lead officer, we received timely and helpful responses to requests for information needed to address the requirements of the Terms of Reference 25 January 2007. The reviewing officers were conscientious and thorough in providing us with additional information.

TVP MSR Review Comment 42:

With reference the MSR:

> *'The Domestic Violence, Crime and Victims Act 2004 places an obligation on agencies concerned in the management of Domestic Violence to work together in conducting a 'Domestic Homicide Review' of the circumstances leading up to and resulting in a domestic homicide.*
>
> *It is clear to the reviewing officers that in order to capture the potential lessons from these tragedies there needs to be a change in the way that we as a force and perhaps as a service seek to establish and understand what happened.*
> *The necessity to establish whether there are lessons to be learnt from the case about the way the Police carried out their responsibilities and duties does not suit comfortably within a service governed by a rigid discipline code.*

From the 'outset 'Gold' clearly set out that the aim of the review was not to apportion blame and did not form part of any disciplinary process, but should be focused on organisational learning. To that end a protocol was agreed with staff associations.

Nevertheless the reviewing officers were frustrated by the necessity to pose written questions, the responses to which were then initially reviewed by legal advisors before being returned to the staff association and then to the reviewing officers. Subsequent questions or attempts to clear up ambiguities were subject to the same process.

Within Thames Valley we have an average of 23 homicides each year, if as an average 5 of these homicides are domestic related the potential demand on time and resources will be high.

The Home Office and service urgently need to consider the implications of the Domestic Violence, Crime and Victims Act requirement to conduct Homicide Reviews in the following areas:

Who will conduct the police reviews?

What is the appropriate methodology for dealing with our staff who may be concerned about potential discipline or subsequent civil proceedings?

What will be the impact on the welfare of our staff subjected to scrutiny within the review process?

What will be the 'scope' of the review? The term' light touch' has been applied to this review, it is the opinion of the reviewing officers that the prolonged nature of domestic violence will nearly always result in the necessity for detailed review and questioning of our staff.

What arrangements are in place with our CSP [WBSCP] *partners to ensure understanding of our obligations under the Act and to ensure that reviews are commissioned expeditiously?*

What funding contribution will be required from each of the agencies involved in the review process?'

Panel comments

We agree with the MSR comments:

In relation to TVP:

- **The Force needs to change the way it seeks to establish and understand what happened in cases of domestic homicide.**

In relation to domestic homicide reviews:

- **The methodology for police service reviews including staff welfare, potential discipline and subsequent civil proceedings needs to be addressed.**
- **Such reviews need to be commissioned expeditiously.**
- **The prolonged nature of domestic violence will nearly always mean that the term 'light touch' has limited application to cases of domestic homicide.**
- **The issue of funding for both the internal and external review processes needs to be fully considered.**

<u>Panel's overall conclusions with regard to TVP MSR</u>

The panel has concluded that:

12.218 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.

12.219 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.

12.220 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.

(b) Berkshire West PCT IMR

Panel comments

12.221 We appreciated that the scope of PCT IMR would reflect the contact with the Pemberton family. However there were issues upon which the IMR needed to have reached a conclusion in relation to future learning, for example in relation to aspects of the role of the GP in the context of domestic violence. This was also the case with regard to whether the police or social services should have been notified in relation to the concerns shared by Julia with the GP on 5 June 2003, concerning her own and her family's safety.

12.222 The IMR did not provide information about the level of training and information available to PCT staff and health professionals in 2002/3 about domestic violence. We acknowledge the difficulties presented by the lack of continuity of managerial knowledge arising from the PCT reorganisation. We have since been reassured that the DoH Resource Manual for Health Care Professionals produced in 2000 had been distributed and that some training sessions were available in addition to those included in child protection training.

12.223 Although the IMR refers to the amount of medical input in relation to Alan and Julia no evaluation, analysis or comment was made concerning:

- **The absence after the initial referral by the GP to the consultant psychiatrist, of ongoing communication from the GP to the consultant psychiatrist.**

- **In light of information received from Julia (5 June) about her concerns for her own and her family's safety, consideration was not given by the GP to notifying the police or social services.**

12.224 The IMR did not provide information about the PCT's contribution at a strategic level in relation to domestic violence services. We were advised subsequently that the PCT was not represented on the Domestic Violence Forum in 2002 or in 2007. Julia's membership of the Forum was in respect of her professional group.

12.225 We were concerned by the lack of rigour in the IMR with regard to suppositions about the way in which Julia and Alan did not keep appointments with the GP and Alan's possible views concerning community mental health services.

12.226 We appreciated the cooperation of the PCT reviewers in providing us with additional information.

<u>Panel's Overall Conclusions with regard to Berkshire West PCT IMR</u>

The panel has concluded that:

12.227 The PCT was not directly responsible for the provision of services to Julia and her family. However 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.

(c) West Berkshire Council IMR

12.228 We appreciated that the scope of the council's IMR would reflect the limited direct involvement with the Pemberton family. However as we have commented elsewhere, we were concerned that initially the IMR did not analyse the school's compliance with contemporary Area Child Protection Committee procedures, nor provide an analysis of the school's contribution to the IMR.

12.229 The council was unable to provide agreed minutes of information gathering interviews which contributed to the IMR; this added to our difficulty in reaching a firm conclusion as to the extent of the school's knowledge of William's situation.

12.230 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.

12.231 The IMR did not provide information about the council's overall strategy in 2002/3 in relation to domestic violence services and interagency cooperation within which practitioners and local services would have operated. Subsequently we received substantial information about the council's contribution in this respect both in 2002/3 and currently.

12.232 We consider that the IMR should have given consideration to the council's duty under Working Together to Safeguard Children (DoH, DfEE & Home Office 1999) to conduct a Serious Case Review (paragraph 8.5) in relation to the death of William Pemberton. The council did not advise us of the existence of correspondence with the family about this matter until we raised the issue.

<u>Panel's Overall Conclusion with regard to West Berkshire Council's IMR</u>

The panel has concluded that:

12.233 Julia had no direct contact with council services. The IMR lacked a degree of rigour in relation to those areas where the council might reasonably have been expected to provide comment with regard to the response of the school in relation to William and the response of the Local Safeguarding Children Board after his death.

13. Conclusions 2002 – 2005 and Domestic Violence Services in West Berkshire 2008

13.1 The focus of this review has been on the response of agencies and professionals to the requests of Julia Pemberton and her family for help in the period September 2002 to November 2003 and their response to the family in the aftermath of her death and those of William and Alan Pemberton. Our conclusions are therefore about the past performance of those agencies and do not reflect the current response of agencies and professionals to requests for help from victims of domestic violence in 2008. We have been told about many improvements in the provision of services and these are referred to in chapter 14 of this report.

Thames Valley Police September 2002 – November 2005

13.2 Thames Valley Police had a primary duty to provide a service to Julia, William and C19, as victims of domestic abuse between September 2002 and November 2003. On the night of 18 November they had a primary duty when responding to the spontaneous firearms incident to protect members of the Pemberton family, the general public, and of course their own officers.

13.3 In this section we have brought together issues concerning Thames Valley Police performance under the following headings; crime investigation; domestic violence services; internal systems; emergency response; airwave communication; firearms response 18 November; Review of the Pemberton Case; information provided with regard to the Inquest. At the end of this section we have drawn overall conclusions about the service provided by Thames Valley Police.

- *Crime Investigation*

13.4 It is our view that 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. There is evidence of instances when police officers did not attend the scene, thoroughly investigate or link incidents or crimes which were reported on:

- 14 and 15 September 2002 - Threat to kill
- 20 September – Alan missing person
- 20 April 2003 - Glued locks
- 15 May 2003- annotated affidavit.

13.5 We have been provided with evidence that Julia and members of her family made a significant number of contacts with the police in relation to each of these incidents. Opportunities were missed to collect evidence in the first or 'golden hour' after the complaint regarding when an incident occurred. Thames Valley Police had policies and systems in relation to the investigation of crime other than domestic violence and we have identified issues in relation to supervisors and officers dealing with each of the three incidents where a crime was reported.

13.6 Officers did not identify or link the significance within the context of domestic violence of the four incidents, including Alan's behaviour in going missing and his threat of self harm. We attribute this lack of direction and focus to the absence in 2002 and 2003 of a Force-wide policy, procedures and training on domestic violence.

13.7 We have concluded that had the threat to kill been investigated as a serious crime in September 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 lead to a more informed police response at a critical time.

13.8 Thames Valley Police 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. As a consequence, Alan Pemberton was not interviewed in relation to the alleged crimes reported and significant opportunities were missed to inform the police response.

13.9 We have concluded that positive intervention by Thames Valley Police in response to reported crime in the preceding fourteen months may have altered the course of events. It is not possible to know whether positive intervention ultimately could have prevented the deaths of William and Julia.

- *Domestic Violence Services*

13.10 We have concluded that in 2002/2003, Thames Valley Police's failure to implement Home Office 19/2000 had significant consequences for the standard of the police response to Julia, William and C19 as victims of domestic violence. Furthermore, Thames Valley Police had an obligation under child protection procedures to identify potential risk with regard to William; there is no evidence that this was ever addressed.

13.11 We learned that members of the Force's senior management team were aware there was no Force-wide domestic violence policy, procedure or training. We consider the failure to develop a policy and disseminate it in a timely way to be significant. This was not remedied until 2004.

13.12 In 2002/2003 Thames Valley Police was a highly devolved force. In the absence of a Force-wide Domestic Violence Policy the service to the victims of domestic violence and their children was left to the interpretation of the Local Police Area. We consider 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.

13.13 In 2002 in West Berkshire the Domestic Violence Coordinator (DVC) had received neither formal training, nor apparently a formal job description and received no specialist supervision in her role. These omissions are symptomatic of the absence of a Domestic Violence Policy and related service framework

13.14 At that time not unlike other Forces, Thames Valley Police had no formal procedures for risk assessment, risk management and victim safety planning. The DVC undertook an implicit rather than explicit risk assessment identifying risks with Julia and offering advice and some options for her to consider.

13.15 The focus of the DVC's role was on support to victims, interagency representation and in ensuring follow up on reported domestic violence which had been flagged to her by police officers. We have concluded that within the limitations of her role and in the absence of a Force wide policy, procedure and service framework including training, the DVC used her best endeavours to support Julia.

13.16 Crime investigation was not included with the DVC's responsibilities. In Thames Valley Police this was in the context that frontline police officers and supervisors with such responsibilities were not trained in the identification of or response to domestic violence.

13.17 We have seen evidence that although incidents were reported to Thames Valley Police by Julia and her brother, officers failed to investigate or to arrest and/or interview Alan in April and May 2003. During this period, in our view, there were reasonable grounds to suspect the commission of a number of criminal offences including harassment, and Alan was in breach of an Injunction, non-molestation and occupation order with a Power of arrest granted in September 2002.

13.18 We have identified a disparity between what might reasonably have been expected of the Force's domestic violence services and what was available to Julia Pemberton and her family in West Berkshire at that time.

13.19 We have concluded that the provision of a domestic violence service to Julia Pemberton and her family by Thames Valley Police was flawed because of the lack of a Force wide policy and procedural framework to advise, focus and support police officers engaged in this important work.

- *Internal systems*

13.20 The identification, flagging and response to domestic violence related incidents was the responsibility of call takers and police officers investigating crime; they were operating without a policy framework, procedures or training in the identification of domestic violence. When the call taker on 20 April saw that a case was flagged on the Command & Control log, he/she needed to be able to identify the potential link between that incident and domestic violence.

13.21 Training was not provided in the use of the system that enabled call takers to access the information on the domestic violence marker and/or cut and paste that into the current log for the attention of officers dealing with an incident.

13.22 The information on domestic violence victims was held by the DVC on individual paper files at Newbury Police station. Police officers based at Pangbourne and Thatcham responding to Julia and her family would not have had access to the DVC paper file.

13.23 We have concluded in relation to the incidents on 20 April and 15 May that there were failures in the internal communication technology and systems which resulted in the DVC not being informed of incidents by officers with responsibility for call taking and crime investigation.

13.24 On 18 November although there had been a number of incidents at the house the address was still imprecisely recorded on the Street Index Gazetteer. 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.

- *Emergency response*

13.25 We have concluded that the DVC's advice to Julia in an emergency to dial 999 was the correct advice; however her reference on the flagging application with regard to the response to silent 999 calls was incorrect as this facility was not available at that time.

13.26 On 18 November it took eleven minutes and repeated questioning of Julia before the call taker was able to identify the correct location of Julia's house.

13.27 The directions to the house were not included with the flagged information; these would only have been available though the information relating to the Sovereign Call centre and would have been immediately available if Julia had activated the alarm.

- *Airwave communication on 18 November*

13.28 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.

13.29 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.

13.30 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.

13.31 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.

- *Firearms Response 18 November*

13.32 At the time that Julia and William were murdered, Operation Saladin was Thames Valley Police's policy for dealing with firearms incidents. The strategic aim in firearms situations was to *'identify, locate and contain and thereby neutralise the threat posed.'* This led to a focus on locating the offender, in this case Alan Pemberton.

13.33 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 times that Julia made her 999 call and Thames Valley Police's subsequent entry into Old Hallowes. It should be noted that during that time the status of Julia and Alan was unknown.

13.34 There were also a number of contributory factors including: 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.

13.35 We have concluded that the length of time taken for the firearms intervention following Julia's 999 call was unacceptable.

13.36 We consider that it is probable that William was killed by his father shortly after Julia dialed 999. From the pathologist's report and information made available to us it would appear that William tried to protect his mother. We have concluded that his life could not have been saved on 18 November. [387]

13.37 We consider that there is less certainty about the exact time of Julia's death on 18 November.

13.38 The time at which officers could reasonably have been expected to attend the scene is therefore of particular significance. Julia made a 999 call at 1911hrs and her last words were recorded at approximately 1925 hrs and 31 seconds (14 minutes and 31 seconds into the call). Alan's voice can be heard on the recording of the call at 1925 and 55 seconds. The sound of Julia's voice was recorded for the last time 15 minutes four seconds into the call: there was no discernable diction. The evidence provided by a neighbour at the Inquest indicated that the last shots were heard at approximately 1940hrs. This information suggests that Alan shot Julia and then himself between 1926hrs and 1940hrs.[388]

13.39 The window of opportunity for police to intervene to prevent Julia's death was therefore between 1911hrs and 1940 hrs. Information subsequently provided to the family by Thames Valley Police estimated that, given the changes to the firearms policy and improved communications systems, an armed response to Hermitage would take approximately twenty minutes. Further tactical decisions would then need to be taken before entry to the house was made.

13.40 We have concluded in the context of the firearms policy and communications systems that were in operation in Thames Valley Police in 2003, it would not have been possible for an armed entry to have been made before Alan murdered Julia.

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[387] Post mortem report to Inquest – William Pemberton - Dr N.C. Hunt and Preliminary Scene Report 19/11/03

[388] Post mortem report to Inquest - Julia Pemberton 26 November 2003 - Dr N.C. Hunt included in his report reference to ' *two apparently relatively close range gunshot discharges to her left lower back …associated with extensive disruption of the intra- abdominal viscera including the left kidney, the liver, the aorta and the inferior vena cava'* and he noted ' *The injury associated with the disruption of the aorta and inferior vena cava would have itself been a fatal injury and I would not expect this injury to have been amenable to medical intervention even with the most prompt response.'*

13.41 We have also concluded that on the balance of probability, in the context of the changes to policy and practice that have taken place since 2003, it would be unlikely that an armed response would be able to effect an entry and prevent Julia's death in the time that was available between her 999 call and the time that the last gunshot was heard by a neighbour.

13.42 We were provided with a copy of what we understand to be the Firearms Operational (tactical) Debrief concerning Thames Valley Police's response on 18 November 2003. We have been advised that Thames Valley Police consider that such a debrief was a proportionate response to the management of the incident. We have concluded that, given the range of difficulties encountered during the firearms deployment, the historic engagement with Julia and the tragic outcome, TVP could reasonably have been expected to carry out an overarching review of their relevant policies and practices.

13.43 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. The recommendations of the Highmoor Cross Review included the following:

> *'the policy in relation to spontaneous firearms incidents needs to be replaced. The new policy must provide clear direction and guidance on dynamic risk assessment, to respond to situations where people are believed to be hurt. It should include a presumption that unless there are good reasons for not doing so, the command function must take place near the scene. These policies need to be supported by new and better training.'*

- Review of the Pemberton Case

13.44 We have concluded that Thames Valley Police did not give due consideration to the need for an overarching strategic review in relation to the Pemberton case. Prior to the 18 November 2003, Julia Pemberton, family and friends had sought help from the Force with regard to four domestic violence related incidents and Julia had contact with the Domestic Violence Coordinator on six separate occasions.

13.45 We have concluded that the Pemberton case warranted a review in relation to the potential for organisational learning. In our view the case met the terms specified in the *'Critical Incident Definition/ Standard Operating Procedure - 2003'* which, we have been informed, applied in 2003 and 2004.

13.46 Prior to and after the Inquest, there were a number of meetings when the Force could have elicited information from the family which could have informed an overarching review of Thames Valley Police's engagement. An overarching review was not undertaken. The Thames Valley Police Management Service Review was commissioned in 2006; the Terms of Reference were set by ACC B prior to the confirmation in January 2007 by WBSCP of the Terms of Reference for the Pemberton Domestic Homicide Review. Relevant information regarding the contact between Julia, her family and the Force in the period 2002/3 has come to light in the latter stages of the Pemberton Domestic Homicide Review.

13.47 The panel find the current ACPO Practical Advice on the Management of Critical incidents to be helpful in this regard and the definition developed by the MPS and now adopted as part of the ACPO practice advice provides a meaningful template:

> *'There are two main facets to Critical Incident Management:*
>
> - *Identifying and dealing with incidents where the effectiveness of the police response may have a significant impact on the confidence of the victim, their family or the community;*
> - *Taking proactive steps to restore public confidence after a critical incident has been identified.'*[389]

13.48 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 Julia and William.

[389] Practical Advice on Critical Incident Management (2007) National Policing Improvement Agency

- *Information provided with regard to the Inquest*

13.49 A primary focus of Thames Valley Police in the aftermath of 18/19 November was the management of the Force presentation at the Inquest in the context of a murder inquiry.

13.50 It is our view that due consideration was not given to the fact that Julia Pemberton, her family and friends had sought help from Thames Valley Police with regard to four incidents and that Julia had contact with the Domestic Violence Coordinator on six occasions in the fourteen months leading up to the murders. This was reflected not in the level of information provided to the Coroner in Thames Valley Police's report dated 3 December 2003.

13.51 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 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.

13.52 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. The Coroner was provided with an edited version of Julia's 999 telephone call on 18 November.

13.53 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.

13.54 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.

Panel's overall conclusions with regard to Thames Valley Police

The panel have concluded that:

- 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.

- 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 and Thames Valley Police's engagement in the preceding fourteen months with Julia Pemberton and her children as victims of domestic violence.

- On the basis of information we have received concerning the Firearms response on 18 November 2003 the unacceptable delay in responding to Julia's 999 call was in our view a result of technical and practical difficulties encountered on the night and complicated by the over cautious approach of Operation Saladin, the Force Firearms policy.

- On the basis of the extensive information provided to us we consider 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 to constitute a system and service failure.

- Notwithstanding our conclusions it would be wrong to attribute the deaths of William and Julia to anyone other than Alan Pemberton.

Domestic Violence Services in 2008

13.55 The situation in Thames Valley Police today is very different from that in 2002/2003. The force has a clear domestic violence policy which incorporates Association of Chief Police Officers' guidance and is reviewed yearly and monitored by the force Public Protection Steering Group (PPSG). The PPSG is chaired by an Assistant Chief Constable with the strategic lead for Domestic Violence investigations. The Force's performance group, chaired by the Deputy Chief Constable and attended by all chief officers, sets priorities and actively monitors performance.

13.56 A strategic level multi-agency Domestic Violence group has been developed across the force area and monitoring of domestic violence incidents is audited on the Force CEDAR[390] system. In an audit commission inspection against National Crime Recording Statistics in May 2007 they were graded as 'Good' with a 93% compliance rate. Multi-Agency Risk Assessment Conferences have been established and the Her Majesty's Inspectorate of Constabulary inspection report of 2007 tells us that *'All operational officers have received a briefing on risk identification.'* Tactically, a supervised positive intervention policy is in place and if an arrest is not made, officers must justify the reasons to their Inspector or Sergeant. The duty Sergeant is responsible for monitoring initial scene attendance and investigations by the first responding officers and each Basic Command Unit has a nominated individual to proactively review incidents and check that standards are being met. We are told that staff in the control room have received training and this is supported by the Her Majesty's Inspectorate (HMIC) inspection of 2007 which gives examples of staff responses to crimes that could be indicative of, or related to domestic violence.

13.57 We note that *'Critical incidents are managed through a robust gold group system which leads to debriefs and recommendations* (Reference HMIC 2007)'.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

[390] Crime Evaluation, Data Analysis and Recording

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.

13.58 Thames Valley Police have provided us with access to their response and ongoing actions to address all of the above issues. They also provided us with a comprehensive presentation and gave us access to current practitioners, highlighting the distance they have travelled and the improvements made since the murders in 2003.

Berkshire West Primary Care Trust formerly Newbury and Community Primary Care Trust

13.59 Newbury and Community Primary Care Trust were involved only through the family's GP, an independent contractor to the NHS. Julia was employed as a Health Visitor by the Primary Care Trust. We learnt that there were no opportunities from this relationship to enable the Primary Care Trust to assist Julia or her son.

13.60 In 2002/3 there is limited evidence of strategic leadership by the PCT in relation to domestic violence policy, procedure or practice. Apart from the interagency child protection procedures and distribution of the Department of Health Resource manual there was no specific framework or guidance provided by the Primary Care Trust in relation to domestic violence for health professionals whether contracted or directly managed. The Primary Care Trust was not represented on the Domestic Violence Forum; Julia Pemberton represented health visitors. We have been advised that the agreement of senior PCT managers for health visitor representation on the Forum would have been in the expectation that there would have been ongoing communication with regard to domestic violence.

13.61 There is no evidence that the PCT provided GPs in 2002/3 with specific guidance with regard to domestic violence; as is likely to have been the position elsewhere in 2002/3. In 1996 the Domestic Violence Forum had put together a leaflet which was revised regularly, provided information on services and was widely distributed and available in GP surgeries. The GP told us he had limited experience of domestic violence amongst his patients. We were advised by the Primary Care Trust that the only local training available was that linked with child protection. The GP provided Julia and Alan with considerable support during this period.

13.62 The GP was the Pemberton family's doctor for fifteen years; he and members of his family had personal contact with members of the Pemberton family and he had worked with Julia in her professional capacity as a health visitor. He had ongoing involvement as the family's GP from September 2002 to September 2003, receiving information from Julia and Alan about their respective views and experiences of the breakdown in their marriage. During that period Julia consulted the GP on 11 occasions and between March and July 2003 Alan consulted him on five occasions. The GP was the one professional who had direct contact with both Julia and Alan during this period.

13.63 The GP acknowledged when acting as GP to both parties the potential conflict of interest which might arise. In this case the GP was confronted with a complex set of issues as a result of his various relationships with members of the Pemberton family as outlined in 3.120 above. Our attention has been drawn to guidance issued in 2002 by the Royal College of General Practitioners with regard to domestic violence in families with children. This guidance acknowledges the potential for a conflict of interest; the need for each situation to be considered independently; and for the GP to make an explicit decision about whether to care for both parties. The GP advised us that he had discussed the case with his partners in the practice. There is no record as to whether he discussed with either Julia or Alan their option to transfer to another partner in the practice.

13.64 The GP acknowledged the potential risks for Julia in the situation but relied on the fact that Julia had communicated her concerns to the police, the domestic violence unit and her solicitor. In doing this he acted on the reasonable assumption that the police were responding appropriately to the information provided to them by Julia and that the Injunction she obtained in September 2002 afforded her protection.

13.65 The GP, in his referral letter on 2 May to the private psychiatrist requesting his help in assessing Alan's depression and risk of suicide, noted that Julia had left after more than 20 years of marriage and that both parties were embroiled in divorce proceedings. In the concluding paragraph of the letter the GP stated that he did not feel there was an immediate risk that Alan would harm his wife or himself. In the electronic record of consultations the designation is given as marital disharmony and separation.

13.66 We acknowledge that in line with the requirement to respect Julia's right to confidentiality, he did not provide the psychiatrist with ongoing information when she drew her concerns to his attention with regard to her own and William's safety arising from Alan's threats concerning his own and her life. At the time the General Medical Council Guidance would have permitted the GP to disclose without her consent Julia's concerns to the police in the interest of public safety (if this had not already been done by the patient); but would have prevented the GP in the absence of patient consent, from sharing this with another health professional.[391]

13.67 Following Julia's consultation with the GP on 5 June when she told him of her concerns for her own and her family's safety, the GP on the basis of his assessment did not arrange to see William himself or contact the police or social services (with or without Julia's consent). In Julia's next consultation with the GP on 19 June she advised him that the stress at home was more relaxed and that a panic alarm had been fitted.[392] As in September 2002 the GP responded to Julia on the assumption that Julia's contact with Thames Valley Police meant that they would be dealing with her concerns appropriately.

13.68 This case illustrates the limitations of relying on the assumption that other professionals and agencies are acting appropriately. In the event that the GP had made contact with either of the agencies, it is possible that initial enquiries under Section 47 of the Children Act 1989 may have been initiated. This may also have led to a refocusing by Thames Valley Police of their response to the risks faced by Julia and William; potentially also to the opportunity for William to share his views and feelings with others who were in a position to help and protect him.

<u>Panel's overall conclusions with regard to Berkshire West Primary Care Trust formerly Newbury and Community Primary Care Trust and medical professionals</u>

The panel has concluded that:

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

[391] Confidentiality: Protecting and Providing Information; General Medical Council 2000
[392] Berkshire Area Child Protection Procedures 2001

- In 2002/3 there is limited evidence of Newbury and Community Primary Care Trust providing strategic leadership to support professionals dealing with domestic violence beyond its work in relation to child protection, the distribution of information and support for health visitor representation on the Domestic Violence Forum.

- The GP provided considerable healthcare support to both Julia and Alan Pemberton and took appropriate steps to refer Alan to a psychiatrist for an assessment with regard to his risk of suicide.

- The GP acknowledged the potential conflict arising in a domestic violence situation of continuing as the GP for both Julia and Alan and acted in accordance with the advice available from the Royal College of General Practitioners.

- We acknowledge the issues raised with regard to patient confidentiality, but identify that the issue of information sharing in the assessment and management of evidence based risk is an important area for further consideration by professional organisations.[393]

- The case illustrates the need for ongoing work by professional organisations with regard to issues of confidentiality and information sharing in the context of child protection concerns or risk involving the potential commission of a serious crime.

- The GP took Julia's concerns in September 2002 and June 2003 seriously. It is acknowledged that the GP's assessment of the risk to Julia and William's safety based on the information she provided then and subsequently on 19 June and 31 July did not result in him arranging to see William nor did he consider it necessary (with or without Julia's consent) to make contact with the police or social services. He relied on Julia's assurance that the police were involved and that they would act appropriately with regard to her concerns and that the stress at home had relaxed.

[393] Information sharing; Guidance for practitioners and managers (October 2008) www.everychildmatters.gov.uk/informationsharing

- This case illustrates the limitations of relying on the assumption that other agencies are acting appropriately. Neither the police nor social services had direct contact with William and he did not have the opportunity to share his views and feelings with them.

- The GP and the private consultant psychiatrist could not have predicted that Alan would murder William or Julia and were not in a position to have prevented the eventual outcome.

Domestic Violence Services 2008

13.69 We were advised that there is now a strategic lead for domestic violence and that the Director of Clinical Services is responsible for progressing the strategic development and implementation of a Domestic Violence Policy, procedures and practice and training for health professionals. The Director is also responsible for providing the strategic link for health professionals on the three domestic violence fora - West Berkshire, Wokingham and Reading - within the area and on the Multi-Agency Risk Assessment Conferences. The Primary Care Trust is also working with the Thames Valley Partnership to agree a Domestic Violence policy for the whole of the area covered by Thames Valley Police.

West Berkshire Council

13.70 West Berkshire Council had limited involvement with Julia and William Pemberton prior to November 2003; this was through William's school and the Connexions service. Neither William's limited involvement with the Connexions service nor Julia's membership as the health visitor representative on the Domestic Violence Forum provided any opportunity for the council to assist the Pemberton family.

13.71 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. We consider because of the limited contact the Pemberton family had with council services, this did not have any bearing on the outcome of the Pemberton case. Interagency child protection procedures did provide guidance to staff in relation to children affected by domestic violence.

13.72 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.

13.73 The primary involvement was through William's school. We were unable to ascertain how well informed the school was about William's experiences of the threats made by his father to his mother and his fears for his own safety. 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 enquiries[394] to be made which may have linked information held by the school and GP with that held by the police.

13.74 The school gave priority to Julia's wishes that William should not be made aware of her call. As a consequence William did not have the opportunity to express his own views. The school appears to have been influenced by the fact that Julia had told them the police were involved and that William was continuing to be a high achiever whose behaviour was not showing outward signs of the impact the situation at home was having on his ability to cope. However we agree with the views expressed by the current West Berkshire Children's services that the school should have notified the police or social services.

13.75 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

[394] Children Act 1989 Sec 47

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.

Panel's overall conclusion with regard to West Berkshire Council

The panel has concluded that

- 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.

- 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.

- 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.
- The school acting as a single agency could not have predicted or prevented the eventual outcome.

- 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.

Domestic Violence Services in 2008

13.76 During the review we interviewed key staff concerned with domestic violence and were provided with a substantial body of evidence to demonstrate that the council was addressing domestic violence through the Safer Communities Partnership. Domestic Violence was agreed as a continuing priority for the Community Safety Strategy and targets associated

with domestic violence had been included as one of the council's first Local Public Service Agreements (LPSA). As a result of the LPSA the council has recently been able to appoint a part-time Domestic Violence Reduction Coordinator to focus on the implementation of the Domestic Abuse Forum's action plan.

13.77 Revised Child Protection Policies and Procedures are in place across the six Berkshire Local Safeguarding Children Boards which strengthen the guidance to staff on domestic violence. The council is also working with the Thames Valley Partnership to agree a domestic violence policy for the whole of the area covered by Thames Valley Police.

13.78 The Joint Area Review of Children's services 2007[395] made favourable comment about the provision of services through the domestic violence forum to support children affected by Domestic Violence.

Learning for the Future – 2008 onwards

13.79 In the following section we have drawn together the key themes which we have identified during the review and which we consider need to inform future service development:

Victims and their families

- Victims, their children, family and friends should be encouraged to report all concerns with regard to safety to police/other agencies and the information should be recorded (covered by guidance and advice facility on National Domestic Violence Helpline).

- Children and young people should be given opportunities to have their experience heard directly and to contribute to the assessment of risk.

[395] The Joint Area Review (JAR) is part of the integrated inspections of Children Services carried out at a local authority area level

For HM Government and all agencies and professionals

- Whilst both public and professionals are often told that the Data Protection Act does not inhibit agencies from sharing information it does not positively encourage or require it, nor, critically does it explicitly offer protection to those charged with making the judgments about sharing sensitive personnel data in cases of suspected risk. Any system for sharing information must also acknowledge the potential implications and consequences with regard to both the victim of domestic violence as well as for the people providing support.

- If we are to develop a multi-agency system with the confidence to share information, the current situation is not tenable. Attempts to deal with this matter by better training and clarification have not worked and it is therefore our opinion that the government needs to amend the DPA to reflect a positive duty to share information in cases where a potential threat or risk is exposed. In this regard, we acknowledge and support the current work being carried out by the ACPO Domestic Violence working group which recognizes that *'Any prevention-based risk management strategy should have as a core requirement, effective information sharing within and between agencies.'* (ACPO lead Domestic Violence strategy paper 2008).

For all agencies and professionals

- Agencies and individual professionals need to develop their understanding about the emotional and psychological affect on victims and their children of living with a partner who has been coercively controlling; especially the kind of support they may need in relation to ongoing contact after the relationship has ended. This needs to be supported by awareness raising, to help family and friends better understand the dynamics of such coercive relationships.

- Professionals and front line staff need to make the link between domestic violence and child protection in order to safeguard children and young people (see respective national and local guidance which makes clear connections).

- All agencies need to contribute to developing and implementing an integrated local strategy for domestic violence.

- All agencies (including police, criminal justice and civil justice agencies and health and social care agencies) should work together towards agreeing a single multi-agency framework for identifying, assessing and managing risk in domestic violence cases. This should build on learning nationally from Multi- Agency Risk Assessment Conferences (MARACs) and other single and multi-agency initiatives relating to domestic violence.

This multi-agency framework for the identification, assessment and management of risk should not be based purely on information from one source or agency, or on the circumstances at one particular stage of a case. The framework and process should be based on a shared understanding of domestic violence and risk, should recognise the dynamic nature of risk in domestic abuse cases and the need to base decisions on information from a range of sources.

For the police service

Chief Constables have an extensive range of responsibilities to discharge and it is appropriate that they will devolve responsibility for the development of key force policies to individual members of their Chief Officer team. Demonstrable leadership and direction is critically important and individuals must accept the responsibility of their role and rank.

Chief Officer training and development programmes should highlight the importance of policy development and create opportunities for senior officers in training environments to review cases and consider links between policy and practice. The ACPO Practice advice on Critical Incident Management highlights that – '*Ineffective and/or inconsistent implementation of force protocols, policies and procedures have been identified as one of the main reasons why critical incidents develop.*'

- It should ensure that Chief Officers evidence their knowledge of key policies and critical incident management relevant to domestic abuse. Ensuring that they understand and can articulate the implications poor management holds for the service and the damage it can

do to public confidence. This should be supported and linked to experiential training in realistic practical scenarios.

- Senior Officers review/performance development programmes should audit their engagement in developing, delivering or reviewing key service policies and evidence their 'grip' on the initiatives devolved to them.

- Chief Officers should routinely demonstrate their values and the ethos of a service configured to protect the vulnerable by frequently engaging with those charged with delivering the practical implications of the policy developed under their leadership. This should include briefing key junior front line staff on their commitment to delivering meaningful policy on their behalf. Such engagements should enable front line officers to test and question their leadership team. Such an approach would ensure that the needs of practitioners and the communities they engage are not lost on those responsible for leading.

- In local Domestic Violence Fora the Chief Officer responsible for the policy should attend a set number of meetings (twice yearly) to allow the forum to test their understanding and delivery of leadership in such areas.

- The provision of a police response to the victims of domestic violence needs to be embedded in a framework based on a force–wide policy, procedures and training for all officers and staff.

- Domestic Violence Incidents should be attended to as a priority (now covered in Guidance 2004 and 2008).

- Threats in cases of domestic violence should be investigated (now covered in guidance).

- Record Domestic Violence incidents/crimes and flag systems (now covered in guidance and will be part of Police national database functions).

- Threats to kill/suicide should always be viewed as high risk (covered in guidance and work being carried out on single assessment model by ACPO lead on domestic violence).

- Update victims of crime appropriately (Code of Practice).

- Investigation should be reviewed at every stage and linked to risk assessment.

- Firearms debriefs related to complex scenarios, and all firearms incidents involving police deployments resulting in death, should be centrally maintained so that best practice can be captured and debriefs measured against a calibrated system - a potential role for the National Police Improvement Agency (NPIA).

- Recognition that where there are children and young people involved separate consideration must be given to their needs in line with Local Safeguarding Children Board procedures.

For PCT and health professionals

- PCTs as commissioners of health care services have the opportunity through their contractual arrangements e.g. with GPs, to include requirements with regard to domestic violence.

- PCTs as commissioners of health care services need to be engaged in their local areas in the development of multi-agency strategies, to reduce the harm caused by domestic violence to the health of victims and participate appropriately in relevant multi-agency fora for this purpose.

- As a primary health care service available to everyone, general practitioners are in a key position to provide support and access to help for victims of domestic abuse and their children. This role may cause problems in maintaining objectivity as GPs may be privy to information not available to other parties in complex cases and should in accordance with their professional guidance report, child protection concerns and information regarding risk involving the potential commission of a serious crime to all relevant agencies.

- Training is required for general practitioners and health professionals with regard to domestic abuse; to include the emotional and psychological implications for victims and their children both during and after leaving an abusive relationship and in managing ongoing relationships.

- Training provided for GPs and other health professionals about domestic abuse should identify risk indicators associated with the perpetrator's behaviour e.g. threatening suicide.

- GPs and health professionals in contact with victims and perpetrators should in accordance with their professional guidance report child protection concerns and information regarding risk involving the potential commission of a serious crime to police/other agencies and these should be recorded (covered by guidance and advice facility on National Domestic Violence Helpline).

For councils

- Should provide leadership in the local community with regard to the response to domestic violence.

- Should ensure that it has relevant policies, procedures and practice guidance with regard to domestic violence which cover all council services.

- In line with the Children Act 2004 should support local agencies, including health and schools to identify at the earliest opportunity the needs of children and young people as a consequence of domestic violence.

- Local Safeguarding Children Boards need to ensure policy, procedures and practice guidance in relation to domestic violence recognize the many different forms that domestic violence can take.

- Local Safeguarding Children Boards need to ensure that when a child or young person dies or is seriously injured in the context of domestic violence, proper consideration is given to the requirement for a Serious Case Review.

14. Recommendations

14.1 The panel has analysed the events of the Pemberton case and the actions of the responsible agencies and our conclusions have been set out above. On the basis of our analysis and conclusions, we make the following a) recommendations about this case and its handling and b) about domestic violence reviews generally:

a) Recommendations in relation to the Pemberton case:

R1 It is recommended that agencies acknowledge the difficulties facing victims, their families and friends through the provision of support and guidance for them and for the wider community, including faith leaders, to help them understand the most effective ways to help victims of domestic abuse.

R2 It is recommended that agencies provide information to the public about the appropriate action to take if a fear is held about an individual. They should be encouraged to report such fears; the police can only positively intervene or develop a risk management plan when they have the information to inform it.

R3 It is recommended that agencies recognise the importance of leadership from senior staff in relation to the development of policy and strategy, giving direction to and control of standards in the delivery of front line services to the victims of domestic violence and their families and ensure that they have relevant strategy, policy and services in place.

R4 It is recommended that local councils recognise the need to exercise their strategic role as community leaders in relation to domestic violence

R5 Each agency should ensure that it contributes positively to the development of multi agency strategy, services and practice.

R6 It is recommended that agencies ensure that their representatives on the Crime and Disorder Partnership, Domestic Violence Forum and MARACs are experienced and at an appropriate level of seniority within each agency and are allocated the required amount of time to make an effective contribution.

R7 It is recommended that agencies better recognise the need to monitor and appropriately challenge, through the Crime and Disorder Partnership and the Domestic Violence Forum, the performance of constituent agencies in relation to the level of service provided to victims of domestic violence and their families.

R8 It is recommended that the Local Safeguarding Children Board and partner agencies for child protection ensure that staff fully recognise the many forms domestic violence can take the impact of domestic violence on parenting and the need to ensure that children and young people are given the opportunity to have their own voice heard.

R9 It is recommended that when training professionals in relation to both domestic violence as well as staff, are reminded of the importance of not assuming that other professionals are aware and taking appropriate action.

R10 It is recommended that agencies should undertake an internal management review immediately following a domestic violence homicide so that learning can inform changes to policy and practice at the earliest opportunity; in the event of the death or serious injury of a child, evidenced consideration must be given to the requirement for a Serious Case Review.

R11 It is recommended that Primary Care Trusts through their contractual arrangements with GPs recognise the important role of GPs in relation to victims of domestic abuse and their families and that appropriate training, guidance and support is provided by commissioners and professional bodies, to include identifying the risk indicators associated with perpetrator behaviour.

R12 It is recommended that all agencies and professionals (including police, criminal justice and civil justice agencies and health, including general practitioners and social care agencies) work together to agree a single multi-agency framework for identifying, assessing and managing risk in domestic abuse cases. This should build on learning nationally from MARACs and other single and multi-agency initiatives relating to domestic abuse.

This multi-agency framework for the identification, assessment and management of risk should not be based purely on information from one source or agency or on the circumstances at one particular stage of a case. The framework and process should be based on a shared

understanding of domestic abuse and risk, should recognise the dynamic nature of risk in domestic abuse cases and the need to base decisions on information from a range of sources. Any system for sharing information must also acknowledge the potential implications and consequences with regard to both the victim of domestic violence as well as for the people providing support.

From a police perspective we suggest that recommendation R12 is adopted under the current work being carried out by the ACPO Domestic Violence working group with regard to information sharing in the context of developing a multi-agency domestic violence system.

R13 It is recommended that domestic violence training is made available to criminal justice and civil justice agencies to ensure their full understanding with regard to domestic violence cases coming to their attention.

b) Recommendations in relation to Domestic Homicide Reviews

14.2 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[396] rather than a template for future Domestic Homicide Reviews. This is due to the length of time, almost five years since the tragedies, and the circumstances surrounding the setting up of the review including the Judicial Review by Lord Justice Moses.[397]

14.3 We consider, however, there are a number of learning points that could be usefully applied in the conduct of domestic homicide reviews and we make the following recommendations:

R14 It is recommended that section 9 of the Domestic Violence, Crime and Victims Act 2004 is enacted.

[396] *Guidance for Domestic Homicide Reviews under the Domestic Violence, Crime and Victims Act 2004* .Home Office Consultation Document June 2006.
[397] See chapter 12

R15 It is recommended that in the event of the death or serious injury of a child due consideration must be given to the requirement for a Serious Case Review.

R16 It is recommended that agencies need to undertake an internal management review as soon as is sensibly possible following a domestic homicide, so that learning can inform changes to policy and practice at the earliest opportunity.

R17 It is recommended in all cases a Chief Officer/Directorate level staff member from outside the force or agency is involved to ensure appropriate examination and consideration of leadership issues.

R18 It is recommended that such reviews should operate on the presumption that they can access all personnel and issues relevant to the incident or identify and capture them as soon as appropriate given regard to other investigations. Such matters should be explicitly addressed in the commissioning terms of reference.

R19 It is recommended that, given the potentially important contribution of family and friends to the review process, the nature and scope of family involvement needs to be clearly established at the earliest opportunity and at all stages of the process.

R20 It is recommended that the methodology for internal management reviews needs to address matters relating to staff welfare, potential discipline and subsequent civil proceedings.

R21 It is recommended that the term 'light touch' should not be used as a description of an approach in the context of domestic homicide reviews.

R22 It is recommended that the issue of resourcing for the review process (internal and external) needs to be fully considered.

R23 It is recommended that an appropriate degree of independence and challenge needs to be incorporated into the review process.

R24 It is recommended that legal advice should be made available to reviews both internal and external.

Appendix A

Terms of reference

NB. These are the final terms of reference as agreed on 25 January 2007

This review is commissioned by West Berkshire Council on behalf of West Berkshire Safer Communities Partnership (WBSCP) in response to the deaths of Julia and William Pemberton and the subsequent death of Alan Pemberton in November 2003. The proposed terms of reference have been agreed following discussion with the Home Office.

Background

The review follows after extensive discussions with the relatives of Julia and William Pemberton, the Home Office (including Ministers and officials) and local agencies within the WBSCP. The review will follow the key processes that are outlined in the guidance for Domestic Homicide reviews under the Domestic Violence, Crime and Victims Act 2004 which was published for consultation by the Home Office in June 2006. Where appropriate the guidance will be developed further to reflect local circumstances. This is to ensure that the review is both thorough and robust and that any learning can help inform the final guidance which is to be published by the Home Office in 2007.

Purpose

The purpose of the Review is to:

1. Establish the facts that led to the events in November 2003 and whether there are lessons to be learned from the case about the way in which local professionals and agencies carried out their responsibilities and duties, and worked together to safeguard Julia and William Pemberton.

2. Identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result.

3. Establish the appropriateness of agency responses - both historically and at the time of the incident leading to the homicides.

4. Establish whether single agency and inter-agency responses to concerns about domestic violence were appropriate.

5. And as a consequence, identify any gaps in, and recommend any changes to, the policy, procedures and practice of individual agencies, and inter-agency working, with the aim of better safeguarding families and children where domestic violence is a feature in West Berkshire and perhaps more widely in the future.

6. Identify, on the basis of the evidence available to the review, whether the homicides were predictable and preventable, with the purpose of improving policy and procedures in West Berkshire and perhaps more widely.

7. Identify from both the circumstances of this case, and the homicide review processes adopted in relation to it, whether there is learning which should inform policies and procedures in relation to homicide reviews nationally in future and make this available to the Home Office.

The Review will exclude consideration of how Julia and William died or who was culpable; that was a matter for the Coroner and Criminal Courts respectively to determine.

Terms of reference

Terms of reference

1) To review events up to the date of the deaths of Julia and William Pemberton on 18 November 2003 unless it becomes apparent to the independent chair that the timescale in relation to some aspect of the review should be extended.

2) To review the actions of the agencies defined in Section 9 of the Act who were involved with the Pembertons and - at the initiative of the chair and subject to their agreement - any other relevant agencies or individuals.

3) To seek to involve the family and include their potential contribution to the review in the way set out in the approach 'b) Family Involvement' (below)

4) To produce a report which:

- summarises concisely the relevant chronology of events including the actions of all the involved agencies
- analyses and comments on the appropriateness of actions taken
- makes recommendations which, if implemented, will better safeguard families and children where domestic violence is a feature.

5) Aim to complete a final overview report by the end of May 2007 acknowledging that drafting the report will be dependent, to some extent, on the completion of agency management reviews to the standard and timescale required by the independent chair.

The Commissioning Body

West Berkshire Council on behalf of the West Berkshire Safer Communities Partnership (WBSCP) which incorporates the Crime and Disorder Reduction Partnership for West Berkshire (CDRP) has commissioned this review and WBSCP have approved these Terms of Reference.

The Chair of the WBSCP (Nick Carter, Chief Executive West Berkshire Council) has been given delegated authority to take decisions on behalf of the WBSCP:

- maintaining a dialogue with members of the family
- liaising with the independent chair to ensure she is able to carry out the remit within the agreed timescale.
- securing the resources required to undertake the Review.
- liaising with the Home Office on matters that are relevant to the roles and responsibility of the Commissioning Body.
- receiving the final overview report from the independent chair.

All other responsibility relating to the Commissioning Body (WBSCP) namely any changes to these Terms of Reference and the preparation, agreement and implementation of an Action Plan to take forward the local recommendations in the overview report will be the collective responsibility of the Partnership.

Independent chair and independent expert advisers

West Berkshire Council on behalf of the WBSCP have commissioned Verita (The Inquiry Consultancy) to undertake this independent external review. The chair will be Mary Walker, one of the associates of Verita.

It will be the responsibility of the independent chair in consultation with the expert advisers to:

1. Prepare a provisional review framework that sets out how the review will be conducted and the timescales involved. The WBSCP as Commissioning Body, and other stakeholders determined by the independent chair will be provided with a copy of this Framework. The Provisional Framework will ensure that the Terms of Reference are met and to an agreed timescale.

2. Conduct the review in accordance with the Terms of Reference and Provisional Review Framework.

3. Prepare the Overview Report for the WBSCP.

Mary Walker will be supported by independent external expert advisers. Two of these have been identified:

- Jim Gamble, Chief Executive of the Child Exploitation and Online Protection Centre

- Christine Mann, Department of Health National Domestic Violence Coordinator

There may be other independent expert advisers yet to be identified, including in relation to education. Other experts may be identified as necessary at a subsequent stage of the review or be asked to undertake specific work. The appointment of further independent expert advisers will be at the discretion of the Independent Chair.

The media consultant to the independent chair will be John Underwood/Lesley Sargeant, Verita directors. All media contacts will be channelled through John Underwood in the first instance.

The independent chair will liaise with the WBSCP Chair on all matters including the process of publication of the report. The independent chair will be responsible for the final overview report and its summary.

Review consultation

The Chair of the WBSCP will receive a monthly written report setting out progress with the Review against the timescale that has been agreed in the Framework document.

Approach

a) General

This Review will:

- be guided by the "Questions and Answers" for Members of Parliament published by the Home Office at the time of the debate on the Domestic Violence, Crime & Victims Act Bill and by the responses of the Parliamentary Under Secretary of State for the Home Department in a parliamentary debate on the case on 16 March 2005;

- be guided by learning from reviews of child deaths (widely known as "Part 8 reviews") under "Working Together to Safeguard Children" (Department of Health, Home Office and Department for Education and Employment 2006).

The Review will frame its thinking in terms of:

> "What might victims or potential victims of potential violence in West Berkshire have expected from statutory agencies in 2003 in terms of:
>
> - their statutory responsibilities
> - policies, procedures, training and implementation of good practice both locally and nationally?"

The range of questions of agencies which flow from this approach will be determined by the independent chair and the independent external expert advisers working with her.

They will incorporate issues and questions identified by others, including family members, which the independent chair considers it appropriate to pursue. It is anticipated that the review will include local authority, NHS, criminal justice agencies and other agencies including:

- West Berkshire Council — Children and Young People and Community Services
- William Pemberton's school
- Pemberton family's General Practitioner
- Berkshire West Primary Care Trust
- Berkshire Healthcare NHS Trust
- Thames Valley Police.

It may need to include others. For each agency the review will consider whether their actions were in accordance with relevant legislation, regulations, guidance and the agency's policies and procedures. It will include:

- the actions taken by respective agencies over the period of time from when concerns first emerged of the risk or threat of domestic violence in the family, and specifically in relation to the incident leading to the homicides.
- any personal or family history relating to the perpetrator and/or victims which is relevant to the homicides and to the review.

- The experiences and perspectives of individual family members (see below) insofar as they are willing to contribute these to the review.
- relevant information from any previous internal or external inquiry or review undertaken by any agency in this case.
- the nature, outcomes and findings of the inquests in this case.
- relevant information and findings from other enquiries or reviews where similar features exist to this case.

The review will then make judgements as to whether the practices of each agency were in accordance with the national and local requirements, reach conclusions about what, if anything, should have been done differently and, where appropriate, make recommendations about what actions are required by each agency and by WBSCP to address the findings of the review. In addition, it may make recommendations regarding any implications for national policy arising from the case.

b) Family involvement

Family representatives should have an involvement in the review process. Contact with the family will be either with the independent chair or with the WBSCP Chair depending on the issue. If the matter relates to the Terms of Reference or the resulting Action Plan then this would be a matter for the WBSCP to consider and contact would be through the WBSCP Chair. If the matter related to the Review Framework or to the review procedure, then contact would be through the independent chair.

It is the intention of both the independent chair and the WBSCP Chair to meet the family prior to the review starting so that there is clarity regarding roles, responsibilities, the Review Framework and procedure, and in particular how the family will be involved. There is a clear commitment by the independent chair to maintain regular contact with the family during the review. In addition it is appropriate that there should continue to be meetings with the family by the Chair of WBSCP, and the independent chair together, at key stages. A first meeting, prior to the review commencing, has already taken place. A further meeting will take place at the end of the information gathering phase of the review. A final meeting will be prior to the report going public.

It is not appropriate that the family should have any part in the material content or process of the review once it has started and until such time as the independent chair is in a position to share a copy of the draft overview report with them.

It is imperative that the independent chair maintains a strongly independent position in relation to all interested parties, both to all agencies involved with the review and to members of the family.

It is appropriate that members of the Pemberton family should be invited individually by the independent chair to provide information to the Review both in writing and in person (with a friend or representative) to say anything they wish about their experiences and perspectives of events in the period up to November 2003 and beyond. In the event that such meetings are held, these will be transcribed and a copy of the transcript provided to the individuals who attend.

Additionally, the independent chair will seek from the family any written chronology of events, reports or contacts they have compiled of the period prior to the deaths of Julia and William.

c) Individual agency management reviews

This Review will adopt broadly the processes used for serious case reviews in relation to children, including that of initial management reviews by each agency and a final overview report from an independent chair. It will learn also from mental health homicide reviews and follow the consultation guidance released by the Home Office in June 2006._General expectations and requirements of all agencies, and specific expectations and requirements of individual agencies will be set out by the independent chair, assisted by expert advisers.

Each individual agency will be asked to prepare a full and accurate report of their involvement with any or all of Julia, William or Alan Pemberton in relation to the issues covered in these terms of reference. Initial guidelines for these agency management reviews are:

1) The person leading the review process and writing the management review report for each individual service will not have been directly concerned with the family, or been the immediate line manager of any practitioner(s) or professionals involved. Agencies should consider whether this person should be a person external to the agency.

2) The individual management review report will be accepted by a senior officer of the agency before submission to the independent chair. This person should be a member of (or be represented on) WBSCP.

3) Each agency will secure records relating to the case and guard against loss or interference.

4) The process looks openly and critically at individual and organisational practice to see whether the case indicates that changes could and should be made, and if so, to identify how those changes will be brought about.

5) Upon completion of the management review report there may need to be a process for feedback and debriefing for staff involved, in advance of completion of the overview report by the independent chair.

6) There may also be a need for a follow-up feedback session if the independent chair's overview report raises new issues for the agency and staff members.

7) Case reviews are not a part of any disciplinary inquiry or process, but information that emerges in the course of reviews may indicate that disciplinary action should be taken under established procedures.

8) Where staff or others are interviewed by those preparing management reviews, a written record of such interviews should be made and this should be shared with the relevant interviewee.

9) Strict rules of confidentiality should be maintained by agencies during the course of their management review processes.

The independent chair and independent external expert advisers, on receipt of the individual management reviews, may wish to review individual agency case records and internal reports personally, or meet with review participants. In the event that such meetings are required these will be transcribed and a copy of the transcript provided to the individuals who attend in order to confirm factual accuracy..

More detailed guidance about the management review process will be given, and discussions had with individual agency lead persons by the independent chair and expert adviser(s) (as appropriate). It may be appropriate for there to be a meeting(s) with individual agency lead persons all together.

Given the time that has elapsed since November 2003 some of the agencies. have already completed management reviews. The independent chair will consider whether these management reviews meet the requirements as set out in the Guidance for Domestic Homicide Reviews under the Domestic Violence, Crime and Victims Act 2004 (June 2006) and therefore can be submitted as evidence.

d) Independent chair's overview report to WBSCP

The overview report of the review will be prepared by the independent chair, on the basis of critical scrutiny of individual agency reports by the independent chair and independent expert external advisers.

The overview report will collate the information in a chronology, analyse all available information and draw conclusions about whether the policies and practices were in accordance with statutory requirements and good practice at the time.

It will summarise what, in the view of the independent chair and independent expert advisers, are the lessons to be drawn from the case and how these lessons should be translated into recommendations for action. Recommendations will include, but will not be limited to, the recommendations made in the individual management reviews.

If possible, review recommendations will be few in number, focused and specific, and be capable of being implemented.

If there are lessons for national, as well as local policy and practice (as is expected by the terms of reference of this review) then they will be highlighted.

A draft of the Overview Report (or relevant sections) and the summary report will be made available confidentially to the WBSCP with a view to checking facts and hearing any other views about the texts. A copy of the text within this Report that relates directly to the comments made by the Family will be made available to the Family on the same basis. Comments on these drafts will be referred back to the Independent Chair by the WBSCP and the Family. The final report will then be submitted to the WBSCP Chair for the wider Partnership first and then made available to the Family. A meeting will take place with the Family to discuss the report prior to publication.

e) Timescale

It is suggested that the final report be ready by the end of May 2007.

f) Publication

It is anticipated at this stage that the final Overview Report and Executive Summary will be published. There will be further discussion about the status of individual management review reports. The WBSCP Chair and the independent chair will seek further advice in relation to data protection and freedom of information, and consult with relevant parties, including family members.

The nature and form of publication will be determined by the Chair and membership of WBSCP. The decision on publication will be taken having regard to the views of the independent chair.

Appendix B

Timeline: Police Domestic Violence Policy (England and Wales) 1990 – 2005

Date	Policy/legislation/training
1990	**Home Office Circular 60/1990 Domestic Violence**: issued to all police forces in England and Wales advising police to ensure that "*all police officers involved in the investigation of cases of domestic violence regard as their overriding priority the protection of the victim and the apprehension of the offender*". The circular also emphasised the importance of multi-agency working, establishment of domestic violence units, reviewing of recording policy and ensuring that officers were aware of the power of arrest and providing support to the victim.
1991	**R v R (1991) 2 WLR 1065**: A husband's legal immunity from the rape of his wife was extinguished.
1995	**Home Office and Welsh Office (1995) inter agency circular/inter agency coordination to tackle domestic violence**: issued to all agencies involved in tackling domestic violence including the police.
1996	**Family Law Act 1996**: changed the legal framework relating to civil injunctions in the context of family law.
1997	**Protection from Harassment Act 1997**: introduced the offence of harassment and power of the court to issue restraining orders on conviction.
1998	**Crime and Disorder Act 1998**: established the framework of multi-agency Crime and Disorder Reduction Partnerships tasked with conducting audits of local crime and disorder and agreeing a local strategy. Section 17 of the Act requires the police (in partnership with local authorities) to exercise all their functions "*with regard to the effect on the need to prevent crime and disorder in their areas*". Domestic violence falls clearly within these duties.
1998	**Human Rights Act 1998**: introduced positive obligations to protect life and protect victims against inhuman and degrading treatment.

1999	**Youth Justice & Criminal Evidence Act 1999**: introduced special measures within a court setting, for vulnerable and intimidated witnesses.
2000	**Home Office (2000) Domestic Violence Break the Chain multi-agency guidance for addressing domestic violence**: the guidance includes advice for the police that "*there must be no suggestion that dealing with domestic violence is in any sense 'second class' police work*" and that specialist officers should maintain close links with other units dealing with issues such as child protection.
2000	**Home Office Circular 19/2000 Domestic Violence revised circular to the police**: this circular provided more specific and detailed information to the police and reflected changes in legislation since 1990 and the findings of recent research.
2002 October	**Centrex Modular Domestic Violence Training 2002**: introduced a modular training programme with modules for call takers, first response officers and more specialist staff.
2003 November	**Centrex Modular Domestic Violence Training 2003**: updated the 2002 programme and added a module for a multi-agency audience.
2004 February	**HMCPSI/HMIC (2004)** ***Violence at home, a joint thematic inspection of the investigation and prosecution of cases involving domestic violence***: includes a number of recommendations relating to policing and prosecuting domestic violence cases.
2004	**Domestic Violence Crime and Victims Act 2004**
2004 November	**ACPO (2004) guidance on investigating domestic violence**: guidance includes a clear focus on the investigation of criminal offences relating to domestic violence.
2004	**Home Office Violent Crime Unit(2004) Developing Domestic Violence Strategies – A Guide for Partnerships.**
2005 January	**ACPO (2005) guidance on identifying, assessing and managing risk in the context of policing domestic violence**: includes a list of risk

	factors and general information about the basic principles of identifying, assessing and managing risk in domestic violence cases.
2005 January	**Adoption and Children Act 2002, section 120 implemented**: amends section 31 of the Children Act 1989 to include the following in the definition of harm: "impairment suffered from seeing or hearing the ill treatment of another" e.g. witnessing domestic violence.
2005 January	**Centrex Modular Domestic Violence Training 2004**: updated the 2003 programme and added a module jointly produced with the CPS and intended to be delivered to CPS prosecutors and CPS staff.
2005 February	**ACPO (2005) policy on police officers who commit domestic violence related criminal offences**: clearly establishes the principle that evidence that a police officer has committed criminal offences relating to domestic violence is not compatible with a police service that has public confidence.
2005 March	**ACPO (2005) guidance on investigating child abuse and safeguarding children**: guidance includes a clear focus on the investigation of allegations of criminal offences relating to child abuse and the need to identify concerns for children which are managed in the multi-agency structure for safeguarding children.
2005 June	**ACPO (2005) Practice Advice on Investigating Harassment: this provides information on harassment including that related to domestic abuse.**
2005 September	**ACPO (2005) Guidance on Investigating Serious Sexual Offences: includes specific investigative guidance on investigating domestic or intimate partner sexual offences.**
2005	**Home Office (2005) Domestic Violence: A National Report: this developed a national delivery plan for services relating to domestic violence.**
2006	**H M Government (2006) Working Together to Safeguard Children: A Guide to inter-agency working to safeguard and promote the welfare of children.**
2007	**ACPO (2007) Police Officers and Police Staff that are Victims of**

	Domestic Abuse
2007	**Home Office (2007) National Domestic Violence Delivery Plan: Annual Progress Report 2006-2007.**
2008 April	**ACPO (2008) Guidance on Investigating Domestic Abuse: this revised and updated the ACPO (2004) Guidance on Investigating Domestic Violence.**

Appendix C

What should a victim of domestic violence or harassment have expected from the police service in 2002 and 2003 when making an allegation (Home Office circular 19/2000)

What should a victim of domestic violence or harassment have expected from the police service in 2003 when making an allegation?

The Home Office Guidance " Domestic Violence (2000): Break the Chain Multi Agency Guidance for Addressing Domestic Violence" provides a summary of how various public agencies should fulfil their obligations when dealing with domestic violence, and how they should undertake joint working.

Although the above Home Office guidance provided general information on the multi agency response, the Home Office Circular 19/2000 (which replaced the HO Circular 60 of 90) provided more specific and detailed information to the police.

In 2003, police forces would have been expected to use the Home Office Circular 19/2000 as their main document when determining their response to incidents of domestic violence.

Below is a copy of the Home Office Circular 19/2000 in its entirety.

Domestic Violence: Revised Circular to the Police

Home Office Circular 19/2000

12 May 2000

Dear Colleague,

In March 2000, the Deputy Home Secretary, the Rt Hon Paul Boateng MP, launched the *Multi-agency Guidance for Addressing Domestic Violence*  (file size 331 Kb), as part of the Government's "Living without Fear" campaign to tackle violence against women.

In this country, two women a week are killed by a current or former partner; around 25% of women experience domestic violence at some point in their lives; and domestic violence is the most common single type of violence against women, accounting for about a quarter of all recorded violent crime.

The Government is clear that one's home should be a place of safety and that domestic violence therefore involves a serious breach of trust. Domestic violence involves crimes of violence which are serious in themselves, but they are often aggravated further by that serious breach of trust. That is why the Government is taking such strong action against them. It must not be forgotten that exactly the same considerations apply when women are the perpetrators and men the victims, and in same sex relationships.

The *Multi-agency Guidance* was addressed to the police amongst others. Before that, the most recent guidance specifically to the police was contained in HO Circular 60 of 1990. As the *Multi-agency Guidance* indicated, HO officials have been working with ACPO on a revision of that Circular to provide more specific and detailed information. This would reflect changes in legislation since 1990, the findings of recent research and current thinking on policy and practice. A new Circular has now been agreed and is attached to this letter.

The Circular covers the following areas:

- the nature and extent of domestic violence;
- the definition of domestic violence;
- legal remedies;
- the role of the police and other agencies;
- force policy;
- the initial response to an incident;
- action after an incident;

- the use of bail;
- reports to the CPS;
- support for victims;
- withdrawal of complaints;
- training;
- problem solving;
- the responsibility of managers; and
- police powers.

Ministers recognise and frequently pay tribute to the progress which many police forces have made in addressing domestic violence effectively, reducing repeat victimisation and providing an appropriate service to survivors. It is important to maintain and develop this work. They commend this Circular for careful study by both operational officers and their managers, with a view to further improvement through increased awareness, knowledge and understanding and through the implementation of its recommendations. It should be of particular value in helping police forces' performance against Best Value Performance Indicators 153 and 154 on domestic violence arrests and domestic violence repeat incidents.

Hugh Marriage OBE

General enquiries about this circular should be addressed to Shirley Clarke, Policing and Crime Reduction Group, Home Office, 50 Queen Anne's Gate, London SW1H 7AT, telephone (020) 7273 2858.

Home Office Circular - Domestic Violence

(Revision of Home Office Circular 60/90 - Domestic Violence)

1. Nature & Extent of Problem

One of the most fundamental provisions in the Human Rights Convention is Article 2 which states that everyone has a right to life. It also places on the state a positive duty to protect life.

Domestic violence encompasses a wide range of abuse, the most serious resulting in murder. It includes physical, sexual, emotional and financial abuse. Every 3 days a woman is killed in a domestic violence incident. Altogether there were in 1995 an estimated 6.6 million cases of domestic violence, involving both women and men, and one in four women have suffered such abuse since age 16 (HO Research Study 191, *Domestic Violence: findings from a new British Crime Survey self-completion questionnaire*).

Research has shown that domestic violence is likely to become more serious and more frequent the longer it is allowed to continue. Victims of domestic violence have often been abused over a long period of time before they call the police, though they may not reveal this fact on police attendance.

Many people are trapped in situations which they cannot readily leave. This may include a relationship in which they are financially dependent. In addition, they may fear being ostracised by other extended family members, losing their children or bringing discredit onto the family.

Domestic violence is a serious crime which is not acceptable, and should be treated as seriously as any other such crime.

A quarter of all reported violent crime is domestic violence. However, there is still a large amount of under reporting of this type of crime to the police. Domestic violence occurs regardless of the victim's class, religion, sexual orientation or ethnicity. It is experienced by both women and men. The majority of violent and repetitive

assaults are however perpetrated by men against their female partners. By comparison with men, women are more likely to suffer domestic violence over a lifetime, more likely to suffer repeat victimisation, more likely to be injured and seek medical help, more likely to receive frightening threats and more likely to be frightened and upset. The practical consequences for women, in terms of accommodation, finances and childcare responsibilities are also likely to be more serious.

The dynamics of abusive relationships are complex. Generally, one individual tries to assert domination over other individuals. Domestic violence is an abuse of power and control, and the process of repeated intimidation, violence and abuse results in vulnerability. This is particularly pertinent where people who are physically and mentally ill, or are elderly, are concerned.

Many people, having contacted the police, then state that they do not wish the police to take any formal proceedings. This can relate to concerns about: the fact that they may lose their partner; financial stability; children; possessions; home; family; employment; support from the extended family; or, most importantly, the possibility or likelihood that they may be subjected to more abuse.

Police officers need to understand this, but it should not detract from the police role which is to ensure the safety of the victim and any children, and to hold the offender accountable when there is evidence of a crime.

Research has shown that children who are either present at or hear incidents of domestic violence can be deeply affected (this could include behavioural, physical and psychological effects). In 90% of incidents occurring within families, children are in the same or next room, which can cause distress and confusion. Some children may not display any visible reaction but one should not assume they are unaffected. Where there is evidence of domestic violence in a family, the likelihood of child abuse is greatly increased.

There is also a correlation between pregnancy and domestic violence, though this may be because young women are a group at higher than average risk of domestic violence, and pregnant women fall disproportionately into this group. Evidence also suggests that the risk of violence against women is increased in separating couples, in poor households and in situations where women lack their own economic resources and are dependent on their partners.

The police cannot deal alone with domestic violence. They must work with the other statutory and voluntary agencies including the Crown Prosecution Service, probation service, judiciary, medical profession, housing departments, social services departments, Women's Aid, Refuge, other local women's organisations, Victim Support and other agencies such as Shelter.

In implementing the Crime and Disorder Act 1998, most local crime reduction partnerships set up under the Act have included domestic violence in their strategies following their audits. The Government has recognised the need to establish performance indicators which encourage the police not only to take positive action but also to find ways of reducing the repeat victimisation of people in this area.

The Best Value performance indicators required by the Home Office are:

- Percentage of reported domestic violence incidents where there was a power of arrest, in which an arrest was made relating to the incident.

- Percentage of victims of reported domestic violence incidents who were victims of a reported domestic violence incident in the previous twelve months.

Through the local crime reduction partnerships, and other local fora, strategies should be developed to stop people becoming victims of domestic violence. Consideration should be given to the use of accredited perpetrator programmes and provision of appropriate support services for victims. Even when there is enough evidence to charge a person, the victim has many needs. These may include: access to safe temporary and permanent housing; arranging a change of schooling; financial assistance; obtaining civil injunctions; and, having people to share their fears/problems with. Where the alleged offender is not charged, these needs may be greater.

It should be the aim of the partnership to provide sufficient intervention, support and assistance to increase and as far as possible ensure the safety of victims. To address domestic violence effectively an appropriate response is needed from all agencies, not only those within the criminal justice system.

2. Definition

Domestic violence is not a specific statutory offence. The term is used to describe a range of criminal offences - and sometimes sub-criminal behaviour – occurring in particular circumstances. There are therefore many different definitions. The two most significant nationally are as follows:

For use in force returns to HMIC,

> *"The term domestic violence shall be understood to mean any violence between current or former partners in an intimate relationship, wherever and whenever it occurs. The violence may include physical, sexual, emotional or financial abuse."*

For the purposes of the Best Value performance indicators for 2000/1,

> *"Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender".*

These are important for national statistical purposes, but are not intended of themselves to affect police operational policy or to prevent the local use of different definitions where these are thought appropriate for particular local circumstances and purposes. A shared definition or understanding is however important amongst agencies working together locally, both to ensure effective operations and to ensure meaningful and comparable data for the assessment of progress and use of resources.

The issue of definition is discussed further in the *Multi-agency Guidance for Addressing Domestic Violence* (file size 331 Kb), issued by the Home Office in March 2000. The *Guidance* also contains other material which officers may find useful to read in conjunction with this circular.

3. Legal Remedies

There have been several developments in both the criminal and civil law since the last Home Office Circular on domestic violence (60/90). Police officers must perform their role diligently and professionally, being aware of their legal powers when attending domestic incidents.

When deciding on the appropriate charge for a crime relating to an assault, the CPS charging standards must be adhered to. This should not detract from the power of arrest available initially. For instance, if a person has a bruised eye, there will be a power of arrest for actual bodily harm, although the charge preferred will be one of common assault.

Police powers and civil remedies to deal with domestic incidents are wide ranging, and some are listed at Appendix A.

4. Role of the Police and Other Agencies

The duty of police officers when attending a domestic incident is to protect the victim and children (if applicable) from any further violence. Where a power of arrest exists, the alleged offender should normally be arrested. An officer should be prepared to justify a decision not to arrest in the above circumstances. The second duty is to hold the offender accountable.

In pursuing an investigation, officers must look at the entire incident, not just the oral or written evidence of the victim. Research shows that enhanced evidence gathering increases the likelihood of successful prosecutions especially in cases where victims would be unlikely to give evidence

The importance of liaising with statutory and voluntary agencies who can supply other forms of help and support should also not be underestimated. Such agencies include doctors, nurses, midwives, social services, housing authorities, victim support groups, refuges for victims, rape crisis services, other community groups, and local solicitors and citizens' advice bureaux. There are 24 hour national helplines for victims of domestic violence, along with other victims' helplines. Victims may however not know of these sources of help, and police officers should ensure that details are automatically furnished to them. There is useful information in the Government leaflet *Domestic Violence – Break the Chain*, copies of which should be kept available.

There is no single structure that can be cited as being the best way of facilitating the policing of domestic violence. Where domestic violence units are in place, it is important to identify clearly the role of such units and decide what staff are required. There are several roles to be performed when dealing with such incidents in

domestic violence units: following up investigations of the offence; supporting the victim; keeping the victim regularly informed; and liaising with statutory and voluntary agencies.

It is important that the Police Service use the relevant skills of their staff, which would include the investigation of offences, and do not try and perform the roles of other agencies, in particular counselling roles. Administrative functions should be performed by a civilian member of staff. As with any other role, staff should be given job descriptions for their respective roles and have an identified supervisor.

Chief Officers and managers must show strong leadership. They must also be committed to dealing effectively with domestic violence incidents, giving appropriate support to their staff. Research has shown that an apparent lack of direction or oversight of domestic violence matters on the part of headquarters can communicate itself down through the command structure resulting in domestic violence work receiving low priority.

The Crown Prosecution Service has a specific policy for prosecuting cases of domestic violence, which is set out in its 1995 public statement on the issue (currently under revision). Forces should liaise with the Chief Crown Prosecutor of CPS when formulating policy, to ensure consistency of aims and approach. Joint Performance Management meetings between the police and the CPS provide an ideal forum to resolve issues relating to file preparation and timeliness.

5. Force Policy

Force Policy on domestic violence should be issued. This should give guidance to officers on how the force prioritises the issue, what standards of investigation are expected and procedures that must be followed. Force policy is integral to the setting of standards and influencing the attitudes and behaviour of officers. The policy should set the direction and should include the following points:

- a statement that the main duty is to protect the victims and, if applicable, any children from further abuse;
- the need to investigate the incident fully;
- provisions as to initial scene management and minimum investigative standards;
- a definition of repeat victimisation;
- a statement of relevant legislative powers;
- guidance for dealing with police officers and civilian staff who may themselves be victims or perpetrators of domestic violence;
- the importance of an inter-agency/partnership approach;
- participation in the setting up, and the meetings, activities and projects of domestic violence fora;
- the importance of increasing awareness about why domestic violence is different from other forms of violence (dynamics of abusive relationships);
- guidance regarding awareness training for both police officers and support staff, particularly control room staff and enquiry office staff;
- highlighted minority group issues;
- job descriptions of Domestic Violence Officers, if applicable;
- the importance of monitoring and evaluating the policy regularly;
- the importance of comprehensive record keeping;
- awareness of rates of domestic violence; and
- protocols for referrals to other agencies

6. Initial Response to Incidents

A manual will be produced by ACPO which provides guidance on how to investigate crimes of violence including domestic violence. It will set minimum standards of investigation and provide an aide memoir to officers attending the scene.

Further details of the police initial response to domestic violence can be found in Appendix B.

7. Action after the incident

Many victims of domestic violence have stated that they did not wish to feel responsible for taking their assailant to court. However, they do not want to be the subject of further violence. The police must remain impartial and uphold the law. If the evidence is present, whether or not including evidence from the victim, then a charge or summons should be preferred, unless there are exceptional reasons. Such reasons should be recorded. The decision on prosecution is for the CPS, who will act in line with their published policy statement, taking account of the realistic possibility of a conviction and of the public interest. If there are exceptional reasons why a prosecution does not take place, again these must be recorded. Officers must bear in mind too that a victim may decide to provide a statement and give evidence at a later stage. In all cases a victim is entitled to a sympathetic response and proper support.

When offenders have been arrested for Breach of the Peace, consideration should also be given to placing them before the next available court for binding over, rather than merely releasing them from custody.

8. Use of Bail

If a person has been charged with an offence, consideration should be given to applying for a remand in custody if applicable. If there is no power to remand the suspect in custody, police officers should give serious consideration to making use of conditional bail. This can enable the police to ensure his attendance at court and discourage him from attending the victim's house, or going within a certain distance of the victim. Breaking such bail conditions will enable officers to arrest the offender again.

Bail can be opposed, or conditions attached if it appears that it is necessary to prevent the suspect from:

(i) failing to surrender to custody;
(ii) committing an offence whilst on bail; or
(iii) interfering with witnesses or otherwise obstructing the course of justice, whether in relation to himself or any other person.

If there is not enough evidence to charge a suspect, consideration should be given to releasing the suspect under Section 47(3) of the Bail Act 1976 to enable enquiries to be completed. This will allow time for other witnesses to come forward. The victim may also reflect on the incident and provide a statement.

When suspects have been bailed from a police station, officers should ensure that the victim is informed of this fact. They should also take what steps they can to minimise the risk of further violence to the victim eg by assisting in the deployment of panic alarms, mobile telephones, and the development of repeat victimisation schemes, regularly visiting the victim's house or contacting refuges and helping if necessary with arrangements for emergency accommodation. Research has shown that it is at the point of seeking help and support, or leaving the abuser that the victim is at most risk of being subjected to further violence.

9. Reports to the Crown Prosecution Service

In order that the Crown Prosecutors can make an informed decision about a particular case, the police must provide them with as much information as possible. This also enables the prosecutors to prosecute the case effectively and ensure the protection of the victim and any children when applying for a remand in custody. Information that is of use includes:

- the history of the relationship, particularly if there has been violence in the past;
- the victim's injuries (medical, photographic and written);
- if the offender used a weapon;

- if the offender made any threats since the attack;
- if the offender planned the attack;
- the effect on any children in the household;
- the chances of the offender offending again;
- the status of the victim's current relationship with the offender;
- the effect on that relationship of continuing with the prosecution against the victim's wishes and
- victims' views on their own and their children's personal safety if a prosecution does/does not follow.

In some circumstances this information will not be readily available, but it should be passed to the CPS as soon as possible. It is important to keep the CPS updated of any change in circumstances.

10. Support for the victim

In order to give the best support, the police service must maintain regular contact with victims, keeping them informed about developments in the case, bail updates, location of offender, and details of court appearances. If it is necessary for victims to move from their home, the police should, wherever possible, take them to where they want to go, such as a friend's or relative's house or a refuge. If there is a need for victims to return home to collect children or belongings and there is a fear of further violence, the police should discuss with them to ascertain how best to make arrangements for the visit to take place. Police should accompany victims if this is considered the best arrangement for a visit. In some circumstances however, the presence of a police officer may inflame the situation and it might be more appropriate for the victim to be escorted by a social worker or a relative. There would of course be no reason why the police could not be nearby to provide assistance if required (perhaps connected via a mobile alarm trigger). The police should provide details of other voluntary and statutory agencies that are in a position to support the victim, regardless of whether criminal proceedings are pursued. Such agencies include housing and social services departments, hospital casualty departments, citizens advice bureaux, local women's refuges, rape crisis services, victim support schemes, VSS and legal advice centres. Officers should also be aware of support groups aimed specifically at minority groups.

If a victim is staying in a refuge, it is vital that this fact is not disclosed to the suspect, as this further endangers the victim and often results in the suspect harassing the staff at local refugesThe Youth Justice and Criminal Evidence Act 1999 provides measures designed to help young, disabled, vulnerable or intimidated witnesses giving evidence in criminal proceedings. These include physical measures to reduce the stress of giving evidence at trial such as
:

- screens, to ensure that the witness does not see the defendant;
- allowing the interview with the witness, which has been video-recorded before the trial, to be shown as the witness's evidence-in-chief at trial;
- allowing a witness to give evidence from outside the court by live television link;
- clearing people from the court so that evidence can be given in private; and
- allowing a witness to be cross-examined before the trial about their evidence and a video recording of that cross-examination to be shown at trial instead of the witness being cross-examined live at trial.

The measures were made available to help witnesses (other than the defendant) who might otherwise have difficulty giving evidence in criminal proceedings or who might be reluctant to do so. Victims of domestic violence are likely to fall into this category so consideration should be given to how their evidence should be obtained and presented.

(NOTE: These powers will be enacted in late 2000)

Minority Groups
All victims of crime should be treated according to their individual needs. Investigating officers should avoid

making assumptions regarding the nature of those needs.

Minority ethnic and religious groups

It is sometimes claimed by suspects that their religious beliefs or community values support violence. This is not the case.

For people who do not speak English or for whom English is not a first language, an appropriate interpreter should be used.

People may also fear or have been threatened that their children will be abducted and taken to another country. There are a number of voluntary organisations that have specific expertise in dealing with domestic violence in particular communities. Officers should consider this resource when investigating such offences.
There may be instances when the use of Family Liaison Officers is needed.

Gay and Lesbian Relationships

When dealing with domestic incidents involving people in same sex relationships, it is important that the police investigate the allegation without making any stereotypical assumptions regarding the relationship.
The person(s) who have custody rights relating to children may not be initially obvious. Officers should not make assumptions regarding such rights.

As with heterosexual domestic violence, officers should be careful about making assumptions about responsibility for violence in relation to physical size, income level and educational background.

11. Withdrawal of victim's complaint

There are numerous reasons why victims seek to withdraw their complaint of domestic violence. They may be threatened by their abuser; too frightened; persuaded by other family members; reconciled with their abuser; choosing to proceed through the civil courts; or feel that they do not wish to give evidence in court and go through the judicial process. There are powers that allow the CPS to introduce the victim's evidence without requiring attendance at court.

A full withdrawal statement should be obtained from the victim if criminal proceedings have commenced. Such statements should include:

- details of the alleged crime;
- the reasons for wishing to withdraw the complaint;
- whether the victim is saying the offence did not occur or not wishing the investigation or prosecution to continue;
- whether any pressure, directly or otherwise, has been placed on the victim;
- who they have discussed the case with;
- whether any civil proceedings have been instigated; and
- the impact on the victim's life and that of any children;

This information will enable the CPS to make an informed judgement as to whether the case should still proceed. While a victim might be compelled to give evidence, this rarely happens and officers should not use the possibility as a threat to put pressure on the victim and cause further distress.

Ordinarily, the CPS should consult the police if they are considering discontinuing the case. However, on occasion this may not be possible, eg if the decision has to be made quickly at court.

If there is any suggestion that there has been interference with the victim, the police should consider arresting the suspect under Section 51 of the Criminal Justice and Public Order Act 1994. This Act created two new offences: intimidating a witness, and harming or threatening to harm a witness.

If a statement has been obtained, but there is a reluctance from the victim to give evidence, there is legislation that can be used to introduce the victim's evidence, without necessitating the victim's attendance at court.

Section 23 of the Criminal Justice Act 1988 allows the CPS in some circumstances to use the victim's statement as evidence without calling the victim to court. Recent cases have decided that the victim does not have to prove that he or she is afraid. The proof can be from someone else, for example, a police officer. It is enough that the victim is afraid because of the original offence or has become afraid after the offence because of the possibility of having to give evidence about it.

Every offence which is a crime and committed during a domestic incident should be recorded unless the victim states that a false complaint has been made, or it is shown to be a false complaint and there is no other evidence to support that it was a crime.

12. Training

All personnel who are likely to come into contact with victims of domestic violence, including control room staff and enquiry office staff, should receive training. This should cover awareness issues, policy, good practice, new initiatives and how to investigate such incidents. It could be linked with other inter-agency training. Key issues include the following: violence is a choice, not an uncontrolled reaction; many people wish to remain in the relationship, but without the violence; offenders may well minimise their behaviour or state that it is acceptable in their religion/culture.

13. Problem Solving

A successful outcome in how the police deal with domestic incidents should not be restricted to the charge and conviction of an offender. The safety of the victim is paramount. Every effort should be made to ensure that the victim is not subjected to further abuse. The police may assist in the deployment of panic alarms, mobile telephones and the development of repeat victimisation schemes. From a problem solving perspective, the offender is at the heart of the problem and issues in relation to repeat offending, whether within the same relationship or moving on to abuse further partners should be considered. All interested agencies, through a forum such as a local crime reduction partnership or domestic violence forum, should look to develop protocols for the sharing of information with others. Joint training can also benefit all concerned as people understand the roles of other agencies and what services can be provided to victims.

14. Responsibility of Managers

The command team should restate their commitment to the quality of the force's response to domestic violence. In turn, divisional commanders should establish and document lines of accountability for their domestic violence response. There must be a clear direct line of supervision for domestic violence officers. This area of policing is stressful and mechanisms should be in place to help alleviate as much stress as possible. Divisions should develop job descriptions for the domestic violence officer role which reflects the priorities set by the force.

15. Summary

Chief Officers should ensure that all members of their organisation who deal with domestic violence incidents are aware of the dynamics of such relationships, cultural and religious issues and the reason why such incidents differ from other violent offences. In addition, they must be appropriately trained to investigate the incidents professionally. The safety of the victim is of paramount importance but officers should not lose sight of their responsibility to investigate the matter thoroughly. Chief Officers are invited to:

- assess whether their force response is appropriate;
- ensure that investigations are carried out and are of a consistent quality, and that officers are held accountable for their actions if they fail in their service delivery;
- define a repeat incident and have a policy on dealing with such incidents relating to domestic violence;
- produce a domestic violence policy that is communicated properly to staff and is monitored and evaluated regularly to ensure that it remains effective;
- if domestic violence units are in place, ensure that there are clear job descriptions for the staff, a clear

line of supervision and they are undertaking the correct role;

- ensure liaison with other agencies is in place, to provide a constructive response to victims;
- ensure that domestic violence is appropriately addressed in local crime and disorder audits and strategies under the Crime and Disorder Act 1998;
- participate in domestic violence fora;
- link domestic violence information with child protection data, as there is routine cross over of information;
- develop appropriate and sensitive strategies with social services and other organisations in recognition of the link between domestic violence and child protection issues;
- produce meaningful performance indicators to concentrate efforts and ensure that policy is adhered to (i.e. an arrest performance indicator);
- ensure the domestic violence records are accessible 24 hours a day;
- produce a service level agreement with the Crown Prosecution Service for domestic violence incidents; and
- ensure staff are aware of how to deal with incidents involving police officers and support staff as victims or offenders.

16. Conclusion

The police service has significantly improved its response to domestic incidents in the last decade. There will be increasing reports of such offences as victims become more confident in how they are treated by the police. It is imperative that the police deal effectively with domestic violence from the beginning. Not only will this provide a better standard of service to the victim but also change attitudes so that domestic violence is no longer regarded as acceptable.

APPENDIX A - Police Powers

Common law

Under Common Law, a Constable has the power to enter premises to prevent or deal with a breach of the peace, and the power to arrest to prevent a breach of the peace.

Police and Criminal Evidence Act 1984

Under section 17(1)(b) of the Police and Criminal Evidence Act 1984, a Constable may enter any premises for the purpose of arresting a person for an arrestable offence, which includes assaults occasioning grievous or actual bodily harm or wounding.
Under section 17(1) (e) of PACE, a Constable may also enter premises for the purpose of saving life or limb or preventing serious damage to property.
Under section 24 of PACE, a Constable may arrest any person who is suspected of having committed an arrestable offence, or is about to commit one, i.e. an offence which attracts a maximum of five years imprisonment or more, or where the penalty is fixed by law, or for certain other specified offences including indecent assault on a woman.
Under section 25 of PACE, a Constable may arrest a person where there are reasonable grounds for believing it is necessary to prevent any physical injury being caused to another or to protect a child or other vulnerable person. The general powers of arrest under Section 25 may also apply in appropriate circumstances.

Criminal Justice Act 1998

Section 23 (3) (b) enables the submission of a written statement in place of oral evidence so that the victim need not appear in court.

General Offences

Section 39 of the Criminal Justice Act 1988 states that a person is guilty of an offence of common assault if he intentionally or recklessly caused another person to apprehend the immediate application to himself of unlawful violence.
Section 47 of the Offences Against the Person Act 1861 states that it is an offence to assault any person, thereby occasioning them actual bodily harm.
Section 1(1) of the Sexual Offences Act 1956 provides that it is an offence for a man to rape a woman or another man. A man commits rape if:

a) he has sexual intercourse with a person (whether vaginal or anal) who at the time of the intercourse does not consent to it; and
b) at the time he knows that the person does not consent to the intercourse or he is reckless as to whether the person consents to it.

Section 14 of the Sexual Offences Act 1956 provides that it is an offence for a person to make an indecent assault on a woman. An indecent assault is an assault which in itself, or taken in conjunction with the surrounding circumstances, is capable of being considered as indecent by right-minded people.
Section 15 of the Sexual Offences Act 1956 provides that it is an offence for a person to make an indecent assault on a man.

(NOTE: the legislation on sexual offences is currently subject to review, and there are proposals for changes to the legislation on offences against the person, though no date for their introduction.)

Section 3(1) of the Public Order Act 1986 provides that a person is guilty of affray if he uses or threatens unlawful violence towards another and his conduct is such as would cause a person of reasonable firmness present at the scene to fear for his personal safety. A constable may arrest any person he reasonably suspects of committing an affray.
Section 1(1) of the Criminal Damage Act 1971 states that a person who without lawful excuse destroys or damages any property belonging to another intending to destroy or damage such property, or being reckless as to whether any such property would be destroyed or damaged, shall be guilty of an offence.
Section 2 of the Protection from Harassment Act 1997 prohibits a person from pursuing a course of conduct which amounts to harassment of another, which he knows or ought to know amounts to harassment of the other. Section 4 created an offence of putting people in fear of violence. Both have a power of arrest. More importantly, in both cases, the court can impose a restraining order on the offender for an indefinite period of time, which if breached, can result in imprisonment of up to 5 years.
Section 51 of the Criminal Justice and Public Order Act 1994 created two new offences:

a) intimidating a witness; and
b) harming or threatening to harm a witness.

Bail

Police Bail - Power to impose conditional bail (Section 27 CJPO Act, 1994)
The police have the power to impose bail conditions on an arrested person following charge. It is important to note that conditional bail may only be imposed where a Custody Officer would have otherwise detained the defendant in custody under the provisions contained in Section 38(1) of PACE following charge.
Where a Custody Officer considers imposing a condition(s) on an arrested person's bail, it can only be done if it appears to the Officer that it is necessary for the purpose of preventing that person:

a) failing to surrender to custody; or
b) committing an offence whilst on bail; or
c) interfering with witnesses or otherwise obstructing the course of justice, whether in relation to himself or any other person.

The Custody Officer effectively has the same powers as a Court to impose conditional bail. Requirements may include a condition of residence, not to go within a specified distance of a person or location, to sign on at a Police Station or the imposition of a curfew. However, the Custody Officer cannot require the arrested person to reside at a bail hostel, or to be available to assist the Court, or to undergo a medical examination.
A further option is for the police to oppose bail on the basis of the grounds listed above and to seek a remand into

custody.

Police Bail without charge

Section 47(3) of the Act states that if the custody officer decides, when the investigating officer brings the person detained before them, that there is insufficient evidence at that stage to charge him but that there probably will be when further inquiries have been made, he may release the person detained on bail, such bail being conditional upon his appearance at a police station at a given time.

Civil Remedies

Section 3 Protection from Harassment Act 1997 allows a court to grant an injunction for the purpose of restraining a defendant from pursuing any course of conduct which amounts to harassment. This is available to any person seeking protection from domestic abuse and harassment and is hence available even if people have never lived together. Breach of such an injunction, without a reasonable excuse, is an arrestable offence. Damages may be awarded for any anxiety caused by the harassment (amongst other things) and any financial loss resulting from the harassment.

Children Act 1989 allows for the exclusion of suspected abusers where children are in need of protection by an exclusion order attached to an Emergency Protection Order or Interim Care Order.
Part IV Family Law Act 1996 created two types of order:
A non-molestation order contains either or both of the following provisions:

(i) a provision prohibiting a person from molesting another person who is associated with the respondent (an "associated person" is one who is living or has lived with the respondent);
(ii) a prohibition from molesting a relevant child.

The presumption is that a power of arrest will be attached, unless there are good reasons not to do so
An occupation order can be made which enforces the applicant's occupation rights against the other person. It may: require a person to leave the dwelling house or part of it; exclude a person from a defined area in which the dwelling house is included; regulate the occupation by both parties; require a person to permit the applicant to enter and remain in that dwelling house or part of it.

APPENDIX B - Initial Response

Identifying violent/non violent incidents

In most cases the first contact between the victim and the police will be by telephone. Members of staff receiving such calls should be sympathetic to the victim, establishing as a priority whether the victim is in any immediate danger. It is important that information is obtained about any aggravating factors eg alcohol consumption, mental illness, any weapons used and what type. Whether there are any other occupants in the house, in particular children and their ages are also significant details. If there is no requirement for immediate attendance, the call must be recorded and action taken. A policy of attending should be invoked for any abandoned 999 calls where domestic violence is suspected.

Check previous history of the relationship

Before an officer attends the scene it would be beneficial to have as much information as possible. This would include details of any previous incidents, what action was taken, any warrants, court orders, restraining orders or injunctions in force, and whether the children are on the Child Protection Register. Computerised logs should be monitored closely by supervisory officers to ensure compliance with force policy. Chief Officers should ensure that arrangements are made with the clerks to the justices to provide details of injunctions or court orders as soon as possible. Where powers of arrest are attached, the relevant paperwork should be in an easily accessible and known location. All reports of domestic violence must be properly recorded. The response should not be downgraded because the incident occurred in a domestic setting. Such incidents should only be 'no-crimed' in line with Home Office guidelines, ie if there is clear evidence that the offence did not occur.

Action at the scene

When police officers attend the scene, they are often confronted with a victim in a very distressed state. It is important that the police do not act as conciliators. On many occasions, the victim has called the police not to take

the matter to court but to make the violence stop. It is inappropriate to ask the victim at this point whether they wish to take the matter to court. The police should not solely focus on the victim, but on the full investigation. The first officer at the scene should secure and obtain as much evidence as possible in order that charges could be preferred at a later stage. The initial investigation should include the following:

- Officers should ensure that they speak to each party separately The victim should be spoken to in a place where the alleged offender cannot overhear as the victim may not feel able to talk freely, if at all;

- If any unsolicited comments are made by the alleged offender, a note should be made of the comments and offered to him/her for signature;

- If a scenes of crime officer is not immediately available, it may be prudent to take some instant photographs of any injuries and of the scene (eg if there has been damaged caused). However, these photographs should not replace scenes of crime photographs and efforts should be made to re-photograph the victim a couple of days later by properly trained personnel when the injuries may be more apparent.

The arrest of an alleged offender may act as a powerful deterrent against their re-offending, at least for some time. More importantly, it shows the victim that they are entitled to, and will receive, support and protection, as well as sending a clear message to the alleged offender that such behaviour will not be tolerated. When an offence has occurred where a power of arrest exists, the alleged offender should normally be arrested. An officer should be prepared to justify a decision not to arrest in the above circumstances. A record should be made by the officer attending the scene explaining why they did not arrest the suspect if a power of arrest exists.
If it is not possible to secure the safety of victims in their home, consideration should be given to removing them to a place of safety with their consent (eg a refuge or relatives).
It may be more appropriate to take the victim to a neutral place to take a statement and receive any medical treatment. The use of victim suites should be considered.

Investigation

Police officers should ensure that all the available evidence is collated in order that an informed decision can be made as to whether a prosecution should be made. Such actions include:

- obtaining a full statement from the victim. The statement should include details of the family composition, the history of the relationship and any other previous incidents, the actual incident, the victim's injuries (physical and emotional), whether a weapon was used, whether anythreats have been made since the attack, whether any children were present and, if so, the effect on them and the victim's view of the future of the relationship. If a victim asks to speak to a female officer, every effort should be made to obtain the services of such an officer;

- obtaining the 999 tape;

- speaking to neighbours;

- speaking with any other potential witnesses;

- considering interviewing children in the household who may have witnessed the incident. The Memorandum of Good Practice should be complied with at all times. The welfare interests of the child should remain paramount; checking children to ensure that they have not been harmed;

- police officers providing comprehensive statements including the condition of the house, and any comments made by the alleged offender or the victim;

- making use of all call recording/intelligence/crime recording systems to establish if this is a repeat incident;

- taking a witness impact statement just before the court appearance if there has been any delay;

- arranging support through victim support agencies; and

- considering the use of Section 23 of the Criminal Justice Act 1988, which allows the CPS to use the

victim's statement as evidence without calling the victim to court

A valuable source of information can be found at Accident and Emergency departments and doctors surgeries. Officers should consider researching such records, as this may show a pattern of historical abuse and injuries sustained. In turn, local crime reduction partnerships should develop protocols relating to the transference of information amongst such agencies.

If a statement has been obtained, but there is a reluctance from the victim to give evidence, there is legislation available to introduce the victim's evidence without the need for the victim to appear in court.
Section 80 of PACE 1984 provides that a wife or husband of the accused is compellable to give evidence for the prosecution if: the offence charged involves an assault on or injury (or threat of injury) to the wife or husband of the accused. Equally, unmarried partners may be required to give evidence under section 97 of the Magistrates Court Act 1980.

It is the decision of the police, not the victim, to charge a suspect.

Appendix D

Extract from Highmoor Cross Review

The Highmoor Cross Review was published on 6 October 2004. The recommendations were:

For Thames Valley Police:

9.1 Operation Saladin should be withdrawn and replaced with a new policy to provide clear guidance to commanders dealing with spontaneous firearms incidents, especially where people have been, or are suspected to have been injured. The policy must highlight the roles and responsibilities of commanders and also provide clear guidance in relation to the transfer of command. It should also stipulate that the command function must, unless there are good reasons for not doing so, be performed near to the scene of the incident. Policy and training needs to provide clear direction and guidance to all firearms commanders in relation to dynamic risk and threat assessing and the making of command decisions under extreme pressure and with limited information or intelligence.

9.2 Firearms training for commanders needs to be co-ordinated across all roles to ensure a consistent interpretation of policy band guidance

9.3 Establish a Head of Profession to lead and provide consistency within the force and to take responsibility for police development and training'

9.4 Technology support in the command and control environment needs to be reviewed urgently to ensure that it is fit for purpose

9.5 Joint training should take place between Thames Valley Police and the Ambulance Service in order to enhance communication, decision making and command protocols. This recommendation has been welcomed by Royal Berkshire Ambulance Service. The issue of joint control rooms and radio systems should also be pursued.

National

9.6 The ACPO Manual of Guidance on the Police Use of Firearms needs to be amended in relation to the 'transfer of command' during a spontaneous firearms incident. It needs to provide clear and unequivocal guidance on the role of a Silver and Gold Commander, when they should be informed of a firearms incident and what is expected of them in the early stagers of an incident. This should be supported by consistent standards in command training.

9.7 Findings from de-briefings of all serious firearms incidents should be disseminated for the benefit of all Commanders and also be used to influence how the police train. This must be a robust process where both best practice and poor practice can be highlighted. Development of a national database of such incidents would greatly assist individual force training and development.

Appendix E

What should a victim of domestic violence or harassment expect from a contemporary police service when making an allegation?

What should a victim of domestic violence or harassment expect from a contemporary police service when making a allegation?

The definition of domestic Violence

The ACPO definition is as follows:

" any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults, aged 18 and over, who are or have been intimate partners or family members, regardless of gender or sexuality." (Family members are defined as mother, father, son, daughter, brother, sister and grandparents, whether directly related, in-laws or step-family.)

The ACPO Guidance on Investigating Domestic Violence 2004 is a comprehensive reference document that builds upon existing best practice and advises on how domestic violence should be policed and investigated effectively. Within its content, the guidance advises how investigations can be improved and how officers can maximise each available opportunity to deliver an evidentially sound case that can be successfully prosecuted. The guidance focuses on every aspect of case handling from initial identification of a domestic violence case to the deployment of officers, through to first response, investigation development and the post arrest management of suspects.

In addition it reinforces that the requirement for positive action in domestic violence cases incurs obligations at every stage of the police response. These obligations extend from initial deployment to the response of the first officer on the scene, through the whole process of investigation and the protection and care of victims and children.

Police forces are expected to use the guidance to determine their response to incidences of domestic violence.

The guidance is divided into 9 chapters and provides a number of checklists for forces. For ease of reference, a summary of each of the chapters is provided below:

Section 1: Identification, Reporting and Referrals

The chapter outlines the way in which reports of domestic violence or reports indicating domestic violence might come to the attention of the police. It also provides information about referrals made from other agencies, both statutory and non statutory, and intelligence in relation to identifying and targeting domestic violence cases.

Section 2: Deployment

The chapter outlines the information that should be recorded by emergency report takers, and considerations regarding the deployment of officers to domestic violence incidents.

Section 3: Fast Track Action

The chapter provides information to officers responsible for the fast track actions or first response. The information provided is not listed in order of priority, but is rather intended to offer information that is relevant to the first police responses in cases of domestic violence.

Section 4: Investigation Development: sources of evidence

The chapter provides officers with information on possible sources of evidence in domestic violence cases. It highlights that officers should focus efforts on gathering evidence in order to charge a suspect and build a prosecution case that does not rely entirely on the victim's statement. It advises that information gained as part of the investigation should be used to identify risk factors and should be fed into any risk assessment processes.

Section 5: Post Arrest Management

The chapter provides guidance on police action after an arrest has been made. Some of the information is relevant in circumstances where an arrest has not been made, but other positive action interventions were put into place.

Section 6: Specialist Investigations and Specialist Advocacy

The chapter provides guidance for those carrying out a specialist domestic violence investigative role. This also includes child abuse investigation officers who are notified of child abuse or protection of children issues in domestic violence cases. It outlines the roles and responsibilities of specialist domestic violence officers and of police domestic violence cordinators. It also focuses upon the dual roles of investigation and protection.

Section 7: Managing Police Officers, Staff and Information Systems

The chapter highlights supervision and management issues of particular significance to domestic violence. It is relevant to all police domestic violence co ordinators and their managers. It is also relevant to ACPO officers nominated with leadership responsibility for cases involving police suspects in domestic violence cases.

Section 8: Multi-Agency Working

The chapter provides an outline of multi agency responsibilities and the variety of ways in which they might be discharged. The section is useful to any officer engaged in partnership working, particularly police domestic violence co ordinators and those working at strategic level in crime and disorder partnerships. In addition, Specialist domestic violence officers in contact with other agencies will also find it useful.

Section 9: Roles and responsibilities of other agencies

The chapter aims to provide a brief outline of the key domestic violence functions of a range of statutory and voluntary sector organisations.

Appendix F

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Appendix G

Interview Schedule

Code	Title	Written evidence	Interview
	FAMILY		
C3	Julia's sister		Y
C4	Julia's brother-in-law (husband of C3)	Y	Y
C5	Julia's brother	Y	Y
C16	Julia's sister	Y	Y
C18	Julia's sister	Y	Y
C21	Julia's nephew		Y
C9	Family solicitor	Y	Y
	FRIENDS		
C8	Family friend	Y	Y
C12	Julia's friend	Y	Y
C13	Friend and colleague of Julia	Y	Y
C17	Julia's friend	Y	
C20	Alan's business partner	Y	Y
Julia Drown	Formerly MP Swindon South	Y	Y
	THAMES VALLEY POLICE		
ACC A	Acting Assistant Chief Constable Specialist Operations - (Gold Commander 18/11/03) *covered Deputy Chief Constable's portfolio August 2003 - February 2004*	Y	Y
ACC B	Assistant Chief Constable (Gold Commander for Management Service Review) Operational Support Thames Valley Police 2005-2008 – formerly Commander Berkshire BCU 2005-2006	Y	Y
CC	Chief Constable (formerly DCC 2002/03)	Y	Y
CS B	Chief Superintendent (co-author Management Service Review) Senior Investigating Officer Major Crime Unit	Y	Y
DCI Y	Detective Chief Inspector (co- author Management Service Review)Major Crime Department	Y	Y
HBI	Inspector Force Control Room 18/11/03		Y
Supt F	Superintendent Crime and Operations West Berkshire; BCU Commander West Berkshire (2nd Silver Commander 18/11/03)	Y	Y
BCU Commander, DI PPU, WPS DVU	Presentations regarding Berkshire West BCU; Public Protection Unit (PPU); Domestic Violence Unit (DVU); Street Index Gazetteer & Command & Control System	Y	Y

BERKSHIRE WEST PCT			
	Area Director, Head of Community Care and Wellbeing (lead officer for internal management review)-joint post with West Berkshire Council; formerly Head and Director of Service Responsible for Mental Health and Learning Disability and Substance Misuse Services Newbury Community PCT).	Y	Y
	Head of Children and Young People Service's; formerly Director of Clinical Services of Newbury and Community PCT.	Y	Y
WEST BERKSHIRE COUNCIL			
	Corporate Director Community Services (lead officer for Internal Management Review)	Y	Y
	Community Safety Manager	Y	Y
	Domestic Violence Reduction Co-ordinator	Y	Y
(HCCQ)	Head of Children's Commissioning and Quality Children's and Young Peoples Directorate (joint post with Berkshire West PCT)	Y	Y
	Former head teacher (telephone interview)	Y	Y
MEDICAL PRACTITIONERS			
GP	General Practitioner (Julia, William, C19 & Alan)	Y	Y
Psychiatrist	Private Consultant Psychiatrist Alan	Y	Y
CORONER			
	Coroner for Berkshire (formerly Coroner for East Berkshire)	Y	Y
EXPERT WITNESSES			
	Dr Carolyn Hoyle	Y	Y
	Roxane Agnew Davies	Y	Y
	Davina James - Hanman	Y	Y