Domestic Homicide Review in the case of Becky Watts published by Keeping Bristol Safe Partnership today

The Keeping Bristol Safe Partnership (KBSP) has today (23 January 2020) published a Domestic Homicide Review (DHR) which was commissioned following the tragic murder of Becky Watts. Becky's step-brother (NM) with his then-partner (SH) were convicted of murder and manslaughter respectively, and sentenced in November 2015.

The DHR has produced a 51-page executive summary which considers the involvement of 16 local agencies, covering 17 services, who worked with Becky, NM and SH in the period of six years leading to Becky's death.

Becky's immediate family and close friends also had the opportunity to contribute their views and perspectives and read the final report. Their comments on the review's findings are included in section 3.3 of the report.

This review, undertaken by Althea Cribb from Standing Together against Domestic Violence, follows the publication of a Serious Case Review (SCR) of Becky's case on 15 March 2018. The SCR identified that Becky's death also fitted the criteria for a DHR.

DHRs do not seek to apportion blame but consider what happened and what could have been done differently. They also recommend actions to improve responses to domestic violence situations in the future.

Findings of the report

The report found that the murder of Becky was the only act of domestic abuse/violence from NM towards Becky documented by agencies. The report also concluded that no agency knew Becky and NM and/ or SH were part of the same extended family network. Many agencies have recognised through the review process that they were not proactively asking or recording information about family networks at the time.

However, the review found that if agencies had asked Becky about her wider family, it is unlikely that NM and SH would have been seen as posing a threat to Becky to the extent that they would murder her. The report concluded that the information provided suggests that Becky and NM did not get on, and that Becky did not like being around NM; but it is not clear whether she felt fear, or at risk from him.

The information presented a picture of Becky as a vulnerable young woman with a difficult past, who was nonetheless attempting to move forward in her life and find a future for herself. She had close friends and cared a great deal for her family.

NM and SH also appeared as potentially vulnerable people with troubled and complicated backgrounds, leading to significant actual and attempted agency intervention. The pictures of them individually and as a couple can be contradictory; and as Becky's family and friends fed back to the review, whatever their backgrounds nothing excuses what they did.

Lessons to be learnt

The review identified lessons to be learnt which fell into the following themes:

- The importance of seeing the whole family, hearing the voice of the child and understanding the historical context.
- Record keeping is essential to ensure that individuals' needs are met.
- Improved multi-agency working and information sharing to ensure there is a holistic response to an individual.
- Use of appropriate language rather than using labels for young people to avoid misunderstanding among professionals working in different areas.
- Child sexual exploitation/violence against women and girls, with the emphasis on the need to build on good practice to challenge sexual harassment, such as through the Bristol Ideal award, which is part of Bristol Healthy Schools.
- A need for greater understanding of, and response to, controlling and coercive behaviours across agencies.
- The importance of GPs having access to specialist advice when responding to individuals with low-level mental health issues who are not accessing specialist support.
- The benefits of having a 'lead professional' (GP) co-ordinating services when an individual has a number of needs.

The report also made nine recommendations for various agencies. They included ensuring training about coercive and controlling behaviour is delivered, the need for all professionals working with young people to take account of full family history and wider social networks, combined with the importance of young people being asked if they would like to speak alone to professionals.

Ivan Powell, Independent Chair of the Keeping Bristol Safe Partnership, said the Partnership accepted the finding and, with partners, has been working towards implementing the recommendations from the report.

He said: "On behalf of the Keeping Bristol Safe Partnership, I would like to express my deepest sympathy to the family and friends of Becky. Our thoughts continue to be with you. We are very grateful for your involvement in this process, requiring you to often give very personal and difficult accounts. You have helped agencies to understand what Becky was like as a person and to hear what she felt about those agencies who worked with her. This has directly influenced the review and the recommendations made.

"I would also like to thank various agencies and professionals who shared their views to support this work. Thanks to everyone's support the review has provided a fuller picture of the circumstances surrounding Becky's death, helping us understand how to improve the response.

“The completion and publication of this review has taken significant time due to the complexity of the case and we acknowledge the impact this has had on Becky’s family.

“The Partnership fully accepts the findings of the DHR and we have been working hard with our members and agencies across the city and beyond to continue to embed the recommendations identified by the reviewers.

“The review highlighted the need for a child’s voice to be heard. Since the Serious Case Review the Signs of Safety tools and methodology have been implemented across children and family services in Bristol, meaning that children and families can put their views across in the assessment in a simple way. This also helps to map their family history and networks to inform the services that are provided.

“Since Becky’s death, coercive and controlling behaviour within an intimate or family relationship has been established as a criminal offence. Whilst we are aware some agencies have updated their training and procedures we will be undertaking a full review of training across the partnership, in particular making sure it adequately covers the identification of, and response to, coercive and controlling behaviours.

“Our hope is that the changes that have been introduced as a result of this case will help develop an improved response and reduce the risk of such tragic events happening in future.”

The DHR was originally commissioned by the Community Safety Partnership known as Safer Bristol. Since that time safeguarding arrangements in the city have changed and Safer Bristol has now become part of the Keeping Bristol Safe Partnership.

The executive summary of the DHR together with family tributes and statements can be found on https://www.bristol.gov.uk/policies-plans-strategies/domestic-homicide-reviews

Ends

Notes to Editors:

1. Domestic Homicide Reviews are part of the Domestic Violence, Crime and Victims Act 2004 and became law from 13 April 2011. A Domestic Homicide Review is a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by—
   (a) a person to whom they were related or with whom they were or had been in an intimate personal relationship, or
   (b) a member of the same household as themselves,
   held with a view to identifying the lessons to be learnt from the death. (Home Office https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews)

2. A Serious Case Review (SCR) was commissioned by Bristol Safeguarding Board shortly after Becky's death and was published on 15 March 2018 https://bristolsafeguarding.org/children-home/serious-case-reviews/bristol-scrs/becky-2018/. The SCR found no evidence that the murder of Becky could have been predicted or prevented by any professional working with her.

3. The family of Becky Watts has engaged with the Partnership during the review and in preparation for the publication of the report. The family continues to grieve for their loss and the Board asks that the press respect their privacy.

4. Please make every effort to include in your coverage details of how readers, listeners or viewers can access support if they are concerned for the safety of a child or young person in Bristol by contacting the First Response team on 0117 9036444 or www.bristol.gov.uk/social-care-health/report-your-concerns-about-a-child

   Please also include details about where to go if you or someone you know is affected by domestic abuse:
   Next Link 0117 925 0680
   Bristol Against Violence and Abuse www.bava.org.uk
   National Domestic Violence Helpline 0808 2000 247
   nationaldomesticviolencehelpline.org.uk

   Those affected by sexual violence can access help via:
   www.survivorpathway.org.uk/bristol/

5. Standing Together Against Domestic Violence is a UK charity bringing communities together to end domestic abuse. It has extensive experience of conducting Domestic Homicide Reviews.

6. Any questions or enquiries regarding this review or the Partnership's response can be directed to:

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