In response to a report by the Bristol Safeguarding Children Board about Becky Watts, a spokesperson for Action for Children, said:

“Becky’s murder was a tragedy and we extend our sympathies to her family.

“Our staff in Bristol, who had limited contact with her in 2012 and in 2014, worked hard to help Becky and her family with complex needs.

“Whilst the official review into her death has found no evidence that the murder of Becky could have been predicted or prevented by any professional working with her, we recognise that the recording of our contact with Becky and our communication with other services fell short of what is expected. As a result of this and an internal investigation, we have reviewed our staff training and practice.

“Becky was killed by someone she knew and sadly, we know there will always be people who are intent on harming children.”

Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Dr Lisa Jenkins, Consultant Child Psychiatrist South Gloucestershire CAMHS, said:

“Our deepest sympathy goes to Becky’s family at what is a difficult time for them

“We welcome the review and its findings and we are pleased to say that some of the issues raised in the report, particularly around communication between agencies have already been or are now being addressed.”

Statement

0117 922 2650 @BristolCouncil

Bristol City Council response to the Becky Serious Case Review

Jacqui Jensen, Executive Director of Care and Safeguarding at Bristol City Council, said: “Becky’s death shocked the city and was incredibly sad, so on behalf of the council I’d like to send our condolences once again to her family and everyone who knew her.

“Whilst the review found that Becky’s death could not have been predicted, there was more that could have been done to better understand Becky and her situation.

“The report highlights five findings including a need to improve communication and note taking practices between agencies, encourage a better understanding of adolescents, and greater recognition of the role of the father as part of the family.

“In the past three years much has changed within the council. We have been working hard to improve our children’s services and have been introducing new procedures and training across all of the front line partners and support services. An example of this is the Signs of Safety methodology, which helps colleagues to better understand a child or young person by looking at their connections with those around them. This focuses on finding the strengths in young people’s relationships with family members and local agencies, and using existing networks to meet extended family. We also now have a specialist team of safeguarding in education advisors to support education settings across the city.

“We have also adopted new software which allows agencies to securely share information and flag concerns to each other, which is a valuable tool and gives partners a central reference point to access important records.

“None of this will help to undo the tragic events from 2015 and nor could they have prevented them. However these changes make it easier for us to work with partners to better understand the context and

circumstances surrounding complicated situations and minimise risks to safety.”

Anne Morris, Director of Nursing and Quality, Bristol, North Somerset and South Gloucestershire CCGs, said:

“This is a very tragic case and our thoughts at this time are with Becky’s family and all those who knew her. Despite the review finding no evidence that Becky’s death could have been predicted or prevented by any professional working with her, we must make sure that we continue to improve our services. Many of the issues in the report, particularly with regard to record keeping and communication have already been addressed by health and care providers.”