

## **Bristol Safeguarding Adults Board publishes Simon Reynolds Serious Case Review**

Today, 14 December 2016, the Bristol Safeguarding Adults Board (BSAB) has published its Serious Case Review (SCR) executive summary into the death of Simon Reynolds who died on 21 November 2014.

The SCR was independently commissioned and the executive summary is published alongside the Board's response. The review is unusual as it focuses on the events and decisions made during a single day ahead of Simon's death from cardiac arrest and subsequent associated problems. A Coroner's inquest looking into Simon's death concluded in July 2015.

Louise Lawton, Independent Chair of the Bristol Safeguarding Adults Board, said: "The death of Simon Reynolds was a tragic incident and the sympathies of the board and its partners are with his family. Taking part in an SCR is not easy for those who have lost a loved one, so I want to thank Simon's family for being involved in this difficult process and giving our author some insight into what Simon was like.

"At the heart of this review is how agencies keep people in mental distress safe. The review looks at the application of relevant policies and procedures, including how a 'Place of Safety' is used to detain people in extreme mental distress for their own safety. The Board fully accepts the recommendations made by the SCR; where recommendations are specific to agencies they will deal to these individually and monitored by the board.

"Two of the four recommendations for the Board, which apply to all agencies, focus on reviewing the Red Flag protocol. This a national agreement between services and agencies involved in the care and support of people in crisis, which sets out how professionals should work together.

"The review also recommends making certain that mental and physical health are given equal footing so that anyone experiencing a mental health crisis is treated in the same way as someone with a physical emergency. The need to review how people are treated according to the Mental Health Act to prevent unnecessary delays is also recommended.

"The board is currently developing an action plan to ensure these recommendations are embedded across different organisations, and that changes made quickly and are long lasting. The board will be supporting agencies, but also challenging them to demonstrate what has changed and how future risk is being minimised.

"It is worth noting that areas of good practice are highlighted in the report around how the Police and Ambulance services responded to the situation and the decision making abilities within agencies.

“I hope that this SCR will help to strengthen how people in mental distress are supported in Bristol so that future tragedies such as Simon’s death can be avoided.”

The role of the BSAB is to lead on adult safeguarding in Bristol, ensuring the right procedures are in place across partner agencies to protect vulnerable people. An SCR’s purpose is look at how professionals worked together and to identify strengths and gaps in safeguarding practices so that future risks can be reduced. The agencies involved have been fully engaged with the review process.

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