IAN MICHAEL ARROW
Senior Coroner for Plymouth, Torbay and South Devon

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Mr Mark Collins, Chief Constable, NPCC Lead for Mental Health,** Dyfed-Powys Police Headquarters, PO Box 99, Llangunnor, Carmarthenshire, SA31 2PF
1	**CORONER** I am IAN MICHAEL ARROW, Senior Coroner for Plymouth, Torbay and South Devon
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 17/05/2017 I commenced an investigation into the death of Trystan Bryant, 38 . The investigation concluded at the end of the inquest on 11 October 2018. The conclusion of the inquest was SUICIDE See attached Multiple Injuries Consistent with a Fall from Height
4	**CIRCUMSTANCES OF THE DEATH** Mr Trystan BRYANT has a history of mental illness dating back to 2005. He was diagnosed with anxiety and depression. Mr Bryant was receiving ongoing support from the Cornwall Mental Health Trust. As a result of his illness Mr Bryant expressed suicide intent on several occasions. Due to missed appointments Mr Bryant's last interaction with Cornwall Mental Health Trust was 7 March 2017. On 11 May 2017 Mr Bryant left the family home and made his way to the Tamar Bridge. On arrival Mr Bryant proceeded to ascend the cable to the top of the bridge. Emergency services were deployed to the scene and after negotiation Mr Bryant was assisted down to the roadside. He was then detained by the police under Section 136 of the Mental Health Act and escorted by two police officers to an ambulance. Two members of the South West Ambulance team entered the ambulance followed by Mr Bryant and the two police officers. After approximately one minute and twenty seconds Mr Bryant exited the ambulance via the rear door. Mr Bryant proceeded to cross three barriers to the outer barrier of the bridge. Mr Bryant spent approximately 20 minutes in conversation with the police in negotiations before falling to the river below. The fall resulted in multiple injuries consistent with a fall from height, resulting in Mr Bryant's death on 12 May 2017.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. –

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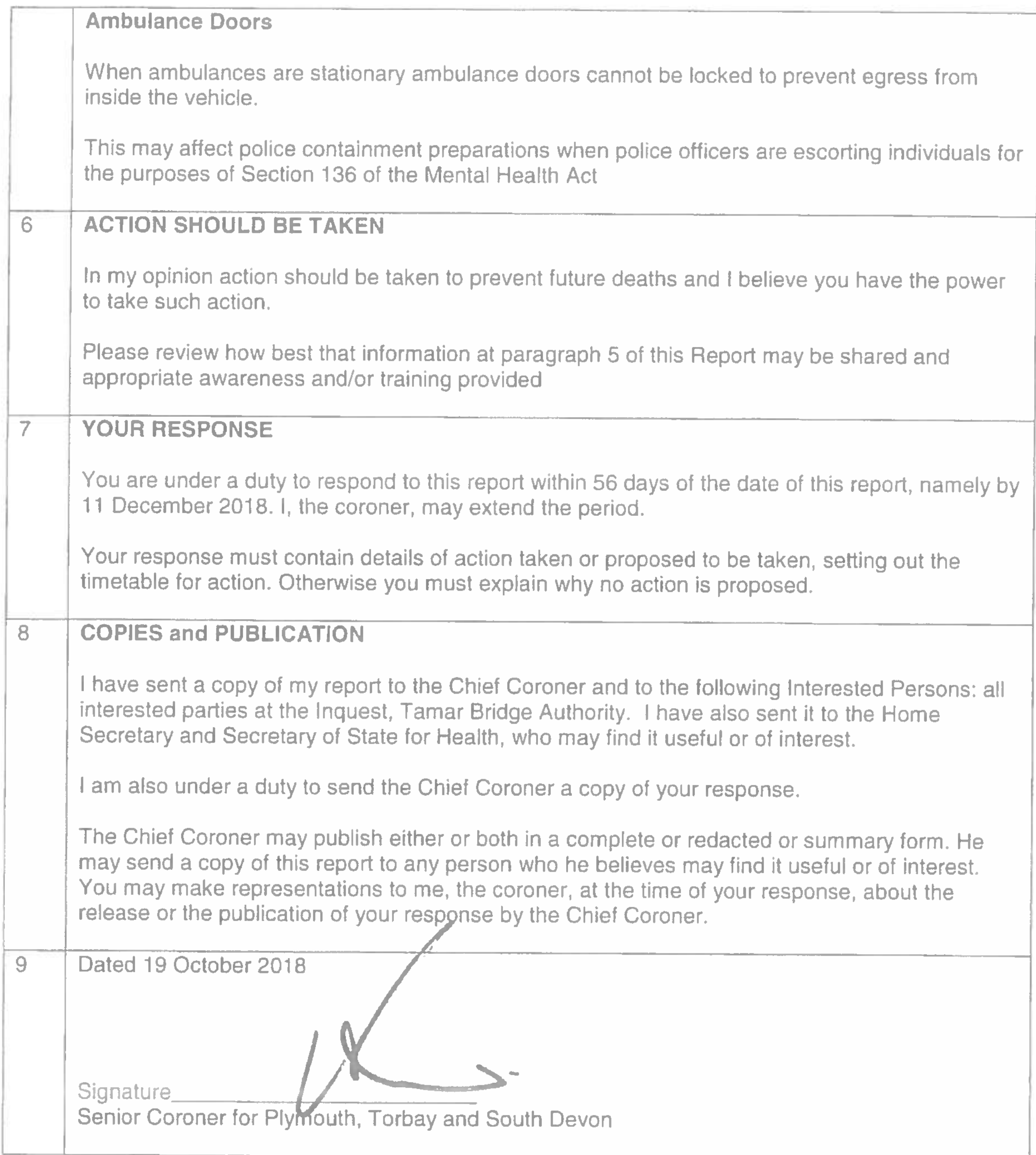

	Ambulance Doors When ambulances are stationary ambulance doors cannot be locked to prevent egress from inside the vehicle. This may affect police containment preparations when police officers are escorting individuals for the purposes of Section 136 of the Mental Health Act
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action. Please review how best that information at paragraph 5 of this Report may be shared and appropriate awareness and/or training provided
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 11 December 2018. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: all interested parties at the Inquest, Tamar Bridge Authority. I have also sent it to the Home Secretary and Secretary of State for Health, who may find it useful or of interest. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	Dated 19 October 2018 Signature_______________________ Senior Coroner for Plymouth, Torbay and South Devon

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