Essex Partnership University
NHS Foundation Trust

05 March 2026

Private and Confidential
Ms Rebecca Mundy
HM Assistant Coroner
Coroner's Court
Seax House
Victoria Road South
Chelmsford
CM1 1QH

Chief Executive Office
The Lodge
Lodge Approach
Wickford
Essex
SS11 7XX

[redacted]

Dear Madam,

Mr Martin Douglas Bryant (RIP)

I write to set out the Trust's formal response to the report made under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013, dated 19th January 2026, received by the Trust on 21st January 2026 in respect of the above, issued to Essex Partnership University NHS Foundation Trust (EPUT) and NHS England following the inquest into the sad death of Mr Bryant.

I would like to begin by extending my deepest condolences to Mr Bryant's family. The Trust sympathises with their sad loss.

The matters of concern as noted within the Regulation 28 Report have been carefully reviewed and noted. I will now respond in full to the concerns as they relate to EPUT in the hope that this provides both yourself and Mr Bryant's family with comprehensive assurance of changes that have been made at the Trust to address the concerns you have raised.

Concern 1) The reliance by EPUT that those suffering a mental health crisis will wait in the MHUCD's open reception area, from which they are free to come and go as desired, whilst medical authority and/or beds are secured for them.

Response:
In line with the evidence presented to Court, Mr Bryant was identified as requiring admission and agreed to informal admission. He waited with his partner in the reception area.

In order to address the risks associated with waiting in an open reception area, management process has changed to ensure a risk assessment has been undertaken whilst patients await medical review and / or beds are secured for them. There are clear escalation processes in place when patients are waiting for beds.

This risk assessment is used to identify if someone is safe to wait in reception area and if not they will remain in an assessment room (this information was included in the action plan shared with Coroner and process had changed at point of inquest).

The assessment rooms are situated in a corridor with ACT (Access through a swipe system so exit can be monitored by staff) which affords an additional level of safety in respect of vulnerable patients.

Staff have been advised on the need to ensure there is not an over reliance on partner support; this learning is being shared via the care unit quality and safety governance structure and the wider learning functions through the 'Learning Oversight Scrutiny Committee (LOSC)'.

As the Court will be aware, the Trust may not detain a patient without legal authority to do so. Where appropriate, and if this is deemed in the patient's best interests, common law is applied to restrict leave if a patient is deemed at risk. These safeguards remain available to the Trust in order to keep patients safe in a proportionate and lawful manner.

Concern 2) EPUT's ability to accommodate improvement to where people wait within the MHUCD, particularly in light of the evidence given by nursing staff and the indication that rooms will always need to be kept vacant for patients requiring triage or assessment.

Response:
It is noted that witnesses in this Inquest were temporary bank staff and may not have been aware of changes that had been undertaken in respect of this concern (please also see our reply to under concern 1 above).

In addition, the Court was provided with evidence in respect of the steps that have been taken by the Trust to continually review service demand and the need to close the MHUCD once capacity has been reached.

The evidence provided at Court also highlighted the steps taken by the Trust to ensure security within the department.

The MHUCD is no different in terms of waiting area as that of an A&E waiting area. However, the MHUCD has a clear criteria and escalation process in place for the temporary closure of the department, based on patient acuity and complexity exceeding safe staffing and resource levels, Triage times at risk of breaching the 30 minute standard, three of the five Assessment Rooms occupied by patients who cannot be safely managed in the waiting area and the department is at full capacity, including walk in patients. If capacity is reached and people can no longer be assessed or accommodated safely within the MHUCD, the department can temporarily be closed and patients will be diverted to local EDs during this time.

Capacity of the unit is reviewed and there is the opportunity for escalation at the morning and afternoon MSE Locality Sit rep calls seven days a week. Capacity issues can also be escalated at lunchtime Senior Bed Escalation Huddles, which are held Monday-Friday.

Concern 3) The lack of beds, locally and nationally, for mental health admissions and the suggestion given in evidence that patients can be waiting in the open reception area for days or sometimes weeks for a bed.

Response:
We respectfully advise that this concern is for NHS England to respond to. However, in an effort to provide assurance on this point, the Trust provided assurance re: the availability of beds as part of our evidence at this Inquest, namely that this continues to be a challenge for the Trust / the NHS as a whole. Every effort is made to assess and manage patients in a safe and timely manner, again flow and capacity challenges remain, leading to patients having to wait to been seen in the UCD.

However, as stated above, there are clear processes for the management of flow and capacity. Escalation and review is conducted daily (up to three times a day); patients are prioritised (dependant on risk factors) whilst they wait in UCD.

As per the evidence provided to the Court, the Trust has implemented the Therapeutic acute Inpatient Operating Model for adults and older adults. The objective of this model is to reduce length of stay when a patient requires hospital admission. This model aligns with national guidance around purposeful admissions including capacity and flow, therapeutic benefit, proactive, safe and effective discharge/transfer planning and trauma informed care.

Datixes are completed for patients who have had to wait in the department for over 24 hours in order that these patients are again urgently considered and escalated where required. Harm review, forms part of the incident reporting process which is aligned with national definition of harm physically and psychologically.

We are also working closely with our integrated care boards (ICBs), NHSE and wider system partners re bed pressures for admission and discharge to and from EPUT beds. This has included a recent workshop with Essex county council to review delayed discharges from EPUT beds into the community where accommodation needs are delaying discharges.

I hope that I have provided reassurances around the steps that we have taken to address the issues of concern contained within your report. We know there is an acute need to embed and effect change, hence we will monitor the above provisions to ensure these are contributing to our overall aim of keeping patents safe and delivering therapeutic care.

Please do let me know if you require any further information at this stage. We understand that the Court will share a copy of this reply with Mr Bryant's family.

Yours sincerely,

[redacted]

[redacted], Deputy Chief Executive
On behalf of Paul Scott
Chief Executive