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**Co-National Medical Director**  
NHS England  
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**2<sup>nd</sup> March 2026**

Dear Coroner,

**Re: Regulation 28 Report to Prevent Future Deaths – Martin Douglas Bryant who died on 19 January 2025.**

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 19 January 2026 concerning the death of Martin Douglas Bryant on 19 January 2025. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Martin's family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about Martin's care have been listened to and reflected upon.

Your Report raised concerns around the following:

1. The reliance by Essex Partnership University NHS Foundation Trust (EPUT) that those suffering a mental health crisis will wait in the open reception area of the Mental Health Urgent Care Department (MHUCD), from which they are free to come and go as desired, whilst medical authority and/or beds are secured for them.
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.
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.

We note that your Report has also been directed to EPUT, who will be best placed to address concerns 1 and 2 listed above.

In relation to concern 3 above and the issue of bed availability, NHS England is currently rolling out dedicated 24/7 neighbourhood [mental health centres](#) to better support the community, including opening more specialist Mental Health Emergency Departments alongside general Emergency Departments and having a 24/7 psychiatric liaison team available. A pilot programme for these centres started in October 2025 and will run until July 2026. This will be followed by an Implementation Support Programme which will roll out to sites from March 2026.

NHS England is aware of the issues in some healthcare [systems](#) around high bed occupancy and limited local bed availability. This is related to long lengths of stay and high numbers of patients clinically ready for discharge but unable to be discharged, leading to flow pressures across systems. To improve this, in 2025/26, NHS England made £75 million of additional capital available for local systems to invest in improving local bed capacity and reduce the use of Out of Area Placements.

Given increasing lengths of stay and the increased number of patients clinically ready for discharge, providing more beds will be considered as part of a whole system transformation approach. This was supported by the [NHS Long Term Plan](#) (LTP), which saw an additional £2.3 billion funding invested in mental health services from 2019/20 – 2023/24, around £1.3 billion of which was for adult community, crisis and acute mental health services to help people get quicker access to the care they need and prevent avoidable deterioration and hospital admission.

NHS England's [2025/26 priorities and operational planning guidance](#) reinforces this focus on improving patient flow as a key priority – with systems directed to reduce the average length of stay in adult acute mental health wards in order to deliver more timely access to local beds. NHS England is taking steps to address current operational pressures driving these issues.

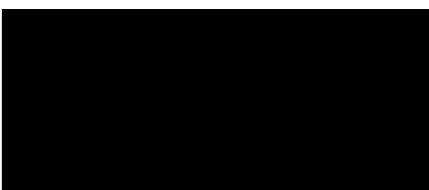
If local beds are not available, Out of Area Placements are currently used to ensure patient care is delivered in an inpatient setting if needed. However, NHS England plans to reduce and eliminate the use of Out of Area Placements as they can result in poorer outcomes for patients and provide additional risk to patient safety.

NHS England was not a party to the inquest, however we consider EPUT would also be best placed to comment upon the evidence referred to under concern 3, that patients can be waiting in the open reception area for days or sometimes weeks for a bed.

I would also like to provide further assurances on the national NHS England work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by the Regulation 28 Working Group, comprising Regional Medical Directors, and other clinical and quality colleagues from across the regions. This ensures that key learnings and insights around events, such as the sad death of Martin, are shared across the NHS at both a national and regional level and helps us to pay close attention to any emerging trends that may require further review and action.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,



**[REDACTED] MRCGP**  
National Medical Director  
NHS England