REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **1.** Chief Executive Officer of Essex University Partnership Trust (EPUT) [redacted] *Essex Partnership University NHS Foundation Trust, The Lodge, Lodge Approach, Runwell, Wickford, SS11 7XX* **2.** NHS England
1	**CORONER** I am Rebecca Mundy, Assistant Coroner, for the coroner area of Essex
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.
3	**INVESTIGATION and INQUEST** On 5 February 2025 I commenced an investigation into the death of Martin Douglas Bryant, 43. The investigation concluded at the end of the inquest on 31 October 2025. The conclusion of the inquest was suicide.
4	**CIRCUMSTANCES OF THE DEATH** Mr Bryant had a diagnosis of Acute Polymorphic Psychotic Disorder, with episodes dating back to 2018. His condition had been stable between June 2023 and early January 2025, however, he did report ongoing concerns with side effects from his medication. He had predominantly been prescribed Olanzapine, which successfully managed and controlled his condition, but had also had some success with Aripiprazole previously. Due to the impact of the side effects of Olanzapine, he began a transition to Aripiprazole in December 2024. The change was poorly tolerated, leading to insomnia, agitation, and worsening psychosis. On 15 January 2025, Mr Bryant agreed to revert to Olanzapine. In January 2025 he attended the Mental Health Urgent Care Department of Basildon Hospital (MHUCD) on a number of occasions seeking assistiance, as his side effects worsened. The MHUCD is essentially an extension of A&E, albeit run by a separate Trust (EPUT), providing those patients suffering from a mental health crisis a separate 'emergency' department in which to be assessed. As in the main A&E department, space is limited and rooms are intended only to be used for triaging and assessing patients, requiring them to wait in the main reception

	area around those processes. In the early hours of 19 January 2025 Mr Bryant tried to take his own life. He, once again, presented to the MHUCD at around 5.30am. He was triaged and assessed by mental health nurses who recommended that he be informally admitted for treatment. Whilst approval by a doctor was awaited, a bed was requested for admission. Mr Bryant was asked to wait in reception, despite his partner raising concerns he would not stay. He did wait. Whilst waiting, he asked staff if he could leave to vape and go to the shop. The nurses had felt reassured that he was willing to be admitted and wanted to get better. He was not seen as a risk and so was free to come and go from the reception area. He last left the MHUCD at around 10:35am, he did not return and efforts to locate him were unsuccessful. An unresponsive male was seen by the multistorey car park (located next to the MHUCD) at 12:50pm. Identification found on the male confirmed this to be Mr Bryant. A review of CCTV footage showed Mr Bryant [redacted] of the multistorey car park, [redacted] before then falling head first. The medical cause of death was established as Ia Traumatic head injury. I found that [redacted] was a deliberate act, that act directly led to Mr Bryant's death and I was satisfied on the balance of probabilities that he intended the act would lead to his death. Accordingly I concluded his death was suicide.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to concern. Despite information provided since (which did allay other concerns), in my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: 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. 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.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and/or your organisation have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 16 March 2026. 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: i. Mr Bryant's Family ii. The Metropolitan Police iii. Mid and South Essex NHS Trust 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. She may send a copy of this report to any person who she 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	19 January 2026