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Senior Coroner for Birmingham and Solihull
Birmingham and Solihull Coroner's Court
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[redacted]

National Medical Director
NHS England
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15th December 2025

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Ricky James Monahan who died on 18th March 2025.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 22nd October 2025 concerning the death of Ricky James Monahan on 18th March 2025. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Ricky's family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about Ricky's care have been listened to and reflected upon.

Your Report raised the concern that there was an unprotected fire escape which gave access to the roof in the rehabilitation unit where Ricky was detained under Section 37 of the Mental Health Act. An environmental risk assessment had not been completed for this fire escape regarding its accessibility and particularly the access to the roof. You were also concerned that there are no current guidelines advising what protections are required for fire escapes in rehabilitation settings. This concern is within NHS England's remit to address.

National Risk Assessment Guidance

The evidence regarding assessment of the risk of harm to self has been recently updated, to indicate that the use of risk stratification tools should be avoided as it can lead to false assurances about a person's risk. There is evidence that many people acting on suicidal or self-harm impulses may have no plans or intentions to do so even minutes beforehand. This means it is really important to develop an understanding of factors that may reduce or increase safety for the individual in future. The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) has been commissioned through the NHS England national Culture of Care programme to support every provider of NHS commissioned inpatient services to move to personalised safety planning in line with evidence.

NHS England also published the Staying Safe from Suicide: Best Practice Guidance for Safety Assessment, Formulation and Management on 4 April 2025. It promotes a shift towards a more holistic, person-centred approach rather than relying on risk prediction, which can be unreliable because suicidal thoughts can change quickly. Instead, it recommends using a method based on understanding each person's situation and managing their safety. The purpose of this guidance is to enable mental health practitioners to adopt best practice principles in working with people of all ages to stay safe from suicide. The guidance highlights environmental safety as one of six steps of safety planning, which should include reducing access to or avoiding high risk locations.

Work is also underway to make training available to all mental health practitioners to incorporate the principles of this guidance into their practice. This training was recently launched and is available via an e-learning module. This complements existing local training on suicide prevention, and a number of other national e-learning products that are already available.

Local Risk Assessments

NHS England's regional mental health team has liaised with the Birmingham and Solihull Mental Health Foundation Trust (BSMHFT) regarding your concerns, including the lack of environmental risk assessment of the fire escape, and particularly its ability to allow unauthorised access to the roof.

The Regulatory Reform (Fire Safety) Order 2005 (RRO) does permit controls to prevent unauthorised access to fire escapes, subject to conditions ensuring that exit from these areas is not impeded. No such controls were in place on the fire escape in this facility to prevent or alert staff to unauthorised access from the garden.

The lack of environmental assessment of the fire escape meant there was no evaluation of the opportunities this route provided to gain a position of height, and the fact that the control measures at the top of the escape were insufficient to prevent unauthorised access to the roof. The inherent nature of a fire escape, to allow unimpeded exit from a building, means it should be considered as part of an environmental risk assessment to establish whether unintended risks are created.

Regular assessment of environmental risks, and their audit and logging within risk registers, allow visibility within the clinical team and enables appropriate controls to be adopted. These controls could include additional physical measures or, if relevant, restrictions on granting or supervising leave. The assessment, logging and reporting within organisational risk registers would be an effective way to manage this risk. The infrastructure for assessment of the environment and its oversight already exists and is subject to scrutiny both by providers' own processes and by the Care Quality Commission (CQC) during routine inspection.

I note that your Report is also addressed to the Birmingham and Solihull Integrated Care Service, who will be able to address the position locally in more detail.

Fire Safety Guidance and NHS Estates

Health Technical Memorandum (HTM) 05-03 Part K (HTM 05-03 Part K) gives comprehensive advice and guidance on the design, installation and operation of specialised building and engineering technology used in the delivery of complex healthcare premises. Appendix C - *Assessment of escape routes including electronic locks on doors* - details how to assess escape routes and security in mental health units:

Escape routes and security

C6 All doors on escape routes and final exit doors should normally open in the direction of travel and be quickly and easily openable without the need for a key. This is the starting point for all securing devices.

C7 Exceptionally, there are specific life-safety protection reasons for additional security. If this is the case, each circumstance should be assessed individually. Such circumstances may include:

- *mental health units where the safety of patients, staff and members of the public could be at risk.*

C8 Additional security measures put in place simply to secure areas from theft or to manage the movement of people are not appropriate. The need for extensive escape routes through sensitive areas should be addressed at the design stage.

NHS England's Estates Team are currently scoping HTM *05-02, fire safety in the design of healthcare premises*, which will to be revised imminently.

The NHS Premises Assurance Model (NHS PAM) is a self-assessment by NHS organisations of their implementation of estate and facilities guidance. This includes fire safety and asks whether all areas of the premises have had a fire risk assessment undertaken, with any necessary risk mitigation strategies applied and regularly reviewed. BSMHFT was noted as "compliant, no action required" for this area of self-assessment within the NHS PAM for 2024-25.

The NHS PAM is being revised for 2025-26 to move from an assurance-based approach to a compliance-based approach.

There is also guidance on security measures for garden areas in secure rehabilitation settings within the Environmental Design Guide for Adult Medium Secure Services, published in 2011. This document outlines physical and procedural security requirements for secure services, including outdoor spaces, considering areas such as:

- Perimeter security: Garden areas should be enclosed with secure fencing that prevents absconding.
- Controlled access: Entry and exit points should be monitored and lockable.
- Visibility and surveillance: Design should ensure staff can observe patients at all times.
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Additionally, the Health Building Note (HBN) 03-01 Supplement 1: Medium and Low Secure Mental Health Facilities for Adults recommends:

- Secure outdoor areas must be designed to support therapeutic use while maintaining safety.
- Physical barriers (e.g. anti-climb fencing) and procedural controls (e.g. supervised access) should be tailored to the patient population.
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Finally, the CQC monitoring highlights that outdoor access is therapeutically beneficial, but security and design quality vary across services. Facilities should ensure safe, well-maintained and supervised outdoor spaces.

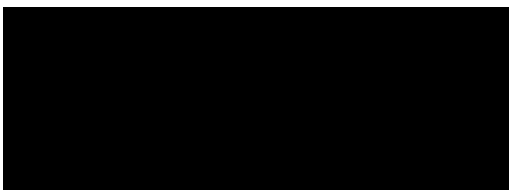
Whilst none of the documents mentioned above specifically refer to fire escapes, secure access to fire escapes should be embedded within the providers' risk assessments. The clinical risk assessment should cover the patient's current level of risk (absconding, self-harm etc) and the patient should be supervised according to the level of risk posed.

Ultimately, there appears to be appropriate guidance in place to ensure that incidents such as this should not happen, however it appears that the local risk assessment did not take the specific risks of the fire escape and access to the roof into account. NHS England is not able to comment further on this and directs the Coroner to the Birmingham and Solihull Integrated Care Service in this regard.

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 Ricky, 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,



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National Medical Director
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