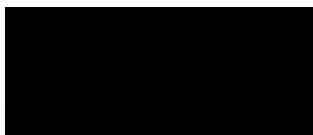


	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: • Care Quality Commission • NHS England • Birmingham and Solihull Integrated care Service
1	CORONER I am Louise Hunt Senior Coroner for Birmingham and Solihull
2	CORONER'S LEGAL POWERS I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	INVESTIGATION and INQUEST On 27 March 2025 I commenced an investigation into the death of Ricky James MONAHAN. The investigation concluded at the end of the inquest. The conclusion of the inquest was; Mr Monahan died of a deliberate act, but his intentions are unclear.
4	CIRCUMSTANCES OF THE DEATH Mr Monahan had a long history of suffering from paranoid schizophrenia which included him hearing command hallucinations (voices) and he had experienced suicidal thoughts and made serious attempts to take his own life in the past. The last attempt to take his own life was jumping off a bridge in 2021. Mr Monahan was a resident at Hertford House from May 2023 under section 37. He was on hourly observations. He was taking his medication for his condition but he was still experiencing persistent voices. Staff reported Mr Monahan said he was able to manage the voices. He appeared to be making progress. He was planning for his future once discharged. On 18th March 2025 Mr Monahan had a normal day with no out of character behaviours. His mood appeared settled. He took his usual unsupervised leave and staff raised no concerns. Mr Monahan was last seen in the dining room at approximately 17.05. He is then seen on CCTV in the garden [REDACTED] towards the roof. The alarm was raised by a resident in room 9 at approximately 17.10. When staff responded to the alarm they could see from the window that Mr Monahan was lying face down on the driveway at the front of the house. Mr Monahan received immediate first aid by staff members and an ambulance was called at approximately 17.15. Emergency services attended but were unable to save him. Mr Monahan was pronounced deceased at 19.11 at the scene. The cause of the fall cannot be determined. It was inappropriate for the trust to rely solely on individual risk assessments when considering who could use the garden unsupervised. There was a failure in the generic risk assessment methodology as [REDACTED] was not deemed a risk to service users regardless of their individual risk assessments. Following a post mortem, the medical cause of death was determined to be: 1a multiple traumatic injuries 1b fall from a height 1c

	1d II
5	<u>CORONER'S CONCERNS</u> 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. – 1. Mr Monahan was in a 10 bedded rehabilitation unit and was detained under S37 of the Mental Health Act. There was an unprotected fire escape at the rear of the building which could be easily accessed from the garden which in turn gave easy access to the roof. No environmental risk assessment had been completed regarding how accessible the fire escape was and how it easily provided access to the roof due to inadequate railings at the top of the staircase. The trust relied on individual risk assessments when considering what controls were required for individual patients when accessing the garden. 2. The inquest heard how there are no current guidelines setting out what protections are required for fire escapes in rehabilitation settings. The lack of any guidelines presents a risk of future deaths and in my view, action should be taken.
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.
7	YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely by 17 December 2025. 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: Mr Monahan's family, Birmingham and Solihull Mental Health NHS Foundation Trust I have also sent it to the Medical Examiner and the Health and safety executive 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. 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	22 October 2025

Signature:



Louise Hunt

Senior Coroner for Birmingham and Solihull