

Black Country Healthcare NHS Foundation Trust
Civic Centre
St Peter's Square
Wolverhampton
WV1 1SH

29 September 2026

IN CONFIDENCE

For the attention of: Mr Zafar Siddique, Senior Coroner for the Black Country

RE: Regulation 28 report, prevention of future death pertaining to Mr Benjamin Pesian, deceased.

Dear Sir,

Firstly, on behalf of Black Country Healthcare NHS Foundation Trust may I extend our most sincere condolences to the family of Mr Pesian.

During the inquest the evidence revealed matters giving rise to concerns in such a way that there is a risk that future deaths will occur unless action is taken. In response to your regulation 28 report to prevent future deaths we have outlined below the actions Black Country Healthcare has taken to address the matters of concern that affected our organisation.

The matters of concern raised were as follows;

- 1. I have concerns about the Trust's organisational learning from these incidents and timely implementation of the recommendations made by the external investigation report author. In addition, I have concerns about the quality and timely preparation of risk assessments. I heard evidence during the inquest that risk assessments weren't always updated and instead reliance was played on handover discussions between staff.*
- 2. Whilst I recognise there have been action plans put in place by the Trust there is still some lack of clarity around timescales and implementation. As stated earlier, an additional factor is the CQC involvement and their findings which also mirror some of the findings from the external investigation.*



In terms of the concerns raised around clinical risk management the Trust has implemented a comprehensive programme to address concerns relating to the quality and consistency of risk assessments. In line with national guidance, the Trust has moved away from risk stratification towards a formulation-based approach that focuses on understanding individual risk, safety planning and recovery-oriented care. To support this, a Trust-wide Risk Assessment and Formulation training package has been developed and rolled out across inpatient and community services. As of 31 August 2026, 405 staff had completed the training, supported by a developing Train the Trainer model to ensure sustainability across all clinical divisions.

Risk assessment quality and compliance are monitored through strengthened record-keeping audits, including specific scrutiny of the alignment between risk assessment, clinical formulation, safety planning and care planning. Weekly ward audits, bi-weekly Matron audits and live compliance dashboards provide ongoing oversight and enable targeted improvement where gaps are identified. The Trust has also revised its inpatient documentation audit methodology to place greater emphasis on the quality of risk formulation and its translation into person-centred care plans.

Oversight of this work is provided through the Clinical Risk Steering Group, which monitors training uptake, audit findings, learning from incidents and progress against improvement actions. Risk formulation is being embedded through supervision, reflective practice, quality audits and divisional governance processes to ensure changes are sustained and translated into clinical practice.

While the Trust recognises there remains a residual risk until these improvements are fully embedded, robust mitigating controls are in place through enhanced supervision, targeted training, audit surveillance and executive oversight. Collectively, these arrangements provide assurance that risks associated with incomplete or insufficiently formulated risk assessments are being actively identified, monitored and addressed, and that the Trust has established a sustainable framework to improve the assessment, management and documentation of clinical risk.

Oversight of the improvement programme is maintained through the Clinical Risk Steering Group, Divisional Quality and Safety governance structures and executive leadership arrangements. Progress against agreed actions, training uptake, audit findings, emerging themes and learning from incidents are routinely reviewed, with escalation of risks and areas of concern through established governance processes. In addition, the Trust continues to maintain regular dialogue with the Care Quality Commission regarding delivery of the improvement plan, providing updates on progress, evidence of compliance monitoring and assurance regarding the effectiveness of actions taken.

More widely the Trust can provide assurance that a comprehensive programme of improvement has been implemented in response to the wider safety actions outlined in response to the independent investigation. Assurance can be provided that the action plan is progressing within the agreed timescales. Four actions due by 30 August 2026 have been recorded as completed and closed, covering EPMA prescribing arrangements, PRN documentation, and governance for clustered PRN use.

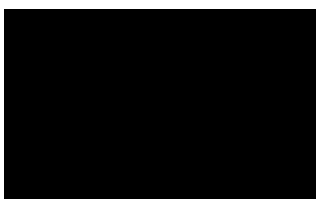


Work remains underway on all other outstanding actions including the occupational therapy and psychology pathway reviews, the multidisciplinary care model, and strengthened digital auditing of clinical documentation. Leave governance, associated training and audit arrangements remain scheduled for completion between November 2026 and February 2027.

Overall, delivery is currently within the recorded timescales. Continued oversight will focus on confirming measurable progress against the forthcoming milestones, securing specific evidence for multidisciplinary team attendance and ward-review quality, and ensuring that any emerging risks or delays are escalated promptly through the Trust's established governance arrangement

I hope this provides you with assurance that the Trust has taken the concerns raised in your regulation 28 report very seriously and will continue to take action to reduce the likelihood of a similar incident from reoccurring.

Yours sincerely,



Chief Executive
Black Country Healthcare NHS Foundation Trust

