

**REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS
2013**

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's [PFD Publication Policy \(2026\)](#).

- | | |
|----|---|
| 1. | CORONER
I am Mr Zafar Siddique, Senior Coroner, for the coroner area of Black Country. |
| 2. | DATE OF REPORT
4 August 2026 |
| 3. | 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. | THIS REPORT IS BEING SENT TO

1.Black Country Healthcare NHS Foundation Trust

You are under a duty to respond to this report within 56 days of the date of this report, namely by 29 September 2026. I, the coroner, may extend the period if an appropriate application is made. |
| 4. | YOUR RESPONSE
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.

I have a duty to send a copy of your response to the Chief Coroner.

In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision.

Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. |

	The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.
5.	SUMMARY OF CORONER'S CONCERN I have concerns about the Trusts 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. Whilst I recognise there have been action plans put in place there is still some lack of clarity around timescales and implementation. An additional factor is the CQC involvement and their findings which also mirror some of the findings from the external investigation.
6.	ACTION SHOULD BE TAKEN In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
7.	INVESTIGATION AND INQUEST On 25 June 2025, I commenced an investigation into the death of Benjamin Pesian, aged 25 years and the inquest was concluded on the 24 July 2026. The medical cause of death was 1a) Multiple Injuries Conclusion: Narrative Conclusion The deceased, Benjamin Pesian died after jumping from the terrace balustrade on the [REDACTED] in Birmingham on the 7 June 2025. He sadly died from the fatal multiple injuries sustained. On the evidence available it is not clear if he intended to take his own life and it is likely at the material time he was displaying behaviours associated with a psychotic episode.
8.	CIRCUMSTANCES OF DEATH Benjamin Pesian had been diagnosed with schizoaffective disorder and bipolar affective disorder. His initial onset of his illness occurred in 2020 while he was living in France. He had hospital admissions in France and also in Hamburg in Germany.

	In April 2025 he stopped taking his medication, Aripiprazole and had a relapse. He travelled to Sussex area where he was detained by Police and then transferred to Dorothy Pattison Hospital. He presented with episodes of mania and psychosis. He was initially detained under Section 2 of the Mental Health Act on 11 May 2025 following a psychiatric assessment. The multidisciplinary team (MDT) discussed options of various antipsychotic medication and ultimately decided that Cariprazine medication should be used in conjunction with Promethazine as required. Although he tolerated and reacted well to Risperidone medication, this wasn't given on this occasion. On the 5 June 2025, MDT discussions led to the removal of his detention and converting him to an informal patient status. He was subsequently granted accompanied leave with his family. On the 7 June 2025 whilst on leave with his family, they attended level 25 of the Cube Hotel, Marquet Pierre White Steakhouse and Bar and Grill in Birmingham. Mr Pesian then climbed onto the balustrade on the terrace [REDACTED] and jumped. He sustained multiple traumatic injuries and sadly died at the scene.
9.	CORONER'S CONCERNS During the course of the inquest I heard evidence giving rise to concern. 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: I have concerns about the Trusts 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. 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.

10.	COPIES AND PUBLICATION OF THIS REPORT I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: 1.Family of Mr Pesian c/o Harding Evans Solicitors 2.Mills and Reeve Solicitors representing Black Country Healthcare NHS Foundation Trust. 3.Clyde and CO Solicitors representing MSHA Global Investments Limited. I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
	SIGNATURE