	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: West Midlands Police**
1	**CORONER** I am Adam Hodson, Assistant 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 19 August 2024 I commenced an investigation into the death of Sebastion Benjamin OLIVER. The investigation concluded at the end of the inquest. The conclusion of the inquest was: "Died after suffering an accidental injury to his hand from climbing a fence whilst under the influence of drugs".
4	**CIRCUMSTANCES OF THE DEATH** **At 06:21 on 29/11/23, Benji was found unresponsive by a member of the public outside [redacted], Sutton Coldfield, and was suffering significant blood loss from an incised wound to his left hand, together with hypothermia. Paramedics duly attended and conveyed him to Good Hope Hospital where sadly he could not be resuscitated, and he was pronounced deceased at 07:56. The evidence indicates that there was no third party involvement, and instead Benji had impaled his left hand after trying to climb a spiked metal fence, for reasons unknown, on Harrison Road off Erdington High Street at about 22:00 on 28/11/23 whilst under the influence of drugs. He was attended to and treated by paramedics twice during the evening of 28/11/23 but refused treatment in hospital and subsequently absconded. It is not possible to say whether he would have been found following absconding from hospital. There were missed opportunities for emergency services to provide instructions on bystander life support and provide defibrillation in a timelier fashion, but on the balance of probabilities these delays did not minimally, trivially or negligibly contribute to his death.** Following a post mortem the medical cause of death was determined to be: **1a Incised wounds to the left hand with hypothermia** **1b** **1c** **1d** **II Mixed drugs intoxication ([redacted])**

5	**CORONER'S CONCERNS** 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. The evidence heard at inquest indicates that following an emergency call at 22:18 on 28/11/23, paramedics from West Midlands Ambulance Service ("WMAS") assessed Mr Oliver as requiring hospital treatment to his hand but he refused. Although he was intoxicated, he was deemed to have capacity and let about his way. 2. At 23:10 on the same night, paramedics attended upon him a second time and deemed him to lack capacity due to intoxication. He agreed to be conveyed and treated in hospital but when paramedics went to handover to the hospital staff, he absconded at 00:41 on 29/11/23. 3. WMAS notified West Midlands Police ("WMP") and requested a "safe and well check". After determining he was not at the last known location, the decision was made by officers of WMP to close the log because WMAS had earlier deemed him to have capacity (following the 22:18 call). 4. However, the decision to close the log was an error - as a person's capacity can fluctuate, it was inappropriate for WMP to rely upon a past capacity assessment taken hours earlier in the evening, particularly when a more recent capacity assessment indicated that he lacked capacity and where WMAS were concerned enough to request a "safe and well check". 5. I stress that the evidence was clear at inquest that even if WMP had not closed the log, they may not have been able to find Mr Oliver as it was not known where he went in the two hours or so after he left hospital. before being recorded on CCTV at 02:55 at [redacted], and being subsequently found unresponsive at 06:21. On the balance of probabilities therefore, it cannot be said that Mr Oliver would have been found had the log not been closed. 6. However, I am concerned that the decision to not seek clarification from WMAS as to Mr Oliver's capacity represents shortcomings in training and/or a failure to ensure that WMP properly and effectively communicate with medical colleagues in WMAS when dealing with incidents where patients have fluctuating or lack capacity and abscond from treatment centres. It is not clear whether this was a "one-off" issue localised to a specific officer, or whether it represents a larger or institutional issue. 7. It is easy to anticipate a similar situation occurring in the future which leads to a death that is preventable, particularly those involving vulnerable persons and those lacking capacity. 8. As Coroner, I cannot compel your organisation to take a particular course of action, but I can request that you give consideration to this issue with a view to preventing future deaths. I therefore await your response.
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 25th December 2024. 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: Next of kin I have also sent it to West Midlands Ambulance Service and the Medical Examiner 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. He may send a copy of this report to any person who he 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	**30 October 2024** Signature: **Assistant Coroner for Birmingham and Solihull**