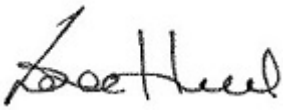
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. The College of Policing 2. IOPC
1	**CORONER** I am Louise Hunt, Senior Coroner for Birmingham and Solihull
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 10 October 2023, I commenced an investigation into the death of Muhammad QASIM. The investigation concluded at the end of the inquest . The conclusion of the inquest was; Road traffic collision
4	**CIRCUMSTANCES OF THE DEATH** In the early hours of 2nd October 2023 Qasim was driving with a male & female in a BMW 123 M sport car LL09 XJF along Church Lane west bound when his vehicle was spotted by a police vehicle driving in the opposite direction. Due to the high speed of Qasim's car, the police officer decided to follow the BMW turning around & illuminating the blue lights. The police car drove along A4040 to obtain a full registration number & gain further intelligence on the vehicle & its occupants, reporting to the police control they were following the BMW. Guided by the rear passenger Qasim turned onto College Road & Friary Road whilst the police car continued to proceed along A4040. Having lost sight of Qasim's vehicle the police vehicle got to the junction of Hollyhead Road & Island Road by Apple Green petrol station turned off blue lights & informed the police control room the vehicle was lost & they had stopped following the BMW. Due to the route Qasim had taken he now found himself behind the police car & was approaching Holyhead road junction where the police vehicle was stationary at traffic lights. Having spotted the police vehicle Qasim used the slip road to turn right onto Island Road. The police vehicle decided to return to Park Lane Police Station making two right turns onto Island Road. After a short period the police vehicle spotted Qasim's vehicle again travelling along Island Road west bound having completed a right hand turn using the cut through in the central reservation. The police vehicle used the same cut through to follow Qasim's car it had not illuminated the blue lights to signal they wished the car to stop at this point as they had not been able to obtain the full registration number of the vehicle. Qasim again proceeded along Island Road & upon reaching the junction of Island Road & Hollyhead Road Qasim took a right turn to return along Island Road East Bound with the police vehicle approximately 8 seconds behind. At this point Qasim & the occupants of the vehicle were aware the police vehicle was behind them & Qasim accelerated quickly to gain distance between his vehicle & the police vehicle with the intention of abandoning the vehicle. As Qasim accelerated out of sight of the police vehicle along Island Road he failed to negotiate a left hand bend, losing control of the vehicle, mounting the grassed central reservation, hitting two trees before the vehicle came to rest on the Road. The road conditions were damp but the weather was dry. Qasim had been ejected from the vehicle when it had hit the tree due to not wearing the drivers seat belt, he suffered catastrophic injuries as a result of the crash. The accident was caused by the speed Qasim was driving, his driving ability was impaired from driving from drinking alcohol & being 1.5 x over the drink drive limit & having smoked cannabis during the day. The way Qasim was driving had also been influenced by the presence of the police vehicle. Upon arriving at the crash scene the police vehicle illuminated its blue lights & attended to the occupants of the

	BMW. The police officer found Qasim on the central reservation & started to administer first aid. A second police vehicle arrived shortly after with one of the police officers assisting with advanced first aid to Qasim before the ambulance service arrived. Qasim was transported to the Queen Elizabeth hospital where he was examined & found that his injuries were unsurviable. Qasim sadly died at 13:17pm on 2nd October 2023 due to a traumatic head injury. Following a post mortem, the medical cause of death was determined to be: **1a Traumatic Head Injury** **1b** **1c** **1d** **II**
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. **For the college of policing**: The inquest heard evidence from 2 specialist police driving instructors in different police forces. Both had a different interpretation of when a spontaneous pursuit could occur as set out in the APP guidance. One force did not train officers who were standard drivers in relation to spontaneous pursuits as these were thought to be a type of pursuit and dependent on first satisfying the main definition of a pursuit under the APP guidance. The other force considered spontaneous pursuit to be a stand alone type of pursuit and trained standard driving officers in relation to it. The confusion around what amounts to a spontaneous pursuit and when one can occur, and the difference in training of police standard drivers, creates a risk of future deaths and action should be taken. 2. **For the IOPC**: The IOPC were investigating the conduct of the police driver in this case. As a result of their investigation no full forensic collision investigation report was obtained. The IOPC need to confirm where investigative responsibilities lie when a conduct investigation is being conducted in all fatal incidents to ensure lessons are learnt from the death and adequate evidence is obtained. The lack of a full forensic collision investigation report in this case creates a risk of future deaths and 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 20 August 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: • The family of Qasim • [redacted] • West Midlands Police • [redacted] • Haven claims insurers 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	**25 June 2025** Signature:  **Louise Hunt** **Senior Coroner for Birmingham and Solihull**