REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** The Rt Hon Victoria Atkins MP, Secretary of State for Health and Social Care **2.** [redacted] Chief Executive Officer for NHS England
1	**CORONER** I am Rachael Clare Griffin, Senior Coroner, for the Coroner Area of Dorset
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 the 23rd March 2022, an investigation was commenced into the death of Richard Andrew Collins, born on the 16th January 1966. The investigation concluded at the end of the Inquest on the 29th February 2024. The medical cause of death was: Ia Traumatic injuries The conclusion of the Inquest was road traffic collision.
4	**CIRCUMSTANCES OF THE DEATH** At approximately 20.45 hours on the 9th February 2022 Richard, who had a diagnosis of bipolar affective disorder, abandoned his vehicle on the verge of the eastbound carriageway of the A421 in Bedfordshire. Following this he was walking about half a metre into the carriageway of lane one of the eastbound carriageway of the A421 about 1.15km west of the roundabout junction with the A421 towards Bedford, when he was struck by the left front side of an articulated lorry. He was found a short time later in a collapsed and unresponsive condition on the grass verge on the side of the A421 and despite resuscitation attempts his death was confirmed.

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. During the inquest evidence was heard that:

   i. There is a legal duty upon a driving licence holder to inform the DVLA of any illness or injury, both physical and mental, that would have a likely impact on safe driving ability. In addition to this, as detailed at page 9 of the ***DVLA Assessing fitness to drive – a guide for medical professionals*** Assessing fitness to drive: a guide for medical professionals - GOV.UK (www.gov.uk), doctors and other healthcare professional should:

   - *advise the individual on the impact of their medical condition for safe driving ability*
   - *advise the individual on their legal requirement to notify DVLA of any relevant condition*
   - *notify DVLA directly of an individual's medical condition or fitness to drive, where they cannot or will not notify DVLA themselves*

   ii. Prior to his death Richard had been detained under section 2 of the Mental Health Act 1983 between 9th December and 20th December 2021 following a relapse of his mental health and his presentation with symptoms of hypomania. He remained a voluntary patient until his discharge on the 7th January 2022. He was advised of his duty to notify the DVLA of his illness by the treating consultant during his admission, however the DVLA were not notified prior to his death and so a full driving licence remained in force.

   iii. Following his release from hospital Richard was under the care of the community mental health team. On the 13th January 2022 his mother contacted his care coordinator, a mental health nurse, and advised that he had purchased a car and had driven it the previous day. On the 31st January 2022 he was assessed under the Mental Health Act 1983 following the police exercising their powers under section 136 of that Act, however was not deemed to require detention.

   iv. Between the date of his release from hospital and his death Richard had a number of contacts with representatives from the secondary mental health services. No medical professional discussed Richard's driving or notification to the DVLA with him after his discharge from hospital, despite there being opportunities to do so. His driving licence remained in force and consideration was not given to its medical revocation prior to his death.

	v. Dorset Healthcare University NHS Foundation Trust (DHUFT), who provide the secondary mental health care services in Dorset, did not have a local written policy in place at the time of Richard's death in relation to assessing patient's fitness to drive and contacting with the DVLA. Since Richard's death DHUFT have implemented a written policy which is accessible to all employees of the trust including mental health practitioners and nurses as well as doctors. This has been well received and felt to be very clear. This provides guidance around the duties upon medical professionals and to support decisions where an individual's ability to drive safely is brought into question. The trust have also changed their practice as a result of the learning from Richard's death. For example, DHUFT have a checklist for all inpatient meetings which now includes the DVLA requirements so that they are considered at every discussion with, or about, the patient. vi. Although there is current guidance from the General Medical Council (GMC) and the DVLA to medical professionals about assessing fitness to drive and notifying the DVLA of concerns, I have not been made aware of any national guidance for NHS trusts on the issue of local trust guidance or policy which could help to ensure awareness of, and compliance with the legal duties relating to the medical revocation of driving licences. 2. I have concerns with regard to the following: i. Whilst considerable work has been undertaken within the secondary mental health services in Dorset, I am concerned that there may be similar issues or missed opportunities nationally within other trusts which could lead to the lack of revocation of driving licences on medical grounds, putting the patients and other road users at risk of death.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe you and/or your organisation 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, 2nd May 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: (1) Richard's Family (2) Dorset Healthcare University NHS Foundation Trust (3) Chief Constable of Dorset Police (4) Chief Constable of South Yorkshire Police (5) Dorset Council (6) Driver of the articulated lorry I am also under a duty to send the Chief Coroner a copy of your response. I have also sent a copy of this report to the following persons for their awareness: a) The Rt Hon Mark Harper MP, Secretary of State for Transport b) Julie Lennard, Chief Executive Officer for the DVLA 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	**Dated** **7th March 2024**	**Signed**  **Rachael C Griffin**