	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO: **1. Driver and Vehicle Licensing Agency (DVLA)**
1	**CORONER** I am Jessica Swift, Assistant Coroner for the City of Kingston Upon Hull and the East Riding of Yorkshire.
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 8 August 2019 an inquest was opened into the deaths of Geoffrey Stewart Toase and Michael William Midgley. The inquest concluded on 2 August 2024, the conclusion reached was the short form conclusion of **road traffic collision**.
4	**CIRCUMSTANCES OF THE DEATH** On 3 August 2019, Mr Toase and Mr Midgley had arranged to spend the day riding their motocycles around Yorkshire, they were accompanied by two associates. At around 3:45pm, whilst travelling down the A166 Garrowby Hill, Mr Toase and Mr Midgley were involved in a head on collision with a car that was travelling from the opposite direction. That car was located wholly on the wrong side of the carriageway at the point at which it collided with Mr Toase and Mr Midgley. The driver of the car involved had a number of health-related conditions, including Type 1 Diabetes Mellitus, controlled by insulin injection. As a result of the diabetes, the driver of the car was required to reapply to the DVLA for a license every 3 years. At the time of the collision, the driver of the car was, on the balance of probability, suffering a hypoglycaemic episode which had compromised their ability to drive in an appropriate manner. Emergency services attended the collision scene swiftly, but the injuries suffered by both Mr Toase and Mr Midgley were such that nothing could be done to save them and they were both declared deceased at the incident scene.

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:– I heard evidence from two representatives of the DVLA at the inquest, including a DVLA employed Doctor. That Doctor gave evidence about their role in the medical review and decision to re-issue a license to the driver of the car involved in the fatal collision. That evidence gave rise to the following concerns: a) DVLA Doctors are not actively encouraged by the DVLA to request further information about an applicant's medical history. b) The DVLA does not generally seek further information from any identified Speciality Doctor that may be involved in an applicant's medical care and treatment; any requests for further information are usually directed to an applicant's General Practitioner (GP). c) The forms sent to an applicant's GP by the DVLA for the purpose of obtaining further information are largely tick box in nature and do not provide sufficient scope for the GP to provide more detailed information and this therefore does not allow for a full assessment to be conducted by the reviewing DVLA Doctor. d) Current DVLA working practices do not appear to allow DVLA Doctors to consider the interplay between different medical conditions an applicant may be suffering with. e) There is no apparent system in place to verify the accuracy of the information provided by an applicant within their medical self-declaration and that this information is generally accepted by the DVLA without question. f) The information provided by an applicant within their medical self-declaration is no longer sent to their GP by the DVLA alongside any request for further information, which limits any scope for the GP to identify if the information contained within a medical self-declaration is accurate. g) The DVLA Doctor involved in this case gave evidence that they felt "constrained" by the DVLA guidance, standards and working practices they are required to work to. h) The decisions made by DVLA Doctors when considering to re-issue a license are not subject to any form of audit procedure to ensure accuracy and consistency of decision-making.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) has 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 **7 October 2024**. I, the Coroner, may extend this 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: ▪ Family of Mr Toase and Mr Midgley; ▪ The driver of the car involved in the collision (via his legal representatives). I have also sent it to the following who may find it useful or of interest: ▪ Department for Transport 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. Your response will also be shared with the above named Interested Persons.
9	**Jessica Swift** **Assistant Coroner for the City of Kingston Upon Hull and the East Riding of Yorkshire** **12 August 2024**