Coroner Service
West Sussex, Brighton & Hove

Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO: The Chief Executive, the Driver and Vehicle Licensing Agency**
1	**CORONER** I am Joseph TURNER, Area Coroner for the coroner area of West Sussex, Brighton and Hove
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 20 May 2024 I commenced an investigation into the death of Kenton Clete BEASLEY aged 54. The investigation concluded at the end of the inquest on 29 January 2025. The conclusion of the inquest was that: On 19th May 2024 Police were called to an address in Ashurst, Steyning by ambulance services where Kenton Beasley had sadly been found hanging. He was confirmed to be deceased at the scene and 3rd party involvement was ruled out. Notes indicating intent were found nearby; he had suffered with his mental and physical health for many years.
4	**CIRCUMSTANCES OF THE DEATH** I concluded that Mr Beasley had sadly taken his own life, due to a severe deterioration in his mental health. A significant contributing factor to that had been his inability to secure long term employment in the transport sector (he had been an HGV driver and transport manager). As a result he had resorted to underpaid and exploitative work, and had been forced to borrow money from friends, leading to a sense of shame and remorse.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters 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: (brief summary of matters of concern) There was a lengthy and unnecessarily protracted period (8 Sep 23 – 12 Mar 24) in which Mr Beasley was attempting to renew his licence, which meant he was unable to secure professional HGV driver employment. The following individual events and consequent frustrations exacerbated Mr Beasley's poor mental state: • DVLA wrote to his GP on 11 October 2023 and the GP surgery responded with the information they believed was required on 18 October 2023. • In a call from Mr Beasley to DVLA of 30 Nov 23 it was apparently confirmed that DVLA had all the necessary information and a 'DVLA Doctor' decision would be forthcoming soon. • It then transpired that was not the case and more or different information was required. There was then a further delay in securing another GP appointment. • Despite that second GP appointment being booked for 10 Jan 24, the DVLA questionnaire was never received by the GP.

	• Despite a GP letter sent after that appointment confirming no concerns at Mr Beasley's physical or mental health in terms of fitness to drive, this was rejected because it did not contain the information in questionnaire format. • It appears to have taken the intervention of his then MP, Greg Clarke, to unlock the impasse • There was a delay in booking a further GP appointment in Feb 24. The above was compounded by the fact that, even once his licence was renewed on 12 Mar 24, this was only for 12 months (to 11 Mar 25) - hence secure long-term employment was not offered. • Mr Beasley was further distressed at the prospect of having to repeat the renewal process. In the period Sep 23-Mar 24, whilst verbally informed that he was able to drive under s.88 RTA 1988, the online checker was showing his licence to have expired, hence over 20 potential employers refused to hire him, notwithstanding his attempts to explain s.88. Mr Beasley had been unable to find out the reason for the delay, nor was he informed until late in the process what the original reason for removal of his licence had been. • It eventually transpired that this arose due to a previous attempt at self-harm over twenty years earlier, since and despite which he had driven professionally for many years. It was never made clear why this was so. He was frequently unable to get through via the telephone advice service. Mr Beasley had attempted telephone contact on multiple occasions, but calls went unanswered and unattended. • Even though an individual medical caseworker was assigned, Mr Beasley's experience was that contact was still difficult and sporadic and he was constantly chasing rather than being kept informed. • On some occasions when he made telephone contact he was in tears of frustration but no vulnerable customer protocol appears to have been followed, nor was there any attempt to expedite his application or provide a fuller explanation as to the delay.
6	**ACTION SHOULD BE TAKEN** In my opinion 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, namely by April 04, 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 [redacted] – wife [redacted] (sister) [redacted] (sister) I have also sent it to who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it.

	I may also send a copy of your response to any person who I believe may find it useful or of interest. 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: 07/02/2025 Joseph TURNER Area Coroner for West Sussex, Brighton and Hove