	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1) Secretary of State for Transport** **2) DVLA** **3) The General Medical Council** **4) The General Optical Council**
1	**CORONER** I am Adam Hodson, Area 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 21 April 2022 I commenced an investigation into the death of Christopher Graham Ayerst SAMPSON. The investigation concluded at the end of the inquest . The conclusion of the inquest was : Road traffic collision
4	**CIRCUMSTANCES OF THE DEATH** **Chris was a front seat passenger in a Mazda automobile (registration [redacted]) being driven along the A45 Coventry Road towards Birmingham in South Yardley on 01/04/22. It was daylight; the road surface was dry; the weather was clear; and the speed limit was 40mph. At around 18.54, the driver of a Mercedes E220 automobile (registration [redacted]) was seen to have a medical episode at the wheel whilst stationary at a set of traffic lights at the junction of Holder Road/Forest Road before then driving off at high speed. The Mercedes travelled a distance of approximately 0.4 miles, changing lanes and reached speeds in excess of 100mph before colliding into the back of the Mazda between the junction of Redhill Road and Kings Road. The collision forced the Mazda across the central reservation and to collide with a road sign before becoming airborne and then landing on its roof on the opposite side of the carriageway. The emergency services attended rapidly, but sadly Chris had sustained unsurvivable injuries and was declared deceased at the scene at 19:43.** Following a post mortem the medical cause of death was determined to be: **1a MULTIPLE TRAUMATIC INJURIES** **1b ROAD TRAFFIC COLLISION AS A FRONT SEAT CAR PASSENGER**
5	**<u>CORONER'S CONCERNS</u>** 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. I heard evidence in this inquest concerning the requirement of drivers' to self-notify the DVLA of any medical conditions that may interfere with their driving. The evidence in this inquest

	was that the driver of the vehicle that caused the fatal road traffic collision - due to an unexpected medical event at the wheel - had a number of health issues. As it could not be proven which medical condition caused him to suffer the medical event, it could not be said that he should (or even could) have regulated his driving accordingly. 2. Furthermore, the driver's medical records were ambiguous as to whether he had been explicitly told to notify the DVLA of his health conditions. 3. The evidence was that the driver played "fast and loose" with the DVLA but that he had not committed any crime. 4. The issue of drivers failing to self-refer their health issues to the DVLA for assessment is a serious and persisting issue. From the Courts and Tribunals Judiciary website for Prevention of Future Deaths (https://www.judiciary.uk/?s=&pfd_report_type=&post_type=pfd&order=relevance), I am aware of at least 6 PFD reports being issued in the past 3 years (References - Ref: 2025-0523 (3 deaths); Ref: 2025-0196; Ref: 2024-0507; Ref: 2025-0031; Ref: 2025-0214; Ref: 2024-0127). 5. Following scrutiny of those reports, it is apparent that the DVLA and Department of Transport previously called for evidence in 2023 seeking views on the current legislative basis for establishing whether a person was medically fit to drive. At that time, officials were considering that evidence and considering policy options as part of the government's road safety strategy which was being developed and the details would be provided, "in due course". 6. Two years later from that call for evidence, and still no national strategy has been announced. I understand that in August 2025 His Majesty's Government announced that a new Road Safety Strategy would be published in the Autumn of 2025. However, we are now in the depths of November and there is no sign currently of any Road Safety Strategy being published. 7. I am aware that the DVLA publishes guidance on GOV.UK called "Assessing fitness to drive: a guide for medical professionals" to support healthcare professionals (https://www.gov.uk/government/publications/assessing-fitness-to-drive-a-guide-for-medical-professionals). What is unclear, however, is whether a) that guidance is well known amongst medical professionals, and b) whether that process is an effective mechanism for doctors to report patients with health issues, as there does not appear to be any published statistical evidence on the issue. 8. I am also aware that The General Medical Council (GMC) and the General Optical Council (GOC) offer guidance about notifying DVLA when the person cannot or will not exercise their own legal duty to do so. Again, it is unclear whether a) that guidance is well known amongst medical professionals, and b) whether that process is an effective mechanism for doctors to report patients with health issues, as there does not appear to be any published statistical evidence on the issue. 9. Drivers may not self-report medical conditions due to a variety of reasons. This can be due to due to a lack of understanding, insight, or simply because someone has not explicitly told them what to do or how to do it. There are then those who are reckless and knowingly avoid notifying the DVLA of a health condition when explicitly told to do so - either through arrogance, pride or through fear of losing employment. The end result is the same: people are dying needlessly on our roads due to people who, legally, should not be on our roads. 10. There is a risk of future deaths occurring where drivers do not self-refer their conditions to the DVLA, or where medical professionals do not report those health issues to protect the wider public. 11. It is not for I, as Coroner, to tell you what action should be taken. However, it is part of my judicial function to bring this matter to your attention so that you – individually and collectively – can consider what steps can and should be taken to reduce the risk of deaths occurring in the future.
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 07/01/26. 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) [redacted]next of kin 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	**12 November 2025** Signature:  **Adam Hodson** **Area Coroner for Birmingham and Solihull**