Middleton Lodge Practice
Church Circle,
New Oilerton,
Newark,
Nottinghamshire,
NG22 9SZ
[redacted]

Friday, June 19, 2026

Mr Nathanael Hartley
Assistant Coroner
Nottingham City and Nottinghamshire Coroners Service
Nottingham City House
Council House
Old Market Square
Nottingham
NG1 2DT

Dear Mr Hartley

Re: Michael Chadwick DOB 27.06.78 (deceased)
Late of 13 Turner Lane, Boughton, Newark, Nottinghamshire, NG22 9HN

Following on from your concerns outlined in your report for Mr Chadwick, we would like to take this opportunity on behalf of the Partnership at Middleton lodge Practice to offer our sincere condolences to the family of Mr Chadwick. We have continued to support his wife at this difficult time.

We have performed a case review of his records and hospital correspondence specifically regarding potential missed opportunity of notification not to drive and the potential risk of future missed opportunity.

Whilst I can see there has been mention on a number of occasions where Mr Chadwick had a sudden loss of consciousness collapse, later noting a diagnosis of cough syncope which is identified from your inquest, this would require advice to stop driving and DVLA notification, no mention of this advice is present in the GP records. I am unable to comment if this information was verbally given but not written, as both clinicians who saw Mr Chadwick during this time have since left our Practice, one emigrating.

We have taken this opportunity to review and discuss Mr Chadwick's case at both senior and clinical level, where I presented a case presentation at a clinical meeting where it was felt that on balance the majority of clinicians present felt

that this was a complex case, had multiple speciality input but on balance would and should have resulted in advice regarding fitness to drive. As a Practice this has highlighted the need to refresh our knowledge of the DVLA standards and guidance for medical professionals. All clinicians were advised to keep this guidance as a bookmark for ease of access. We have also identified the importance of accurate documentation, if this advice is given verbally but not documented, even if fitness to drive has been consider but deemed safe, both relevant and need clear documentation. There is also the ability to quick code this advice via our clinical system, SystmOne. This also includes a quick guide and notification responsibilities of the patient and clinicians. One clinician reflected on a recent case of collapse where it was unclear if this advice was given, where they have since reviewed this case and contacted the patient for review, communicating the specialities involved that this advice has been given.

Following from this I plan to run a system audit in 6months to audit the use of readcodes/identification.

We continue to offer support to Mrs Chadwick and offer opportunity for further discussions.

Yours sincerely

[redacted]

Advanced Clinical Practitioner