Please ask for the Medical Director's Executive Assistant
[redacted]

[redacted]
19 June 2026

Medical Director's Office
3rd Floor, Trust Headquarters
City Hospital Campus
Hucknall Road
Nottingham
NG5 1PB

[redacted]

Mr Nathanael Hartley
HM Assistant Coroner for Nottingham City and Nottinghamshire
HM Coroner's Court
The Council House, Market Square,
Nottingham NG1 2DT

Dear Mr Hartley

Inquest: Michael Chadwick - Prevention of Future Death Report [PFDR] Response

I am writing in my capacity as Medical Director of Nottingham University Hospitals NHS Trust in response to the Prevention of Future Death Report issued on 27th April 2026 following the Inquest into the sad death of Mr Michael Chadwick. The enclosed commentary document responds to each of the concerns raised relating to Nottingham University Hospitals NHS Trust.

May I begin with offering my sincerest condolences to Mr Chadwick's family for their loss. I am deeply sorry for the missed opportunities and issues that were highlighted during the Inquest.

The actions taken in response to the learning from the inquest are summarised in the attached document. Oversight of the delivery of these actions will be through our Quality and Safety Governance Committees, with Executive oversight and the Committees of our Board will receive a progress report.

I hope that this document provides assurance that we are committed to learning from this, and other incidents to significantly enhance the care of patients across the Trust.

Yours sincerely

[redacted]
Medical Director and Responsible Officer

GMC Number 4535218

Concerns identified through the PFDR

The Trust responds to the concerns raised as follows:

1. On the multiple occasions that Mr Chadwick was assessed, and his cough syncope brought to the attention of the medical professionals, there was no advice given him to stop driving and to notify the DVLA of his cough syncope, either orally or in writing.

The Coroner highlighted concern that clinicians may fail to provide similar guidance to other patients, which may lead to episodes of syncope whilst driving, with potentially fatal consequences.

The Trust acknowledges the Coroner's concerns regarding the lack of advice given to Mr Chadwick on his ability to drive and need to notify the DVLA.

In response, the following actions are being taken:

1. **Review of the NUH guidelines relating to Transient Loss of Consciousness**

   The Trust's current 'Transient Loss of Consciousness' guidance is approved until 2027 and includes guidance on providing patients with suspected transient loss of consciousness information on driving. The information provided links to the current DVLA guidance on assessing fitness to drive. This guideline was circulated on 15th June 2026 to all consultants across the Trust to ensure awareness.

2. **Guidance from the Medical Director and DVLA circulated to all Consultants and Care Group Governance teams within the Trust to confirm the importance of providing this information to patients.**

   A letter from the Medical Director has been circulated to all Consultants at the Trust (Appendix 1) to remind them of their professional duty to advise patients if their diagnosis may impact fitness to drive and to inform patients of their obligation to contact the DVLA in this regard. This guidance has also been included on the Trust's KOHA system within which the Clinical Guidelines, Trust Policies and Standard Operating Procedures sit.

Summary

The actions outlined above are intended to address the concerns identified in the Prevention of Future Deaths Report regarding provision of driving advice to patients.

I hope this response provides both you and the family reassurance of the Trust's commitment to learning from this case and to strengthening the safety and quality of care for our patients.

Appendix 1

NHS
Nottingham
University Hospitals
NHS Trust

Please ask for the Medical Director's Personal Assistant

[redacted]

Medical Director's Office
Trust HQ, 3rd Floor
City Hospital campus
Hucknall Road
Nottingham
NG5 1PB

[redacted]

15 June 2026

TO: All NUH Consultants

Dear Colleagues

Guidance on Providing Driving Advice to Patients

I am writing to remind colleagues of the importance of giving clear driving advice to patients whose medical condition or treatment may affect their fitness to drive.

This follows a Regulation 28 Prevention of Future Deaths Notice issued to NUH by Miss Laurinda Bower, Area Coroner, relating to driving advice for a patient who experienced transient loss of consciousness.

Doctors have a professional responsibility to assess whether a patient's condition or treatment may affect their ability to drive, and to give appropriate advice. In the UK, patients are responsible for notifying the DVLA. However, doctors must advise patients when notification may be required and must document this advice in the clinical record and correspondence.

If written information leaflets are given to patients, this should also be recorded.

- General information: assessing fitness to drive - GOV.UK
- Patients' fitness to drive and reporting concerns to the DVLA or DVA - professional standards - GMC

The NUH clinical guideline relating to Transient Loss of Consciousness can be accessed via Koha.

Please review your local processes and ensure practice is compliant with current DVLA, GMC and NUH guidance.

Yours sincerely

[redacted]

Medical Director and Responsible Officer

[redacted]