



REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Clinical Director for Sherwood Forest Hospitals NHS Trust Clinical Director for Nottingham University Hospitals NHS Trust Practice Manager at Middleton Lodge Practice
1	CORONER I am Nathanael Hartley, assistant coroner for the coroner area of Nottingham and Nottinghamshire.
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 22 December 2025 an inquest was opened into the death of Michael Chadwick, aged 47. The inquest concluded on 27 April 2026. I made a determination at inquest that he died as a result of injuries sustained in a road traffic collision.
4	CIRCUMSTANCES OF THE DEATH Mr Chadwick approached his GP at Middleton Lodge Practice (MLP) in 2022 with reports of breathlessness and headaches. He was later seen by a Consultant Neurosurgeon at Nottingham University Hospitals (NUH) and informed them of coughing, shortness of breath of exertion and having "blacked out" on a couple of occasions. Cough induced syncope episodes were reported to a Respiratory Consultant and a Consultant Cardiologist at Sherwood Forest Hospitals (SFH). He was seen at the Urgent Care Centre (UCC) at King's Mill Hospital at SFH and reported the same. Mr Chadwick's family accompanied him at appointments and do not recall him ever having been given advice about not driving and informing the DVLA of the change to his health. None of the letters sent to his GP confirming the outcome of these appointments make any reference to this advice being given. MLP was aware of the contents of a letter from SFH following his attendance at the UCC, which included the words "probable (sic) Cough Syncope", and no guidance around driving was provided to Mr Chadwick by MLP. Mr Chadwick died following injuries sustained in a road traffic collision when the motorcycle he was driving left the road. An investigation revealed Mr Chadwick made no steering or other kind of input to the motorcycle when he left the road. I did not find, on balance, that a cough syncope caused the loss of control.
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 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. – 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. I am concerned that clinicians may fail to provide similar guidance to other patients, which may lead to episodes of syncope whilst driving, with potentially fatal consequences.
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 22 June 2026. 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 will send a copy of my report to the Chief Coroner (upon receipt of your reply) and to the following Interested Persons: 1. Mr Chadwick's family. I am under a duty to send the Chief Coroner a copy of your response 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. 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	Dated: 27 April 2026 Nathanael Hartley HM Assistant Coroner For Nottingham and Nottinghamshire