SHERIFFDOM OF LOTHIAN AND BORDERS AT EDINBURGH

[2024] FAI 43

EDI-B211-24

DETERMINATION

BY

SHERIFF PRINCIPAL N A ROSS

UNDER THE INQUIRIES INTO FATAL ACCIDENTS AND SUDDEN DEATHS ETC (SCOTLAND) ACT 2016

into the death of

ALEXANDER IRVINE

EDINBURGH, 18 October 2024

Determination

The Sheriff Principal, having considered the information presented at the Inquiry, determines in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 (the "2016 Act") that:-

1. Alexander Paul Thomas Irvine ("Xander") was born on 22 April 2017. His parents are Paul Irvine and Victoria Irvine. He resided with them at their family home. He died, aged three years, on Tuesday 30 June 2020 at The Royal Hospital for Sick Children, Edinburgh at 15.07 hours.

2. In terms of section 26(2)(b) of the 2016 Act: Xander died as a result of having been struck by a Kia Picanto motor vehicle on Morningside Road, Edinburgh, on 30 June 2020 at approximately 14.25 hours.

3. In terms of section 26(2)(c): Xander died as a result of catastrophic injuries incurred in the collision. Following post-mortem examination, the medical cause of death was certified as: 1a. Multiple Injuries and 1b. Road vehicle incident (pedestrian).

4. In terms of section 26(2)(d): The cause of the collision was the loss of control of the vehicle by the driver and owner, Edith Duncan. Ms Duncan's date of birth was 27 March 1929. She was aged 91. Ms Duncan lost control of the vehicle while attempting to perform a turning manoeuvre on Morningside Road, Edinburgh, a two-way street in an urban area. As a result of loss of control, Ms Duncan drove her vehicle onto the opposite carriageway, over the kerb and onto the pavement, striking Xander and his mother. The loss of control was entirely caused by Edith Duncan's inability to perform safely what would otherwise have been a routine turning manoeuvre. She was, at the time, suffering from significantly impaired cognitive ability as a result of frontotemporal dementia, and was unfit to drive or hold a driving licence.

5. In terms of section 26(2)(e): The collision could have been avoided by prior revocation of Ms Duncan's driving licence. Revocation was both reasonable and required in light of her cognitive impairment and consequent inability to drive safely. Had reasonable precautions been taken, prior to the collision, to assess Edith Duncan's cognitive ability, these would have identified that she required further assessment of her driving ability. That further assessment would have, in turn, led to the conclusion that she was significantly cognitively impaired and unfit to hold a driving licence. The DVLA would have revoked her licence on that basis. Accordingly, had her cognitive impairment been detected, the incident would have been avoided.

6. In terms of section 26(2)(f): The current regime of self-certification of fitness for drivers over 70 years of age is significantly defective. It relies on self-certification by the applicant driver. It fails to identify unfitness to drive in applicants who either deliberately or unintentionally fail to give correct information on the relevant application form. It fails to recognise that driving ability may decline with age, or that dementia sufferers may be unaware of their own condition.

7. In terms of section 26(2)(g): The foregoing are the facts relevant to the incident. Other relevant facts to the circumstances of the death are discussed below.

Recommendations

In terms of section 26(1)(b), I recommend:

1. That the present system of self-certification of fitness to drive after the age of 70 years be changed as a matter of priority, by limiting self-certification of fitness to drive only to applications before the age of 80 years. Application for renewal should continue to be required every three years, from the age of 70 onwards. Any application for renewal by a driver aged 80 or older should not be granted unless the applicant driver has successfully undertaken a short initial cognitive assessment. Failure to pass that assessment should result in both the application for renewal, and any current licence, being suspended pending further assessment. This recommendation would require changes to primary legislation, on a reserved matter under Schedule 5 to the Scotland Act 1998, and is therefore a matter for the UK Government.

2. That the present application form for renewal of a driving licence, form D46P, be changed by the DVLA as a matter of priority, to include further questions which elicit information about recent driving history.

3 Consideration should be given to reducing the age limit in recommendation 1 to 75 years of age.

NOTE

[1] This note follows the prescribed structure, and comprises Introduction; Legal Framework; Summary; Submissions; and Discussion and Conclusions. The reasons for the recommendations are discussed under Discussion and Conclusions.

Introduction

[2] This Inquiry was held under the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 (the "2016 Act"). The death of Xander was reported to the Crown Office and Procurator Fiscal Service on 6 July 2020. Notice of an Inquiry was lodged on 13 February 2024 and warrant for citation granted on 16 February 2024.

[3] Preliminary Hearings were held on 11 April 2024, 21 May 2024, 18 June 2024 and 29 July 2024. The Inquiry was held on 12 to 16 August, and 21 August, 2024. The Crown was represented by Mr Crawford, Advocate-Depute. The participants were: Xander's parents, Paul and Victoria Irvine, who were represented by an agent for two of the preliminary hearings, but were not represented at the Inquiry itself; and the Office of the Advocate General for Scotland, represented at the Inquiry by Mr Crabb, advocate. The

Crown issued more than one invitation to the Royal College of General Practitioners to participate, but participation was declined. The Association of British Insurers also declined to participate, but a director, Philippa Handyside, gave evidence.

[4] The Inquiry heard evidence from: Clare Kavanagh, Paula Drury, Sally Phillips and Judith Maxwell, who were all witnesses to the accident and its aftermath. PC John Lang gave expert evidence on procedures involving unfit drivers. Dr Mark Stevenson and Dr Beth Townend spoke to Edith Duncan's health history and to general approaches to unfitness to drive in patients. Professors Gary Macpherson and Alistair Burns, and Dr Sarah Keir, gave evidence on Ms Duncan's mental health and on methods of assessing cognitive impairment. Dr Lynne Hutton gave evidence on rehabilitation medicine and assessment of fitness to drive in the impaired. Philippa Handyside spoke to insurance practices. Dr Nick Jenkins, senior doctor at DVLA, spoke to the re-licensing regime and assessment of fitness to drive. Andrew Swain, Driveability Scotland, spoke to the practical assessment of fitness to drive amongst impaired drivers. Statements were made available from other witnesses to the incident.

The legal framework

[5] This Inquiry was held in terms of section 1 of the 2016 Act. The Inquiry was a discretionary inquiry held in terms of section 4, in that the death occurred in circumstances giving rise to serious public concern. The Inquiry is governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017.

[6] The purpose of an Inquiry is, in terms of section 1(3) of the 2016 Act, to establish the circumstances of the death of Xander Irvine and to consider what steps (if any) might be taken to prevent other deaths in similar circumstances. It is not the purpose of an inquiry to establish civil or criminal liability. An inquiry is an inquisitorial process. . The procurator fiscal, in investigating the death and arranging for an inquiry, represents the public interest.

[7] Section 26 of the 2016 Act sets out the matters to be covered in the determination. These include setting out findings (as above) on the following:

(a) when and where the death occurred,

(b) when and where any accident resulting in the death occurred,

(c) the cause or causes of the death,

(d) the cause or causes of any accident resulting in the death,

(e) any precautions which –

(i) could reasonably have been taken, and

(ii) had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided,

(f) any defects in any system of working which contributed to the death or any accident resulting in the death,

(g) any other facts which are relevant to the circumstances of the death.

They also include setting out such recommendations (if any) in relation to:-

(a) the taking of reasonable precautions,

(b) the making of improvements to any system of working,

(c) the introduction of a system of working,

(d) any other steps,which might realistically prevent other deaths in similar circumstances.

Summary

[8] The facts surrounding the death of Xander are not disputed and are proved.

[9] On Tuesday 30 June 2020 at about 14.25 hours Xander and his mother, Victoria, were walking down the east side of Morningside Road, Edinburgh. It was daylight, dry and clear weather. They were walking slowly and looking in shop windows. Unknown to them, on the other side of the road, Edith Duncan was preparing to drive her vehicle, a red Kia Picanto car. She had been shopping nearby and returned to the vehicle, having left it parked illegally on zig-zagged white lines adjacent to a pelican crossing for around 35 minutes.

[10] The vehicle was on the west side of the street, facing north. Edith Duncan began to manoeuvre the vehicle to face south. She commenced a U-turn across the road. As she did so, she caused the vehicle to accelerate quickly towards the opposite kerb, where Xander and his mother were standing. The vehicle continued to accelerate, and mounted the kerb on the east side of the road, with sufficient force to cause a tyre to deflate. Xander and his mother were standing with their backs to the vehicle and did not see it. The vehicle collided with them both, pushing them violently into a shop frontage, where Xander remained trapped. The vehicle was only halted by colliding

with the shop frontage. Ms Duncan did not depress the brake at any point prior to the collision. Xander and Victoria Irvine were seriously injured.

[11] There was no relevant defect in the car and no other contributing factor. The collision was entirely caused by dangerous driving by Ms Duncan. She failed to keep the vehicle under control.

[12] As a result of the collision, Xander suffered catastrophic injuries. Cardiopulmonary resuscitation was attempted at the scene by members of the public before the arrival of the emergency services. He was taken by ambulance to The Royal Hospital for Sick Children, Edinburgh. Despite all medical efforts to save him, he died at 15.07 hours on 30 June 2020. A post-mortem examination was carried out on 3 July 2020. The medical cause of death was certified as:

1a. Multiple injuries

1b. Road vehicle incident (pedestrian)

[13] On 24 September 2002 Ms Duncan appeared on petition at Edinburgh Sheriff Court charged with contraventions of sections 1, 3ZB, 143(1) and (2) of the Road Traffic Act 1988; Regulation 20(2) of the Zebra, Pelican and Puffin Pedestrian Crossings Regulations and General Directions 1997; Regulation 14(5) of the Traffic Signs Regulations and General Direction 2016; and section 25(5) of the Road Traffic Regulation Act 1984.

[14] Ms Duncan died before an indictment was served.

[15] Ms Duncan's driving killed Xander Irvine. She drove her vehicle into collision with Xander and his mother as a result of cognitive mental impairment.

[16] Her mental impairment was unknown, either to herself or to others, at the date of the incident. She did not recognise or understand that she suffered from cognitive impairment or diminished ability to drive. That is an inherent feature of age-related dementia, from which she suffered. Her diminished ability to drive was undetected, even by her general practitioners, because her presentation was such as to disguise her underlying cognitive impairment. Her impairment was also unknown to the Driver and Vehicle Licensing Authority (the "DVLA"), the body responsible for the licensing of drivers within the UK. There was no means of the DVLA becoming aware of her diminished ability to drive.

[17] The events of 30 June 2020 appear to be out of character for Edith Duncan. Her history was consistent with observing rules. She told the police and a psychologist at interview that she was a theatre sister in Orthopaedics for 30 or 40 years, and had an advanced drivers licence. She had no known previous convictions, despite having held a driving licence since passing her driving test in 1964. She had owned her vehicle for 8 years.

[18] She was, however, suffering from dementia on 30 June 2020, sufficiently severely to render her unfit to drive. There are a number of factual events which together lead to this conclusion:

[19] The first was the occurrence of the accident itself. One witness, Judith Maxwell, saw the car as it collided with the pavement, then with Xander and his mother. The car was "revving like it was going up a hill". The car stopped as a result of collision with the building, not because of any braking by the driver. The driver "looked confused".

Ms Duncan said to other witnesses at the time, and in her police interview, that her foot must have slipped on the accelerator. That explanation made no sense in the context of a car which continued to accelerate. During her interview, when pressed on the fact that her brake lights did not come on, she could not explain the mechanism of how the car had stopped. Accordingly, Ms Duncan was largely unaware of how she had driven.

[20] The second was her conduct after the accident. Another witness, Clare Kavanagh, who helped Edith Duncan out of the car and looked after her in a nearby office, described her as very calm, and clearly not having realised what she had done. Edith Duncan spoke about shopping, and worried that the eggs she had bought would be smashed. She kept saying she had new shoes and her foot must have slipped. Ms Kavanagh described Edith Duncan's presentation as "quite eerie". Another witness, Sally Phillips, spoke to Edith Duncan worrying about "them taking my licence off me". There was a lot of crying going on amongst bystanders, but Ms Duncan was "quite detached". Accordingly, even immediately following a dramatic and fatal event, Ms Duncan was unable to recognise the seriousness of what had happened, or to discern which were the important facts.

[21] The third was that she was driving uninsured. She had cancelled her insurance in March 2020. A recording of a conversation between her and a call handler was played. She was heard to say "I only drive once a week or so now and I don't want to pay all that money". She was concerned about the cost of insurance, and asked for the policy to be cancelled. Ms Duncan's decision to cancel her motor insurance and then continue to drive was illogical, and contrary to her previous practice of obtaining

insurance. She disregarded the legal requirement not to drive without insurance. This is all apparently contrary to her previous rule-observant career as an orthopaedic theatre sister, and show a lack of consequential thought.

[22] The fourth is that she had, immediately prior to the incident, left her car illegally parked on zig zag lines adjacent to a pelican crossing, on a main thoroughfare, for an extended period of 35 minutes or so. That raises doubts whether she recognised that parking there was illegal, or that there was a high risk of receiving a parking ticket. In her interview she said she did not notice she was within the confines of a crossing, despite the markings being highly visible. Ms Duncan exhibited very low awareness of her environment.

[23] The fifth is her conduct at the subsequent police interview. Ms Duncan showed no sign of recognising the seriousness of her position. She gave a nonsensical description of how the collision occurred (her "foot must have slipped on the accelerator") despite evidence that the car continued to accelerate throughout. She could not remember whether she had paid her insurance renewal, despite having cancelled the renewal some months before. She considered herself a good driver. She could not remember parking on zig zag lines but knew it was not permitted. She had to be prompted into remembering that a child had died. Her presentation was inconsistent with her facing serious criminal charges. It was incongruous.

[24] The sixth is based on psychological assessment, and review of her medical records. She was assessed by Professor Gary Macpherson, professor of forensic and legal psychology, on 30 April 2021, 10 months later. She presented as an elderly lady

with a "no-nonsense" presentation. She thought the whole thing was a fuss, which was a gross misunderstanding of her circumstances in facing serious criminal charges. She was extremely articulate and able to outline her background and functioning in reasonable detail. She presented as cognitively intact, and could recall historic detail with little difficulty. There was, however, an emotional disconnect between the gravity of her criminal changes and her emotional response. Attention span and short-term memory were significantly impaired. She had no concerns about her own cognitive abilities.

[25] For these reasons, it is established that Ms Duncan was medically unfit to drive or hold a driving licence on 30 June 2020.

Submissions by participants

[26] For the Crown, Mr Crawford AD submitted that this incident raised a matter of serious public concern. The background to, and mechanism of, the incident leading to Xander's death were not in dispute. The probable explanation was that Ms Duncan suffered at the time from dementia, and that her disease contributed materially to the loss of control of the vehicle. It was likely a form of dementia affecting the frontal lobe. Whether this was frontotemporal dementia or a frontal variant of Alzheimer's disease was of no material significance. The evidence showed that Ms Duncan could have had her symptoms for up to three years prior to the incident, with symptoms potentially noticeable by others approximately 12 months to 18 months after the onset of symptoms. Events surrounding the incident tended to confirm a change of behaviour, including

cancellation of insurance, illegal parking, loss of control of the vehicle, lack of awareness following the collision, and subsequent denial of a previous accident in 2019. Her conduct was remarked upon by others as showing little recognition of the seriousness of the incident. A cognitive test carried out in April 2021 showed poor memory and attention functioning, as well as serious defects in visuospatial awareness.

[27] Mr Crawford submitted that various precautions could have avoided the death. These are discussed below. He identified defects in the system of driver licensing. Safe driving requires complex interactions involving behaviour, strategic and tactical abilities, and personality. Dementia and cognitive impairment can affect these. The symptoms can be hidden. Sufferers may not be self-aware. There are adverse consequences from a diagnosis. There is a significant shortfall in the number of diagnosed sufferers compared to the total number of sufferers. That risk is likely to increase. It is estimated by the Scottish Government that the number of people with dementia is likely to rise by 50% in the next 40 years. The risk posed by drivers by dementia is not monitored. The system of self-certification is not effective to meet this risk. Information sharing by insurers and by the DVLA is limited.

[28] On behalf of the Crown, the Inquiry was invited to conclude that there was a pressing need to address the risks created by failing to identify drivers with dementia. It is readily foreseeable that future deaths will occur for similar reasons. Basic cognitive tests would go some way to identifying future risks. Such testing could be inexpensive and take little time. There is a general lack of data, national or international, around the risk to public safety posed by dementia in drivers. The level of risk could, at best, be

described as unknown but potentially very high. Awaiting such data and analysis would create lengthy delay and leave the problem unresolved. Various possible solutions included mandatory testing; countersignature of renewal forms by a medical practitioner; increased criminal penalties for failure to disclose known conditions; guidance to insurers; and sharing of medical information between DVLA and clinicians.

[29] For the Advocate General, it was accepted that the facts and circumstances were as set out by the Crown. There was no divergence from the Crown submission about the prevalence or risks posed by dementia in drivers, or the issues which require to be addressed. Ms Duncan had been suffering from a mental impairment which had not been detected by the medical professionals with whom she had contact. While this may have been detectable by those who had regular contact with her, she lived alone and had no immediate family. Her excellent command of language had served to mask the symptoms. Her unfitness to drive was a matter of assumption, because cognitive impairment does not automatically equate with unfitness to drive, which had not been tested.

[30] If dementia were to be found to be the cause of the loss of control, the evidence did not establish any precautions which might reasonably have been taken. Input from family and friends in assessment is important, but she did not have that. A minor accident in 2019 would not have triggered investigation. Countersignature of the renewal form would have been ineffective where her doctors had not detected in her presentation any signs of dementia. Cognitive assessment would have led to advice not to drive but not, on the evidence of the driving assessor, necessarily unfitness to drive.

Driving assessment had been referred to as the gold standard, but even that may not have revealed unfitness to drive.

[31] It was submitted that no defect in the system of licensing was established. Ms Duncan's symptoms may not have been detected by any of the proposed changes. There was no evidence that mandatory age-based cognitive assessments would be effective. Not all the experts had suggested such a change. Attempts in England at dementia testing had failed. There was insufficient data. There was no agreement as to the way forward, as any solution raised complex issues. The DVLA had already called for evidence on licensing drivers with medical conditions. The evidence was submitted by 22 October 2023. This was an exercise in seeking input to help formulate proposals which could support potential future changes to the legislative framework. A publication date of the summary has not yet been confirmed.

[32] Xander's parents were the only other participants. They did not make separate representations and were content that the Crown had raised the issues they wished to be considered.

Discussion and conclusions

[33] The evidence supports the following conclusions:-

<u>Conclusion 1:</u> Edith Duncan's age-related cognitive decline could have been detected in advance, but only by formal testing.

<u>Conclusion 2:</u> If Edith Duncan's condition had been detected, her licence would have been revoked and she would not have driven her car on 30 June 2020.

<u>Conclusion 3:</u> Edith Duncan was permitted to keep driving as a result of a significant and preventable defect in the present system, which allows drivers with dementia to self-certify fitness to drive.

<u>Conclusion 4:</u> The serious failure in the system can be remedied by introduction of compulsory age-related testing.

<u>Conclusion 5:</u> The minimum effective type of testing is a short initial cognitive assessment, and introduction would be feasible, proportionate and effective.

<u>Conclusion 6:</u> The short initial cognitive assessment ('SICA') should be in a form similar to cognition tests currently available to GPs, and should become compulsory for applications from age 80 onwards.

<u>Conclusion 7:</u> Separately, the current application for renewal of driving licence form D46P should be extended as a matter of priority, to include further relevant questions.

<u>Conclusion 8:</u> No changes to the duties on the police, medical practitioners or insurance companies would have avoided the incident, or are otherwise necessary.

Each of these conclusions is discussed below, but first it is necessary to set out a summary of the law as it is presently:

<u>Background</u>: what is the current regime for relicensing people over the age of 70 years?

[34] The licensing regime has complex provisions and reference should be made to these for their full terms. The following is a restricted summary only for the purposes of this Determination.

[35] The Secretary of State for Transport acts through the DVLA in Scotland, England, and Wales. The DVLA is responsible for ensuring that licence holders in Great Britain are fit to drive. There is no upper age limit in the UK for holding a driving licence. The Road Traffic Act 1988 (the 'RTA 1988') at sections 92 to 96 and 99, and the Motor Vehicles (Driving Licences) Regulations 1999 ("the 1999 Regulations") set out the statutory requirements regarding fitness to drive. Drivers require to be fit to drive. When applying for a licence, an applicant must declare if they are suffering, or have suffered, from any 'relevant' or 'prospective' disability (section 92(1)), which is defined (section 92(2)). Severe mental disorder is a prescribed disability (1999 Regulations 71(1)(b) and 71(1)(4)(a)). If it appears from the applicant's declaration, or after inquiry, that the applicant is suffering from a relevant disability, the Secretary of State must refuse to issue a licence unless certain conditions are met (section 92(3) and (4)).

[36] The Secretary of State must serve notice in writing where, as a result either of failure of a test of competence to drive, or of information obtained, the Secretary of State is satisfied that the person is suffering from a disability such that there is likely to be a danger to the public if they drive any vehicle (section 92(5)). The Secretary of State may revoke or refuse a licence where satisfied on inquiry that the licence holder is suffering

from a relevant or prospective disability (section 93(1)). A person whose licence is revoked must deliver the licence to the Secretary of State following revocation, or commits an offence (section 93(3)).

[37] A licence holder or applicant must notify DVLA of any medical condition that may affect safe driving, including dementia. The DVLA has published an 'A-Z' list of notifiable medical conditions. If a licence holder becomes aware that they are suffering from a relevant or prospective disability which has not been previously disclosed, or has become more acute, they must notify the Secretary of State (section 94(1)). Failure to do so is an offence punishable by a fine of up to £1000. A person who drives after such a failure to notify may be disqualified, have up to six penalty points endorsed on their driving record and/or be fined up to £1000 (section 94(3A)).

[38] If the Secretary of State has reasonable grounds for believing that a person may be suffering from a relevant or prospective disability, they may serve notice on the person requiring them to (i) authorise a registered healthcare professional to release any information about the disability to the Secretary of State; (ii) attend a medical examination; or (iii) complete a driving competence test (section 94(4) to (6)). If that person fails without reasonable excuse to comply with the notice, or fails any driving competency test, the Secretary of State may proceed as if satisfied that the applicant is suffering from a relevant or prospective disability (section 94(8)).

[39] A person is guilty of an offence if they drive after their licence has been refused or revoked (section 94A), with a penalty of up to six months' imprisonment, an unlimited fine, discretionary disqualification and up to 10 penalty points.

[40] A licence will usually remain in force until the licence holder reaches the age of 70. Renewal of a licence every three years is required for drivers over the age of 70 (section 99(1)(a)). Where the Secretary of State determines that the person (below age 70) suffers from a relevant or prospective disability, the licensed period will be not more than ten years and will in any event end on or before the person's seventieth birthday (section 99(1)(b)). When a driver reaches the age of 70 years, they must apply for renewal of their licence, however long they have held it. This is an application for a full (not 'conditional' or similar) licence, and grant is for a period of three years or less. The application form is "Driving Licence Renewal Application" in form D46P.

[41] On 30 June 2020 Edith Duncan was the holder of a full driving licence. She had held a full driving licence since 1964, and had no known road traffic convictions. At interview she claimed to have an advanced driver qualification. Her 70th birthday was on 27 March 1999. She thereafter applied for repeated renewals of her full licence, which were all granted. Her last four applications were dated 12 January 2011, 16 January 2014, 9 January 2017 and 7 January 2020. On each of the renewal forms she declared that she did not suffer from any of the prescribed conditions, including any serious problem with memory or periods of confusion. Following each application her full driving licence was renewed for a period of three years.

[42] Against that background, the evidence in this Inquiry supports the following conclusions:-

<u>Conclusion 1</u>: Edith Duncan's age-related cognitive decline could have been detected in advance, but only by formal testing

[43] Edith Duncan was assessed by Professor Gary Macpherson, on 30 April 2021, some 10 months following the incident. Professor Macpherson is Professor of Forensic and Legal Psychology at Erasmus University, Rotterdam, and a doctor of clinical psychology. He holds a number of senior professional appointments and qualifications and has published widely.

[44] At interview, Professor Macpherson noted Ms Duncan's very good language skills, and considered most individuals who met her would assume her to be cognitively intact due to an excellent command of English. He had no concerns on first meeting her. He completed a preliminary mental health test with her, revealing no mental health problems other than occasional anxiety. He then asked her to complete a cognitive test. Given her initial presentation, the results were surprising.

[45] The cognitive test was the Addenbrooke's Cognitive Examination–III ("ACE-III"). It is a test used by specialist psychologists and psychiatrists to assess cognitive abilities in later life. He considered it a very good measure, well respected and well-researched. He described it as the gold-standard screening measure as a first step in detecting cognitive impairment. It is a test typically used in diagnosing dementia, having been medically developed for that purpose. It assesses five cognitive domains, namely attention, memory, verbal fluency, language and visuospatial functioning. It is scored out of 100. A score of 88 and above considered is normal; 83 to 87 inconclusive; and below 83 a signifier of dementia, increasing the lower the score.

[46] Edith Duncan's scores were consistent with cognitive decline and probable frontotemporal dementia. She scored 66 overall. She had particularly poor results for memory (5 out of 26) and attention (11 out of 18). Her test results were consistent with significant cognitive decline in the form of dementia, most probably age-related. ACE-III includes a "clock" test, which she undertook. The clock test is a simple task of drawing a clock face and inserting the numbers 1 to 12, and then drawing clock hands showing various times. Edith Duncan drew a circle, and then the numbers 1 to 6 on the right hand side, and then stopped, satisfied that she had carried out the task. This showed a visuospatial deficit.

[47] Separately, she also appeared to have undergone a personality change. Her history was, so far as known, as a person with respect for the law. Professor Macpherson described her career as a lifelong follower of rules and regulations. She had been a theatre nurse and holder of an advanced driving qualification. She appeared to have been a competent driver throughout her driving career. Now, however, she was now someone who breached a lot of rules. All of these things pointed to significant cognitive decline. Her loss of competence was attributable to a medical condition which is age-related and becomes more debilitating with the passage of time.

[48] Professor Macpherson diagnosed Edith Duncan as suffering from frontotemporal dementia, which particularly affects memory. Dementia is an umbrella term for a number of conditions. All the brain regions are interconnected with quite an overlap in functions. He noted that Professor Burns, who also gave evidence, had diagnosed Alzheimer's with a frontal variation, which was a more general dementia causing

problems with executive function. The essential feature was a loss of executive functioning, with frontal lobes to the fore. The diagnoses were very similar. Dementia of this type worsens over time. There is little clinical research as to rate of decline.

[49] Dr Sarah Keir, Consultant Physician, a specialist in Medicine for the Elderly and Stroke Medicine, gave evidence. She is clinical lead for Medicine for the Elderly for NHS Lothian, holds a number of senior professional appointments and supervises and trains specialist doctors. She commented that the diagnosis of dementia, and specifically frontotemporal dementia, may affect an individual's fitness to drive by reducing executive function capability in general, and specifically reducing inhibition and increasing impulsivity. Dr Keir noted that Edith Duncan's medical notes contained no warning flags in relation to dementia. She noted further that the various GPs saw no evidence that Edith Duncan was demonstrating signs of cognitive impairment consistent with dementia. It was clear, following cognitive testing, that in fact she had significant deficits in multiple aspects of executive function. Executive functions are a set of cognitive processes that are necessary for the cognitive control of behaviour, and include basic cognitive processes such as attentional control, cognitive inhibition, inhibitory control, working memory and cognitive flexibility. These changes can be inapparent unless specifically looked for using a test such as ACE-III. She agreed it was feasible Edith Duncan had a degree of dementia without manifesting signs sufficient to raise suspicion.

[50] Dr Keir initially considered it was not possible to determine if she was suffering from the condition at the time of the accident. She was, however, later supplied with

contemporary reports about Edith Duncan's conduct at and surrounding the incident. These led her to conclude that Edith Duncan was likely suffering from frontotemporal dementia at the time of the incident, the behaviours all being consistent with that diagnosis. Ms Duncan's superior language skills would help to obscure the existence of the deficit, and it would be difficult to detect that in a short consultation. There was nothing in the medical history, medical records or recorded interactions with healthcare professionals which raised concerns as to fitness to drive.

[51] Professor Alistair Burns gave evidence. His specialism is clinical academic psychiatry in the field of mental health in older people. He has been Professor of Old Age Psychiatry at the University of Manchester since 1992. He holds a considerable number of senior professional appointments and qualifications and has published widely. In particular from 2010 to 2023 he was seconded to the post of National Clinical Director with the Department of Health and latterly NHS England. Amongst other appointments he is a trustee of Dementia UK.

[52] Professor Burns did not have the opportunity to meet Ms Duncan, but from the evidence identified her condition as a frontal variant of Alzheimer's disease, rather than frontotemporal dementia. This assessment was based on a slightly different emphasis on symptoms. However, he and Professor Macpherson agreed that such a difference in diagnosis was of minor significance and of no practical importance in the present case.

[53] Professor Burns identified that the symptoms would likely become noticeable only sometime after her dementia began. It was difficult to estimate for how long Ms Duncan would have had her symptoms. However, the ACE-III examination she

undertook with Prof Macpherson in May 2021, scoring 66 out of 100, was significant. On the basis that decline is approximately 10% per year, he was able to estimate that she would have had symptoms for up to three years prior to the examination (approximately two years prior to 30 June 2020). For her symptoms to have deteriorated rapidly in the intervening 10 months she would have had to be in a state of delirium, which she was not. It is likely that any friends or family would have noticed symptoms between 12 and 18 months prior to examination (or between 2 and 8 months prior to the incident).

[54] Professor Burns considered that, by the date of the incident, Edith Duncan would have started to manifest the symptoms of dementia. The diagnosis of dementia is a complex one and requires a thorough clinical and mental state examination, information from an informant, neuropsychological testing and brain imaging. It is not a condition that can be easily diagnosed in a GPs' surgery. There is no single test which can achieve the diagnosis.

[55] His view was that, although detection of dementia can be difficult due to the gradual progression from mild cognitive impairment to dementia, there was a high chance that the condition would have been detected prior to the incident.

[56] From this evidence it was plain that there was nothing in her social presentation around the time of the incident to indicate, at least on passing acquaintance, any significant cognitive failure. This was confirmed by the evidence of two general practitioners from her local medical practice.

[57] Dr Mark Stevenson gave evidence. He is one of the general practitioners at the Braids Medical Practice which Edith Duncan attended. He met her for the first time on the day following the accident, at police request. He attended her home. He found her to be upset but physically well. He reviewed her medical records. They discussed the incident. Nothing in her presentation told him that she had cognitive difficulties. He saw her again in September 2020 and in March 2021 for unrelated reasons. Even on those occasions he had no reason to assess her for cognitive decline. She was referred for assessment in April 2021, but only because of a request in relation to legal proceedings. She was seen by Professor Gary Macpherson.

[58] Dr Beth Townend is another general practitioner at the Braids Medical Practice. She spoke to Edith Duncan's medical records. There was regular attendance, including annual reviews, vaccinations and other matters. Ms Duncan's presentation did not raise any concerns, and she did not mention to her GP a car-park collision she had had on 5 September 2019. Dr Townsend agreed that a formal capacity assessment would be available on referral, but there would have to be a reason to refer – it would not otherwise be done.

[59] The Inquiry heard evidence that Edith Duncan had been involved in a car-park collision in 2019. None of the experts, however, regarded that fact as significant in coming to a diagnosis. It is not an unusual event, and it would not have influenced any of them in making a diagnosis.

[60] In conclusion, the evidence indicates that it is likely that Edith Duncan's condition would have been detected in advance, had she undergone cognitive testing.

Observation was not sufficient, because she was able to disguise her condition by a social façade, assisted by her language skills. Her last two applications for renewal of her licence were dated 9 January 2017 and 7 January 2020. It is unlikely that testing in 2017 would have revealed a deterioration. It is, however, likely that testing in early 2020, less than 6 months prior to the incident, would have revealed her to be cognitively impaired and unfit to drive. In the absence of such testing, her condition would not have been, and was not, detected. It is likely that she was not aware of her own deteriorating cognitive condition.

Conclusion 2: If Edith Duncan's condition had been detected, her licence would have been revoked and she would not have driven her car

[61] The position would have been different had Ms Duncan's dementia been diagnosed. Professor Burns described the system, of diagnosis and review of licences, as relatively robust. The DVLA provides guidance to registered healthcare professionals, set out in the document 'Assessing fitness to drive – a guide for medical professionals'. There is a dedicated contact point which allows registered healthcare professionals to discuss any concerns with a DVLA registered doctor.

[62] He described an effective regime whereby the GP can breach patient confidentiality in the interests of public safety. The General Medical Council ('GMC') has set out reliable guidance for GPs, on which they are prepared to rely. While there is no legislative requirement of registered healthcare professionals to notify the DVLA, the guidance states that they should advise patients about the impact of a medical condition

on driving, the effect of any treatment, and the patient's legal requirement to notify the DVLA. Good clinical practice will involve a discussion between the clinician and the patient. If a patient is unwilling or unable to notify the DVLA, the GMC gives guidance about when doctors should report such concerns. The guidance ('Confidentiality: patients' fitness to drive and reporting concerns to the DVLA or DVA') states that where a person has a condition that could impair fitness to drive, the doctor should: (i) explain this to the patient and tell them that the patient has a legal duty to inform the DVLA; (ii) tell the patient that the doctor may be obliged to disclose relevant medical information about them, in confidence to the DVLA if they continue to drive when they are not fit to do so; (iii) make a note of any advice given in the medical record; and, (iv) where the patient is incapable of understanding the advice, inform the DVLA as soon as possible.

[63] The DVLA has a medical panel which considers driving and psychiatric disorders. The panel helps to maintain and improve road safety by providing expert advice about medical conditions and their impact on driving. The panel meets at least twice a year.

[64] Dr Nick Jenkins gave evidence. He has been Senior DVLA doctor since 2019, employed by the DVLA since 2015. He was formerly a consultant in emergency medicine between 1991 and 2015, holding a number of examination, training and board appointments. In his role with DVLA he is involved in assessment of people with a wide range of medical conditions which affect fitness to drive. He spoke to cognitive problems, including dementia, being an increasingly important part of the role. There is

a Drivers Medical Group at DVLA comprising 700 individuals, of whom approximately 45 are doctors. Assessments follow decision algorithms.

[65] He spoke to the system of receiving a medical referral. The DVLA will open a case. Medical enquiry falls into a first, second and third series. The first series is DVLA sending forms to the individual, to capture information. The information pack will give the option of surrendering the licence or proceeding with medical enquiry. Most recipients opt for the latter. There is a legal obligation to comply with the process, so if the driver does not reply, the licence is revoked on the grounds of non-compliance. It is sometimes possible to make a decision at that stage, for example to impose limitations on a licence or to cease enquiry on the grounds that the medical standard is not met. There is a set of forms marked 'CG' (for cognitive). Form CG1 goes to the customer, CG2 to the clinician. The second and third series follow on, depending on results.

[66] He confirmed the position on renewal of a licence. Upon application, an applicant or licence- holder provides information about their medical condition by answering a series of questions on a DVLA questionnaire, specific to the medical condition declared. This is designed to obtain information relevant to the decision-making process. In many cases, a licensing decision can be made based on the information provided in the questionnaire. In more complex cases, the DVLA may need to gather further information from registered healthcare professionals involved with the individual's care, by way of a medical condition questionnaire designed to be completed from medical records. The DVLA doctors will consider poor short-term memory,

disorientation, and lack of insight and judgment as indicators of whether or not the driver is fit to drive.

[67] In some cases the DVLA may need to commission a test, examination or an assessment of driving competence.

[68] The DVLA has, in his view, sufficient regulatory powers. If the Secretary of State has reasonable grounds for believing that a person may be suffering from a relevant or prospective disability, they may serve notice on the person requiring them to authorise a registered healthcare professional to release any information about the disability to the Secretary of State, attend a medical examination, or complete a driving competence test. If that person fails without reasonable excuse to comply with the notice, or fails any driving competency test, the Secretary of State may proceed as if satisfied that the applicant is suffering from a relevant or prospective disability.

[69] There is a specific questionnaire on dementia. The individual will be assessed against the medical standards of fitness to drive which can be found in the 'Assessing fitness to drive – A guide for medical professionals' guidance for cognitive impairment and/or dementia. This may lead to the decision to revoke the licence or issue a licence for a short period, for example one year, to allow for more regular review and monitoring of the individual's condition.

[70] The decision on whether to issue or renew a licence for a person diagnosed with dementia is in most cases based on medical reports. The DVLA may also utilise on-road driving assessments as part of its medical investigations where appropriate. These assess reaction time, concentration, and other features of driving. The resulting report

forms part of the evidence which the DVLA uses to decide whether the person should keep their licence.

[71] Dr Lynne Hutton, consultant in rehabilitation medicine, gave evidence. She is director of a NHS driving assessment centre at Astley Ainslie Hospital, Edinburgh. This is the only such assessment centre in Scotland, and is NHS based. It provides driving assessments on referral from GPs. There are also approximately 200 referrals a year from the DVLA, with whom the NHS has a contractual service agreement. This is approximately 20 per cent of the total assessments.

[72] She spoke to the process of assessment, which is carried out by doctors, clinicians, physiotherapists or occupational therapists. The assessment, carried out for each referral, has 7 components. These include taking a medical history, a driving history, visual assessment, cognitive testing, physical assessment, reaction time testing on a static rig, and on-road assessment. The process is designed to pick up the most salient parts of presentation.

[73] She described the test as whether the medical condition impacts ability to drive. Similar diagnoses may have different impacts in different people. It is not a test of driving skills, but of the medical condition as it affects ability. If driving unsafely, it was necessary to understand whether this was caused by a medical condition. It was a matter of assessing the impact of the medical condition, then assessing what they saw, then reflecting the two together.

[74] One test is cognitive testing. If there was no obvious language impairment, and good understanding of English, then they used the MOCA test. It was used as an initial

test, as part of a video consultation. They looked at any problem identified. It involved the clock drawing test to test visuospatial skills, although there was a whole battery of tests for other things, such as frontal lobe deficit. These included the Frenchay aphasia screening test, a computer game, coloured words test and others. The purpose was not to diagnose, but to understand the impact of their condition.

[75] A further test was reaction testing on a static rig. This was a car chassis, dashboard and seat. It allowed testing of reaction time, braking, field of vision and so forth. The last test was an on-road test, carried out on the streets of Edinburgh.

[76] On average, approximately one-third of drivers were cleared to continue driving, and one-third were advised to stop driving. The middle third needed either adapted controls, further information or assessment of an unresolved medical condition. The biggest diagnostic group was those with dementia or mild cognitive impairment. Of that group, close to two-thirds were advised not to drive.

[77] Andrew Swain, CEO of Driveability Scotland, spoke to the system of driving assessment. His organisation is responsible for the NHS assessment centre at the Astley Ainslie Hospital, as well as other test centres in Scotland. Their function is to assess drivers with physical disability, or with cognitive impairment, for fitness to drive. Most of their clients are referrals from the DVLA, most of the remainder from GPs. His organisation provides on-road assessments of ability to drive. He supplied statistics for the last three years. In year 2021/22, of 13,006 drivers tested, 2,933 had dementia and 598 had mild cognitive impairment. 54% of the drivers with dementia were deemed unfit to drive, as were 45% of those with Mild Cognitive Impairment ('MCI'). In 2022/23, 2,642

drivers with dementia were tested, and 50% found to be unfit, and for MCI the figures were 675 and 49%. In 2023/24, 3,273 drivers with dementia were tested and 47% found unfit, and for MCI the figures were 745 and 41%. For other conditions (Parkinson's, stroke and the like) the unfitness rate was 20%.

[78] He stated that in early dementia, when sufficient skills are retained and progression of the disease is slow, a licence may be issued by the DVLA subject to annual review. When assessing notifications of dementia, the crucial factor for road safety is physical and mental fitness to drive. A diagnosis of dementia is not an automatic bar to driving a car.

[79] The foregoing evidence indicates that in diagnosed cases of dementia and/or cognitive decline, the present system appears to operate efficiently to identify fitness to drive. Where there is no such diagnosis, but the medical clinician has concerns, there also appears to be sufficient power for the GP to report these concerns to the DVLA, whereupon fitness to drive will be assessed. Separately, the GP can recommend that a willing patient undertake assessment at a memory clinic. In accordance with Professor Macpherson's evidence, had Edith Duncan's symptoms been detected, she would most likely have been referred to a memory clinic, which would have taken a thorough history, carried out mental and physical examination, neuropsychological tests such as the ACE-III, and a brain scan. It is probable that this would have identified her medical condition. As part of that diagnostic process, her ability to drive would have been considered and, if necessary, tested.

[80] The evidence supports the conclusion that had Edith Duncan's condition been known about, or suspected, she would have been referred to a memory clinic for assessment. It is very likely that, given the low score on the cognitive test, she would not have passed a driving assessment. Thereupon the DVLA would have revoked her licence, which would have been effective to prevent her driving. Edith Duncan expressed fear of removal of her driving licence in the immediate aftermath of the collision. She was aware she could not drive without one.

[81] That would have led to her not driving on 30 June 2020.

<u>Conclusion 3</u>: Edith Duncan was permitted to keep driving as a result of a serious failure in the present system, which allows drivers with dementia to self-certify fitness to drive

[82] The risks of drivers continuing to drive while suffering from age-related loss of cognitive ability are self-evident, and all the medical witnesses discussed this. Driving a vehicle on the public roadway involves executive functions, complex interactions with a continuously changing environment and a constant need for awareness of external hazards. It involves a variety of mental processes involving behaviour, strategic and tactical abilities and personality. Dementia and cognitive impairment affect these. The risk created by a driver who is unable safely to drive their vehicle in public is high. That is the case no matter what type of vehicle is driven. The incident which killed Xander involved a Kia Picanto motor car, which is one of the smallest vehicles on the road.

[83] Cognitive decline can occur in a variety of circumstances, but the reason in this case was decline due to age. Age-related cognitive decline is inevitable, albeit it occurs at different rates and has different effects between one driver and another.

[84] One feature of dementia-related cognitive decline is a lack of self-awareness. A system of licence renewal which purports to exclude those with "problems with memory or periods of confusion" (Form D46P), but relies purely on self-certification of those problems, has an obvious flaw. Where those cognitive problems are caused by a medical condition which results in lack of self-awareness, the afflicted driver is likely to give wrong information. A driver suffering from dementia may, with complete honesty, give false information about their own mental state. There are no external checks. There is no medical or other input. The result is that a driver with dementia may self-certify themselves to be free of that condition, and receive an automatic three-year extension of their licence. The same observation may be made in a wider context, that self-certification is vulnerable to lack of self-awareness of other conditions, or of the extent of any deficit, or to deliberate dishonesty to avoid the loss of a licence.

[85] Professor Burns discussed the features of cognitive decline. Most people learn to live with a slightly impaired memory as they get older. There has been much greater awareness in the public in recent years about this, and more people seek advice. Where there are complaints about memory, and some objective results from testing, a diagnosis of Mild Cognitive Impairment is given. This describes a situation where memory is not as good as expected for age. For a diagnosis of dementia, however, there has to be difficulties in activities of daily living, and significant impairments on cognitive testing.

[86] He stated that often the person themselves will not be aware or concerned about memory problems. This leads to downplaying of symptoms. There may be an element of denial. Dementia is a clinical syndrome, describing a collection of signs and symptoms. There are many causes. The brain has four lobes. The frontal lobe governs how we act and some aspects of personality and damage can cause disinhibition. The temporal lobe governs memory, and shrinkage is associated with Alzheimer's disease. The parietal lobe governs the performance of executive tasks, such as driving, or using a phone. The occipital lobe is associated with vision and perception. There are complex interconnections and damage to one can affect the other lobes.

[87] Executive function results from a number of psychological functions and cognitive capabilities, involving forming an intention to act, monitoring progress towards the act, remaining flexible to overcome difficulties, and deciding when the act is complete. Judgment is an essential element, and highly relevant to driving a vehicle.

[88] The most common cause of dementia in older people is Alzheimer's disease. The second commonest is vascular dementia. The conditions commonly co-exist in older people. Frontotemporal dementia is a rarer form. It covers a number of conditions. It can often be manifest by changes in personality and behaviour, such as becoming disinhibited. It can also be associated with language change, and with symptoms of Parkinson's disease. It is not an accurate diagnosis in itself, but merits investigation in a memory clinic, taking a thorough history, and performing a clinical and mental state examination, detailed neuropsychological tests and brain imaging. People with

frontotemporal dementia may, however, still have relatively intact abilities to perform complex tasks such as driving. It varies from person to person.

[89] Against that background, it is necessary to consider how prevalent age-related dementia may be, particularly in the driving population. Counsel investigated and agreed the following statistics, and I accept them as evidence.

[90] Alzheimer's Scotland estimates that there are 90,000 people with dementia in Scotland, of whom only 3,000 are below the age of 65 years. The number is growing. Total cases in the UK are estimated to increase from a 2019 figure of 883,100 to 1,590,100 by 2040, an increase of 80 per cent in 21 years. Over the same period, cases of severe dementia are estimated to increase by 109% (from 510,600 to 1,066,000). In Scotland, total cases are estimated to increase from 66,300 in 2019 to 115,200 in 2040, an increase of 74% in the same period, within which cases of severe dementia are likely to increase by 74,000 (104%). The Scottish Government figures (May 2023) estimate that the numbers of people with dementia are set to rise by 50% over the next 40 years. The average age of diagnosis is 75, but the prevalence at that age is only 10 per cent of the population. The Alzheimer's Society estimates that 1 in 3 people born in the UK today will be diagnosed with dementia in their lifetime.

[91] Professor Burns identified that approximately one-third of the population who suffer from dementia are undiagnosed. This was based on accurate records from GPs divided by the estimated level in the population at large. Under-diagnosis is driven in part by a misunderstanding that there is no treatment available, or fear of the consequences of a diagnosis. Removal of a driving licence is a prevalent fear. He agreed

with the figures from Scotland's own dementia planning that the number of people with dementia will rise by 50% over the next 40 years. It was certainly an issue, and he saw many more referrals to his memory clinic than was formerly the case. In March 2024, the Department of Health and Social Care estimated that there were around 253,800 people in England over the age of 65 with undiagnosed dementia. It is accordingly apparent that there is a significant shortfall in the number of sufferers who have been diagnosed with dementia in the UK compared to the estimated numbers of actual sufferers. The risk presented by drivers with dementia in the UK is likely to increase.

[92] The next question is how many of those people with dementia continue to drive a vehicle. This is unknown, but there are statistics which tend to suggest the number is significant. The following statistics were presented by counsel, and I accept them as evidence.

[93] According to DVLA statistics, in 2024 there are currently approximately 4,428,832 drivers aged between 70 and 79 years in the UK. There are approximately 1,662,239 drivers aged between 80 and 89 years. There are approximately 157,133 drivers aged between 90 and 99 years. If the estimate of one-third of people with dementia being undiagnosed remains true, that leaves a considerable number.

[94] That figure is not reflected in the number of notifications. The DVLA holds figures for those whose impairments have been notified so as to lead to a driving assessment. That figure is available only for 2018 and 2019. In 2018, 2,475 driving assessments were arranged. In 2019 the figure was 3,077. The DVLA does not hold information on the number of individuals in the UK who have cognitive impairment or

dementia. In 2019, the DVLA was under notification of 237,064 drivers (not including Northern Ireland) who were suffering from either cognitive impairment or dementia. That figure represents a cumulative figure and does not reflect the figure for that singular year. It is not known what number of these hold a valid licence. It is not known what percentage of the figures are attributable to cognitive impairment or dementia respectively.

[95] The DVLA has received the notifications of cognitive impairment or dementia as follows:-

2017 – 40,310 drivers

2018 – 39,109

2019 – 39,676.

That in turn led, following medical investigation, to the issue of licences in the following number of cases:

2017 – 20,104

2018 – 18,832

2019 – 21,191.

In the large majority of these cases a licence of limited duration (less than three years) was issued.

[96] The police notified DVLA of drivers suffering from all medical conditions, as follows::

2019 – 11,533

2020 – 10,958

2021 – 9,986

2022 – 11,239

2023 – 10,640.

[97] The DVLA have received notifications from third parties, such as family, as follows:

2019 – 15,105

2020 – 13,011

2021 – 10,480

2022 – 16,311

2023 - 15,787.

[98] These figures suggest that the risk posed to public safety is significant. This is by reason of (a) the number of drivers who have undiagnosed or undeclared dementia (b) the high risk of serious incident when a car is involved. The numbers of cases declared or reported appears to be a small fraction of the likely number of drivers with age-related cognitive decline.

[99] Quite apart from the statistics, there is an inherent and obvious flaw in failing to check the accuracy of self-reported results, particularly where there is powerful social pressure not to relinquish a driving licence.

[100] Dr Nick Jenkins, Senior Doctor at DVLA, spoke to the challenges. The Drivers Medical Group were aware that even among non-cognitively affected population, not everybody complies with their legal obligation to notify. The licensed public comprises approximately 52 million people, yet only 3.5% of that population are known to the

DVLA as having a medical condition. Although it was not possible to know the true figure, it was plain that 3.5% per cent is a gross under-representation. In relation to dementia, about half a million people are diagnosed in Britain. The DVLA, however, have approximately 30,000 on their medical books. It is unknown how many drivers with dementia continue to hold a full licence. Getting notification is a hurdle, made worse in cases of cognitive impairment, as lack of insight means the individual often does not appreciate they have a problem. That was different from, for example, a heart or visual problem. The DVLA required to place reliance on third party sources, such as doctor or family. He spoke to the difficulty of spotting signs of dementia in brief medical consultations. They might be excused as caused by personality or eccentricity.

[101] Professor Macpherson's view was that self-certification of fitness to drive, in Edith Duncan's case and similar cases, was useless, as sufferers are the last persons to understand that they are suffering. There was no question that Edith Duncan would have failed a test of fitness to drive.

[102] Professor Burns agreed that the present regime of self-certification would not work, due to lack of self-awareness. In addition, the risk of non-reporting was increased if loss of licence carried significant implications for the driver. Family members, who were normally very important in identifying loss of function, could be very conflicted at reporting concerns. For that reason, Professor Burns always made clear that the decision was his, not that of the family member who accompanied the driver.

[103] Dr Hutton agreed that self-determination of fitness to drive was never going to be the answer, due in part to lack of self-awareness, but was not able to suggest an

alternative. If a test were to be imposed, she recommended that a specific driving-related tool be used, rather than the more general MOCA test.

[104] Dr Stevenson spoke of the pressures on the elderly surrounding a diagnosis of dementia. People sometimes do not recognise it. Some are worried about the consequences of a diagnosis, particularly for continuing driving. There is a feeling of stigma in some cases. He identified that there was a serious problem with self-diagnosing on the renewal form. It relied on an entirely subjective opinion of a medical condition, of which the applicant may not even be aware. Dr Townend considered there was a problem in relying on self-reporting of medical issues to DVLA. If the applicant was being untruthful, or did not have mental capacity, that could not be detected. Often patients will mask the symptoms, or be in denial and downplay incidents such as losing items or locking themselves out of their house. Often they do not realise the extent of their own decline. There can also be a fear of being sent to a nursing home, or losing their driving licence. They may be worried about their own condition and afraid to express those worries to their GP.

[105] The existing regime relies on a statutory form (D46P) which poses a number of formal questions. A system based on this has obvious vulnerabilities. The unaware but impaired driver will certify themselves as not suffering from any cognitive deficit. The driver who depends on driving for core functions of living may be severely tempted to minimise or mislead about their condition. Those who fear a diagnosis which strikes at their mental condition may be similarly tempted. Similarly, poor engagement or lack of perspective may lead to false answers being given.

[106] The stark conclusion, both in logic and on the evidence, is that a system which allows drivers to self-certify fitness to drive, which does not monitor the answers, and which has no limit in age, is ineffective in identifying drivers with dementia. It is also ineffective in identifying drivers who refuse to answer honestly, in relation to any medical condition. The consequence is that unfit drivers are left to drive road vehicles, which pose an extreme risk to safety unless competently controlled by the driver. The public is unavoidably at risk. The risk is substantial, and occurrence unpredictable. This system requires to change.

<u>Conclusion 4:</u> the serious failure in the system can be remedied by introduction of compulsory age-related testing

[107] The evidence shows that this problem, however, can be solved in a proportionate and straightforward manner. The critical issue is how to address the problem of cognitively-impaired people, such as Edith Duncan, being granted driving licences. Had an effective system been in place when she applied for renewal on 7 January 2020, this incident would not have occurred.

[108] For drivers whose cognitive impairment is recognised, the present system works. There is an effective system of relicensing, discussed above. The problem, and risk, is detection of unknown cases.

[109] So, what has to change? The Crown suggested a number of possibilities.

[110] The first was counter-signature of the licence renewal form by a GP. That would involve the applicant driver taking the form to their GP and for the GP to consent to the

application being made. There is an initial attraction in this, in that it was clear from the evidence of the GPs, Drs Stevenson and Townend, that they would not have signed the form had they known of Ms Duncan's condition. That would not address the issue created by the patient's social façade, which in Ms Duncan's case misled every medical practitioner who met her. Dr Townend agreed she would probably have signed such a form, as Ms Duncan showed no signs of her dementia.

[111] In addition, there is an issue of resources. This is one area where it would have assisted to have had representation from the Royal College of General Practitioners. In their absence, it was left to the individual GPs to address issues of capacity and resources, without access to wider statistical information.

[112] Both GPs spoke to having limited resources to address additional demands on their medical practice. Dr Stevenson was clear that there is not enough capacity in the system to countersign such an application for every patient over 70 years of age. It would only be practically feasible if there were an external service provider. In addition, the decision whether to countersign would be similar to the present conversations about whether to declare a disability to the DVLA. Dr Townsend's evidence was that there was also a balance to be struck in following the DVLA guidelines. It could involve a challenging and time-consuming discussion. GPs did not have a lot of time. It would be worse in a rural area, where doctors might feel pressure not to report, albeit GPs recognised a very clear duty of care to the public, and were accustomed to having difficult conversations with patients.

[113] Accordingly, the evidence does not support countersigning as an effective remedy. If the cognitive impairment were unrecognised, countersigning would not be an effective filter. If it were recognised, the current requirements of discussing disclosure would apply. The only difference would be that, if the medical practitioner recognised cognitive impairment, they could refuse to countersign. That would involve a major decision, inevitably involving time-consuming discussion with the patient and, except in the most obvious cases, further testing such as reference to a memory centre. It is likely, given Dr Stevenson's evidence, that considerable further GP resources would be required to address the influx of over-70s, every three years.

[114] A further suggestion by the Crown was higher penalties for failure to make disclosures. The current penalty is up to £1,000 fine. There was no evidence supporting this, and no reason to think that the loss of a driving licence is influenced by the prospect of sanction.

[115] In any event, recent statistics show almost no prosecutions in the last six years. Counsel gave statistics, which I accept as evidence. Between 1 January 2018 and 31 May 2024, there were five prosecutions under the Road Traffic Act 1988 s94(1) & (3) (failure to notify), one of which resulted in a conviction. Between those dates there were two Scottish prosecutions under the Road Traffic Act 1988 s94(1)&(3A) (Driving after failure to notify), one of which resulted in conviction, and 112 Scottish prosecutions in terms of the Road Traffic Act 1988 s94A(1) (Driving after licence refused), 35 of which are ongoing and 36 of which resulted in conviction. Between 2017 and June 2020, 148 cases were reported to Crown Office by Police Scotland where either death or serious injury

had been caused by careless or dangerous driving. Five of those cases raised questions of cognitive impairment. In those five cases, the ages of the drivers were 71, 75, 77, 80 and 82. These numbers are a very small percentage of the likely number of drivers of dementia. The evidence does not suggest alteration of tariffs would be effective.

[116] A further suggested remedy was the imposition of a duty on insurance companies. That would involve placing duties on customer-facing staff to conduct what would be similar to a medical interview, and to make decisions akin to diagnosis. The evidence does not support such a step, not least because these are complex medical decisions, and this is discussed further under Conclusion 8 below.

[117] Another suggested remedy was to augment the existing questions in form D46P, the licence renewal application form. While that would not solve the problem of unaware or dishonest replies, there is significant merit in asking more specific questions. This is addressed further at Conclusion 7 below.

[118] The last suggestion is compulsory testing. The evidence shows there is considerable merit in this, and this is recommended.

[119] This proposition received support from most of the medical witnesses. Professors Macpherson and Burns both recognised that self-certification of fitness to drive by someone unaware of their own decline was unworkable. Sufferers lacked insight and capacity. Professor Macpherson described a recheck of abilities as perfectly feasible and sensible. Professor Burns regarded an initial cognitive test as an effective measure. Compulsory testing was favoured by Dr Keir as both reasonable and possible. Dr Stevenson was in favour of compulsory and repeat testing, albeit with reservations

about capacity within the system to manage this. Dr Jenkins noted that testing was a policy issue, but welcomed mandatory assessments intuitively as putting the licensing authorities in a better position to assess fitness. Dr Hutton agreed that self-determination of fitness to drive was never going to be the answer, due in part to lack of self-awareness, but was not able to suggest an alternative. If a test were to be imposed, she recommended that a specific driving-related tool be used. From a driving examiner's view, Andrew Swain indicated that an initial cognitive test would help to focus the issues which needed to be investigated.

[120] The introduction of mandatory testing will require careful consideration of detail. This is discussed in the next section. The conclusion, supported by almost all of the medical evidence, was that mandatory testing should be introduced, on an age-related basis. Separately, as a matter of basic logic, this is an obvious required change. It is recommended.

<u>Conclusion 5</u>: The minimum effective type of testing is a short initial cognitive assessment, and introduction would be feasible, proportionate and effective

[121] The evidence shows that action is required to meet the increasing risks caused by an increasingly older driving population. It shows that compulsory testing is required. It requires careful identification of what, and who, is to be tested, for what purpose, and what realistic resources can be devoted to the exercise. The answer has to be effective but also pragmatic, meeting issues such as scarce resources and public acceptability.

[122] When assessing fitness to drive, tests can be performed at a number of levels. The test referred to in evidence by various parties as the "gold standard" would be a formal driving assessment, involving an observed exercise in driving in either real or simulated circumstances. Such tests, according to those involved in assessment, are painstaking and require considerable resources. Mr Swain, CEO of Driveability Scotland, described how a practical driving test was the best test of ability to drive.

[123] He spoke to the same regime as spoken to by Dr Lynne Hutton. The process of assessment involved considering the background reason for assessment, then assessing physical range of movement and abilities. There are then cognitive assessments, tailored to the individual. Thereafter there is an on-road driving assessment of up to 60 minutes. There is no definitive medical test for medical fitness to drive. It is possible to score well in an initial cognitive test, but to perform poorly while driving on road, and vice versa. Skills vary with the driver, and for example a professional driver may have cognitive defects but may retain their ingrained professional skill at driving. A cognitive test is, in his view, a useful initial tool.

[124] Dr Hutton described a less comprehensive series of tests, short of on-road driving assessments, carried out in the NHS driving assessment centre. The exercise included vision testing and cognitive testing, using the MOCA test, at an initial stage, as part of a video consultation. Practical testing included reaction testing on a static rig; a car chassis, dashboard and seat. It allowed testing of reaction time, braking, field of vision and other practical skills.

[125] Professors Burns and Macpherson spoke to a still lower level of testing, involving cognitive tests. These are also currently used in practice by GPs. Professor Burns spoke to a number of cognitive tests being available. A driving test would, in his view, be the gold standard. DVLA centres could provide a shortened assessment test. His evidence was that cognitive tests measure only cognition. Driving safely requires a wide range of cognitive functions including judgment, executive function, memory, attention and concentration. Most importantly, driving safely represents the implementation and integration of these cognitive functions into practice. It is a functional test. Generally speaking, if a person scores low on cognitive tests, certainly if severe impairment is detected, it is unlikely they would be able to drive safely.

[126] Professor Macpherson confirmed the effectiveness of the Addenbrooke's Cognitive Examination-III (ACE-III) which is a specialist screening tool, and more thorough than MOCA or MMSE. It was a well-researched and effective cognitive screening tool, normally used by psychologists and memory centres rather than GPs. He agreed that compulsory testing was a good thing. Every driver will eventually lose the cognitive ability to drive safely. Most people realise for themselves when their abilities were no longer sufficient, or have friends and family who are prepared to tell them. In the cases of those who are not self-aware, or are not prepared to disclose unfitness, compulsory testing would be appropriate.

[127] Dr Stevenson spoke to the use of more basic cognitive tests in daily use. They use the MOCA test, which is commonly used in Edinburgh. He described how it works. It takes 10 to 15 minutes to work through, and comprises exercises and questions. The

patient replicates shapes, draws a clock face, has a test of recognition and short-term memory, a simple maths test, and a test of awareness of location and the calendar. It is not a diagnostic tool but is for screening. It gave some quantifiable numerical guide to the measure of impairment. A more detailed test, if required, would be carried out by psychiatry colleagues on referral to a memory centre. It was possible for people to present well, but score poorly on the test, and vice versa. Social presentation could mask symptoms. If he had seen the ACE-III test carried out by Professor Macpherson, he would have advised Edith Duncan of her duty to inform the DVLA.

[128] Dr Townsend spoke to the practice use of MOCA and MMSE, both cognitive tests. These would take 10 to 15 minutes. Her evidence was similar to that of Dr Stevenson. If there was reason to suspect loss of cognitive function, a GP would always have a discussion about driving with the patient, and remind them of the duty to self-report to the DVLA. Fitness to drive could be assessed at the Astley Ainslie Hospital, Edinburgh, Scotland's only driving assessment centre, which could carry out a very complex assessment. While it would not be fair to base an assessment of driving ability on a short cognitive test, it would allow the capture of patients who may be unable, and could be assessed further. Tests such as the MOCA could definitely be administered by non-doctors, such as a practice nurse. She too expressed reservations about capacity. While a screening test such as a MOCA could be administered by a practice nurse, they were in short supply. Their practice did not have the resources to cope if a MOCA became compulsory. If the test could be outsourced, that might work.

[129] Dr Keir spoke to the possibility of devising a system to pick up cognitive deficit in elderly drivers. It was both reasonable and possible, in her view. There is not a great deal of good research, and this made it more difficult to be certain about the correct procedures. Dementia is not a spot diagnosis, but requires a process of investigation. It would be a reasonable thing to do, in her view, to have a revalidation process for older drivers. The process should certainly be more that self-certification. The purpose of such a test would be to trigger further investigation, depending on the results. It would be helpful to have objective criteria, to lighten the load on the GP. Because loss of a driving licence can be a great loss, it is helpful to a GP to be able to point to DVLA guidance, for example on blackouts, to show that it is a requirement. An objective criterion doesn't need judgment and takes the emotion out of the situation.

[130] Dr Keir explained that a cognitive test would only be a pause point, to allow further testing to be identified. Testing required to be handled sensitively. MOCA was less good as a test of driving, and a trails test would be better. The clock assessment was a good test of cognitive inattention. An ACE-III test would be quite effective, but could take longer than 20 minutes. Ideally assessment would involve both a medical component and a practical component. Attention could be tested by adding an extra component. A test such as walking backwards might be easy if concentrating, but attention deficit might be revealed if the patient was asked to spell a word while doing so.

[131] Dr Keir considered that an extra assessment, with a cognitive and a vision component, would be enough to identify a sizeable proportion of people with dementia

who would otherwise continue to drive. This subject was not getting enough attention, and was urgent. Being pragmatic, it was not enough to hold off making changes until further research was completed. Such a process was very time consuming and the need to address the situation was urgent, due to the rise in cognitive problems. It was reasonable to recommend immediate changes, while collecting more data.

[132] From the foregoing evidence, various levels of testing are available. These range from the gold standard of a driving test for everybody of a certain age, through a variety of practical driving assessment tests, to a medical only tests for dementia, carried out by specialists and assisted by the ACE-III cognitive assessment, to the lowest level of cognitive screening test, using a form such as MOCA or MMSE, administered at a medical practice level.

[133] The evidence strongly supports the introduction of cognitive assessment as a screening test. It is not diagnostic of dementia, and those discussed do not specifically assess driving-related impairment. It is, however, recognised by all the medical professionals and the driving professional as a useful initial tool. It tests mental processes necessary for driving. It is quick to administer, at 10 minutes. It is objective and not influenced by the social façade of a patient such as Edith Duncan, who would have failed such a test. It does not need a doctor to administer, although it does require some training. It could be administered by a practice nurse, physiotherapistor an occupational therapist. It could not be avoided by drivers who might otherwise elect not to engage. It would detect those cases where the driver is unable or unwilling to disclose medical impairment.

[134] The purpose of the short initial cognitive assessment would not be diagnostic, but as an early warning of potential problems. Depending on results, referral could be made to a memory centre, or a driving assessment centre, or advice given to stop driving. It could provide a formal point where a GP was permitted, or obliged, to notify the DVLA. It would be the first step in a stepped programme of investigation. If passed, however, no further investigation would be carried out.

[135] This conclusion supports a recommendation that the DVLA introduces a system of short initial cognitive assessment, and as a matter of priority. It would be age-related. The question is then: what should the content of the test be, and from what age.

<u>Conclusion 6:</u> the short initial cognitive assessment ('SICA') should be in a form similar to tests currently available to GPs, and should become compulsory for applications from age 80 onwards

[136] The questions here are: what type of SICA should be created, and at what age it should be applied?

[137] There was general agreement that the basic cognitive tests presently administered by GPs would provide a sound basis for a cognitive test aimed at elderly drivers. While there are a variety of such tests, the Inquiry heard about four, in greater or lesser detail. These were the MOCA test, the MMSE test, the ACE-III test and the Rockwood test.

[138] The MOCA test (short for "Montreal Cognitive Assessment") was regarded by the GPs as an effective test, and is presently used by the NHS driving assessment centre

as part of their testing. It is simple and short, and does not require a medical practitioner to administer (although it would require some clinical training). It consists of a single page, and takes 10 minutes to administer. Its benefits and limitations are discussed above.

[139] Another test mentioned was MMSE, or Mini-Mental State Examination. It is regarded as broadly equivalent to the MOCA, but no further detail was discussed. It performs a similar function to the MOCA and appears to be widely used in GP practice.

[140] The other test which featured prominently in evidence was the Addenbrooke's Cognitive Examination III, or ACE-III. It is broadly similar in focus to MOCA, but is more time-consuming and detailed and has a wider range of questions. It takes longer to administer that MOCA, and requires a greater degree of specialism. Both Professor Macpherson and Professor Burns favoured this, but this was as a specialist tool in the context of considering a diagnosis of dementia. It involves a more sophisticated level of testing than would be required to merely identify, as opposed to identifying and investigating, cognitive impairment. It would therefore not be suitable for administering at a non-specialist medical centre or occupational therapist level.

[141] Dr Hutton mentioned a further tool, namely the Rockwood Test, developed in Wales. This was, in her view, the best of the screening tools, because it was developed with reference to driving-related cognitive impairment. No further evidence was led on this, but it may repay investigation.

[142] These tests are not diagnostic tests for dementia. They are no more than screening tools. They can be the first of several stages. Professor Burns described it as a

stepped approach. The initial cognitive assessment would just be getting on to the first step. Poor performance would lead to further assessment steps. Such a process would, he considered, be a great improvement on the present position.

[143] The attraction of a MOCA-like test is that it could be performed by a trained practice nurse, an occupational therapist, or other non-doctor resources. It therefore need not be a drain on general practitioner or specialist psychological resource. It is short, and easy to understand. It should not be unduly intrusive or personal. It should be capable of being performed repeatedly for a large number of applicants.

[144] The content of a SICA was discussed in evidence. It was recognised that these tests are not specific to driving-related investigation, albeit they give a good general indication of any cognitive deficit.

[145] For the purposes of an easily-administered initial test at a medical centre, and specifically focused on driving-related assessment, Professor Burns thought a SICA would be effective in the form of (i) the existing MOCA (or equivalent); plus (ii) four additional inquiries, being:

> "In the last 12 months:
>
> (a) Have you had significant problems with memory which impacts on your daily life?
> (b) Have you been involved in a car accident?
> (c) Have you had a speeding or parting fine?
> (d) Has anyone expressed concern over their driving?"

and; (iii) the clock-face tests, as described above.

[146] These tests would tend to bring out questions of judgment, visuospatial awareness, impulsivity control and other skills important in executive functioning and,

in turn, driving. Dr Keir described the clock face as a good test, which would reveal various areas for further investigation, such as changes to awareness on one side, classic inattention in drawing some figures but omitting the remainder, and visual inattention. The exercise would indicate further testing was required. Inattention could indicate a problem with the parietal lobe. There may have been a stroke or a space-occupying lesion, such as a tumour or brain injury. Frontotemporal deficit was particularly dangerous because it created risks at an earlier stage than other types of dementia, due to impulsivity while driving. An extra form by itself would make people think.

[147] The evidence supports, therefore, the introduction of a short, easily administered, initial cognitive test, along the lines of MOCA or MMSE, plus a few supplementary questions/tests which would be focused on driving skills and recent experience. It is of note that the MOCA form (version 7.1 was produced to the Inquiry) already contains a clock-face test, marked for contour, numbers, and hands. Such a test (a SICA, or short initial cognitive assessment) would provide a pragmatic solution and an effective screening mechanism. Although the GPs expressed concern about capacity of their medical practice to administer such tests, the evidence is that these would not require a doctor, or even a nurse. A suitably trained clinician would be able to administer such a test.

[148] There may be further benefits in alerting drivers to the fact that a cognitive test will, at some point, be required, and influencing expectations and behaviours. Such consequential effects go beyond the evidence heard at the Inquiry, but may repay further specialist investigation.

[149] The second question is: at what age should a SICA be required? None of the medical witnesses had been asked to consider the question in advance. When asked, however, there was a striking degree of consensus on the age around which cognitive testing should be introduced. Those who were prepared to commit to an answer identified 75, or 75 to 80, as the appropriate age. Professor Macpherson was prepared to be drawn on the age of 75 years as being an appropriate age. That was based on his experience of having seen many patients, but he was careful to say this was an impression only. There was no question in his mind that Edith Duncan would have failed such a test at 90 years. Professor Burns identified that it was as good an age as any, not least because it was close to the age of 70 at which the DVLA itself required self-certification.

[150] Dr Keir identified that a suitable age would be around the ages of 75 to 80. The reason was that there is a prevalence within that age range of conditions which can cause problems for driving. These include blackouts, strokes, dementia and other conditions which increase significantly around that stage. Other conditions, such as heart disease, diabetes and arthritis also have the potential to impede driving. As well as direct effects, these conditions will commonly require medications which cause further consequential problems. A patient with, for example, arthritis may require very strong painkillers.

[151] It might be noted that Edith Duncan also suffered, according to her police interview, with arthritis in the knees and high blood pressure, for which she took daily medication, and had done for 30 years.

[152] Neither GP would be drawn on an age at which testing might take place. While they recognised that cognitive testing would have benefits, there was no single age at which deficits appeared. In their medical centre, in a high socio-economic area, people were healthy during their 80s and 90s, and therefore likely to remain fit to drive for longer than patients who did not have their advantages.

[153] Allowing for the lowest element of intervention, the evidence supports the introduction of a SICA for applications after the age of 80. If the current system is to be retained, of self-certification, this suggests that applications will be made at age 70, 73, 76, 79 and 82 onwards. At the least, the application at age 82 should be subject to such a test.

[154] A SICA, to accompany a form D46P, should be required for applications from the age of 80 onwards. That would customarily be the fifth application from age 70 onwards. The foregoing figures suggest that this would apply to approximately 1.8 million drivers at present (1,662,239 drivers between 80 and 89, plus 157,133 drivers between 90 and 99). There is a sound argument for reducing it to age 79, as an application then will allow driving until 82, or to age 75, as the medical witnesses discussed.

<u>Conclusion 7:</u> Separately, the current self-certification form D46P should be extended as a matter of priority, to include further relevant questions

[155] Introduction of cognitive screening tests will take some time. In the meantime, the current form should be changed.

[156] The evidence before this Inquiry was, primarily, that self-certification is inadequate as a safeguard. As a secondary point, the evidence showed that the present self-certification form questions are inadequate and should be improved. They need to better identify potentially significant impairments. Changing the questions in form D46P can be addressed in a straightforward way. This is a short-term precaution which can be introduced quickly and easily. I recommend that it should be done as a matter of priority.

[157] The Driving Licence Renewal Application form D46P consists of two pages. The first page contains section 1 (current details), section 2 ("the licence you want"), and section 3 (a declaration about eyesight, no proof required). The second page has section 4, about medical conditions (no proof required), and sections 5 and 6 (proof of identity). It ends with section 7, a declaration that the applicant is a resident in the UK and understand that it is an offence to make a false declaration in order to get a driving licence or to fail to provide information. The form is then signed.

[158] Section 4 asks "Have you ever had, or do you currently suffer from any of these following conditions", then lists 21 conditions which include matters such as diabetes, epilepsy, eye conditions, stroke, fits or blackouts, any type of brain surgery, alcohol or drug misuse and so forth. For present purposes, question 13 ("serious problem with memory or periods of confusion") is the most pertinent. It is left to the applicant to identify any relevant conditions. No vouching or proof is required.

[159] As discussed above, the problem is that an applicant with dementia may have no insight into their own condition, and might honestly, but incorrectly, certify themselves

as suffering no relevant condition. The medical witnesses identified that there was a serious problem with self-diagnosis. It relied on a subjective opinion of symptoms, of which the applicant may not even be aware.

[160] The form, even assuming honesty and accuracy in reporting, does not reveal enough information to identify cognitive impairment. Professor Burns suggested that some of the known risks and features of dementia could be included, such as:

- Have you had scratches and scrapes while driving your car over the last year?
- Have you had any insurance claims in the last year?
- Have you received any parking tickets or speeding fines in the last year?
- Do your family think you are safe to drive?

[161] These were suggestions only, and have been addressed elsewhere in more detail (for example, British Geriatric Society Guidelines for Driving with Dementia or Mild Cognitive Impairment at bgs.org.uk).

[162] The clear consensus was that the existing questions on form D46P are inadequate. They should be augmented by further questions. In order to limit the number of additional questions, while covering the necessary issues, the evidence supports the addition of two further questions to the form, in or approximating the following terms:-

- Have you, in the last two years, been involved in an accident, while you were driving, which was partly or mostly your fault?

- Has anybody, in the last two years, told you they are concerned about how you drive?

[163] The first question would introduce a more objective standard, and addresses fact rather than opinion. The second question introduces the single most useful source of information, namely the opinion of friends, family and others, and is broad. Of course, in the case of a driver with significant frontotemporal dementia, neither would be effective. This serves to illustrate that self-certification is not a supportable long-term solution.

<u>Conclusion 8</u>: No changes to the duties on the police, medical practitioners or insurance companies are necessary or would have avoided the incident

(a) The role of the insurance company

[164] A question arose as to whether the incident could have been prevented by any action on the part of the insurance company. The evidence does not support such a proposition. There is also no obvious reasonable change which could be made to insurance renewal practices which would decrease the likelihood of further incidents.

[165] The main reason is that there was no fair indication to the insurance company that Edith Duncan proposed to drive without insurance. The recording of a conversation with the call handler, on 24 February 2020, records that she said "I only drive once a week or so now and I don't want to pay all that money". She was concerned about the cost of insurance, and asked for the policy to be cancelled. The call

handler asked if she wanted to cancel immediately or from the renewal date in March. Ms Duncan agreed the latter.

[166] There is nothing to indicate that this was not a routine conversation, involving a 90 year-old driver electing either to stop driving, or to find a cheaper quote elsewhere. Every driver knows they require insurance. Hitherto that was scrupulously observed by Ms Duncan. To drive without insurance is illegal. There was nothing in her call to alert the call handler that she was intending to do something both bizarre and illegal by cancelling the insurance policy and continuing to drive. The call handler cannot fairly be faulted for thinking otherwise.

[167] The question arises as to whether there is any wider need for reform. Philippa Handyside, Director and General Counsel for the Association of British Insurers, spoke to the cancellation of Edith Duncan's insurance, and the issues arising. She noted the existing legal notification obligations on an insurer. If an authorised insurer refuses to issue to any person a policy of insurance on the ground that the state of health of that person is not satisfactory, or on grounds which include that ground, the insurer shall as soon as practicable notify the Secretary of State of that refusal and of the full name, address, sex and date of birth of that person as disclosed by him to the insurer (section 95). An 'authorised insurer' means an insurer who is a member of the Motor Insurers Bureau (section 95(2)).

[168] Accordingly, an insurer will already not issue a motor insurance policy to a driver who is medically unfit, and will notify the DVLA.

[169] In cases in which the insurer is not aware of any medical unfitness, it was suggested to her that call handlers could be trained to ask further questions. She pointed out that persons answering phones were absolutely not medically trained to make such assessments. She compared the GMC guide to doctors in making assessments of fitness to drive. The guidelines run to many pages, and are complex even for medical professionals. It could not be appropriate for non-medical service providers to be making those kind of enquiries or judgments. It was not appropriate either as a matter of medical investigation or as a matter of intrusive questioning. Most customers would not find it acceptable to be probed in that way.

[170] Even if it became clear on a call that a customer was vulnerable, the call handler would not be in a position to assess if the section 95 standard was met. The call centre staff would give additional support. There is an existing regulatory responsibility to take account of vulnerable customers. There is an existing divergence of legal opinion whether, if a call handler becomes aware of a vulnerability, it is appropriate to record the reason for vulnerability, due to strictness of data protection legislation. There are strict rules about the handling of personal medical information.

[171] Motor insurance is not medically underwritten. Insurers don't take account of medical history as a risk factor in providing it. It would be much more expensive if they did. If there is a licence without relevant conditions, then they will offer insurance cover. Fitness is assumed from the fact that there is a licence. The responsibility of notification is on the driver. There were only a few medical conditions which were binary, in other words which were in themselves evidence of unfitness to drive.

Epilepsy might be an example. Even then, it was possible to have epilepsy and be medically fit to drive. The same went for dementia.

[172] Ms Handyside could not identify any guidance which could be given to call centre staff. It would involve judgments which were complex even for medical professionals. There were strict rules about data protection. Reporting may have the effect of requiring a customer to undergo medical assessment, even for someone who was fit to drive. It would be intrusive and unacceptable to customers to have such reports made by customer-facing staff.

[173] In my view these reasons are sound. To place a duty of investigation on non-medically trained sales staff, which may have highly intrusive consequences, does not seem proportionate, or even workable. The effect would be to create additional demands on both the insurance industry and the DVLA, without any reliable indication that they could be met or would represent a proportionate use of resources. Data protection issues also arise around data sharing. Guidance would require to cover a very large number of potential medical and personal issues, and the right information obtained. Judgment of medical fitness is currently considered challenging for medical professionals, far less customer service workers.

[174] There is therefore no evidential basis before this Inquiry to make any recommendations for change to insurance industry practices or guidance.

(b) The role of the police

[175] Evidence was sought from police witnesses only in general terms, about possible means of identifying medically unfit drivers.

[176] PC John Lang, a qualified police accident investigator, spoke about the process involved in reporting unfit drivers. If there was any concern about fitness to drive, the police would fill out a D751 form and submit this to DVLA. Police Scotland had submitted 30 such forms in 2023, and 26 forms to date in 2024. Police officers would encounter situations which raised questions of driver fitness – tell-tale signs were often stopping for no reason, erratic driving, being lost or blacking out. Collisions, particularly those without clear explanation, would cause further enquiry. Police are not qualified to judge medical conditions, but reporting concerns to the DVLA allowed further investigation. There is no formal police training, but experience helped.

[177] Police Scotland do not keep records of damage-only collisions. Only accidents which cause injury are reported. There was accordingly no way of knowing how many minor collisions had occurred. It would not be easy to keep a database of minor collisions, and in any event less obvious medical conditions would not be detected.

[178] Chief Inspector Mark Paterson gave evidence in writing. He confirmed that there was no requirement to refer drivers to DVLA, but that the facility was there. There is no written guidance, and it is a matter of learning by experience to know those cases which should be referred. He suggested that the medical profession were better placed to collect information, because the police would only come across drivers who had done something wrong. There would only be limited time at a crime scene or other incident in which to make an initial assessment of impairment.

[179] The report form, D751, required to be updated to keep abreast of developments. He suggested that some sort of assessment would be appropriate before renewal of a

licence. He was aware of a pilot scheme in Grampian between Police Scotland and the Scottish Government, to assess fitness to drive in senior drivers. The referral criteria were presently unclear. In an ideal world, there would be regular re-testing for every driver, but funding would be an obstacle, and such a level of interference with civil liberties would require to be a political decision.

[180] There is no evidence before this Inquiry which would justify a recommendation to change police practices in recording incidents. Keeping records of all minor incidents which raise questions about driver fitness would yield further information, but it is not presently possible to say that this would be proportionate in its use of police resources, or would yield effective results. Neither Professors Macpherson nor Burns regarded Edith Duncan's 2019 collision, for example, as particularly helpful in diagnosing dementia.

(c) The role of General Practitioners

[181] Following declinature of representation by the Royal College of General Practitioners, the individual GPs who gave evidence were the only source of information about practices and possible improvements. They answered to the extent of their own knowledge, but the absence of an overview is to be regretted, particularly where questions of duties on GPs are concerned.

[182] No legislative requirement is placed on registered healthcare professionals to notify the DVLA. Guidance provided to doctors by the GMC is that they should advise patients about the impact of their medical condition on driving, the effect of any

treatment, and the legal requirement of notification. The DVLA also provides guidance. The question is whether regulation requires to be altered or introduced. The evidence before this Inquiry does not support any change to present practice.

[183] Dr Stevenson considered that there was no requirement to impose a legal duty on GPs to report potential driving-related impairment to the DVLA. That was because there was such a practice in place already. GPs are already aware of their wider duty to the public, and have been given advice from the General Medical Council that, in such circumstances, they could breach their duty of confidentiality to the patient by reporting such concerns.

[184] Dr Townend discussed the process of reporting. Following a discussion with a patient which raised such concerns, guidance was available from the GMC and also the DVLA. The latter set out how the balance was to be struck, which was in practice tricky and time-consuming. Time was limited. It was challenging for the GP to take steps towards removing a licence, particularly in rural areas. GPs were, however, able to take difficult decisions. The process inevitably involved trusting the patient to report. It was not a speedy process. She did not consider that the system of reporting to DVLA required change. Notwithstanding patient confidentiality, the GMC guidance was clear about reporting concerns to the DVLA, and patient confidentiality was not a block to reporting in extreme cases. Her own practice was to phone the DVLA advice line, where she could speak to a doctor who was specially trained in driving medicine.

[185] From this limited evidence, there is insufficient basis to comment on the effectiveness of the reporting regime between GP and DVLA in identifying drivers with

dementia. However the present system does allow reporting and there is no reason to identify any fault.

Any other information, observation or comment

[186] There are some topics which would repay investigation, but for which the evidence before this Inquiry was too limited to support any conclusions.

(a) Sharing of information

[187] Dr Jenkins, Senior Doctor at the DVLA, raised concerns about sharing of information. As this evidence was peripheral to the issues, and came after that of the GPs, the matter was not raised with them. There was a practical problem about sharing information between bodies. If the DVLA conclude a driver is unfit by way of dementia, they have legal advice that data protection legislation prohibits sharing that information with the driver's GP. They cannot even advise the GP that the licence has been revoked, and have to couch any correspondence in anodyne terms. It causes a lot of friction, as the GPs often need to know what the result has been. The DVLA doctors would like to share the information, but are open to censure from the GMC if they do so. The GP may need the information, not only in treating and advising the patient, but also to know that a dangerous driver is off the road. An inability to discuss matters means the GP does not know if the DVLA is aware of the medical condition.

[188] The problem continues if the DVLA detect a medical problem while testing a patient. If a test, for example a treadmill test, shows there to be a serious health

problem, the legal advice is that this cannot be shared with the patient's GP. They can only tell the patient, and hope that the information gets back.

[189] Dr Jenkins commented that it would be good to be able to speak in confidence to the driver's own nominated clinician. It is difficult to disagree. Because this issue came from a single, albeit eminent, witness, there is not enough evidence to make a recommendation. This topic would, however, repay investigation. If data protection provisions prevent confidential doctor-to-doctor conversations designed to impart important information, this should be addressed and, if necessary, the law amended.

(b) Conditions other than dementia

[190] This Inquiry is limited to consideration of age-related dementia. There are many other conditions, listed by the DVLA, which render drivers potentially medically unfit to drive. It may be that some conclusions reached in this Inquiry would assist in addressing other conditions, for example eyesight or blood pressure. It may be that the recommendations in this report can be extended to cover such conditions.

(c) Creation of a class of 'conditional' licence for the over-70s.

[191] During the medical evidence, it emerged that some drivers are lulled into a false sense that they are certified competent for three years every time they apply, and are therefore safe and need not self-examine during that three year period. Legally, this is not the case, because all drivers remain subject to the overall duty to report medical conditions which may affect their driving.

[192] As Professor Macpherson pointed out, every one of us will eventually lose the cognitive ability to drive safely. While most drivers do recognise degeneration and loss of ability, a lot of that depends on comments made by friends and family. It is a somewhat imprecise and unpredictable method of encouraging drivers to recognise their own decline. Not all will take responsible action in stopping driving, particularly if it leads to significant adverse consequences for their quality of life.

[193] It is necessary for drivers to recognise that executive function does not decline in three-year stages but gradually, and that time erodes ability to drive. It may be of benefit if the inevitability of decline, and the need to be self-aware, is reflected in the nature of the licence granted. A licence granted to over-80's might no longer be referred to as a full driving licence, but instead as a conditional driving licence, or similar. That would highlight the requirement for continuing daily good health to a level sufficient to achieve safe driving. Again, the evidence was not sufficiently focused to allow a recommendation to be made, but this would repay further consideration.

[194] There is nothing else I have presently identified as of assistance.

[195] I would like to express again my condolences to the family of Xander, and in particular to his parents, Paul and Victoria, who attended the Inquiry and conducted themselves with great dignity throughout. He was clearly a well-loved little boy, and his loss is a tragedy.