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Driven to despair

How drivers have been let down by the
Driver and Vehicle Licensing Agency

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Foreword

This report highlights major failings in the way the Driver and Vehicle Licensing Agency (DVLA) makes decisions about whether people with certain medical conditions are safe to drive.

We have upheld investigations into eight separate complaints where people with complex medical conditions were unfairly prevented from driving, sometimes for several years, as a result of flawed decisions, significant delays, poor communication and complaint handling. We have seen the significant impact that DVLA's actions have had on people's lives: causing them to lose their jobs, be cut off from friends and family, and suffer significant stress and frustration. DVLA has accepted our findings and recommendations for all eight cases and in six of them has granted the licence applied for, thereby overturning its own original decision.

Our outstanding concerns are two-fold. First, that there will be others who have experienced the same injustice and hardship for whom things have not yet been put right. Secondly, that insufficient action has been taken, or is planned, to prevent the same failures being repeated and impacting many more people in the future. In particular, further action is needed to improve the robustness of assessments of fitness to drive for people with certain medical conditions and disabilities.

Without this, there are risks that people fit to drive will be denied a licence to do so, and others, who pose a risk to the public and themselves, will keep their licence and continue to drive. In coming to our view we have considered evidence, reinforcing our concerns, from a range of organisations and individuals including the Department for Transport's own Independent Complaints Assessors, the British Medical Association, the International Glaucoma Association, eminent specialists in the area of vision and many driving groups and charities.

The Department for Transport has accepted our findings about the failures we have identified. I am deeply concerned, however, that it has not accepted our recommendations to put things right by providing justice for everyone who may have been affected or by improving the robustness of the criteria applied in future medical assessments.

As a result, I am publishing this report in the public interest and laying it before Parliament under Section 10 (4) of the *Parliamentary Commissioner Act 1967*.

Dame Julie Mellor, DBE
**Parliamentary and Health Service
Ombudsman**

October 2016

Executive summary

Between April 2014 and March 2015, we received eight complaints about the Drivers Medical Group (DMG)¹, the part of the Driver and Vehicle Licensing Agency (DVLA)² that considers whether drivers with a medical condition are safe to drive. The complaints concerned licensing decisions made by DMG between 2009 and 2014. The complaints were about delays by DMG in making licensing decisions, poor communication, the quality of the information provided, and poor complaint handling. People told us that DMG's handling of their cases prevented them from driving for an unreasonable period of time, causing them losses of employment and freedom, and significant levels of stress and frustration. Several people's cases took years to resolve, and in most cases DVLA failed to accept that it had made mistakes or handled things poorly.

Putting things right for the people who had brought their complaint to us was our priority. We have therefore investigated all eight of these complaints, and in six³ of those the failings identified have been remedied in full by DVLA. The similarities in the eight complaints pointed to a potentially wider problem with the way DVLA handles medical fitness to drive cases. This report sets out our findings on the overarching similarities between these cases as well as recommendations for improvement to the system as a whole.

Taking into account the regulatory and legislative requirements on DVLA, we expect DMG to:

- make fitness to drive decisions in accordance with the law and guidance;
- operate an open and transparent decision-making process, so that the public can understand the reasons for its decisions;
- take relevant factors into account and discount irrelevant ones; and
- engage with the public and stakeholders so that there is clarity about its roles and responsibilities and so that licence holders and other stakeholders properly understand what is required of them.

Our investigations have shown that this does not currently happen. We have found fault in the way that DMG operates, which means that it is not meeting its obligations. We have seen no evidence that proper standards or criteria are in place to enable DMG to meet its required aim of road safety. We have seen no attempt to relate medical conditions to functional ability to drive safely. We have also seen a lack of assessment of condition specific risks and how those risks might affect road safety.

¹ DMG is the part of DVLA that considers whether drivers with a medical condition are safe to drive. It makes between 600,000 and 750,000 licensing decisions every year.

² DVLA is an executive agency of the Department for Transport with responsibility for driver and vehicle licensing. As part of its role it also ensures that those who have a driving licence (both for ordinary and commercial or vocational vehicles) are safe to drive.

³ One of the complainants was not in a position to submit a claim for financial remedy to DVLA before we had completed his individual investigation. In the final case, we are still in the process of agreeing the appropriate level of financial remedy due with DVLA.

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During the course of our investigations, the Glasgow bin lorry inquiry⁴ was concluded. Its findings echo our own. It found that the system needs to be easier for GPs to use, and that DVLA needs to engage more with people who use its service, particularly the medical profession. It went so far as to suggest that DVLA should produce a flow chart to assist medical professionals advising patients in the area of loss of consciousness.

In almost every case we investigated, the driver was eventually given the licence that they had applied for, thereby overturning DVLA's original decision and showing that the decision-making processes followed are flawed. This led to significant levels of unnecessary inconvenience and distress, sometimes over several years.

That inconvenience and distress has, in the cases we have seen, only been made worse by DVLA's complaint handling which we have found to be defensive, demonstrating a failure to admit when things go wrong, and a failure to learn from complaints to make the process better.

We are therefore recommending that DVLA:

- apologises to the individuals who have complained to us about their individual cases;
- produces a set of clear evidence-based standards to assess whether people are fit to drive that take into account risk within the UK context⁵, and that are in line with the requirements of the Regulators' Code⁶;

- takes account of the evidence in this report to design a process that is administratively fit for purpose in all cases, including the most complex cases, and meets the requirements of the Regulators' Code;
- improves its communication so that information about fitness to drive is readily available, open, transparent and understood by both applicants and the medical profession, and is in line with the requirements of the Regulators' Code;
- provides remedies to the eight people who complained to us to put them back in the position that they would have been in if there had not been any failings; and
- designs and puts in place appropriate arrangements so that others who may have been affected by the failings we have found have the opportunity to seek appropriate redress. When considering the design of the arrangements, DVLA should take account of HM Treasury's guidance *Managing Public Money*.⁷

As the responsible Department, the Department for Transport should:

- use all relevant information, including from complaints and stakeholders, to make sure that DMG's process fully meets the needs of people who use its service and also the legislation.

⁴ A fatal accident inquiry was carried out by Sheriff John Beckett QC following the loss of consciousness at the wheel of a Glasgow bin lorry driver in December 2014 which resulted in the death of six people: www.scotland-judiciary.org.uk/10/1531/Fatal-Accident-Inquiry--Glasgow-bin-lorry-crash.

⁵ DVLA's current standards are measured against a formula devised with Canadian road safety and usage in mind.

⁶ The Regulators' Code is a set of regulatory principles which all regulators should abide by: www.gov.uk/government/uploads/system/uploads/attachment_data/file/300126/14-705-regulators-code.pdf.

⁷ www.gov.uk/government/publications/managing-public-money.

In response to our findings DVLA has accepted that it has not always got things right in assessing people's fitness to drive, and agrees with the findings in our report. It has told us about work that it has already started and projects it has planned, and says it will put right the failings that we have identified. It says the Department for Transport has recently published a motoring services reform strategy⁸. DMG is a significant part of that strategy and the Department for Transport will monitor its performance over the next four years. Although we note the steps DVLA has already taken, we think there is more that it can do as we have set out in this report and in our recommendations.

The Department for Transport has accepted most of our recommendations. It has not agreed to introduce arrangements aimed at others who may have been affected by the failings we have found. The Department for Transport's response has been to say it will review previous complaints in line with our findings using its existing complaints process. This approach does not address the many other people potentially affected who have not previously complained.

The Department for Transport has also not agreed to produce a set of evidence-based standards for assessing fitness to drive. In response to our report it has said its current standards will remain subject to continuous improvement. It is not clear to us how DVLA will be able to respond to the problems we have identified in this report recurring for other drivers in future without reviewing its current standards.

The complaints that we have investigated

DMG is the part of DVLA that is responsible for investigating whether licence holders with certain medical conditions are safe to drive. DMG is made up of administrative and casework staff. It also has a pool of medical advisers who deal with the more complex cases. DMG relies on the Department for Transport's Honorary Medical Advisory Panels (Panels)⁹ to keep up to date on developments in the main medical conditions that are considered to affect a person's ability to drive.

DMG makes between 600,000 and 750,000 decisions every year. The complaints that we received were all about cases that had been escalated to medical advisers. Around 10% or 60,000-75,000 cases a year are considered at that level.

The drivers who complained to us have pointed to several common points of concern with the way that DMG has handled their cases. The complaints cover licensing decisions made between 2009 and 2014 and were about delays by DMG in making licensing decisions, poor communication, the quality of information provided, and poor complaint handling.

The time taken for DMG to come to a final decision ranged from six months to several years. In most cases a decision to revoke or refuse the licence was overturned once the complainant gave DVLA additional information or evidence.

⁸ www.gov.uk/government/uploads/system/uploads/attachment_data/file/522761/motoring-services-strategy.pdf.

⁹ The Department for Transport has established six Honorary Medical Advisory Panels that provide it (in reality DVLA) with up to date scientific research results and information to support it in its role when considering medical conditions affecting road safety.

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However, the complainants told us that the information they provided that later changed the decision, was in the main no different to the information that would have been available to DMG had it done what it should have. In one case the decision to revoke a licence was taken without any prior communication with the complainant or his GP. No investigation was undertaken into the complainant's condition, even though it was not one that allowed DVLA to revoke his licence. In another case the complainant questioned the appropriateness of the test used by DVLA to revoke his licence.

The complainants told us that DMG's actions prevented them from driving (at all, or for their work in some cases) for an unreasonable period of time, causing them to lose their freedom and, in some cases, their livelihood. All of the complainants were significantly affected by the delay in DMG reaching a decision to issue them with a full, or time limited, licence¹⁰. The impact of DMG's actions included social isolation, financial loss, and reduced quality of life. Many of the complainants told us that the stress of the situation also had a detrimental effect on their family lives. Many of them were vocational drivers whose sense of identity was closely connected to their occupation. Not being able to drive meant there was an additional impact on their sense of self-worth as well as on their family life and incomes.

All the complainants expressed frustration at the way that DMG communicated with them. They said this made the whole experience even more stressful and frustrating. In reality there was no direct communication between DMG and most of the complainants while it was dealing with their cases. This, coupled with limited publicly available information, extremely poor complaint handling and a refusal to accept that it had mishandled or made mistakes in these cases, compounded the stress caused by DMG's actions.

¹⁰ In certain instances a driver's right to drive must be re-evaluated in one, two or three years to make sure that their condition has not deteriorated and caused them to pose a risk to road safety. Vocational drivers must be periodically re-evaluated regardless of whether or not they have a medical condition affecting fitness to drive.

Our approach

We make final decisions on complaints that have not been resolved by the NHS in England, UK government departments and some other UK public organisations. We do this independently and impartially. We are not part of government, the NHS in England or a regulator. We are neither a consumer champion nor arbitrator. We look into complaints where an individual believes there has been injustice or hardship because an organisation has not acted properly or fairly or has provided a poor service and not put things right.

We normally expect people to complain to the organisation they are unhappy with first, so it has a chance to put things right. If an individual believes there is still a dispute about the complaint after an organisation has responded, they can ask us to look into it.

We are accountable to Parliament and our work is scrutinised by the Public Administration and Constitutional Affairs Committee. Our role is formally set out in the *Parliamentary Commissioner Act 1967*.

When conducting our investigations we selected eight complaints that illustrated to us the complainants' experiences of different aspects of the DMG process, and that enabled us to take a wider look at the processes it followed and the problems identified in the individual cases. This report summarises the findings of those investigations and makes wider recommendations for improvement to the system as a whole.

As part of our work, we have made recommendations to put things right for the complainants whose cases we investigated. This report sets out what more we believe needs to be done to provide a remedy for the wider group of people affected by the problems that we have found in DMG's system.

During the course of our investigations we visited DMG twice, carried out interviews with, and shadowed, a range of its staff, and met with senior managers. We also liaised with, and gathered evidence from the Department for Transport and the Independent Complaints Assessors (ICAs)¹¹. We met with the Chair of one of the Panels and observed a Panel meeting. We also conducted a workshop with several of the people who complained to us and spoke at length on the telephone with others. We took account of the evidence they provided in support of their complaints.

We considered the relevant legislation, policy, and guidance and looked to see how fitness to drive might relate to other assessments (for example, local authority road safety schemes, fitness to work assessments, occupational health). We also looked at other relevant research about medical conditions that affect fitness to drive. This came from charities and other organisations with members affected by DMG investigations, including the International Glaucoma Association (IGA) and the Freight Transport Association.

¹¹ Independent Complaints Assessors (ICAs) review complaints about the administrative actions of the Department for Transport and its agencies. The service is independent of the Department for Transport. There are certain limitations to their role. In particular, they are not able to comment on Departmental or Agency policies.

We consulted with several relevant stakeholder groups, including driving organisations and relevant charities,¹² to learn more about the experiences of those involved from different perspectives, and to get a sense of the scale of the problem. While we have not included in this report all the information we have seen for the purpose of this investigation, we are satisfied that nothing of significance has been left out.

The relevant standards

When we investigate, we generally begin by comparing what actually happened with what should have happened. To decide what should have happened, we use general standards that we apply to all cases¹³ as well as standards specific to the organisation complained about. We then assess the facts against the standards. If the organisation's actions fall far short of the standards, we decide if that is serious enough to be maladministration.

The Regulators' Code

DVLA is a regulator and has to abide by the Regulatory Principles and should have regard to the Regulators' Code¹⁴. This sets out the requirements for regulators to:

- Carry out their activities in a way that supports those that they regulate. This includes the need for the approach to be proportionate, that their officers have the necessary knowledge and skills to support those they regulate, and that their officers understand the statutory principles of good regulation.
- Provide straightforward ways to engage with those they regulate and hear their views. This includes engaging with those they regulate, taking on board customer feedback and satisfaction ratings and providing clear complaints and appeal procedures.

¹² Diabetes UK; Insulin Dependent Diabetes Trust; International Glaucoma Association; National Association of Disabled Bikers; Parkinsons UK; Age UK; British Motorcyclist Federation; Sleep Apnoea Trust; Institute of Advanced Motorists; Road Haulage Association; Confederation of Passenger Transport; Freight Transport Association; RAC Foundation; the AA; General Medical Council; British Medical Association; GOLD scheme; SAGE scheme; Business Disability Forum; Phil and Friends; Health Management Limited.

¹³ These are our *Principles of Good Administration*, *Principles of Good Complaint Handling* and *Principles for Remedy*, which are available at www.ombudsman.org.uk.

¹⁴ www.gov.uk/government/uploads/system/uploads/attachment_data/file/300126/14-705-regulators-code.pdf.

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- Base their regulatory activities on risk. This includes taking an evidence-based approach to determining risks in their area of responsibility, considering risk at every stage of their decision-making process, designing a risk assessment framework and reviewing it regularly, and reviewing the effectiveness of their activities in delivering their desired outcomes.
- Ensure clear information, guidance and advice is available to help those who they regulate to meet their responsibilities. This includes providing guidance that is published in a clear and accessible form and having mechanisms in place to consult those that they regulate.
- Ensure that their approach is transparent. This includes publishing clear service standards, setting out what can be expected from them, and providing information on how they can be contacted, how they provide information and guidance and what those being regulated can expect.

The Road Traffic Act 1988

The *Road Traffic Act 1988* (the 1988 Act) sets out the rules for safe driving and covers driver licensing. Section 92 (2)(a) of the 1988 Act requires licence holders to tell DVLA about any medical condition that may affect their fitness to drive if that condition is likely to last longer than three months. The 1988 Act refers to prescribed, relevant and prospective disabilities when talking about medical conditions.

There is also a legal obligation, under section 94 (1), on the applicant/licence holder to notify DVLA of any medical condition which may affect their fitness to drive at any time. In addition members of the medical profession, the police and members of the public may

also notify DVLA if they become aware that a licence holder might cause a threat to road safety because of a prescribed or relevant disability.

Section 88 of the 1988 Act allows licence holders to drive while their application is being considered as long as their application for a licence is less than one year old; they have not previously had their licence revoked; they drive under the conditions of their original licence; and they are confident that their condition would not cause DVLA to revoke their licence.

If DMG concludes that a person is not fit to drive, it should provide the medical reason for this and let the licence holder know when they would be eligible to re-apply. DMG should also let licence holders know that they have a right to appeal to the Magistrates' Court. DVLA normally recommends that the applicant or licence holder checks with their doctor that they meet the medical standards of fitness to drive (set out in DVLA's *Assessing fitness to drive*¹⁵) before re-applying.

The legislation clearly shows that DVLA's role is to assess whether a driver with a medical condition poses a threat to road safety because of the effect of that condition on his or her ability to drive. Our reading of this is that a licence should be revoked if a medical condition means that the driver is no longer able to carry out this activity safely. It therefore follows that a decision to revoke a licence should be based on an understanding of how the condition affects a driver's functional ability to drive. Despite much research and investigation, we have been unable to establish any standards that can be used to measure how a medical condition affects fitness to drive.

¹⁵ *Assessing fitness to drive – a guide for medical professionals* was published in March 2016 and replaces the *At a Glance Guide* that had been in place for the preceding 25 years. www.gov.uk/government/publications/assessing-fitness-to-drive-a-guide-for-medical-professionals.

Prescribed disabilities are:

- epilepsy;
- severe mental disorder;
- liability to sudden attacks of disabling giddiness or fainting which are caused by any disorder or defect of the heart as a result of which the applicant for the licence or, as the case may be, the holder of the licence has a device implanted in his body, being a device which, by operating on the heart so as to regulate its action, is designed to correct the disorder or defect;
- liability to sudden attacks of disabling giddiness or fainting, other than attacks listed above; and
- persistent misuse of drugs or alcohol, whether or not such misuse amounts to dependency.

In the case of disorders of the heart there are exceptions, which allow a licence to be granted if the condition is controlled.

Relevant disabilities:

The 1988 Act defines relevant disabilities as a disability that is either prescribed in legislation or any other disability that is likely to cause the driver to be a *'source of danger to the public'*.

The legislation does not say how DVLA must assess whether someone has a relevant disability, although it gives DVLA the powers to seek medical evidence. Section 92 says that DVLA must revoke or refuse to grant a licence if it *'appears'* to it from the driving licence application declaration, or it is *'satisfied from other information'*, that the applicant has a relevant disability. As such, DVLA has wide discretion about how it makes licensing decisions in this group and to decide what disabilities it considers causes the driver to *'be a source of danger to the public'*.

Prospective disabilities:

A prospective disability is any medical condition which, because of its progressive or intermittent nature may develop into a prescribed or relevant disability in the course of time. Examples of prospective disabilities are Parkinson's disease and dementia. Drivers with prospective disabilities are normally issued with a driving licence subject to review in one, two or three years.

The Motor Vehicles (Driving Licences) Regulations 1999

The Motor Vehicles Regulations 1999 (the Regulations) set out the rules around who can hold a licence and what is needed to allow the Secretary of State for Transport to award licences. The Regulations set out the need for vocational drivers to provide the Secretary of State (in reality DVLA) with a signed medical report showing that s/he *'is not suffering from a relevant or prospective disability'* when they apply for or renew their licence. It also sets out the need for the Secretary of State to carry out investigations into visual field defects and cognitive functions and behaviour, and high risk offenders (those with drug or alcohol dependence) in considering fitness to drive for all licence holders (Section 75). Diabetes, visual acuity, sight in only one eye, liability to seizures and epilepsy are set out as prescribed disabilities for vocational drivers (Section 73) under the Regulations.

EC Directive 2006/126/EC (the 3rd EC Directive)

The Directive was implemented by *The Motor Vehicles (Driving Licences) (Amendment) Regulations 2012* and came into force in the UK on 19 January 2013. This legislation brought in mandatory medical checks on the renewal of a Group 2 (bus or lorry) licence and allows shorter period licences on grounds of age or disability. It increases the level of medical checks that must be made of vocational drivers. The Directive also enables the Secretary of State to require medical evidence on administrative renewal of any licence.

DVLA service standards

Until recently DVLA's published service standard for considering fitness to drive was that it would complete 90% of investigations within 90 working days. This service standard was in place when all of the cases that we have investigated were being considered by DMG. It does not currently have a published service standard setting out how long it will take to consider fitness to drive applications. DVLA has explained that it is focusing its work on improving customer experience across the board and is therefore moving away from arbitrary numerical targets.

Types of driving licence

All drivers have to hold an ordinary (or Group 1) driving licence. However, those who drive large or heavy goods vehicles (HGV) can also apply to hold a vocational (or Group 2) licence. In order to hold a vocational licence a driver must periodically demonstrate that they meet more stringent medical standards than ordinary drivers. Vocational drivers have to periodically renew their licences. They must give DVLA a signed medical report showing that they are *'not suffering from a relevant or prospective disability'* when they apply for or renew their licence. Vocational licences are renewable every five years for drivers between the ages of 45 and 65 and annually after this.

Exceptional case criteria

The exceptional case criteria states that Group 1 (or ordinary) drivers who have lost their licence because of a visual field defect which does not satisfy the standard, may be eligible to re-apply to be considered as exceptional cases on an individual basis, subject to strict criteria. These are that the defect has been present for at least 12 months; the defect must have been caused by an isolated event or a non-progressive condition; there must be no other condition or pathology present which is regarded as progressive and likely to be affecting the visual fields; the applicant has sight in both eyes; there is no uncontrolled diplopia¹⁶; there is no other impairment of visual function, including glare sensitivity, contrast sensitivity or impairment of twilight vision; and there is clinical confirmation of full functional adaptation. If these criteria are met a driving assessment can be arranged to assist DVLA in its decision whether to issue a licence.

Roles and responsibilities in fitness to drive decisions

DVLA

DVLA is an executive agency of the Department for Transport with responsibility for maintaining over 45 million driver records and over 38 million vehicle records. The www.gov.uk website lists its strategic goal as being '*to get the right drivers and vehicles taxed and on the road, as simply, safely and efficiently for the public as possible*'. Its responsibilities include: maintaining records of licensed drivers and registered vehicles; issuing licences to drivers and the maintenance of vehicle driving entitlements; and maintaining records of driver endorsements, disqualifications and medical conditions.

DMG

As the part of DVLA with responsibility for ensuring that licence holders with medical conditions are safe to drive, DMG is required to make licensing decisions in accordance with the relevant legislation and regulatory guidance set out above. It should:

- refuse or revoke the licence of any driver who appears to it to be suffering from a disability that is prescribed in legislation;
- refuse or revoke the licence of any driver who appears to it to be suffering from a relevant or prospective disability which is likely to cause the driver to pose a '*danger to the public*';

¹⁶ A pathological condition of vision in which a single object appears double.

- set the standards for assessing whether a driver has a relevant or prospective disability which is likely to cause the driver to pose a danger to the public. It should do that in accordance with the regulatory guidance;
- administer licensing decisions in accordance with the regulatory guidance and good administrative practice; and
- engage with the public and the medical profession in accordance with the regulatory guidance.

Drivers

All licence holders are required by law to tell DVLA about any medical condition that may affect their fitness to drive if that condition is likely to last longer than three months.

The medical profession

There are no legal obligations on the medical profession to assist in DMG licensing decisions. However, DMG requires the medical profession to:

- advise its patients about whether they are fit to drive while an application for a new or renewed licence is being considered by DMG; and
- provide advice and complete reports or questionnaires at DMG's request.

The General Medical Council is carrying out a consultation into confidentiality. The consultation includes an intention to strengthen the guidance it gives GPs about their responsibilities to notify DVLA if they have concerns that their patients have medical conditions affecting their ability to drive safely.

Our findings

From the investigations that we conducted, we have concluded that the processes set out here do not allow DVLA to meet its purpose, or for DMG to meet the requirements of its role. We have set out our detailed findings below, referring where relevant to the individual investigations that we have undertaken.

Standard setting

DMG's process for setting the standards to assess fitness to drive

Over time, DVLA has created a list of medical conditions that it considers may indicate a prescribed, relevant or prospective disability that the driver must tell it about. Until recently these medical conditions were set out in its *At a Glance Guide*. This has now been replaced by *Assessing fitness to drive (the Guide)*¹⁷. The Guide details eight categories of conditions affecting fitness to drive¹⁸.

Underneath each of these categories, the Guide sets out the results of tests, and particular features of specific medical conditions that require the driver (or the relevant third party) to inform DMG of their condition. DMG uses these categories to create the standards against which DVLA assesses a driver's fitness to drive. The Guide also gives an indication of the likely outcome of a referral (whether the driver will be considered fit to drive or would need to refrain from driving for a specific period of time).

¹⁷ We will refer to this document as the Guide throughout the report for ease of reference. The Guide is not aimed at the public but at medical professionals. It is 127 pages long and now includes colour-coded symbols showing whether a particular condition is an automatic bar to driving, or whether further investigation is required.

¹⁸ These are: neurological disorders; cardiovascular disorders; diabetes mellitus; psychiatric disorders; drug or alcohol misuse or dependence; visual disorders; renal and respiratory disorders; and miscellaneous conditions.

Honorary Medical Advisory Panels

The Guide was created (and is periodically re-evaluated) on the basis of advice from scientific opinion provided by the Panels. DVLA describes advice from the Panels as being: *'those of peer reviewed, evidence based contemporary medical practice within the UK. As such DVLA is ensured of the most accurate, complete and consistent medical advice to allow it to maintain the highest standards in relation to medical licencing decisions'*.

There are six Panels covering a range of medical conditions¹⁹. They are made up of medical experts in relevant fields (who are usually of national or international renown), lay members, and representatives of DMG. DMG's own medical advisers (MAs)²⁰ act as Panel Secretaries. DMG say the role of the Panels is to interpret recent medical developments so that they can make sure that the standards, including the conditions, tests or information DMG asks for to make decisions, are up to date and evidence-based against contemporary medical practice.

During the investigation we met one of the Panel Chairs. He explained that the terms of reference that the Panels work to demonstrate that the Panel is a scientific advisory panel. The Panel does not set policy, but gives advice to help DMG to make decisions about road safety. The Chair said it is for DMG to do what it will with Panel advice. He explained that the Panels cannot change the standards DMG work to, but they do bring forward evidence that might give DMG cause to set new standards, or amend the existing standards.

The Chair was clear that the setting of standards and consideration of risk are policy decisions for DMG, and not the Panel, to make. He said it was for that reason that DMG staff attend Panel meetings - to feed in operational requirements as appropriate.

From the standards in the Guide, DMG MAs create the operating instructions that caseworkers use to make licensing decisions. As such, Panel advice and opinion informs DVLA's decision making on fitness to drive. The operating instructions align with standard questionnaires, filled in by the applicant or their doctors. The operating instructions take the form of flow charts which allow DMG caseworkers to decide whether the person can be issued with a licence, simply by following the flow.

Lack of transparency about how standards are set

Our investigation has found a lack of transparency about how DMG sets the standards it uses to assess fitness to drive. It is not clear whose role or responsibility it is to set those standards. DMG does not appear to take full responsibility for setting the standards. It chooses to relinquish much of that to the Panels without providing robust direction to, or oversight of, the Panels to enable them to carry out that role. We have seen no clear framework of accountability for the standards and there appears to be an element of potential confusion between DMG and the Panels as to their understanding of their respective roles in setting standards.

¹⁹ The Panels cover: alcohol, drugs and substance misuse; nervous system disorders; cardiovascular disorders; visual disorders; diabetes mellitus; and psychiatric disorders.

²⁰ Medical advisers are all medical professionals who work for DMG and consider the most complex cases. They also interpret the information received from Panels and include it in the Guide to apply it to driving. Although none of them practise, they are all required to hold the appropriate accreditation from their Royal College.

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There is little in the terms of reference that the Panels work to that explains how the underlying criteria for the standards in the Guide are related to Panel advice or, therefore, the basis on which Panels should be giving their advice. For example, what DMG requires in respect of the availability and feasibility of medical tests is not specifically set out in the terms of reference. Equally, there is no guidance that we could find about what research should be considered or how this should be selected - that seems to be left entirely to the Panel members.

The research relied on by Panels is not published, so there is no publicly available information to demonstrate what relevant considerations have been taken into account when setting the standards for measuring fitness to drive. Evidence obtained from some of DVLA's stakeholders (notably the International Glaucoma Association), our discussion with the Panel Chair, and evidence obtained during our investigation into Mr A's case, also shows that not enough thought is given to what research might support DVLA in setting such standards. This could be one way of making sure a clearer process is in place.

Flawed decision-making

Our investigations showed DVLA regularly ignores relevant considerations, such as information from a person's own GP or specialist in coming to its decisions. A flawed decision-making process does not automatically mean that the decisions DVLA makes are wrong.

However, a flawed decision-making process, which does not take account of all the relevant considerations, causes us concern about the robustness of those decisions.

To illustrate this, one of the most frequently voiced concerns from our complainants and external stakeholders was about why DMG decisions were being made contrary to advice from an applicant's own doctors and consultants²¹. Our clinical adviser also raised concerns based on his experience that DVLA often takes a different view to that expressed by a consultant without explaining why or clearly saying what the consultant should be measuring so as to be able to robustly answer DVLA's questions. Our investigations have shown that on average 7% of cases are referred for additional medical information even after a licence holder's own doctor (GP and/or consultant) has given information to DMG. In Mrs W and Mr M's cases, information provided by consultant was rejected in favour of DVLA appointed MAs, who are by definition generalists, or by doctors/ophthalmologists with no prior knowledge of the licence holder. In the cases that we investigated, DVLA gave no clear explanation as to why one opinion was preferred over the other.

While there may be cases where there is conflict in the decisions made by DMG and the opinion of the driver's own doctors, leading to the need to seek further information, we are concerned that this happens in so many cases. The cases we have investigated suggest that a more flexible approach can mean that cases are resolved more quickly without the need or expense of more medical advice.

²¹ This point was raised by the Freight Transport Association, Road Haulage Association, Confederation of Passenger Transport, Diabetes UK, and the Insulin Dependent Diabetes Trust.

Risk

We have seen nothing to show that DVLA has taken a risk-based approach to setting the standards, as required in section 3 of the Regulators' Code.

DMG told us that Panels work to the *Canadian Risk of Harm Formula* (the Formula) (Annex A) and that the assessment of risk was therefore '*built in*' to licensing decisions. The evidence suggests this Formula is complex and was specifically designed for drivers with cardiac conditions. It is also based on various assumptions rooted in Canadian road safety and accident data.

We have seen no evidence that DMG has considered how, or indeed if, the Formula can be properly applied to conditions other than those affecting the heart. We have also seen no evidence that DMG has considered how the Formula might apply within a UK context before using it to inform its decision-making. Even if we had seen such evidence, the recommendations accompanying the Formula specifically say they are for guidance and should not replace the clinical judgement of the driver's clinician. Overall we cannot say with any certainty whether the risk model the DVLA uses is suitable or not.

A further example of DMG's failure to properly consider risk is seen in the minutes of a March 2015 Cardiovascular Panel meeting. At that meeting the DMG representative asked the Panel to define '*incapacity*' in the context of driving. It seems to us that in some cases DMG is applying the parameters to a risk of seizure, or any episode where the driver will lose consciousness, but there is no information about the other types of event being tested for. The driving risks posed by people with different medical conditions have not been clearly defined or articulated by DMG.

For example, an 'event' in a person with dementia is unlikely to be loss of consciousness but could still pose road safety risks that are as serious as loss of consciousness.

Overall we cannot be confident of the link between the standards relating to risk that DMG is applying and its ability to properly and appropriately identify drivers who may pose a danger to the public. In the course of our investigations, not only has DMG been unable to give us any evidence to show how it considers risk in setting its standards, it has also told us that it does not have a risk framework for considering DMG cases.

Link between medical conditions and driving

One of the key flaws we identified is DMG's failure to properly consider how a person's medical condition impacts on road safety. In Mrs W and Mr K's cases we found that decisions were made based on assumptions rather than on the specifics of their individual circumstances. We have looked across different sectors to try and find out whether there are other standards that DVLA can refer to when making its decisions about fitness to drive, but we have had no success.

Information that we received from the Business Disability Forum has shown that from an employment perspective, any robust decision to restrict work activities because of a medical condition should be based on an assessment of what constitutes real and perceived risks. To that end, decisions to stop or limit work activities should include the involvement of the individual, an assessment of the individual's own insight into their condition, and a medical assessment of the impact of the condition on the person's functional abilities.

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This approach links closely to road safety schemes that are run across different local authorities in the UK to help older drivers to continue driving safely and who fall outside of DVLA's usual medical criteria²². Based on our investigations, we cannot agree that the current system of standard setting takes these considerations into account.

DMG has told us that the composition of Panels, being largely specialists in their field, assures the best advice, and that its staff provide the necessary balance to enable the advice to be relevant to the applicant's danger to the public. However, we are not persuaded that DMG has considered the composition of the Panels carefully enough to make sure that they are best placed to offer advice on the impact of medical conditions on driving.

The Road Traffic Act requires DMG to determine whether licence holders and prospective licence holders have a medical condition that means they pose a risk to road safety²³. The legislation and standards allow DVLA wide discretion in how it measures and assesses this, apart from in some very specific circumstances. In addition, the Regulators' Code requires it to take a proportionate approach to those it regulates, making sure that its officers have the necessary knowledge and skills to carry out their functions.

It requires DVLA to base its regulatory activities on risk, and to take an evidence-based approach to determining risks in its area of responsibility. It also requires DVLA to consider risk at every stage of its decision-making process, design a risk assessment framework and review it regularly, and review the effectiveness of its activities in delivering its desired outcomes.

We have not seen evidence to show that DMG has ever shown the underlying basis or criteria for the standards it sets in assessing fitness to drive. The evidence that we have seen suggests that its main consideration when assessing fitness to drive appears to be focused on a medical diagnosis rather than considering how a given condition affects a person's functional ability to drive safely.

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- ²² The GOLD (Guidance for Older Driver) scheme run by Norfolk County Council and SAGE (Safer Driving with Age) run by Gloucestershire County Council both work with drivers, their clinicians and driving assessment centres to advise people how they can continue to drive safely, and also when it is more appropriate for them to consider giving up their licence. Both schemes run at relatively low cost and have demonstrated that by working collaboratively, GPs feel more confident to discuss road safety risks posed by medical conditions, and drivers are more likely to agree that they are no longer safe to drive.
- ²³ In January 2015 DVLA was criticised by a judicial review for revoking a licence on the basis of a bad performance at a driving assessment without medical grounds to suggest that there was a relevant disability. The basis of the decision was that DVLA needed to identify clear evidence of a physical or mental disability that is likely to cause driving to be a source of danger to the public in order to revoke a licence as set out in Sections 92 and 93 of the *Road Traffic Act 1988*.

Mr H's story

Mr H is a known drug user and so his licence is renewed on a yearly basis to ensure that he is safe to drive. When his licence came up for renewal in 2012 he was sent for a pre-arranged urine drugs test.

The test showed levels of opiates in his system that meant his licence was revoked on the basis of '*persistent misuse of opiates*'. Mr H told DVLA that he had not taken opiates and he questioned the sample. He provided supporting evidence from his drug dependence consultant and asked DVLA to pay for him to have a hair test as he had found out that this was a more reliable test to show whether or not he had persistently misused opiates.

DVLA did not respond for five months to Mr H's correspondence or representations about the type of test that it had used to revoke his licence. As time was running out for Mr H to prove that his system had been clear of opiates on the date that the urine sample was taken, he paid to have the hair test done privately. This showed no traces of opiates in his system.

We would not argue that DVLA would be wrong to revoke a person's licence if it had evidence to suggest that the person had a prescribed disability (in this case drug dependence). However, in this case we concluded that DVLA could only have based its decision, '*persistent misuse of opiates*', on the results of the urine test as there was no other information to suggest that Mr H had ever taken opiates.

DVLA's consideration of the case was not recorded on its case management system and there was no indication that Mr H's past history was taken into account when DVLA took the decision to revoke his licence. The test used by DVLA only showed that opiates were present in the urine sample taken on the pre-arranged date.

However, when challenged, DVLA argued that Mr H's known amphetamine use was a factor in its decision-making. This is not supported by its case management system or the reason that it recorded for revoking Mr H's licence. DVLA did not properly provide Mr H with the reasons for its decision when it revoked his licence. This was a failure to be open and accountable.

We obtained independent clinical advice during the course of our investigation which showed that a urine test cannot determine what DVLA says it did in Mr H's case (persistent misuse of opiates). We questioned the appropriateness of the test employed by DVLA in this case. We said that as misuse of opiates was the only thing referred to in its decision, that decision was maladministrative as it took irrelevant considerations into account (Mr H's past history) and did not consider relevant ones (the suitability of the test used to determine his right to hold a driving licence).

Our investigation also showed a failure by DVLA to directly respond for several months to Mr H's representations about the suitability of the test used. We said that its actions compounded his frustration and distress. We said it was reasonable for Mr H to challenge the test employed and the conclusions reached on the basis of the test. Despite Mr H's obvious frustration and the fact that he was increasingly desperate in his correspondence, DVLA failed to respond to, or address the reasonable questions that he asked.

We said that DVLA's actions caused him to go to the trouble and expense to show that he had not used opiates. We concluded that we had no confidence that DVLA's actions to investigate Mr H's case were appropriate and we saw no evidence to justify its delay in responding to him.

We criticised DVLA for failing to accept that there were failings in its handling of this case, particularly as its own legal adviser had suggested a payment in recognition of its delays in responding to Mr H's correspondence. DVLA refused to put things right or be customer focused in this case, even when his concerns were considered as a complaint.

Mrs W's story

Mrs W had suffered a mini-stroke and gave up her driving licence on the advice of her doctor. When she returned her licence to DVLA it did not give her information to explain when she would be eligible to re-apply for her licence, even though this was covered in its Guide.

Mrs W found this information out by chance a year later and applied for a licence. DVLA did not explain the basis under which Mrs W's case could be considered or tell her what that involved²⁴.

Mrs W applied for a temporary licence to allow her to practise driving before a driving assessment, but DVLA refused her application. When she had the assessment she had not driven for two years. While the assessment report noted some minor failings, the assessor considered her safe to drive. DVLA refused her application because it had assumed that the minor failings at the assessment were caused by an underlying visual field defect. It did not verify or check this assumption before making its decision. It took over a year for a further assessment to be arranged, at which point Mrs W was considered to be safe to drive and DVLA issued her with a full licence.

Mrs W wanted to appeal the basis of DVLA's decision not to give her a licence after she had passed the first driving assessment. DVLA initially failed to respond to her requests for a copy of the email that explained the basis for its decision in her case. By the time her solicitors had asked for this evidence, the email had been destroyed. This email had not been recorded on DVLA's case management system and the basis for its initial decision to decline her licence was recorded almost a month after it had actually been made.

²⁴ Mrs W's case fell under the exceptional case criteria.

We concluded that Mrs W could have been on the road more than a year earlier if DVLA had taken steps to verify the assumptions that it made in light of the first driving assessment. Information obtained by DVLA for the purposes of the appeal suggested that it would have been able to calculate whether Mrs W's error was caused by vision loss at the time that it made its decision. We said that it made its licensing decision without proper consideration of the facts.

We also found that DVLA inappropriately failed to give Mrs W a provisional licence for the first driving assessment and that its explanation for this (that she could drive under Section 88 of the *Road Traffic Act* 18 months after she had surrendered her licence) was inappropriate and provided at a much later date. When Mrs W challenged DVLA's decision, DVLA added additional reasons that had not been included on its case management system at the time the decision was made. In addition, we said that it brought in considerations of cognitive function that had not been tested and was not recorded previously as the basis for its decision.

We said that it was not open and accountable in the way it handled Mrs W's challenges to its decision and its actions prolonged the appeal process. This caused Mr and Mrs W additional and unnecessary distress.

While the appropriate route to challenge a decision is through the courts, we noted that DVLA routinely reviews cases when a credible challenge has been presented. We said that Mr and Mrs W had presented a credible challenge to DVLA's decision but DVLA failed to accept that it had made any errors and its defensive stance prolonged the resolution of this case. This meant there was a failure to promptly put things right. Our investigation highlighted significant delays in DVLA's handling of Mrs W's applications, there were unreasonable delays in its responses to correspondence, and some letters were not responded to at all.

DVLA failed to give Mrs W clear and open information about her rights when she surrendered her licence and this led to a missed opportunity. It also failed to respond openly to a request for information and then went on to destroy evidence that it knew was the subject of a request for the purposes of an appeal. We concluded that DVLA's complaint handling in this case was defensive, with limited evidence of a willingness to learn from or accept mistakes.

Mr R's story

Mr R is a self-employed lorry driver. He had a heart attack in 2008, after which DVLA had concluded that he was fit to drive vocational vehicles. He had been asymptomatic since his heart attack. When he came to renew his vocational licence in 2010, his licence was revoked (in May 2011) because of problems with the results of an ECG reading following a treadmill test. This meant that he was not able to work.

Mr R had several tests and procedures over the following year to determine his fitness to drive including two angiograms, a myocardial perfusion scan and a second treadmill test. A second application was refused by DVLA in February 2012. In March 2012 Mr R's cardiac surgeon wrote to DVLA to say that he thought the treadmill test results had been '*false positives*'. He set out his view that Mr R should be re-issued his licence. In April 2012, DVLA decided to refer the case to a cardiologist from one of the Panels but did not act on this until September 2012. The Panel member responded the following month to say that Mr R should be granted a three-year vocational licence. This was issued two weeks later.

We could not see that the tests used by DVLA had helped it to establish Mr R's fitness to drive vocational vehicles. We concluded that the information DVLA needed to make a licensing decision in Mr R's case was contained in the correspondence that it received from his consultant. Mr R's consultant was satisfied with his fitness to drive for much of the history of the case, but there was little contact between DVLA and the consultant to assess what Mr R's actual physiological situation was.

Once the consultant wrote to DVLA in 2013 the case was reconsidered and a relatively long licence was granted. This must have caused Mr R significant frustration as he had not had any symptoms throughout the period in question. We also concluded that there were significant and unnecessary delays in DVLA's handling of Mr R's case.

We found that DVLA failed to respond to correspondence from Mr R in a timely way or to keep him updated on progress of his case. In addition it was not open about how it was dealing with his case. When Mr R complained to DVLA it failed to address all of his concerns and missed opportunities to learn from the failings in its handling of his case. It gave no reasonable explanations for the delays in its handling of this case and failed to acknowledge mistakes or put things right.

Administration

DMG's administrative process for making fitness to drive decisions (three stages)

Stage one

DMG makes a decision based on questionnaire completed by driver, or passes case to casework team.



Stage two

Casework team may send out further questionnaires and arrange tests. Decision is made or case is passed to stage three.



Stage three

Casework team manager or experienced caseworker looks into case. Decision is made or case is escalated to a medical adviser.

Stage one

When DMG receives information or a licence application (or application for renewal) which suggests the licence holder (or prospective licence holder) suffers from a medical condition that may affect their ability to drive safely, it sends a questionnaire(s) relevant to that medical condition(s) to the driver to complete²⁵.

DMG has told us that in the majority of cases (around 60% or between 360,000 and 450,000) it can make a licensing decision on the basis of a single questionnaire, and this can be made within days²⁶.

Stage two

When it receives the completed questionnaire, if the case is one where DMG cannot come to a decision on the basis of the answers given, it is passed on to the casework teams. At this point it may send out further questionnaires to the driver, and usually to their GP or consultant. In some cases, additional tests may also be arranged at DVLA's expense²⁷. Generally DMG staff do not speak to licence holders or medical professionals at this stage.

DVLA told us that decisions can be made at this stage in around 30% of the remaining cases (between 180,000 and 225,000 cases). In 2014-15 the average time taken to complete this group of cases was 47 days.

²⁵ These can also be downloaded from the www.gov.uk website and included with the initial application.

²⁶ Data for the last five years shows that DVLA is making significant improvements and continuing to invest in better service for this group, which means that licensing decisions can now be made within days in most cases. It is working towards automating this system and making it available interactively online, to further speed up the process.

²⁷ Some tests are required by DVLA, for example, visual field tests for people suffering from glaucoma. Other tests are arranged at DVLA's discretion depending on the circumstances of the licence holder's medical condition and in line with the standards that DVLA set.

Stage three

The case is escalated to a First Line Manager (casework team manager) or MedEO to resolve if there are discrepancies in the information received from the driver and the clinician; confusing or contradictory information in responses on a questionnaire; discrepancies between the current questionnaire and a previous one completed by the driver or their clinician; or the responses given do not allow a decision to be made using the operating instructions. MedEOs are experienced caseworkers who have normally had more specialised training. This means that they are more likely to be able to interpret some of the information received, despite it not fitting neatly with the operating instruction flowchart. They can either direct the case back to casework teams to make a decision; make the decision themselves; or pass it on to an MA for further investigation. Around 10% (60,000-75,000 cases) of cases are passed to MedEOs or MAs before they can be resolved.

When cases reach this stage, at the discretion and judgement of the MA, DVLA may request further information or reports, either from the driver's own clinicians or from independent clinicians. DVLA arranges and pays for this. If a case raises issues that can be applied to more than one case, it can be referred to a Panel for discussion. Some cases are sent to individual Panel members for a decision or guidance if DMG is unable to make a decision on the basis of the information that it has gathered. In 2014-15 the average time taken to complete this group of cases was 162 days.

Case ownership

DMG's process is that each action on a case is taken by the next available officer, rather than a case being managed by the same caseworker for its duration. This means caseworkers do not build up familiarity with individual cases and are unlikely to be alert to the individual needs of the applicant if they only handle the case briefly and never discuss it with the licence holder. At the time of our investigation there was no facility for cases to be managed or owned by a single individual - regardless of the circumstances of the case.

This was true even in the more complex cases that involved MAs. This lack of ownership, while unlikely to be a cause of delay by itself in the majority of licensing decisions, seems to have contributed to DMG's failure to respond to the individual circumstances of the cases we investigated. It is clear that DMG does not adapt its service to make it work for people who have specific requirements. Examples include cases where the applicant has said the issue is urgent (Mr M); cases where the applicant has special requirements due to disability (Mr S); and cases where the applicant has multiple medical conditions (Mr R, and we have seen that this has been raised as an issue in several ICA cases).

There was a failure to take a proportionate approach when clarifying confusion or missing information in the majority of the cases that we investigated. When we shadowed staff on our visits to DVLA we asked caseworkers what they do about missing or ambiguous information on a questionnaire.

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They told us that this could only be resolved by escalating the case through the procedure, or sending a questionnaire out again for the additional information to be added. We saw this happening even when the missing information was of limited importance, such as the date of an appointment.

When we asked DMG staff why missing or ambiguous information could not be clarified over the telephone, they told us that the information had to be provided to DVLA in writing and could not be accepted verbally, but we could not see any reason why this should be the case. DVLA told us that it does train staff to use the telephone and that the behaviour we had observed was not in line with procedures. However, we have not seen any evidence to support this statement.

Delays also occur once a case is escalated. This seems an obvious outcome of several hundred caseworkers passing approximately 10% of cases through to the ten MedEOs and 22 MAs employed by DMG²⁸. Complaints data from DMG also shows that over the last five years, one of the main causes of complaint about its service has been delays which it has classified as *'heavy workload on team and with MAs²⁹'*, *'heavy workload with MAs'*, and *'detailed necessary medical enquiries'*.

We found in every case that the delays experienced by our complainants were unreasonable, and that there were long periods when no action was taken to move cases on.

In Mr H's case, for example, the delay of five months to respond to his enquiries about a time limited matter was wholly unreasonable. In Mr S, Mr N, Mr G, Mrs W and Mr M's cases there were significant periods when no action was taken to progress their cases.

The average time to make a licensing decision in 2013-14 was 35 calendar days for a casework team; 103 days for a MedEO; and 174 days for an MA; and in 2014-15 it was 47 days for a casework team; 127 days for MedEO; and 162 days for MAs.

²⁸ Information DVLA provided in July 2015.

²⁹ DVLA told us that there have historically been problems in filling MA positions but that it has now had more success in this area.

Lack of flexibility and tailored correspondence

DMG's lack of flexibility (progressing cases in a linear way and failing to clarify or obtain missing information in a tailored way) builds delay into cases. Its current process makes it more likely that a licence holder may be required to undergo a variety of tests, and that their clinicians may be asked to complete several questionnaires (at significant cost to DVLA³⁰) that prove to be of limited use before the case reaches an MA who then finds it necessary to request further information to make a decision. In some of the cases we investigated, the MA only needed to make an enquiry to the licence holder's clinician to make a decision, but failed to do so. This is further supported by what Diabetes UK told us about its experiences of DMG. It said that delays were often caused by DMG's lack of flexibility in responding to errors people have made completing questionnaires.

We met with DVLA, the Department for Transport, and the ICAs in September 2015. At the meeting, DVLA's Chief Executive agreed that there is a problem in the way staff use standard letters to correspond with medical professionals and complainants. We agree. Our investigations have found that DMG communications are almost exclusively in writing and based on standard letters, meaning DMG rarely responds to specific points when complainants write to it. In the cases that we investigated this led to confusion, ambiguity, frustration and delay while the matter was clarified. DMG also only corresponds by post. The Confederation of Passenger Transport UK told us that this practice adds weeks of delay to cases. Licence holders cannot email DMG or speak to the person dealing with their case over the telephone. They are only given a central customer service telephone

number which is answered by staff working in a different part of DVLA who have no actual knowledge of how DMG cases are dealt with. There is a dedicated telephone line for medical professionals staffed by the MAs, but our understanding is that this was only reinstated in the last year.

The IGA told us that its members regularly complain that DMG fails to make reasonable adjustments or deal with the person as an individual. The concerns it raised with DMG resulted in special arrangements being put in place with a single point of contact for its members. Unfortunately this service is not available to non-IGA members or other members of the public. Given that DMG have recognised this is a problem, we cannot see why this facility is not available to other people who use DMG's service.

Records management

In almost every investigation we carried out we found evidence of poor records management by DMG. The reasons for licensing decisions were often not recorded openly in correspondence with licence holders, and in some cases the reason given to the licence holder did not match DMG's reason (which it later relied on when its decision was challenged). It is a core requirement of the legislation that licence holders are given clear reasons for DMG's decisions, but DMG is failing to meet this requirement. This means it is more difficult for licence holders to properly challenge DMG's decisions. At the same time it leaves DMG open to inappropriate challenge from other licence holders because it has not properly recorded the basis of its decision. In Mrs W's case DMG destroyed evidence that was the basis of its decision, even though it had been requested for an appeal.

³⁰ Information DMG provided shows that more than 50% of its budget in 2014-15 was spent obtaining medical information.

Mr M's story

Mr M had been made redundant and found alternative employment as a vocational driver. When he applied to renew his previously held vocational licence, he told DVLA that he suffers from bipolar affective disorder.

Even though DVLA knew that Mr M's offer of employment depended on him getting a vocational licence, there was a delay in it progressing his application when it received it. When DVLA contacted Mr M's consultant to ask for information about his illness, the responses he gave were confusing and contradictory. Rather than make a direct enquiry to the consultant to clarify the information received, DVLA rejected Mr M's application for a vocational licence and started to investigate whether he was safe to drive ordinary vehicles.

During its investigation, DVLA asked Mr M and his consultant to complete further questionnaires, Mr M was sent for an independent assessment for alcohol dependence and was required to be tested for heavy consumption of ethanol. When these further activities failed to enable DMG to make a decision, a medical adviser contacted Mr M's consultant to ask specific questions about Mr M. As a result of the consultant's answers, DVLA issued Mr M with a full ordinary licence and one year vocational licence.

We concluded that there was limited risk to road safety in this case as Mr M did not have a vocational licence at the time DVLA was assessing his fitness to drive. Once DVLA contacted Mr M's consultant, it made a more appropriate licensing decision relatively quickly. DVLA had wasted time and money pursuing medical enquiries that were unnecessary when it could have contacted Mr M's consultant right at the start to clarify the information provided.

DVLA's actions built unreasonable delays into its consideration of the case and caused Mr M distress and financial hardship at a difficult time. As a result of the way his licence application was handled, Mr M was unable to take up the job he had been offered. Mr M told us that telling DVLA about his bipolar diagnosis was the worst mistake that he ever made. We criticised DVLA for its delay in assessing his case when it was aware from the outset that Mr M's job depended on its consideration of his application.

Mr N's story

Mr N is a vocational driver whose work required him to drive in continental Europe. When his licence became due for renewal, he returned it with his application, in line with DVLA's requirements.

DVLA told Mr N that he did not meet the eyesight standards required and said that it might be able to process his licence if he said he would wear corrective lenses. It provided him with Section 88 cover (allowing him to drive in the UK) while it considered his case. Mr N returned an amended application form a month later, confirming that he would wear corrective lenses, along with the results of a recent eye test.

DVLA said that the latest eye test result still showed that Mr N did not meet the necessary standards. It asked him to provide evidence that his sight had improved. A further visual acuity and visual field test was provided by Mr N's optician, and DVLA identified a problem with his visual field. It told him that he would need a further visual field test. DVLA did not tell Mr N the reason behind its decision or the standards against which he was being measured.

Following input from a DVLA medical adviser, DVLA decided that Mr N should be sent to see an ophthalmologist to determine the cause of his visual field defect. Mr N was still in the dark about DVLA's consideration of his case. The initial tests were inconclusive and the medical adviser decided to renew them in three months' time, but Mr N was not aware of these decisions. He was, however, getting increasingly desperate to resolve the issue of his licence as he was unable to carry out his duties to drive in Europe while his right to hold a vocational licence was being investigated.

It took over a year for DVLA to conclude that Mr N was entitled to his vocational licence. However, its failure to keep a proper record meant that the new licence was sent to his old address and he did not receive it for a further three months.

Throughout the period that DVLA was considering his licence renewal, Mr N was entitled to drive under Section 88 of the *Road Traffic Act*. However, he had explained to DVLA that he was required to drive in continental Europe and that his employer was not satisfied that Section 88 was sufficient cover for those purposes. DVLA failed to respond to his enquiries about that and Mr N decided that he had no option but to resign from his job as he could not perform his duties.

Mr N complained to DVLA about the impact of its delays on his life. He said he had felt he had no option but to leave his job as he was unable to carry out his duties. He said he had been unable to work as many companies refused to accept the Section 88 cover as being sufficient. He said that he was never made aware of what condition DMG was investigating and to his knowledge he had no defect affecting his ability to drive. He said as a result of DVLA's actions he had suffered significant financial loss, had to move house and break up his family. Its actions had also caused him stress and affected him and his family emotionally.

While DMG could not control all of the delays that occurred in this case, it failed to take prompt and timely action to move Mr N's application forward. Once DMG received the information it needed to make a decision, it took six weeks to consider the application and issue a licence. Once a licensing decision was made, DMG's failure to keep accurate records meant that Mr N did not receive his licence until almost three months later. This further delayed his return to work.

DVLA's communication with Mr N was not open or accountable. DVLA did not explain the basis for its further investigations nor did it consider whether there were any steps that could be taken to respond to the specific concerns he raised about the impact its enquiries were having on his ability to work in his chosen profession. In addition, DVLA did not accept failings identified by the Independent Complaints Assessor (ICA) or that it had got it wrong in this case. In response to the ICA report, DVLA suggested that Mr N could have obtained insurance cover to allow him to drive in continental Europe while his application was being considered. We saw no evidence that such cover exists.

Wider engagement and openness

DMG's processes for engaging with the medical profession

DMG issues guidance for the public on www.gov.uk. This includes its *Assessing fitness to drive* (the Guide) which is meant to provide guidance and information to the medical profession. The website includes limited guidance³¹ about when a driver can drive while DMG considers their application. The main information is contained in a leaflet that is available to download from the website.

We found that there is little understanding from within the medical profession of what information DMG needs to help it make sound decisions on cases at an early stage. Engagement between DVLA and relevant medical professionals is also poor, although in the past year this has improved. We have seen no attempts by DVLA to develop training, or provide information and resources to help medical professionals fulfil their responsibilities in relation to fitness to drive, beyond what is available in its Guide.

Better education around roles and responsibilities in relation to driving could reduce delays and ensure the right information is sought and provided at the outset. This would reduce the costs and time involved in assessing medical fitness to drive. In other cases we have noted confusion and poor information about the criteria used to consider exceptional cases.

DVLA's Guide is intended to help medical professionals advise their patients about their fitness to drive if they are diagnosed with a relevant medical condition. However, it does not explain clearly enough what exactly is being measured, and how the various conditions affect fitness to drive. It also does not adequately explain how DMG assesses or measures risks to road safety caused by prescribed, relevant, or prospective disabilities.

The General Medical Council told us that doctors have complained that the information about DVLA is very hard to find and that the Guide is not 'at a glance'³². It suggested that a portal or separate website would be useful, and we know from research carried out on behalf of the Department for Transport in 2011 that doctors would welcome a more interactive resource which they say would be of far greater benefit to them. This has not been put into practice to date³³.

Since we began our investigation DVLA published a new guide for medical professionals. This includes colour coded symbols showing whether a condition or set of symptoms requires further investigation or is an immediate bar to driving. While we welcome this development, it is a far cry from the interactive resource being requested.

³¹ www.gov.uk/driving-medical-conditions/telling-dvla-about-a-medical-condition-or-disability.

³² In August 2015 we had discussions with several external stakeholders including the General Medical Council. Since the comments were made DVLA has re-written and re-launched its *At a Glance Guide*.

³³ Referred to in the RAC Foundation report *Driving Choices for the Older Motorist*: www.racfoundation.org/assets/rac_foundation/content/downloadables/driving_choices_for_the_older_motorist_lang_parkes_and_fernandez_medina_0213.pdf.

Communicating with licence holders

There is also very little publicly available information for drivers that explains what DMG does, how it considers cases, and what people's rights are while their case is being looked at or once a decision has been made. During the period covered by our investigation there has been inconsistent information available to drivers about this.

All our complainants experienced problems in understanding what criteria DMG used to consider their case, and what evidence they needed to give DMG to help it in its investigations. They told us that they did not understand how their cases were being dealt with. We found there is no publicly available information about this, and it has taken us intensive investigation over several months to be able to understand how the process works.

Lack of information about Section 88 of the Road Traffic Act

The majority of licence holders are entitled to continue to drive while DMG considers their case. This is set out in Section 88 of the *Road Traffic Act*. Throughout the period covered by our cases the ICAs have repeatedly asked DVLA to give licence holders more information about their rights to drive under Section 88. Last year DVLA produced a new leaflet explaining Section 88 and gave various scenarios to help people understand their rights while their application was being considered. We understand that DVLA now sends this information out to all applicants and it is also available on the www.gov.uk website.

It is clear that the question of whether or not people can drive while their case is under consideration has caused considerable confusion. It is also clear that the impact of that confusion has caused significant additional distress to the people who complained to us. We found that when licence holders asked DVLA and the Department for Transport about this, there was more confusion rather than clarity on the situation.

In Mrs W's case, she was refused a provisional licence to allow her to prepare for a driving assessment because DVLA wrongly believed that she could drive under Section 88 even though she had given up her licence almost two years earlier.

While we note the steps taken by DVLA in the last year, the information available remains, in our view, confusing. It only allows driving under Section 88 if licence holders and/or their medical professionals are confident that their condition is not one that would cause DVLA to refuse the application. This is not something that some people and/or their GPs necessarily would feel qualified to determine, as in Mr A's case, and we understand why. Given the lack of information available to medical professionals about the standards applied, together with the lack of clarity about how DVLA considers risk, it is difficult to see how most drivers could be confident that they are legally covered to drive until they receive DVLA's decision.

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Information provided by external stakeholders supports this view. The Freight Transport Association, the Confederation of Passenger Transport, the Insulin Dependent Diabetes Trust and the Road Haulage Association have all told us that their members regularly raise concerns about how DVLA has taken a different view from that expressed by the licence holder's own medical professionals, without explaining why.

Diabetes UK also told us that in the experience of its members, medical professionals can make errors when giving information on the forms as they do not fully understand the rules on fitness to drive for people with diabetes or what the DVLA requires. We asked our own clinical adviser about Mr A's case and he explained that, in his experience, it is difficult for consultants to understand what DVLA requires of medical professionals and that DVLA regularly comes to a different view from that given by the consultant without explaining why.

The Road Haulage Association also told us that there is total confusion in people's dealings with DMG; that DMG's requirements are not clear; and it is a box ticking exercise which the DVLA could handle more quickly and sympathetically. The Sleep Apnoea Trust told us that it has produced its own leaflet to support members, and that the quality of publicly available information has decreased since DVLA moved to the www.gov.uk website.

More worryingly, it has given us information about a 2012 Freight Transport Association survey into sleep apnoea which showed that 98% of drivers and employers would not refer themselves to DVLA following diagnosis of sleep apnoea for fear of losing their licences³⁴. This puts DVLA's role of ensuring road safety into doubt, and we have to ask if better information and communication with people who use its service might lessen that.

The IGA supports our findings on this. It told us that while there is some information about glaucoma and driving available (it worked with DVLA to produce this), it would be useful if DVLA provided information about how it makes a decision about fitness to drive. The IGA said the experience of its members is that the process is not clear. It wants DVLA to be more open about what it does and to give information about the informal appeals that it now accepts. It says that information about Section 88 of the *Road Traffic Act* could be made clearer.

DMG's lack of both openness and written policies creates the feeling that the system is unfair, that decisions are not robust, and that licence holders are beholden to the whims of DVLA MAs. This is not always the case by any means, but the lack of information makes it difficult for people to understand and come to terms with decisions that DVLA makes. This also makes it less likely that people will volunteer information that might threaten their ability to drive if they perceive the system for measuring that to be unfair.

³⁴ <http://www.sleep-apnoea-trust.org/wp-content/uploads/2016/01/fta-survey-on-osa-0212.pdf>.

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We have seen that the DMG's lack of communication and publicly available information extended to medical professionals who struggled to understand what DVLA required from them to enable them to make quick and informed decisions about how the licence holder's condition affected their ability to drive. Our investigations also showed that people were unclear about the rules about fitness to drive when they were being assessed by DMG.

Mr A's story

Mr A (a vocational driver) fell from the back of his lorry and suffered a skull fracture. When he notified DVLA of this, he was told that he would need to be assessed to show that he had a less than 2% risk of a seizure per year before he would be considered safe to drive vocational vehicles

DVLA was not able to find a specialist in Mr A's local area who would agree to assess his risk and, as he was deemed not to require ongoing treatment or assessment in respect of the accident, he was not under the care of a consultant who could make representations to DVLA on his behalf.

Mr A offered to pay for his own consultation or travel outside his local area, but DVLA did not respond to these points. His case was referred to a member of the Panel for consideration but not followed up for several months. During this time two Panel hearings took place where several other cases were discussed. When the Panel member finally did respond to DVLA, he could not say whether Mr A posed a risk of seizure of less than 2% per year without further medical examination.

Mr A had not suffered any seizures during the time that his case was under consideration or at the time of the accident. In addition, the correspondence that he and his GP had received from DVLA caused him to believe that he could not continue to drive vocational vehicles while he was being assessed under Section 88 of the *Road Traffic Act 1988*. This was because his GP was not qualified to make a judgement on whether or not he was less than 2% likely to have a seizure. As a result Mr A remained in limbo while DVLA considered his case.

Mr A, his GP and his MP corresponded frequently with DVLA while it was considering his case, to try to establish what could be done to help him. It is clear from his correspondence to DVLA that Mr A was increasingly desperate for a decision to be made on his case as he was struggling financially while he was unable to do his job. He told DVLA that he had to downsize his home and get rid of belongings while he was waiting for it to declare him fit to drive.

As part of our investigation we obtained independent clinical advice as we could not see that Mr A's case was so complex that it required the sort of treatment that it received from DVLA. Our adviser explained that while Mr A's accident had not caused significant damage in his case, the 2% risk level used by DVLA for vocational drivers is applied to all skull fractures and contusions irrespective of the severity of the wound.

Our adviser went on to say that there have been very few studies into the impact of skull fractures on fitness to drive and that the standard study used by DVLA relies on data from 20 years ago when scanning was much less sensitive and there needed to be more blood present for the machinery to pick up a reading. He said that modern machinery is able to pick up much lower levels of bleeding but the standard applied is not adjusted to allow for this.

Our adviser said that even those with fairly minor injuries like Mr A would be prevented from driving longer than might be necessary. This is because there has been no investment in measuring the real impact on skull fractures and contusions on potential seizures for 20 years.

We criticised DVLA for the delays in the way it handled Mr A's case. We could have no confidence that DVLA's actions to investigate his case were necessary, and there were administrative failings in progressing his case. This meant there was an unreasonable delay in its consideration of Mr A's application.

We also criticised DVLA for its lack of clarity over the legislation that allows people to drive while their medical fitness is being considered. We said in Mr A's case that, although DMG clearly picked up on his confusion about his right to drive, it failed to clarify the points or spell out what he could and could not do. We added that the GP's contact with DVLA medical advisers compounded the problem as he was not in a position to assess Mr A's risk of seizure and there was no evidence that he was made aware of any discretionary powers to allow Mr A to continue driving.

We concluded that DVLA failed to properly engage with the users of its service. It also failed to be open and accountable because it did not give medical professionals sufficient, clear information to allow them to respond appropriately to medical enquiries.

Mr S's story

Mr S had a disability that meant it was difficult for him to sit in a fixed position for any length of time. Because he also suffered from diabetic retinopathy he held a short term driving licence that was renewed every three years.

When he came to renew his licence in 2011, DVLA told Mr S that he did not meet the minimum standard for driving and revoked his licence. DVLA's correspondence with Mr S and his representatives and consultants following its decision was confusing, failed to address specific points that he and his representatives made, and failed to fully explain his rights under the exceptional case criteria. We said DVLA's failure to write tailored letters or clearly explain the situation to Mr S over the telephone caused unnecessary confusion, delay and distress over the course of several years. This was a failure to be open and accountable and customer focused.

We also saw evidence of DVLA failing to be flexible in its handling of Mr S's case. In one instance it failed to identify that a vision test it received was dated (it clearly was). It failed to take any action for six months when it received the test and then returned it because it believed that it was undated. We concluded that DVLA should have telephoned Mr S or his consultant to check, particularly in light of its delay in taking action for six months. There were several long gaps when no action was taken to progress Mr S's case. We had no confidence that DVLA properly handled Mrs S's case, so we could not conclude that its delays were justified.

Our investigation revealed that DVLA was fully aware of the difficulties that Mr S had in completing the visual field test since at least 2008. However it took three years for it to respond to the fact that his disability meant that he could not take the prescribed test. By the time an alternative test was offered, Mr S told us he had lost faith in DVLA and refused to take the test as he believed that it would not meet his needs.

Mr S was supported by Diabetes UK during his dealings with DVLA. As part of its correspondence with DVLA on Mr S's behalf, it was established that Mr S had been denied consideration under the exceptional case criteria despite the fact that his condition had been stable for three years.

Diabetes UK argued that DVLA had not been clear with Mr S and others in his situation that information about how long a patient's retinopathy had been stable was crucial to a consideration of exceptionality. DVLA failed to respond directly to the points made by Diabetes UK or to address the wider points that it made, which could have implications for other cases.

In doing this, DVLA missed an opportunity to be open about the basis for its consideration of stable conditions. In addition it failed to reconsider the case under the exceptional case criteria once it was established that his condition was stable. We have seen no evidence to explain why it failed to do this.

Mr S died while we were investigating this case. His widow told us that Mr S loved driving and that after his licence was revoked he was a changed man. She explained that as she does not drive, the loss of his licence caused them both difficulties in attending hospital appointments and getting around. She said DVLA's actions caused him significant distress.

DVLA's poor communication with Mr S and his representatives caused unnecessary confusion and distress and meant that it was difficult for anyone outside of DVLA to understand what was actually required to move his application on. Our investigation also found that DVLA failed for several years to make reasonable adjustments for Mr S's disability and that it missed several opportunities to progress his case.

Complaint handling

DVLA's complaints process

DVLA's published complaints procedure says that in the first instance, complaints or concerns should be referred to the department within DVLA dealing with the issue. In these cases that would be DMG. If the matter remains unresolved, licence holders can make formal complaints to DVLA's complaints team who aim to respond to complaints within ten working days. After that, complaints can be sent to DVLA's chief executive who also aims to respond to complaints within ten working days. If the complaint remains unresolved, it can be referred to the Department for Transport's ICA for an independent review before it can be considered by us. Medical licensing decisions can be challenged via the Magistrates' Court within six months of the date of the decision. DVLA has also recently put in place a process that allows licence holders to ask for a reconsideration of medical licensing decisions if they or medical professionals can provide new evidence to support the request. There is no publicly available guidance or service standards about this process.

Poor responses and learning from complaints

The complaint responses that we have seen through our investigations often fail to respond to difficult questions from licence holders (Mrs W, Mr A, Mr N, Mr R, Mr H). The apologies and explanations DVLA gave also regularly failed to reassure the licence holder that their complaint has been taken seriously. This demonstrates a failure to be open and accountable.

The key causes of complaints to DMG (as recorded by it) over the last five years are '*detailed/necessary medical enquiries*' and the '*heavy workload of MAs and/or teams*'. However, on the basis of our investigations, we are concerned that the '*detailed/necessary*' enquiries are neither detailed nor necessary. This does not appear to be something that DMG has ever considered despite numerous complaints, critical ICA reports and the Reilly review³⁵. There needs to be a culture of learning from complaints, but our investigation suggests that this does not happen at DVLA. Our evidence (for example, Mr K, Mr R, Mr H and Mrs W's cases) suggests a failure to admit when a licensing decision was wrong. In acting in this way DVLA failed to accept when it had got things wrong, be open and accountable, and failed to put things right.

Our investigations show that the same sorts of issues recur in complaints about DMG and we have received evidence from the ICAs to support this view. The evidence that we have seen also suggests that there is a reluctance to implement changes in the light of criticism. An example of this is sequential medical investigations³⁶. This was raised regularly by the former and current ICAs as something that should be changed as it caused unnecessary delays. However, it has taken several years for DVLA to implement this change. Equally the ICAs have repeatedly raised concerns over several years about the information available to drivers about their rights under Section 88 of the *Road Traffic Act*, but DVLA did not take action to address this until 2015. This demonstrates a failure by DVLA to seek continuous improvement and to be customer focused.

³⁵ www.gov.uk/government/uploads/system/uploads/attachment_data/file/283795/review-of-dvla.pdf.

³⁶ Up until 2014 DVLA would investigate each medical condition at a time.

Failure to properly consider the impact of delays on complainants

All the people who complained to us told us that they suffered significant levels of distress and delay because of DVLA's poor handling of their cases, and many suffered loss of earnings. DVLA authorised very few consolatory or financial loss payments to those people, and usually such payments were small and only offered after the involvement of the ICAs.

It is not evident from the cases that we have seen that DVLA considers claims for compensation for loss of earnings or ex gratia payments for the impact of incorrect decisions on drivers in line with our *Principles of Good Complaint Handling*. We consider DVLA's approach demonstrates a failure to put things right when they go wrong, and a failure to learn from complaints.

We have concerns about the way that DVLA handles complaints about its service. We found that DVLA generally provided poor responses to complaints and did not properly consider the impact of its actions on those making them. We have also not seen any evidence that it has tried to learn from complaints.

This fails to meet the standards set in our *Principles of Good Complaint Handling* which require organisations to develop an organisational culture that values complaints, deals with complaints sensitively bearing in mind individual circumstances, provides honest evidence-based explanations giving reasons for decisions, keeps full and accurate records, acknowledges mistakes, and uses feedback and lessons learnt to improve service design and delivery.

Mr K's story

Mr K suffers from chronic fatigue syndrome. When he wrote to DVLA to ask about the status of his Statutory Off Road Notice (SORN – a declaration that his vehicle was off the road) he included a letter from his GP that explained that his condition meant that it was sometimes difficult for him to keep up with paperwork.

The GP asked DVLA to take this into account if Mr K was late in arranging his SORN. DVLA took this correspondence as notification from Mr K's GP that he had a medical condition affecting his fitness to drive. It revoked his licence a few days after receiving the letter on the basis of cognitive impairment. Cognitive impairment is not a condition that DVLA can use to instantly revoke a licence without further investigations. Chronic fatigue is listed in its Guide as a condition requiring investigation to determine whether it affects the licence holder's fitness to drive.

Mr K complained about the decision. DVLA asked Mr K to fill in a questionnaire designed to assess the impact of cognitive impairment on a driver. When it received the completed questionnaire, DVLA issued Mr K with a one-year licence without any further investigation. When Mr K came to renew his licence a year later, further medical investigations were carried out, information was sought from his GP, and a full licence was issued (this was not time limited).

Mr K complained about the way that DVLA handled his application and that it had failed to release the evidence that it had relied on to make its original decision to revoke his licence. In its response to his complaint, DVLA said that Mr K's licence was correctly revoked on the basis of the information that it had received, there was no evidence of poor service or error and so there was no basis to make him a consolatory payment.

Mr K complained to the Independent Complaints Assessor (ICA) who found fully in his favour. The ICA recommended that DVLA pay him £800 because it had made its original decision outside of the requirements of its own Guide, the decision was based on assumptions instead of facts, it failed to prioritise the case, communicated poorly and failed to release information. DVLA rejected the ICA's findings and said that its decision was both justified and correct. It offered a consolatory payment of £100 for its poor handling of Mr K's correspondence.

Mr K explained that DVLA's initial decision to revoke his licence came as a shock to him and caused him to lose his Motability car. He said that when he was without a licence he had trouble getting around as there is limited public transport where he lives. He added that the stress of dealing with the complaint had had a detrimental impact on his health. He said his chronic fatigue meant it was hard for him to deal with correspondence normally, but this was compounded by the way that DVLA handled his case and subsequent complaint.

We agreed with the ICA's findings. We said there was no medical evidence to suggest that DVLA had established that Mr K suffered from a condition that affected his ability to drive. We could not say that DVLA's decision in his case was justified. We went on to say that cognitive impairment (DVLA's original reason for revoking the licence) was not a condition that allowed it to instantly revoke his licence without checking whether this impacted on his ability to drive.

We also criticised DVLA for issuing a time-limited licence to Mr K when it initially reconsidered his case.

We said that the fact that it had granted him a full licence the following year (after DVLA it had sought medical evidence from clinicians involved in Mr K's care), suggested that more robust decision-making at an earlier stage would have meant that Mr K was awarded a full licence much sooner than he was. DVLA had not established that Mr K had ever suffered from a prescribed disability, so we could not see that its actions in this case were appropriate or that it had acted in line with its own guidance or legislation. This was a failure to get it right.

We also criticised the way that DVLA communicated with Mr K. Its failure to communicate with him and his clinicians when the original correspondence was received resulted in a significant injustice to Mr K. We said that DVLA was not open about the reasons for its decision to revoke his licence. We also said that later correspondence from DVLA lacked openness about its failings in this case. We concluded that DVLA failed to take reasonable steps to check the original information that it had received because of its inflexible approach to the administration of its fitness to drive investigations. We said that this meant it missed an opportunity to make an informed decision. We went on to say that its failure to provide Mr K with the basis for its original decision was a failure to be open and accountable and a failure to get it right.

We criticised DVLA for not accepting the ICA's findings which we fully supported. We did not agree with DVLA that its original decision was '*justified and correct*'. We said that DVLA's response to the ICA report demonstrated a failure to learn from complaints or to accept failings in the way that it handled Mr K's case.

Comments from DVLA and the Department for Transport

During the course of our investigation and in response to a draft of this report, DVLA gave us information about what it has done, and is planning to do, to put right the failings that we have found. We recognise that DVLA is taking steps to make improvements to DMG's service since we started our investigation, and DVLA has already shown some of the work that it has done to improve its own service. As part of this, it has carried out the following pieces of work:

- Put in place a new triage team who aim to complete the first action on the case (including making a licensing decision on a case where that is possible) within five days of DMG receiving a complaint.
- Developed a semi-automated system for dealing with the most straightforward ordinary licence cases within the triage area³⁷. DVLA has told us that 60% of cases can be dealt with in this area.
- Started to develop an automated portal on its website which in time will make the process of notifying DVLA of a medical condition more interactive. This would speed up the time it takes for cases to get to DMG (currently it can take up to two weeks for correspondence to reach DMG after it has reached DVLA).
- Entered into a formal contract with SpecSavers to provide eye-tests so that there is consistency in eye tests and improved turnaround times of test results being returned to DVLA.

- Redrafted standard letters and reminders sent to doctors as well as template letters and questionnaires to make them easier to understand and complete.
- Made changes to its communication processes so it is now more likely to inform licence holders if their case is being delayed by their GP or consultant.
- Started to investigate multiple medical conditions simultaneously rather than sequentially.
- Made changes to reduce the number of vocational drivers whose cases need to be assessed by DMG.
- Launched a new reference document for medical professionals in March 2016 to replace its *At a Glance Guide*.

DVLA also told us that it has (and is continuing to) recruit both caseworkers and MAs in an effort to improve the service offered. It is also carrying out a detailed review of how it investigates the most complex cases. It has set up a bespoke team to prioritise customers who wish to challenge its decisions. DVLA has also carried out research with medical professionals about its *At a Glance Guide*. This has informed changes to the Guide and its communication campaign about that.

A senior manager has been appointed to ensure continuous improvement of medical services, including analysis of complaint and call data to inform further, ongoing service improvements. DVLA has also told us that a significant programme of work is underway to bring together changes to process, organisational structure, technology, policy and communication of DMG services.

³⁷ When we visited DVLA in July 2015 the semi-automated system was being piloted for simple diabetic, cognitive, chronic neurological, HI (pacemaker), defibrillator, sleep issues and Parkinson's cases with a view to expanding the number of conditions covered over time. This system is used if a licensing decision can be made on the basis of the questionnaire received from the licence holder alone.

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DVLA is also working towards reviewing and improving the way that medical standards are set and evaluated. It has not shared details of this with us so we are unable to say whether this will rectify the failings that we have identified in this report.

The Department for Transport has also told us that its new motoring services reform strategy agenda will focus on DMG performance. It told us that this will be monitored closely over the next four years by the Department.

We are pleased to see that DVLA and the Department for Transport are taking action to address some of the concerns that we have identified in this report. In light of their decision not to accept our recommendations around medical standards and the implementation of an effective process to put right the failings identified for others similarly affected, we engaged in further discussions with them. As a result, the Department for Transport told us that it agrees that the legal requirement is for it to make sure that a driver does not cause a threat to road safety because of any medical condition that affects that person's ability to drive. It told us that in the majority of cases DVLA's assessment of societal risk has to focus on the risk of a sudden event causing a danger to the public rather than an ongoing reduction on functional ability. It added that DVLA MAs make decisions based on the balance of probabilities using their clinical judgement, in line with relevant legislation and advice from its Panels.

We do not dispute the need for DVLA to make evidence and risk-based decisions on fitness to drive, in fact we endorse that. We also accept fully the need for DVLA to take the risk of a sudden event into account when evaluating fitness to drive. We are not suggesting that DVLA disregards risk in any way, rather we are asking it to make sure that it develops a more robust approach to risk, taking into account all relevant considerations.

As we have explained in our findings above, we are concerned that there is a lack of transparency around the standards applied by DMG. There is very little in the terms of reference for the Panels from the Department for Transport and no clear framework of accountability in relation to who sets the standards in cases not covered by legislation. The research relied on by Panels is not published so there is no publicly available information to demonstrate that relevant considerations are taken into account in setting standards. We have not seen any attempt by DVLA or the Department for Transport to set out a strategy towards identifying or commissioning appropriate research to support the application and setting of standards that takes into account the most recent scientific research and evidence.

We are also concerned about DVLA's failure to take into account information from a driver's own clinician in preference to that provided by its MAs (who are generalists) or DVLA commissioned medical professionals. We have also questioned DVLA's approach to risk. It says that it relies on the Canadian Risk of Harm Formula but has provided no evidence to show how it has applied this to a UK context or to conditions not affecting the heart. The formula says it is for guidance only and should not replace the clinical judgement of the person's medical professionals. In addition, we have seen no evidence that DVLA has put the impact of potential sudden events into the context of specific conditions when assessing risk.

Finally we describe in this report a lack of consideration for the driver's needs or situation as an individual. We are seeking reassurance that DVLA makes proper assessments in each case based on real and perceived risks. As DVLA and the Department for Transport have accepted our findings, we cannot see that there is a reasonable basis for them to refuse to accept our recommendation in this area.

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The Department for Transport has also given us assurances that steps are being put in place at DVLA to improve its complaints handling. It told us that DVLA recognises the impact that decisions concerning driving licences can have on its customers, particularly if a licence is revoked. It told us that if any customer has their driving licence revoked because of a medical condition, they have the opportunity to provide further supporting information which may help their case. We understand that this information is prioritised to ensure a quicker outcome for the licence holder. The Department for Transport told us that since the work with us began, DVLA has simplified its complaints process to make it easier for customers to understand and use. It is also undertaking a further review of its complaints processes, taking on the learning from our investigations which it says will involve increased scrutiny from senior managers and the setting up of a specific quality assessment team with responsibility for looking at complaints from the perspective of the customer, and the introduction of externally accredited specialised complaints training. The Department for Transport has also told us that DVLA will be undertaking much more detailed trend analysis of complaints to ensure root causes are identified and resolved.

We are pleased that our investigations have resulted in learning from complaints and that this will potentially lead to improved services in the future. Nevertheless, the Department for Transport has repeated its view that a publicised process to put right failings for others similarly affected is not the best approach to resolving our concerns. Instead it argues that DVLA should review previous complaints to identify areas for improvement and to ensure that similar cases identified are dealt with in line with its new approach. The intention behind our recommendation was to ensure that a robust process to deal with such cases once and for all would be implemented and that this would not disadvantage those who had not previously complained. The approach put forward by the Department for Transport fails to provide this reassurance, particularly when there is an unwillingness to identify precisely how redress would be applied to anyone eligible without them having to go through the full complaints process.

We are publishing this report in the public interest and laying it before Parliament so that its findings and recommendations can be considered.

Recommendations

Our investigation shows that there is fault in the way that DMG assesses fitness to drive, sets standards, administers its process, engages with its stakeholders, and handles complaints. For these reasons we have concluded that DVLA needs to put things right for the individuals who complained to us and others who have been similarly affected. We therefore recommended that DVLA:

- apologises to the individuals who have complained to us about their individual cases;
 - produces a set of clear evidence-based standards that take into account risk within the UK context and that are in line with the requirements of the Regulators' Code;
 - takes account of the evidence in this report to design a process that is administratively fit for purpose in all cases – including the most complex - and meets the requirements of the Regulators' Code;
 - improves its communication so that information about fitness to drive is readily available, open, transparent and understood by applicants and the medical profession in line with the requirements of the Regulators' Code;
 - provides remedies to the eight people who complained to us that puts them back in the position that they would have been in if there had not been any failings; and
- designs and puts in place appropriate arrangements so that others who may have been affected by the failings we have found have the opportunity to seek appropriate redress. When considering the design of the arrangements, DVLA should take account of HM Treasury's guidance *Managing Public Money*.

As the responsible Department, the Department for Transport should:

- use all relevant information, including from complaints and stakeholders to ensure that DMG's process fully meets the needs of its users and the legislation.

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Questions for Parliament

We think Parliament will want to satisfy itself that the findings from this report have been acted upon by DVLA and the Department for Transport and specifically that action will be taken to address the two recommendations that they have so far not accepted.

Annex A: The Canadian Risk of Harm Formula

The risk of harm (RH) to other road users posed by the driver with heart disease is assumed to be directly proportional to the following:

- a. time spent behind the wheel or distance driven in a given time period (TD)
- b. type of vehicle driven (V)
- c. risk of sudden cardiac incapacitation (SCI)
- d. the probability that such an event will result in a fatal or injury-producing accident (Ac)

Expressing this statement as Formula 1: $RH = TD \times V \times SCI \times Ac$

In Canada fewer than 2% of reported incidents of driver sudden death or loss of consciousness have resulted in injury or death to other road users or bystanders. In Formula 1, therefore, $Ac = 0.02$ for all drivers.

There is evidence that loss of control of a heavy truck or passenger-carrying vehicle results in a more devastating accident than loss of control of a private car. In Canada vocational drivers are involved in only about 2% of all road accidents but in approximately 7.2% of all fatal accidents. In Formula 1, if $V = 1$ for a vocational driver, then $V = 0.28$ for a private driver.

There is no published standard or definition of what level of risk is considered acceptable in Canada even though this is crucial in the formulation of guidelines based on the probability of some event occurring in a defined time period. It was necessary, therefore, to develop such a standard.

For several years, the guidelines of the Canadian Cardiovascular Society, the Canadian Medical Association, and the Canadian Council of Motor Transport Administrators have permitted the driver of a heavy truck to return to that occupation following an acute myocardial infarction provided that he or she is functional class 1 with a negative exercise stress test at 7 metabolic equivalents, has no disqualifying ventricular arrhythmias and is at least 3 months post infarct.

On the basis of available data, however, such a person cannot be assigned a risk lower than 1% of cardiac death in the next year. The risk of sudden death would be lower than this but would be at least partially offset by the risk of other suddenly disabling events such as syncope or stroke. For such a person, SCI is estimated to be equal to 0.01 in Formula 1. It may be assumed that the average commercial driver spends 25% of his or her time behind the wheel (5). Thus, in Formula 1, $TD = 0.25$. As indicated above, V may be assigned a value of 1 for commercial drivers and $Ac = 0.02$ for all drivers.

Substituting into Formula 1: $RH = TD \times V \times SCI \times Ac = 0.25 \times 1 \times 0.01 \times 0.02 = 0.00005$

Allowing such a driver on the road is associated with an annual risk of death or injury to others of approximately 1 in 20,000 (0.00005). This level of risk appears to be generally acceptable in Canada.

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A similar standard may be applied to the driver of a private automobile. The average private driver spends approximately 4% of his or her time behind the wheel (TD = 0.04). As indicated above, for such a driver, V = 0.28 and Ac = 0.02. The acceptable yearly risk of sudden death or cardiac incapacitation for such a person would be calculated as follows:

$$RH = TD \times V \times SCI \times Ac = 0.04 \times 0.28 \times SCI \times 0.02 = 0.000224 \times SCI$$

Thus, the private automobile driver with a 22% risk of sustaining an SCI in the next year poses no greater threat to public safety than the heavy truck driver with a 1% risk.

Finally, for the commercial driver who drives a light vehicle, such as a taxicab or delivery truck, V = 0.28 and TD = 0.25, placing them at a risk between that of the private driver and the tractor-trailer driver.

Source: Final report of the Canadian Cardiovascular Society Consensus Conference 2003.

Annex B: Honorary Medical Advisory Panels Term of Reference

Terms of Reference

To contribute to the Department for Transport/DVLA's primary aim of achieving continued improvements in road safety by:

- providing the Secretary of State with informed medical advice in relation to (medical condition) and driving, taking account of available medical data and opinions. Where available information is insufficient, to provide expert judgement on implications of (medical condition) and driving. To inform the Secretary of State of the assumptions and uncertainties underlying the advice;
- providing expert informed medical advice on policy options proposed by the Secretary of State;
- considering on behalf of the Secretary of State relevant clinical developments published in medical literature and to advise on issues requiring research; and
- advising the Secretary of State on individual cases relating to (medical condition) and driving, ensuring consistency of standards. Such advice may be requested of individual members outside scheduled meetings for which remuneration will be awarded.

Source: www.gov.uk/government/uploads/system/uploads/attachment_data/file/205607/Code_of_practice__including_terms_of_reference_.pdf

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Parliamentary and Health Service

Ombudsman

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