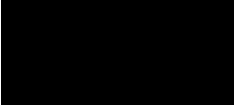


## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	<p><b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO:</b></p> <ol style="list-style-type: none"> <li>1. ██████████ Chair, Wheelchair Accessible Vehicle Converters Association, 11 Yeo Business Park, Axehayes Farm, Clyst St Mary, Exeter EX51DP</li> <li>2. The Directors, The Wheelchair Alliance</li> <li>3. The Directors, British Health Trades Association</li> </ol>
1	<p><b>CORONER</b></p> <p>I am Andrew Bridgman, Assistant Coroner, for the coroner area of Manchester South</p>
2	<p><b>CORONER'S LEGAL POWERS</b></p> <p>I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013</p>
3	<p><b>INVESTIGATION and INQUEST</b></p> <p>On 17.10.25 an inquest was opened into the death of Susan Toft who died at Stepping Hill Hospital on 28.09.25, aged 77 years. The inquest concluded on 27.03.26.</p> <p><b><u>Medical Cause of Death</u></b></p> <p>1a) Myocardial Infarction and Pneumonia (joint causes) 1b) Sepsis of unknown aetiology 1c) Fractures to right femur, tibia and fibula II) Myasthenia Gravis</p> <p>The conclusion was: Accidental Death</p>
4	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>In May 2024 ST suffered a traumatic spinal injury rendering her paraplegic. ST was discharged from hospital in November 2024. In December 2024 ST purchased a converted vehicle to allow rear ramp access for a wheelchair, to be anchored in place of the front passenger seat. On collecting the vehicle ST's husband was shown how to secure a 'demonstration wheelchair' to the floor of the vehicle. ST's wheelchair was not used to demonstrate, nor was ST asked to sit in the wheelchair being used for the demonstration purposes.</p> <p>In January/February 2025 ST was provided with A Sunrise Q300 wheelchair, later replaced in May 2025 with an Invacare TDX SP2. The Vicair cushion provided with the Sunrise wheelchair was transferred to the Invacare wheelchair. The cushion attached to both wheelchair seat bases with Velcro strips.</p> <p>On 24 September 2025 ST was a front seat passenger, in her wheelchair fixed to the floor of her adapted vehicle, being driven by her husband, which was forced to brake suddenly and sharply. As the car braked ST slipped from her wheelchair into the passenger footwell resulting in fractures of her right leg, being taken to hospital the next day.</p> <p>That ST did not remain restrained in her wheelchair, and submarined beneath the vehicle seat belt (lap section) was as a result of,</p> <ol style="list-style-type: none"> <li>1. the seat cushion (held by Velcro) becoming detached from the wheelchair base. The adhesive to the wheelchair failed on one side. It is not clear what</li> </ol>

	<p>happened to the other side, but it was later noted that the Velcro strip attached to the wheelchair base was missing.</p> <p>2. The fact that the lap part of the vehicle seat belt did not fit properly across ST's lap as the seat belt buckle was higher than her lap.</p>
5	<p><b><u>CORONER'S CONCERNS</u></b></p> <p>During the course of the course of the inquest reference was made to the International Best Practice Guidelines BPG1 Transportation of People Seated in Wheelchairs.</p> <p>Throughout that document there is clear reference to the risk of persons submarining because of the risk of failure of the cushion and/or an inadequately fitted vehicle seat belt restraint.</p> <p><b>Concern One</b></p> <p>Section 4.5 deals with the seat cushion, and 4.5.1 – cushion attachment. From a seating function perspective, the stability of a cushion is a fundamental requirement. Therefore, the means of attachment of the cushion to the wheelchair support surface needs to be capable of repeated fitting and removal without impairment or deterioration. Cushions may need to be frequently removed for cleaning and maintenance, and an individual user may have a number of cushions for short or long term use.</p> <p>This cushion's attachment failed after just 9 months of use.</p> <p>The above said Guidelines state that Velcro is strong in shear but less so in tension. Also that the adhesive must have sufficient shear strength. It seems that repeated removal of the cushion for cleaning and maintenance risks exceeding and weakening the relative strengths of the Velcro system itself and the adhesive used to secure the Velcro strip to the wheelchair base.</p> <p>In the circumstances my concern is that there may be more robust and more reliable methods of securing the seat cushion to the wheelchair base, that would negate the risk of detachment, as occurred in this case.</p> <p><b>Concern Two</b></p> <p>Section 5 of the above said Guidelines sets out in some detail the importance of ensuring the adequacy of the fit of the vehicle restraint system to the individual wheelchair and wheelchair user.</p> <p>It was surprising therefore to learn at the inquest that upon collecting the adapted vehicle STs husband was only given a demonstration of how to secure the wheelchair to the vehicle. That there was no assessment of any need to make adjustments to the vehicle occupant restraints to ensure an adequate fit by assessing ST's position and safety in the vehicle, using her current wheelchair, and to advise a reassessment should the wheelchair be changed.</p> <p>As a consequence, the vehicle occupant seat belt did not fit properly across ST's lap, contributing to her being thrown into the footwell.</p>
6	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>In my opinion action should be taken to prevent the risk of future deaths and I believe you have the power to take such action. I have raised this matter with you collectively and as individual organisations.</p>
7	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report <b>9<sup>th</sup> June 2026</b>. I the coroner, may extend the period.</p> <p>Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain why no action is proposed.</p>

8	<p><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the Chief Coroner and to the following Persons namely, who may find it useful or of interest.</p> <p>I have sent a copy to Susan Toff's family.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.</p>
9	<p><b><u>Andrew Bridgman</u></b> <b><u>HM Assistant Coroner</u></b></p>  <p><b>14/04/2026</b></p>