

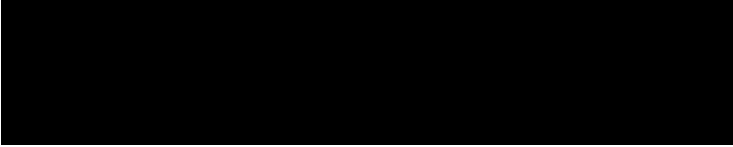
**REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS
2013**

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's [PFD Publication Policy \(2026\)](#).

1.	CORONER I am Mr Nicholas GRAHAM, Area Coroner, for the coroner area of Oxfordshire.
2.	DATE OF REPORT 19 May 2026
3.	CORONER'S LEGAL POWERS I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
4.	THIS REPORT IS BEING SENT TO 1. Driver and Vehicle Standards Agency You are under a duty to respond to this report within 56 days of the date of this report, namely by July 14, 2026. I, the coroner, may extend the period if an appropriate application is made.
5.	YOUR RESPONSE 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary .
6.	SUMMARY OF CORONER'S CONCERN

	This report concerns the safety of disabled access doors on coaches, specifically the risk of passengers falling from a vehicle when such a door is opened from the exterior without warning or checks, in circumstances where the vehicle is stationary and not in operational use for boarding or alighting. In my opinion, unless this risk is reviewed and addressed at a regulatory and design level, there remains a risk of future deaths.
7.	ACTION SHOULD BE TAKEN In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
8.	INVESTIGATION AND INQUEST On the 4 June 2025 I commenced an investigation into the death of Patricia Hazell, aged 82, following injuries sustained in a fall from a coach. On the 18 May 2026 I held an Inquest with a Jury. The medical cause of death was confirmed as 1a. Bilateral bronchopneumonia, caused by 2. Hypertensive heart disease, and rib and spinal fractures following a fall The Jury determined how, when and where Mrs Hazell died, finding that: On the 9th April 2025, at Broadway Rail Station, Gloucestershire, Mrs Hazell fell from a coach, when the wheelchair access door she was leaning against was opened from the outside without warning or checks being undertaken. The significant injuries Mrs Hazell sustained led to decreased mobility and a fatal chest infection which caused her death on the 25th May 2025 at the John Radcliffe Hospital, Oxford. Their Conclusion was Accident.
9.	CIRCUMSTANCES OF DEATH The deceased was a passenger on a coach and was standing adjacent to the wheelchair access door. The door was opened from outside the vehicle without warning to those inside and without checks being undertaken as to whether any passenger was leaning against it. As a result, the deceased fell from the coach and sustained serious injuries. Those injuries led to a reduction in her mobility. Subsequently, she developed a chest infection from which she died. Evidence was heard that the operator had undertaken a risk assessment relating to the risk of falling from the access door when the door was in use for boarding or alighting, but not in circumstances where the door was simply opened from the exterior while the vehicle was otherwise stationary. Following the incident, the company took steps within its control, including issuing warnings and notifications to passengers when disembarking (although it was accepted that notifications given when disembarking may not always be

	heard or understood) and changing seating practices so that non disabled passengers were not seated adjacent to the access door. Evidence was also given that any design changes to the door mechanism or safeguards were matters for the DVSA.
10.	CORONER'S CONCERNS During the course of the inquest I heard evidence giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The MATTERS OF CONCERN are as follows: During the course of the inquest I heard evidence giving rise to concern. In my opinion, there is a risk that future deaths could occur unless action is taken. The matters of concern are as follows: • The design and operation of wheelchair access doors on coaches may permit the door to be opened from the exterior • That risks of falling was dependant solely on giving warnings to passengers inside and checking whether a person is leaning against the door. Such warnings may not always be effective. • Where operators have identified residual risk, they may have no ability to mitigate that risk through design or engineering controls, as responsibility for such matters lies with the vehicle approval and safety regime overseen by the DVSA. • In those circumstances, there is a concern that similar incidents could recur involving disabled access doors on coaches, with the potential for serious injury or death. For these reasons, I consider it appropriate to report this matter to the DVSA so that the safety aspects of disabled access doors on coaches may be reviewed in light of the circumstances of this death.
11.	COPIES AND PUBLICATION OF THIS REPORT I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: <i>[please do not use individual's names, but instead roles/titles]</i> • Mrs Hazell's Family • The Coach Operating Company • Any other Interested Persons as appropriate I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the

	contents of this report in line with Chief Coroner's PFD Publication Policy (2026) . Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
12.	SIGNATURE  Mr Nicholas GRAHAM Area Coroner for Oxfordshire