**HM Senior Coroner**
**for Wiltshire and Swindon**

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**The Managing Director/Head of Safety**<br>**Allied Vehicles Limited trading as Allied Mobility**<br>**230 Balmore Road**<br>**Glasgow**<br>**G22 6LJ** |
| 1 | **CORONER**<br><br>I am David Ridley, HM Senior Coroner for Wiltshire & Swindon |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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.<br><br>http://www.leqislation.qov.Uk/ukpqa/2009/25/schedule/5/paraoraph/7<br>http://www.leqislation.qov.uk/uksi/2013/1629/part/7/made |
| 3 | **INVESTIGATION and INQUEST**<br><br>On the 24 January 2024, I opened the Inquest into the death of Frank James Ronald Lawrence (date of birth 14 October 1942). Frank sadly died at Salisbury District Hospital, Odstock Road, Salisbury in Wiltshire on the 24 December 2023 following an incident that occurred, whilst he was a wheelchair passenger on board an adapted Ford Torneo. I concluded Frank's Inquest on the 7 July 2026. In terms of how Frank came by his death I recorded at paragraph 3 of the Record of Inquest as follows:<br><br>"Frank died at 2020 on 24 December 2023 st Salisbury District Hospital in Wiltshire from respiratory failure due to a cervical spine injury involving C4 and C5 vertebrae. The injury was caused when both front restraints became undipped en route, more likely than not by Frank himself, during the latter stages of the journey. As the Ford Torneo, wheelchair accessible vehicle ("WAV"), exited north at the Countess Road Roundabout in Amesbury at around 1300 on 22 December 2023, the movement of the WAV caused the wheelchair to flip backwards causing Frank to strike his head against the stowed rear access ramp."<br><br>In terms of the medical cause of death I recorded as follows:<br><br>1a Respiratory Failure<br>b Cervical Spine Injury Involving C4, C5<br><br>Prior to reaching the final Inquest hearing I secured an expert report from PC [redacted] (copy enclosed), and I am additionally grateful to your company for facilitating the reconstructive work undertaken by PC [redacted] His instruction was principally to provide his expert opinion as to how the incident occurred and how the front restraints became unclipped from Frank's wheelchair allowing the wheelchair to flick backwards when the Ford Torneo accelerated forwards as it pulled away from the traffic lights. |

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| | In relation to the 3 potential causes highlighted by PC [redacted] at paragraphs 7.16, I did not find based on the evidence that the front restraints had not been attached to Frank's wheelchair. Neither did I find that the front restraints had been incorrectly positioned which allowed them to come free whilst the wheelchair was in transit. Assessing the evidence on the balance of probabilities I did find that more likely than not that the front restraints had been removed by Frank more likely than not during the journey itself. |
| 4. | **CIRCUMSTANCES OF THE DEATH**<br><br>See section 3. |
| 5 | **CORONER'S CONCERNS**<br><br>Having reached and made a factual finding that more likely than not Frank, who had suffered a brain injury back in 2014 and more likely than not did have some form of capacity issues, removed the front restraints I wanted to understand how this could have happened. The training that had been given to the care home staff in securing Frank's wheelchair inside the wheelchair accessible vehicle for all intents and purposes followed the instructions provided by your organisation. When both the front and rear restraints were attached to the wheelchair the wheelchairs own brakes were applied and this according to PC [redacted] could introduce a degree of slack up to as much as 3 centimetres sufficient to allow the front restraints to be unclipped by Frank, which is what I found was more likely than not to be what happened. This degree of slack could be avoided if when making the rear ratchet adjustments and ensuring appropriate tension of both the front and rear restraints that at the time of making those adjustments using the ratchets on the rear restraints, the wheelchairs brakes were not applied. Undertaking this task whilst the wheelchair's brakes are applied, according to PC [redacted], introduced a degree of slackness in relation to the front restraints as the tension was created against the parked wheelchair brake and not the front restraints. Of course, once the rear restraints had been adjusted and as a further measure security the wheelchair brakes could then be applied, but training that was given to staff very much pointed to the wheelchair brakes being engaged at the time of making the adjustments. Your own instructions to be fair are not 100% clear as reference to the wheelchair's own brakes is made having winched the wheelchair on board the vehicle that if you proceed straight to making front restraint attachment and adjustments and thereafter rear restraint adjustments the instructions are silent on the point (instructions enclosed).<br><br>I am sure you will appreciate that when installing a wheelchair and securing it inside a WAV that the restraints should not provide for any degree of slack and should not be capable of being removed whilst in transit. |

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| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by.14 September 2026. I, the coroner, may extend the period.<br><br>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. |

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| 8. | **COPIES and PUBLICATION**<br><br>1have sent a copy of my report to the Chief Coroner and to the following Interested Persons,<br><br>The Family of the Deceased<br>LG Training Solutions<br>Vehicle Certification Agency<br><br>1am also under a duty to send the Chief Coroner a copy of your response.<br><br>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. |
| 9. | Dated 20 July 2026 K<br>[redacted] ~~Dauid~~ Ridley, HM Senior Coroner for Wiltshire & Swindon |