

**IN THE SURREY CORONER'S COURT**

**IN THE MATTER OF:**

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**The Inquest Touching the Death of Raymond Dathan Berry  
A Regulation 28 Report – Action to Prevent Future Deaths**

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	<p><b>THIS REPORT IS BEING SENT TO:</b></p> <ul style="list-style-type: none"><li>• Gareth Llewellyn, Chief Executive, Driver and Vehicle Standards Agency, The Ellipse, Padley Road, Swansea SA1 8AN</li><li>• The Rt Hon John Hayes, Minister of State for Transport, Department of Transport, Great Minster House, 33 Horseferry Road, London SW1P 4DR</li><li>• [REDACTED], Managing Director, Honda UK Manufacturing Limited, Highworth Road, South Marston, Swindon, Wiltshire SN3 4TZ</li></ul>
1	<p><b>CORONER</b> Ms Anna Loxton, HM Assistant Coroner for Surrey</p>
2	<p><b>CORONER'S LEGAL POWERS</b> I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.</p>
3	<p><b>INVESTIGATION and INQUEST</b> The inquest into the death of <b>Raymond Dathan Berry</b> was opened on 6<sup>th</sup> January 2016. A Pre-Inquest review took place on 14<sup>th</sup> October 2016 and the Inquest was concluded on 3<sup>rd</sup> April 2017.</p> <p>I found the medical cause of death to be:</p> <p>1a. Head and Chest Injuries</p> <p>I determined that Mr Berry had died from injuries he sustained when the Honda Jazz car he was a passenger in collided with a tree; that he had not been wearing his seatbelt at the point of collision and that the</p>

	<p>Supplementary Restraint System had not met the required parameters to be activated in the collision, no fault having been found by Honda.</p>
<p>4</p>	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>Raymond Berry was travelling home from visiting relatives shortly before midnight on Christmas Day 2015 in a Honda Jazz car driven by his Wife, along the B311 Red Road. The car drove onto the roundabout at the junction with the A322 Guildford Road and crashed into a tree. Mr Berry was not wearing a seatbelt at the point of collision and sustained serious head and chest injuries and died at the scene early on 26<sup>th</sup> December 2015. [REDACTED] suffered serious injuries and has no recollection of the event.</p> <p>Airbags in the vehicle were not deployed. Honda UK examined the vehicle having been contacted by Police who queried the fact the airbags had not deployed and gave evidence that parameters had not been met to activate the Supplementary Restraint System. Sensors at the front of the car were located either side of the front bumper, below the headlights. The collision with the tree had occurred at the centre of the front of the car and Honda gave evidence the crumple zone in this area absorbed much of the impact meaning the rate of deceleration was not sufficient to trigger the airbags to deploy. It was not possible to calculate the speed at which the car had been travelling at the point of impact but the Police Collision Investigation officer estimated this to be around 30 miles per hour. No faults were found with the vehicle.</p>
<p>5</p>	<p><b>CORONER'S CONCERNS</b></p> <p>The court heard evidence that the Supplementary Restraint System is only deployed when certain parameters are met. Honda gave evidence that the fact the SRS did not deploy was due to the crumple zone at the front centre of the car, incorporating the car engine, absorbing much of the impact. However Mr Berry died as a result of this collision and [REDACTED], who was strapped into the car, sustained serious injuries.</p> <p>The <b>MATTERS OF CONCERN</b> are:</p> <ul style="list-style-type: none"> <li>- The parameters required to activate the Supplementary Restraint System may require adjusting or amendment to activate airbags in cases where a collision occurs away from the vicinity of the sensors, for example to the front centre of the vehicle</li> </ul>

	<p>Consideration should be given to whether any steps can be taken to address the above concerns.</p>
6	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action.</p>
7	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of its date; I may extend that period on request.</p> <p>Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.</p>
8	<p><b>COPIES</b></p> <p>I have sent a copy of this report to the following:</p> <ol style="list-style-type: none"> <li>1. See names in paragraph 1 above</li> <li>2. [REDACTED]</li> <li>3. The Chief Coroner</li> </ol> <p>In addition to this report, I am 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.</p>
	<p><b>Signed:</b></p> <p><b>ANNA LOXTON</b></p> <p><b>DATED this 7<sup>th</sup> day of April 2017</b></p>