IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquests Touching the Deaths of Charlie Hopkins and William Robinson
A Regulation 28 Report – Action to Prevent Future Deaths

1	**THIS REPORT IS BEING SENT TO:** The Rt Hon Mark Harper Department for Transport Great Minster House 33 Horseferry Road London SW1P 4DR [redacted] Chief Executive Driver and Vehicle and Standards Agency Croydon Street Bristol BS5 0DA [redacted] Chief Ombudsman The Motor Ombudsman 71 Great Peter Street London SW1P 2BN
2	**CORONER** Miss Anna Crawford, H.M. Assistant Coroner for Surrey
3	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.

4	**INQUEST** An inquest into the death of Charlie Hopkins was opened on 19 October 2021 and an inquest into the death of William Robinson was opened on 30 December 2021. Their inquests were resumed and evidence was heard from 26-28 April 2023. Thereafter, a referral was made to the Director of Public Prosecutions pursuant to rule 25 (4) of The Coroners (Inquest) Rules 2013. The inquests were resumed and concluded on 30 April 2024. William Robinson The medical cause of William Robinson's death was: 1a. Hypoxic Brain Injury 1b. Traumatic Cardiac Arrest 1c. Multiple Traumatic Injuries (26.9.21) The inquest concluded with the following findings of fact and conclusion in Box 3 and Box 4 of the Record of Inquest: Box 3 William Robinson was 17 years old. On 26 September 2021 at approximately 00:55 hours he was a front seat passenger in a Volkswagen Polo travelling northbound on the Oxenden Road, Tongham. As the car approached the roundabout connecting to the A331 and the A323, it made contact with the nearside curb prior to travelling into the opposing southbound lane, where it collided with an oncoming Ford Tourneo. As a result of the collision Mr Robinson sustained serious traumatic injuries, leading to a traumatic cardiac arrest, which in turn led to hypoxic brain injury, resulting in his death at St. George's Hospital in Tooting on 4 December 2021. Box 4 Road Traffic Collision. The Volkswagen Polo was travelling in excess of the speed limit of 30 mph and the driver was under the influence of alcohol, both of which contributed to the collision. Charlie Hopkins The medical cause of Charlie Hopkins' death was:

1a. Blunt Head Trauma

The inquest concluded with a narrative conclusion as follows:

Road Traffic Collision.

Charlie Hopkins was 18 years old.

On 26 September 2021 at approximately 00:55 hours Mr Hopkins was driving his VW Polo travelling northbound on the Oxenden Road, Tongham. As he approached the roundabout connecting to the A331 and the A323, he made contact with the nearside curb prior to travelling into the opposing southbound lane, where it collided with an oncoming Ford Tourneo.

As a result of the collision Mr Hopkins sustained a fatal traumatic head injury and died at the scene.

Mr Hopkins was travelling in excess of the speed limit of 30 mph and was under the influence of alcohol which contributed to the collision.

The Hopkins family purchased the VW Polo for Charlie in January 2021.

The VW Polo was fitted with airbags which did not deploy at the time of the collision.

There was a fault with the VW Polo's airbag system which had occurred on 9 August 2013. As a result, the airbag system had been automatically disabled to prevent the risk of it deploying whilst the car was being driven in normal conditions. Accordingly, from 9 August 2013 onwards the VW Polo did not have functioning airbags and the airbag warning light on the car's dashboard was permanently illuminated from that time onwards.

The owners of the vehicle in August 2013 were aware that the airbag warning light was illuminated, indicating a fault with the airbag system. At some point during the period from 9 August 2013 and the onward sale of the car on 1 March 2014 an unidentified individual removed the instrument cluster from the dashboard and deliberately concealed the airbag warning light with a piece of paper before returning the instrument cluster to the dashboard. As a result, the illuminated warning light was obscured and not visible to future drivers of the car.

	If the airbag warning light had not been concealed the airbag fault would have been identified and remedied prior to the collision on 26 September 2021. In May 2014 and July 2015 the new owner of the vehicle took it to a Volkswagen garage where diagnostic tests were carried out on the car's engine control unit. The tests identified a fault with the airbag module with no corresponding warning light and the owner was advised to carry out further investigations, which was declined. Had further investigations been carried out at that time the faulty airbag and concealed warning light would have been identified and remedied prior to the collision on 26 September 2021. In the event that the airbags had deployed, Charlie's injuries would have been less severe and he would have survived the collision.
5	**CIRCUMSTANCES OF THE DEATH** The circumstances of the deaths of William Robinson and Charlie Hopkins are set out above. In addition, to the matters set out above, the court heard evidence that: - Charlie Hopkins had passed his driving test on 11 September 2021, shortly before the collision on 26 September 2021. The Court found that it was possible that Charlie being a new driver, who had only recently passed his test, contributed to the collision. - At the time of the collision, in addition to Charlie Hopkins and William Robinson, there were six other passengers in the car, five on the back seat and one in the boot of the car, making a total of eight people in the car. The court found that it was possible that Charlie Hopkins had been distracted by the other passengers in the car, thereby contributing to the collision. - The VW Polo involved in the collision underwent an annual MOT and regular services at both VW and non-VW affiliated garages. The airbag fault and non-functioning warning light was not identified during any of the MOTs and at only two of the services the car underwent prior to the collision.

6	**CORONER'S CONCERNS** The **MATTER OF CONCERN** is: **Concern 1** As set out above, the court found that it was possible that the fact that Charlie Hopkins had only just passed his driving test contributed to the collision. During the course of the inquest, the court's attention was drawn to statistics which suggest that road traffic collisions involving young, new drivers, are a leading cause of death for young people. As such, you are invited to consider whether any additional measures ought to be introduced to mitigate the ongoing risk in respect of young, new drivers, including by way of the introduction of restrictions on when they can drive and who they can carry as passengers. **Concern 2** It is deeply concerning that such a significant safety fault with the VW Polo was not identified during the course of any of the annual MOTs it underwent from 14 March 2014 onwards. The court heard that the MOT manual itself does not require MOT testers to: (i) Check whether airbag warning lights are actually working. The court heard that it is quick and simple to check that a car's airbag warning light is working. It is done by checking that the light illuminates briefly when the engine is switched on. Further the court heard that the MOT manual requires MOT testers to check that the anti-lock braking system (ABS) warning light is working in this manner. (ii) Carry out a diagnostic check of the car's electrical systems to check whether there are any faults with the airbag module. The court heard that MOT testers rely on the illuminated warning light to assess whether there are any faults with the car's airbag module. However, this will not identify a fault if

	the airbag warning light has been concealed. The court heard that there are universal diagnostic tools which can diagnose electrical faults, including airbag module faults, on any type of car, regardless of the manufacturer. The Coroner considers that there is a gap in the MOT manual which presents a risk of future deaths and you are invited to consider whether any amendments ought to be introduced to the MOT Manual to mitigate against that risk. **Concern 3** It is concerning that such a significant safety fault with the VW Polo was not picked up during many of the regular services that the car underwent during the same time period. The court heard evidence that it is not standard practice for car services to include a check of whether the airbag warning light is functioning. Further, the court heard that it is not standard practise to carry out a diagnostic check of a car's electronic safety systems unless a car is being taken to a garage that is associated with the particular car's manufacturer, despite the availability of universal diagnostic tools. Given the limitations of the MOT test, as set out above, the Coroner considers that this presents a risk of future deaths and you are invited to consider whether additional standards and/or guidance on these matters ought to be introduced for garages/mechanics involved in the conduct of car services.
7	**ACTION SHOULD BE TAKEN** 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.
8	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. 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.

9	**COPIES** I have sent a copy of this report to the following: 1. Chief Coroner 2. William Robinson's family 3. Charlie Hopkins' family 4. [redacted] 5. [redacted] 6. [redacted] 7. Glyn Hopkins Limited 8. British Car Auctions 9. Goodman Retail Limited (Slough Audi) 10. Allens of Chobham 11. Chobham Motor Company 12. Marshall Motor Group 13. Volkswagen Group
10	**Signed:** **ANNA CRAWFORD** **Anna Crawford** **H.M Assistant Coroner for Surrey** **Dated this 14th day of May 2024**