



Linda Lee Acting Area Coroner for Warwickshire Coroner Service

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

1. THIS REPORT IS BEING SENT TO

1. Chief Executive, Health and Safety Executive (HSE)
2. Chief Executive, Driver and Vehicle Standards Agency (DVSA)
3. Chief Executive, Society of Motor Manufacturers and Traders (SMMT)

2. CORONER

I am Linda Lee, Acting Area Coroner for Coventry and Warwickshire.

3. CORONER'S LEGAL POWERS

I make this report under paragraph 7 of Schedule 5 to the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

4. INVESTIGATION AND INQUEST

The investigation into the death of Richard Gary Hopkins aged 39 who died on 15 February 2024, was opened on 23 February 2024 and concluded on 12 March 2026. The inquest was conducted with a jury. The conclusion reached was a short factual narrative: Accident owing to the concurrence of two main

factors; a defective trailing arm and Mr Hopkins being situated under the rear axle at the time of the malfunction.

The medical cause of death was:

1a Traumatic Brain Injury

5. CIRCUMSTANCES OF THE DEATH

On 14 February 2024, Mr Hopkins was carrying out a visual under chassis pre delivery inspection of a newly assembled vehicle raised on four mobile column lifts. The air suspension system remained pressurised. While he was positioned beneath the rear axle, the nearside trailing arm failed suddenly due to a hidden manufacturing defect. The airbag and bracket dropped and struck him, causing fatal injuries.

Metallurgical examination identified a pre-existing internal crack together with a fresh overload fracture. The residues within the crack showed that it had formed at, or before, the quenching stage of manufacture. Although the manufacturing processes and available production data were reviewed, the underlying reason for the defect could not be determined and therefore cannot presently be prevented. The defect was not detectable during a pre delivery inspection.

Thousands of similar trailing arms have been produced without incident, and this appears to be the only recorded fracture of its kind. Batch sample non-destructive testing is widely relied upon for components not categorised as safety critical in operation. This incident demonstrates, however, that such testing, while providing assurance as to general production quality, cannot eliminate the possibility of a rare, isolated defect in an individual component. The remainder of the batch was tested after the incident, and no further defects were identified.

Existing national guidance acknowledges that parts within pressurised air suspension systems may fail when work is being carried out on those systems, particularly where the task may disturb components. Before this incident, it was not considered possible for a component to fail in comparable fashion during a

purely visual inspection when the system was undisturbed and no work was being performed on it. This incident demonstrates that such failure can occur during inspection and can expose an operative to risk solely due to proximity beneath a raised and pressurised suspension system.

Following the incident, the employer introduced straightforward measures that removed exposure to this risk in the pre delivery inspection environment. These included carrying out relevant checks earlier in the production process, before the vehicle is fully assembled and before the suspension is raised and pressurised and introducing an exclusion zone beneath the rear suspension whenever a vehicle is raised.

6. MATTERS OF CONCERN

a) Previously unrecognised proximity risk

The investigation revealed a previously unrecognised proximity risk to inspectors working beneath raised and pressurised air suspension systems during visual pre delivery inspections. Although the defect in this case was exceptionally rare, a sudden and undetectable failure in these circumstances presents a clear risk of fatal injury.

b) Absence of guidance addressing failure during undisturbed inspection

Existing national guidance recognises the possibility of component failure when work is being carried out on a pressurised suspension system. It does not address the distinct risk demonstrated by this incident: that a component may also fail unexpectedly during an undisturbed visual inspection when the operative is not working on the system.

c) Limitations of batch sample testing

Batch sample non-destructive testing, although widely accepted for components not designated as safety critical, cannot fully guard against a rare, isolated

hidden defect in an individual part. Inspectors may therefore be unknowingly positioned beneath a component capable of unexpected failure under pressure.

d) Lack of awareness of this inspection phase risk across the sector

The evidence demonstrated that the inspection phase proximity risk identified in this case was not appreciated by the employer or more widely within the sector. The measures introduced after the incident show that the risk can be effectively eliminated once recognised, but its existence had not been understood before this incident.

7. ACTION

In my opinion, action should be taken to prevent future deaths and I believe your organisations have the power to act.

8. RESPONSE

You are under a duty to respond to this report, setting out what consideration you have given to the concerns raised, namely by 18 May 2026.

9. COPIES

A copy of this report is being sent to the Chief Coroner. It may be published on the judiciary website.

It is also being sent to the following Interested Persons:

- The family of the deceased
- The employer
- The Health and Safety Executive



Linda Lee

Acting Area Coroner for Coventry and Warwickshire

23 March 2026