ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** Department of Transport and the Driver Vehicle Standards Agency **2.** Royal Society for the Prevention of Accidents **3.** **4.** **5.** **6.** **7.** **8.** **9.** **10.**
1	**CORONER** I am Professor Paul Marks, Senior Coroner, for the Coroner Area of City of Kingston Upon Hull and the County of the East Riding of Yorkshire.
2	**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.
3	**INVESTIGATION and INQUEST** On 30th December 2022, I commenced an investigation into the death of Daniel Pinkney, aged 26 years. The investigation concluded at the end of the inquest on 21st October 2024. The conclusion of the inquest was: **ROAD TRAFFIC COLLISION**
4	**CIRCUMSTANCES OF THE DEATH** These are set out in my summary and findings of facts which are attached. At approximately 21:13 hours on 19th December 2022, Daniel PINKNEY was driving his Ford Focus motor car in a northerly direction on the A164 in the Skidby area. He encountered a large amount of surface water on his carriageway whilst travelling at approximately 50 miles per hour. His vehicle was subject to aquaplaning and consequent loss of directional control. As a result, he entered the opposite carriageway and collided with a third party vehicle travelling in the Hessle-bound direction. The force of the impact was such that the engine of Mr. PINKNEY's vehicle broke free of its mountings and came to lie 28 metres from the vehicle. Mr. PINKNEY suffered

	devastating head and other injuries which were unsurvivable, and he was declared deceased by paramedics in his vehicle at 21:57 hours on 19th December 2022. Both of the involved vehicles were free from mechanical defects which could have caused or contributed to the accident.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – I believe that greater awareness of the phenomenon of aquaplaning is important, together with the need to reduce speed when surface water is present, coupled with basic knowledge about braking and steering, should a vehicle experience this phenomenon. I was informed by a forensic collision expert that the Highway Code is at present silent on this matter but road user should be familiar with it.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation has the power to take such action by considering adding guidance in the next iteration of the Highway Code.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by Thursday 2nd January 2025. I, the coroner, may extend the period. 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: - The insurers of Mr PINKNEY's vehicle - The insurers of the third-party vehicle - East Riding of Yorkshire Council - The family of Daniel PINKNEY I am also sending a copy to NHS England and equivalent organisations in the other countries of the United Kingdom. I am also under a duty to send the Chief Coroner a copy of your response. 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	**7th November 2024**