REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

1.	**CORONER** I am Crispin Giles BUTLER, Senior Coroner, for the coroner area of Buckinghamshire.
2.	**DATE OF REPORT** 06 July 2026
3.	**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.
4.	**THIS REPORT IS BEING SENT TO** 1. Howarth Properties Ltd You are under a duty to respond to this report within 56 days of the date of this report, namely by August 31, 2026. I, the coroner, may extend the period if an appropriate application is made.
5.	**YOUR RESPONSE** 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.
6.	**SUMMARY OF CORONER'S CONCERN** At the time of the incident in which Eleisha Skinner died there were issues with regard to the safe use of the driveway at 223 West Wycombe Road, High

	Wycombe. (More particularly detailed in Section 10).
7.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
8.	**INVESTIGATION AND INQUEST** On 16 January 2026, I commenced an investigation into the death of Eleisha Jacqueline Patricia Skinner aged 21. The investigation concluded at the end of the inquest on 23 June 2026. The conclusion of the inquest was: Accident
9.	**CIRCUMSTANCES OF DEATH** Eleisha Skinner died at John Radcliffe Hospital, Oxford, during the afternoon of 8th January 2026 from the effects of the crush injuries Eleisha sustained when, on the evening of 4th January 2026, she became trapped between the rear of her Audi motor vehicle and the front wall of the house in which she resided as a tenant. On balance, the incident appears to have occurred as a result of Eleisha's vehicle slipping after having been parked with the handbrake on and dropping off the rear of the driveway, at a time when the boot was open, and Eleisha was behind the car in the process of unloading. It was a very cold night with frost on frozen snow, which made the inclined drive very slippery. There were no railings or other barrier or obstacle to prevent a vehicle over-run from the drive, nor was there evidence that the driveway had been salted or gritted.
10.	**CORONER'S CONCERNS** During the course of the inquest I heard evidence giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: At the time of the incident, there were issues with regard to the safe use of the driveway at 223 West Wycombe Road, High Wycombe. (1) The driveway had a clear downwards incline towards a sheer drop of around 3 feet with no upward-projecting protective retaining wall, armco barrier or other method of preventing vehicle over-run. Railings have been installed at the top of the sheer drop, but the inquest was not able to examine whether or not these would address the issue or if they have created a new potential crush risk. (2) At the time of the incident, the driveway was very slippery as a result of the winter weather conditions. It remains unclear whether the tenants have access to gritting or salting materials and equipment and instructions as to how and when to utilise, or whether the owners or managers have any procedure in place to mitigate against such icy conditions.

	(3) The particular mechanics of this incident indicated a vehicle was being unloaded from a rear boot with the potential downwards trajectory of the vehicle in the event of slippage or rolling being directly towards the individual undertaking the unloading. There was no evidence of any instructions to users of the driveway regarding safe unloading of vehicles from the upper end of the driveway such that a vehicle will run away from those unloading if an issue arises.
11.	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: *[please do not use individual's names, but instead roles/titles]* • **The Family of Eleisha Skinner** • **Buckinghamshire Council - Head of Regulatory Services** • **Buckinghamshire Council - Planning Technical Response** • **Buckinghamshire Council - Environmental Health Residential Team** I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
12.	**SIGNATURE**  **Crispin Giles BUTLER** **Senior Coroner for** **Buckinghamshire**