	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] Product Marketing Manager – Harvesting AGCO Ltd Abbey Park Stoneleigh Kenilworth CV8 2TQ
1	**CORONER** I am John Penhale Ellery, Senior Coroner, for the coroner area of Shropshire, Telford & Wrekin
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 19th September 2012 I opened an Inquest into the death of Valerie Anne HANCOX aged 67 years. I adjourned that inquest under the then Coroners Act 1988 provisions to await the conclusion of criminal proceedings taken against the driver of a tractor which had been towing a baler. Those criminal proceedings concluded at the Crown Court at Shrewsbury on the 24th February 2014 when the driver concerned was convicted of causing death by careless driving and was sentenced. Following notification of the conclusion of the criminal proceedings I was satisfied that the circumstances as to how the deceased came by her death had been established and did not resume the Inquest. I have notified the Registrar accordingly. I was though notified of concerns by the investigating officer as to the lack of markings on the baler which may have contributed to the collision and having considered those concerns I consider that a formal report is required with a view to preventing future deaths.
4	**CIRCUMSTANCES OF THE DEATH** On the 14th September 2012 on the A5 at Burlington, Shifnal, Shropshire a collision occurred between 2 vehicles, a motor car driven by the husband of the deceased and a Fendt tractor towing a Massey Ferguson 2190 baler. The collision occurred during the hours of darkness and lighting would have been required. The tractor and baler driven by the defendant pulled off the A5 at Burlington where he intended to turn left off the road and into a field to continue baling. As he pulled the large combination of equipment off the road he was faced with 2 gates. The 1st nearest the road being open but the 2nd was closed and opening towards him. At this point the tractor was stopped and the baler, in particular the chute, was left blocking the oncoming cars carriageway. The car driver was completely unaware of the blockage. He did not see the bale chute prior to the collision and his wife died from the injuries sustained.
5	**CORONER'S CONCERNS** During the course of the Investigation 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. (1) The bale chute, when on the public highway, should not be in its lowered position. However it appears to be standard farm practice to leave the bale chute down when moving from one field to another along or to cross a public highway. (2) The bale chute was just short of 2 metres in length and falls under the legislation that, when on roads, it should be clearly marked. If it were over 2 metres then it would have to be lit. (3) The bale chute had no markings and was painted matt grey. The manufacturers state in their handbook that the chute should be stored in the up position for travel on roads. This may explain why there is no marking but relies on the driver adhering to that instruction. (4) Given the potential for obstructing the highway, all the more so as the manufacturer's instructions appear to be not followed, bale chutes should be clearly marked so that anyone approaching side on, day or night, as the deceased's husband was, should be able to see it.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 27th May 2014. 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: i. [redacted] daughter of the deceased. ii. Browne Jacobson solicitors for NFU mutual insurers of the deceased iii. DWF LLP solicitors for the defendant iv. [redacted] Regional Director for the NFU West Midlands Region who may find it useful or of interest. 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	31st March 2014 J.P. Ellery