## **Regulation 28: REPORT TO PREVENT FUTURE DEATHS**

#### **REGULATION 28 REPORT TO PREVENT DEATHS**

## THIS REPORT IS BEING SENT TO:

The Department for Transport, Great Minster House 33 Horseferry Road London SW1P 4DR

## 1 CORONER

I am Joanne ANDREWS, Area Coroner for the coroner area of West Sussex, Brighton and Hove

## 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

I opened an investigation on 31 October 2023 into the death of Richard Ellis which concluded by the inquest. The findings in relation to section 5 of the Coroners and Justice Act 2009 were:

Richard Ellis died on 23 October 2023 at Harwoods Green Lane, Stopham, West Sussex from injuries he sustained when a tractor struck him. The tractor was being used to tow the deceased's stranded vehicle up an incline. Having freed the deceased's vehicle, whilst still on the incline facing downhill, the tractor stopped towing and was held on its handbrake. At that time the tractor's handbrake failed allowing the tractor to roll forwards into the deceased who was removing the tow strap attaching his vehicle to the tractor.

#### 4 CIRCUMSTANCES OF THE DEATH

The deceased was contracted to collect an electricity generator from a property which was accessed via a track on a country Estate ("Estate").

The deceased was using an Isuzu pick up ("Isuzu") and trailer to do so. He collected the generator from the property but due to the narrow nature of the track, he was unable to turn his vehicle around to drive out forwards. Therefore, he reversed down the track with the trailer. During this manoeuvre he became stuck on an incline facing upwards as the wheels of the Isuzu and trailer had become stuck in a ditch which ran alongside the track.



The deceased therefore sought assistance from local Estate workers as he needed to be towed out.

The Estate workers went to the location where the deceased had become stuck with a 1996 Valmet 8130 tractor ("Tractor") which was owned by the landowner. The Estate workers placed the Tractor facing downhill pointing towards the front of the deceased's Isuzu which was facing up the incline. The trailer was detached at that time.

A strap was attached between the front of the Isuzu and the front of the Tractor. The Tractor reversed and pulled the Isuzu from the ditch. The Isuzu became free whilst still on the incline. The deceased and Tractor driver both got out of their vehicles and detached the towing strap. The Tractor driver had placed the handbrake on the Tractor prior to leaving the cab.

The Tractor handbrake then failed and allowed the Tractor to roll down the incline onto its driver and the deceased. The deceased sadly died at the scene from his injuries.

The handbrake was examined after the incident which demonstrated that the pawl of the handbrake was significantly worn and would likely have slipped previously. The evidence of the Tractor driver was that he had no concerns about the operation of the handbrake prior to this event.

The Tractor had last been serviced in 2021 but the evidence that I heard was that it was not a legal requirement for there to be any prescribed maintenance or servicing of tractors solely used for agricultural, horticultural or forestry.

## 5 CORONER'S CONCERNS

During the course of the investigation my inquiries revealed matters 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:

(brief summary of matters of concern)

The evidence was that there are no legal requirements for the servicing and maintenance of agricultural tractors which do not fall within the requirements of the Road Traffic Act 1988 and the associated regulations. As such, the maintenance of these vehicles is dependent on the discretion of the vehicle owners.

# 6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) have 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 November 22, 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 family of Mr Ellis
The driver of the Tractor at the time of the collision
The owner of the Tractor
Southern Electric Power Distribution Plc
Plateline Limited

who may find it useful or of interest.

I am also under a duty to send a copy of your response to the Chief Coroner and all Interested Persons who in my opinion should receive it.

I may also send a copy of your response to any person who I believe may find it useful or of interest.

The Chief Coroner may publish either or both in a complete or redacted or summary form. They may send a copy of this report to any person who they believe 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** Dated: 26/09/2025

Joanne ANDREWS

Area Coroner for

West Sussex, Brighton and Hove