REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

HOLLY CHEVASSUT (died 2 November 2018)

	THIS REPORT IS BEING SENT TO: • [redacted] General Manager GRS Recovery 3-4 Churchlands Business Park Ufton Fields Harbury Leamington Spa CV33 9GX
1	**CORONER** I am Assistant Coroner Leeper Assistant Coroner for the Coroner area of Coventry and Warwickshire The Warwickshire Justice Centre Newbold Terrace Leamington Spa CV32 4EL
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 08/11/2018 an investigation was commenced into the death of Holly Chevassut. The investigation concluded at the end of the inquest on 02/12/2020. The determination of the inquest as to the medical cause of death was a traumatic spinal cord injury owing to impact with a vehicle, and as to conclusion, Road Traffic Collision.
4	**CIRCUMSTANCES OF THE DEATH**

	On 31/10/2018 at approximately 1723 hours, the Deceased was walking along Plough Lane, Harbury when she was hit by apparatus protecting the wing mirror of a passing recovery lorry belonging to GRS Recovery. Plough Lane is a rural unlit lane with no footpath on either side. The incident took place in the hours of darkness. The height of the wing mirrors and the protective metal plates on both the nearside and offside of the recovery truck was under 2ms from the road surface. They projected more than 20cms from the widest part of the vehicle.
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 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. - (.1) GRS continues to operate vehicles with mirrors and guards the height of which are under 2 ms from the road surface and which project more than 20 cms from the widest part of those vehicles. Such a configuration creates a risk of personal injury and death to people overtaken by these vehicles.
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 27/01/2021. 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 • Holly's Parents [redacted] • The Local Safeguarding Children Board • The Chief Coroner at the Chief Coroner's Office. 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 other 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. 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.
9	**DATE:** 02/12/2020.... **Signature** ..... SIGNED BY ASSISTANT CORONER LEEPER