WEST MIDLANDS TRAFFIC AREA

DECISION OF THE TRAFFIC COMMISSIONER

PUBLIC INQUIRY HELD IN BIRMINGHAM ON 30 JANUARY 2019

OPERATOR: MIDLAND RED (SOUTH) LTD T/A STAGECOACH MIDLANDS

Decision

1. The standard international PSV operator's licence held by Midland Red (South) Ltd trading as Stagecoach Midlands is varied so that the maximum number of vehicles it can operate is reduced from 261 to 200 for the period of 28 days, with effect from 0001 on 1 April until 0001 hours on 29 April 2019. The variation is pursuant to Section 17(2)(d) and 17(3)(aa) of the Public Passenger Vehicles Act 1981 ("the 1981 Act").

2. The repute of the company and of its transport managers is retained.

Background

1. Midland Red (South) Ltd holds a standard international licence authorising 261 vehicles. The company is a subsidiary of the Stagecoach Group and trades as Stagecoach Midlands. It has an overall fleet of 227 vehicles in posession, including reserves and spares.

2. On 3 October 2015 a Midland Red (South) bus driven by Kailash Chander was involved in a tragic incident in which two people were killed and two more seriously injured. Mr Chander was aged 77 at the time. Following a trial pursuant to the Criminal Procedure (Insanity) Act, the jury concluded that he had committed two offences of causing death by dangerous driving and two offences of causing serious injury by dangerous driving.

3. Midland Red (South) Ltd pleaded guilty to offences contrary to Sections 2 and 3 of the Health and Safety at Work Act 1974. In November 2018 the judge concluded that "the failings of the company were a significant cause of the events of 3 October 2015." He further concluded that the offences fell into the "high culpability" category although he also accepted that there was substantial mitigation available to the company. He imposed a fine of £2.335 million on Midland Red (South) Ltd.

4. The reasons the judge concluded that the company had a high degree of culpability are set out in his decision. In brief they were that:

   i) from 2012-2014 driver Chander was involved in four fairly minor collisions but none resulted in his driving being assessed by the company;

   ii) Mr Chander's "safety score" was poor, with data flagging up issues with braking and cornering. The company sent eight letters warning him about aspects of his driving between July 2014 and September 2015;

   iii) there were several passenger complaints about the standard of Mr Chander's driving during 2012-15;

   iv) Mr Chander was a retired driver who continued to be employed by the company on a casual basis. The company assessed Mr Chander's driving in April 2015: the conclusion was that he was capable of driving satisfactorily if properly rested. The instructor recommended that the driver should avoid working too many days. However, although the deputy manager at Mr Chander's depot in Leamington instructed controllers to limit Mr Chander's driving to three or four days per week, this instruction was not recorded in writing or enforced. In practice Mr Chander continued to work for more than 50 hours most weeks;

   v) the safe driving "champion" at the Leamington depot wrote twice in summer 2015 to Mr Chander to request a meeting to discuss how to improve his score but the meeting never took place. The champion complained to the depot manager in July 2015 that drivers were not being released for him to talk to;

   vi) Mr Chander was seconded to the Rugby depot in September 2015. Rugby was not informed of the need not to over-burden Mr Chander: he worked for an average of more than 72 hours per week in the four weeks preceding the incident;

   vii) While he was at Rugby there were several passenger complaints about Mr Chander's driving. The Rugby depot manager emailed the Leamington managers on 1 October 2015 expressing thanks for the loan of Mr Chander while suggesting that, owing to complaints about timekeeping and driving standards, they should think of stopping using him as a casual driver. This email was not read by anyone in Leamington or therefore acted upon before the incident on 3 October.

5. In the light of the company's conviction, the issues summarised above and the judge's conclusion of "high culpability", I decided to call the company to a public inquiry to consider its good repute. The call-up letter was sent on 19 December 2018, citing Sections 14ZA and 17(1) and (3) of the Public Passenger Vehicles Act 1981. By letters of the same date, the transport managers at time of the incident, Stephen Burd, James Mortimore, David Morgan and Philip Medlicott were also called to the inquiry to consider their good repute.

Public inquiry

Holding of public inquiry

6. The inquiry was held in Birmingham on 30 January 2019. Present were company managing director Philip Medlicott, engineering director David Morgan and operations director and transport manager James Mortimore. Stephen Burd had left the company and now works in Saudi Arabia. He had offered to fly back to attend the hearing but I had not considered that to be necessary. The company and transport managers were represented by Jonathon Backhouse, solicitor, of Backhouse Jones.

7. In advance of the hearing Mr Backhouse provided me with a full and detailed submission by James Mortimore, the operations director and transport manager, for which I was grateful. In summary, the company accepted that:

   i) Mr Chander should have been referred to the company's training school in 2012 and again in 2014 after (on both occasions) his second blameworthy collision within 12 months;

   ii) the main error was that the local management in Leamington had failed to monitor whether the deputy manager's instruction not to use Mr Chander for more than three or four days a week was being carried out. He had been very keen to take on casual work and turned up at the depot on a daily basis, offering his services: it was therefore easy for controllers to use him;

   iii) the eco-driving (including safe driving) "champion" had not had the time to meet one to one with Mr Chander. The depot managers should have ensured that the champion was given sufficient time to have such meetings with poorly performing drivers and also that any drivers with high adverse safety scores were taken off the road when the champion requested it. Pressure of business had led to the champion being deployed almost full time on normal driving duties;

   iv) the Rugby depot should have been made aware of the instruction regarding Mr Chander's hours when Mr Chander was loaned to them;

   v) the email from Rugby on 1 October 2015 advising Leamington that, owing to the complaints received about Mr Chander's driving performance during his loan period, he should have his hours reduced or no longer be used at all was not read by Leamington managers until too late, as they were both off work on Friday 2 October 2015.

8. The submission also sought to put Mr Chander's driving performance in context:

   i) the four collisions in three years incurred by Mr Chander were of a relatively minor nature, mostly involving clipping obstacles or vehicles;

   ii) some of the passenger complaints against Mr Chander had proved to be without merit when investigated in detail. For example, one passenger complained that Mr Chander had nearly come "off the road at a roundabout" on 28 September 2015, a few days before the incident. The Rugby operations manager had reviewed the CCTV record of this trip and found nothing untoward however;

   iii) although poor, Mr Chander's driver score was not the worst: there were 16 drivers who had a worse average score at the time of the incident. In the week of the incident, Mr Chander actually had a green score;

9. The submission listed the actions taken by the company since the October 2015 incident with a view to preventing anything like this ever happening again:

   i) medical reviews of drivers over 70 now take place every six months rather than the statutory 12 month requirement;

   ii) any driving instructor's report highlighting a need to restrict a driver's hours must now be brought to the attention of the company's operations director and

managing director. Instructions/advice about such restrictions must now be issued in writing;

iii) ecodriver champions now get their full 20 hours per week stand-down time (to advise and train other drivers);

iv) the company had limited casual drivers to 40 hours work per week since the incident and had now (since 5 January 2019) ceased using casual drivers altogether;

v) operations managers now had email capable phones to ensure that they could be contacted at all times;

vi) senior management now reviewed data every four weeks, to ensure that the company's accident reduction strategy was being followed comprehensively.

Evidence of Messrs Mortimore and Medlicott

10. James Mortimore and Philip Medlicott both gave evidence detailing the points outlined by the submission and summarised above. I asked why the Rugby depot manager's email of 1 October 2015 had not been picked up by some other responsible person at Leamington in the absence of the two managers: I was told that the email had been sent to the two managers' individual email addresses and had not been copied more widely.

11. I asked if the deputy manager at Leamington had ever checked to see whether her instruction about employing Mr Chander for a limited number of hours was being carried out. I was told that this had not been followed up.

12. I asked Mr Mortimore how he could be sure that the new systems which the company had adopted would be applied in practice, given that the company's previous systems, if they had been correctly applied, would probably have prevented the incident too. He replied that, in addition to the extra procedures introduced there was now much more checking that the procedures were being correctly and fully applied: accidents were reviewed every four weeks at both business review meetings and senior management meetings at which depots were challenged on their performance and action taken re, amongst other things, accidents and complaints. These improved procedures had now been implemented throughout the Stagecoach Group.

Concluding submission

13. Summing up, Mr Backhouse noted that the judge had accepted that the majority of the failures which led to the incident arose at a depot level rather than at very senior management (although I note that the judge also concluded that this was not a reason to draw back from the finding of the company's high culpability). The company had been extremely upset by the incident and had sought to learn from it (viz the improved procedures set out in the submission). It had entered a guilty plea to the charges against it under the Health and Safety at Work Act 1974 at the earliest opportunity. It had not appealed against the fine imposed by the judge, even though it had not fully agreed with all his conclusions (the significance of Mr Chander's four accidents and of the complaints received from passengers for instance). The constructive response of the company should weigh heavily in my decision on the company's and the transport managers' repute. The company in general had an excellent record concerning the standard of its maintenance and of its vehicles. It was accepted that several driver and training procedures had not been properly followed in Mr Chander's case. The company had received a very significant financial penalty from the court and I should take this into consideration also.

Consideration of the issues

14. One of the basic duties of a bus company is to ensure that its drivers are capable of driving its buses in a safe manner which endangers neither passengers nor other road users and pedestrians; and that the drivers possess the appropriate levels of skill and health with which to do so. Somehow, Midland Red (South) Ltd's procedures were inadequately applied to Mr Chander, at various instances and over an extended period of time, with the result that he was allowed to drive very long hours even after the company's driving assessor had recommended that his hours be limited. Even if one accepts that Mr Chander's accident and passenger complaint rate over the period 2012-2015 did not put him amongst the worst of the drivers, the fact remains that he should have been referred twice for driver assessment during this period but was not. Further, the ecodriver champion wanted to see Mr Chander in the summer of 2015 but was not given sufficient time off from his normal driving duties in order to carry out his responsibilities as champion. The deputy manager at Leamington gave instructions in April 2015 that Mr Chander should not be given too many days work per week, but these instructions were not followed for any significant period of time and the manager did not monitor whether they were being followed. Mr Chander was seconded to the Rugby depot without Rugby being made aware of these instructions. When Mr Chander's loan ended, the Rugby depot recommended that he be used less or not at all in the future, but this recommendation was not read in time by its addressees. Throughout this period, Mr Chander, a 77 year old driver, was regularly working a seven day week, often around 72 hours a week (I accept that these figures relate to duty time, not driving time). Surely this should have rung alarm bells with managers even if Mr Chander's driving record had been good (which it was not)?

15. It is clear to me from the evidence that the tragic incident on 3 October 2015 was not the result of a one-off error by one person within the company, but of a series of errors, committed over time by several people at various levels within the company, and of a system which was not adequate to identify and address those errors before they had tragic consequences. As the judge concluded, the culpability of the company is very high. It would not be appropriate for me to make any different finding, nor would I wish to do so.

Finding

16. The company has been convicted of offences against the Health and Safety at Work Act 1974. I find therefore that it has clearly failed to fulfil its undertaking to ensure that the laws on the driving and operation of vehicles are observed (Section 17(3)(aa) of the 1981 Act refers).

Regulatory action

17. In considering whether to take regulatory action against the company, and if so the degree of such action, I must first myself the *Priority Freight* question: how likely is it that the company will comply in future? In this instance, I recognise that am not – as I so often do - dealing with a company whose compliance record is generally poor. Indeed, its compliance record generally is very good. I have therefore asked myself the more specific question of how confident I can be that there will be no repeat of the circumstances in which the company failed to identify a potentially dangerous driver and allowed him to continue to drive and work for excessive hours. Having heard the evidence of the company's new procedures, under which Mr Chander as a casual driver could not have been employed at all, and (equally importantly) the improved monitoring of such procedures, I conclude that on balance I can be confident that there will be no such repetition. As such, I conclude that revocation of the operator's licence would be disproportionate and inappropriate.

18. In considering regulatory action, I have also borne in mind that, if I were to revoke the company's licence or impose a substantial period of suspension, there could be a perverse result in that some or all of its services might be taken over by other operators some of which might have less rigorous standards and/or driver safety procedures than Midland Red (South) Ltd has now developed. Or, if large numbers of people were to be displaced from the company's bus services into cars or onto bicycles for a period of time, the roads would be more congested and incidents made more, rather than less, likely.

19. However, the scale of the company's culpability (marked with a £2.3 million fine from the court) is such that issuing a simple warning – regulatory action at the lightest end of the spectrum – would also be inappropriate. I have sought therefore to determine upon regulatory action which is significant enough i) to send the necessary strong signal to the company that its level of failure has been unacceptably high - with disastrous consequences for the people killed or injured in the incident and their families; while ii) also taking account of everything the company has done since to make sure that the same mistakes cannot be repeated and iii) avoiding action which might reduce the safety of passengers and pedestrians by moving some business to some operators who do not have the improved procedures or shifting traffic to other modes.

20. I have concluded that a variation of the company's licence so that the number of vehicles it can operate is reduced from 261 to 200 for a 28 day period is the form of regulatory action which strikes the right balance. This regulatory action is a strong warning to the company that it has failed to come up to expectations in ensuring the safety of its staff and other road users, and that if such a failure is ever repeated then the complete loss of its right to operate would be the likely consequence.

21. I have allowed a reasonable period of time for the company to prepare for the variation and make any necessary alternative arrangements.

Transport managers

22. I did not see any evidence to suggest that the failures of any individual transport manager were any more serious than those of the company as a whole. The transport managers named on the licence in October 2015 (Messrs Burd, Mortimore, Medlicott and Morgan) were not personally involved in any of the poor decision making recounted above, although they bear some collective responsibility for the lack of robustness in the company's procedures and for its failure to ensure the procedures were properly applied. Equally, however, they deserve credit for the company's improved procedures and for its serious response to the incident and determination to learn lessons. I find that the removal of their repute would be disproportionate: it is consequently retained.

Nicholas Denton
Traffic Commissioner
2 March 2019