DECISION
OF THE TRAFFIC COMMISSIONER
FOR THE NORTH WEST OF ENGLAND

In the matter of the
Public Passenger Vehicles Act 1981 (the 1981 Act)

COMMUNITY TRANSPORT FOR TOWN AND COUNTY
PC1120641

&

PATRICK LINDLEY DAWSON
TRANSPORT MANAGER

Public Inquiry held in Golborne
on 18 February 2019

Decisions

Community Transport for Town & County

On findings under S.17 (3) (a), (aa) and (b) of the Act, I make the following direction against this operator's licence.

The relevant condition on the licence limiting the size of the fleet that may be operated under the licence is varied as follows:

The fleet capable of use at any one time will be reduced from 6 vehicles to 4 vehicles. This direction will take effect at 23.45 hours on Friday 8 March 2019 and conclude 28 days later on Friday 5 April 2019 at the same time. This will operate as an effective curtailment of the licence.

A formal warning will be recorded in respect of the licence.

Patrick Lindley Dawson - TM

I find his repute is lost.

I declare him unfit to act as a TM and disqualify him from holding office as a TM *indefinitely*.

Background

1. **Community Transport for Town & County (PC1120641)** (hereafter CT4TC) is the holder of a Standard National Public Service vehicle operator's licence for 6 vehicles, granted on 17 June 2013. As its name suggests, this company, limited by guarantee and exempt from the use of the attachment - "Ltd" - in its name, is engaged in community transport, school and social care-contracted work. Aside from this PSV licence, the operator possesses a large number of S.19 permits issued under the Transport Act 1985, and a single S.22 permit not directly within the ambit of this hearing.

2. The PSVs are deployed to deliver the demand-responsive Derbyshire Connect service, which covers the Amber Valley, Bolsover, Chesterfield, Erewash and North East Derbyshire district and borough council areas. According to the County Council's website, it provides transport to shopping destinations for people unable to use conventional buses because of age, disability or because they live in areas where public transport is limited.

3. There are a number of directors (and trustees, since this is also a charity). The business has been wholly owned by a parent company, the HCT Group (hereafter HCT), since 3 April 2019. It was evident that some of the systems and processes from the parent company had been instituted by the new transport manager (TM), who had previously worked for another HCT business. I noted however that the operator was said to enjoy "effective independence within the (HCT) structure".

4. Until recently, the directors of CT4TC included Patrick Lindley Dawson. Upon the change in ownership to HCT, he took the role of Chief Executive (CEO) and ceased acting as "Managing Director". He had, however, also been nominated, throughout the life of the licence, as one of two Transport Managers, until he resigned his TM position on 12 February 2019.

5. The operator had never previously been called to Public Inquiry and the record of both the operator and TMs hitherto had been without blemish.

The calling-in to Public Inquiry

6. The calling-in letters issued referred to alleged failures to comply with licence conditions, to breaches of the statements of intent and undertakings given on the original application. Those concerns were such as to bring into question the operator's good repute, financial standing and professional competence.

7. Patrick Lindley Dawson, as sole TM at the relevant time, was called in respect of his repute and professional competence. Another TM, Peter Hatfield, had resigned from the role on 13 July 2018, and his replacement, Lee Murphy, was not formally appointed until 7 November 2018.

8. The trigger for the calling-in was the disclosure that a vehicle FN04 FKM (operating under a permit on 24 October 2018) had been subject to a wheel loss incident at 8.30 that morning. There had been a complete detachment of the rear wheel set on the offside of the Mercedes vehicle, then carrying four passengers and a passenger assistant. Those carried were vulnerable persons but fortunately no accident occurred and no injuries were sustained by any person.

9. A follow-up investigation by Vehicle Examiner (VE) Foulds in November 2018 had resulted in an unsatisfactory outcome for this operator.

10. Record keeping had been found to be unsatisfactory; there was evidence of an extended maintenance interval, concerns about driver defect reporting and discrepancies in brake test reports. It appeared that a single brake test inspection report had been "adjusted" to support more than one maintenance inspection. No maintenance records were available for a vehicle added to the licence some months earlier. The record for one vehicle reported brake pads as low but with no repair details. No records were available at the time of the visit for another vehicle, except for a pre-delivery inspection. The forward planner for maintenance of vehicles was said to be confusing and awkward to follow.

11. It was declared intention and practice of this operator that the vehicles operated, whether under the operator's licence or the permits in force, are kept fit and serviceable under a single, common regime.

The Public Inquiry

12. So it was that the operator and TM attended the Public Inquiry on 18 February 2019. The company was represented by Astra Emir of counsel, instructed by Michael Oliver, solicitor. Michael Usherwood, a director, who was also the company's chair, gave evidence, as did Lee Murphy, now the sole TM.

13. Patrick Lindley Dawson, former TM, and current CEO gave evidence. He was separately represented by Tim Culpin, solicitor.

14. Helpfully, each of Messrs Usherwood, Murphy and Dawson had filed written statements of their evidence in chief.

15. At the end of the hearing, I reserved my decision so I could read the audit reports. I indicated that I would issue a written decision.

The evidence and its consideration

The wheel loss incident

16. The wheel loss incident attracted neither a prohibition, nor a prosecution. Lee Murphy had carried out an investigation, the report of which I received. He concluded that there were six "key failures", which had led to the incident:

- The poor quality of walk round checks,
- Poor standards within the external maintenance contractor,
- An absence of quality assurance processes of the work of contractors and gate checks of drivers,
- An absence of routine check procedures directed to the re-torque of removed wheels,
- General wheel security procedures, and
- Lack of consistent arrangements across the fleet for the use of wheel markers.

17. Whilst I would share his conclusion about the key factors relevant to the adverse incident, I would add that the primary responsibility for ensuring that such factors might not adversely affect vehicle operation lies with the nominated TM. The statutory position is that a TM is responsible for the continuous and effective management of transport operations. Of course, it is the case that the responsibilities for professional competence may be shared between one or more TMs but when only one such postholder is in place, he/she will carry that responsibility. Further, the ultimate responsibility for compliance lies with the operator itself, often in the form of the director with responsibility for line managing that TM. In this case, of course, at the relevant time, Patrick Dawson held both roles.

18. To his credit, Patrick Dawson accepts that responsibility, although he admits that the reality of the position was that he was little more than a "transport manager in name only". Peter Hatfield had held his TM role full-time until his departure, and Patrick Dawson's time was consumed substantially in an all-embracing senior management role. Whilst in theory he was Mr Hatfield's manager, he had done little to supervise, check or manage Mr Hatfield, although he did have some contact so that a report could be prepared for monthly Board Meetings. He admitted that he had "put his faith in" Mr Hatfield without actually monitoring or quality assuring his work. Later, when Mr Hatfield departed, he had taken no additional steps to prepare himself to take on Mr Hatfield's role, had not sought any refresher training (since qualifying in 2007), nor had he issued special instructions for staff at sites so that they could contact him directly, in the period when no other TM was in place. He told me he had visited the other operational site more frequently but he accepted he was at the material time operating as the director and not as TM. In short, I find he abrogated his responsibility to others and that this represents a serious and unacceptable dereliction of his responsibility.

19. It was against this background that a wholly avoidable incident with significant risk in terms of the safety of passengers carried under contract, and other road users took place. It was common ground that the vehicle in question had developed a problem but there was uncertainty what it was. Written records refer on the day prior to the incident to a "suspect propshaft knocking". I was told that in response to that information that the Depot Manager had arranged to have the vehicle "road-tested" by his operations team, and having found no faults, he had allowed it to be returned to service. This decision was made without referring it either up the management chain, or to the nominated TM (Mr Dawson), nor by having the vehicle checked by the nominated maintenance contractor.

20. Mr Murphy (as current TM) accepted the likelihood that the walkround check carried out by the driver on the day of the incident, and potentially that completed the day before (by a different driver) was inadequate: I agree with him. VE Foulds referred to drivers failing to notice the iron filings, a consequence of the ever-loosening wheels hitting against the wheel nuts. Drivers were also said to have bypassed the driver defect reporting system by making verbal reports initially.

21. I received little assurance, when I was told no disciplinary action had been taken against any member of staff: that is the driver (a volunteer) or drivers, the Depot Manager, who signed off on an unfit vehicle bringing it back into service, or against Patrick Dawson.

Current arrangements and change

22. Michael Usherwood accepted that events had shown that "the level of scrutiny in place was not as a robust" as was required under the licence. He saw as a positive that the higher standards imported into the business upon the appointment of Lee Murphy from the wider outside world had been integrated into the business. He pointed to the engineering audits, which had taken place in October 2018 as representing a positive opening up of the business to review and challenge.

23. Mr Murphy described the systems, which he found on joining the company to be *"adequate for basic systems: some were simplistic and lacking a robustness".* He referred to a lack of quality assurance processes. A series of changes had since been made with fail-safes put in place and he had undertaken a root and branch review of compliance against recent legislation change. He said he enjoyed regular support from others in the HCT network and had been invited by Mr Usherwood to attend at relevant meetings with the board, or its members, where necessary.

24. I had access to the Lloyd Morgan audit reports, which painted a picture of systems in need of substantial overhaul and renewal. Prepared in October 2018, only shortly before the wheel loss incident and the visit of VE Foulds, it was little surprise that so many of the wheel and tyre check sections were scored "Unsatisfactory" or "Area for improvement".

Submissions

25. Mr Culpin on behalf of Patrick Dawson believed he had learned from his experience. He argued that his client had been candid and frank and had not sought to avoid his responsibility for what had happened. He enjoyed a greater level of support from the board.

26. Ms Emir for the company argued that if regulatory action were deemed necessary that it should fall into the 'moderate to low' category. She emphasised that the circumstances of the incident were isolated in nature and not typical of operations that had continued with many vehicles over 30 years without serious problem. She described the context in which they occurred as being an unsettled period without a full-time transport manager. She referred to root and branch reorganisation including the appointment of an experienced TM and other links with a much larger group in HCT.

Decision

27. I have weighed all of these matters, alongside the major concerns in this case, which lie both in matters of road safety and in the protection of fair competition in the industry. Foremost in my consideration is whether I can have trust and confidence in this operator going forward.

28. As I have already set out above, the wheel loss incident was serious in nature, yet wholly avoidable. I find that if the most basic of arrangements had been in place and subject to effective management by a TM carrying out the full extent of the role, the risk, which both individual passengers and the public faced, would not have materialised. In that sense, this was a highly culpable failure.

29. Any regulatory analysis would have to recognise that a failure to have in place proper arrangements for professional competence is a serious matter going directly to repute, whether for the company, or its TM. Significant issues about competence and trust going forward are raised here, the more so since the TM, whose repute in that role is in serious question, also holds the most senior executive position in the business. Further, that whilst this business takes pride in its position as "the first semi-autonomous group operating within the (HCT) Group", I conclude that some of the shortcomings exposed in this case probably flow directly from such status, which has brought with it, examples of ineffective management and clear failings in accountability.

30. Turning first to the position of Patrick Lindley Dawson as TM, having weighed the arguments, I conclude that the loss of his repute is an unavoidable consequence of his failure to carry out his proper responsibilities both before the departure of Mr Hatfield but particularly during the time when he was the sole TM. I make such a finding notwithstanding that this was not, at the outset, a case of him "pretending" to be a TM when he was not but a seriously naive and negligent misunderstanding of the expectations of a TM in the 21st century. A situation compounded by his failure to recognise that after the departure of Mr Hatfield that the already unacceptable arrangement, whereby he played no real role in transport management, had to change very significantly. It did not, and this too was a most serious failure on his part, which placed others at risk and brought the future of this operator's licence into question. The reality is that this operator had no functioning TM in post for a period of 2 to 3 months in the autumn of 2018.

31. I conclude that even taking into account in the openness and transparency with which he has dealt with these proceedings and the refresher-training course attended that his repute as TM has been lost. I declare him unfit to act as TM, and as required by the statute, disqualify him from holding office as a TM *indefinitely.* I do not anticipate that he would in the future seek to offer himself as a TM and therefore have not set down rehabilitation measures in his case.

32. Turning to the position of the operator, I ask myself whether it is likely that this operator will be compliant in the future. This is a consideration that is taken in the context of a business in which its former TM, now declared by me to be without repute (in the TM role), is in post as CEO, albeit he is no longer a director.

33. I ask myself whether I am confident that I can trust this operator.

34. In reaching conclusions, I take into account that a Board, comprised by a series of volunteer directors/trustees, whose proactive but non-executive chair I have met and observed, sits above the senior staff group. There is now a TM in post, who would appear to be progressing necessary changes against the backdrop of the wider support available through the HCT Group. Whether the sort of autonomy, which the business enjoys provides for weakness already evident in the circumstances of this case, or if integration into a larger business would provide support, expertise and resilience, will be a key issue for directors to grapple with going forward.

35. This operator has no previous history before the regulator. Whilst the decision that I make is necessarily a finely balanced, but by narrow margins, I conclude that the repute of the operator is not lost. It will plainly be the case, however, that this operator's compliance will remain in the spotlight.

36. I have gone on to consider what if any orders I might make in this case. I agree that the impact of a suspension of the licence would be likely to be disproportionate, and I reject it.

37. I judge however that 'serious' regulatory action against the licence is justified, having taken account of the Senior Traffic Commissioner's Guidance Document No.10 "The Principles of Decision-Making and the Concept of Proportionality". Variation of the relevant condition on the licence that limits the size of the fleet that may be operated under the licence is appropriate here. The fleet capable of use at one time will be cut by one third from 6 vehicles to 4 vehicles with immediate effect. This direction will take effect at 23.45 hours on Friday 8 March 2019 and conclude 28 days later on Friday 5 April 2019 at the same time. This will operate as an effective curtailment of the licence.

38. A formal warning will be recorded against the licence.

39. I make these findings under S.17 (3) (a), (aa) and (b) of the Act.

Simon Evans
Traffic Commissioner
for the North West of England
4 March 2019