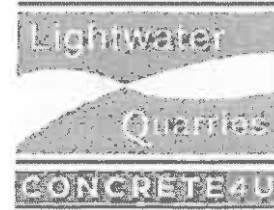


# Lightwater Quarries Ltd.

## CONCRETE4U

Company registered in England No 01267442  
VAT registration No.500 1726 06



Potgate Quarry  
North Stainley  
Ripon  
HG4 3JN  
Tel 01765 635435  
Fax 01765 635413  
sales@lightwaterquarries.com

Ms M Williamson  
Assistant Coroner  
Coroner's Office  
Symons House  
Belgrave Street  
Leeds  
LS2 8DD

636/12

14th March 2014

### IN THE MATTER OF THE INQUEST TOUCHING UPON THE DEATH OF ADRIAN PICKARD RESPONSE BY LIGHTWATER QUARRIES LIMITED (LQL) TO SECTION 28 REPORT TO PREVENT FUTURE DEATHS

Dear Assistant Coroner,

We are grateful for the extension of time to provide a response and do so in the following terms.

There is no legal requirement for the vehicles quoted within the report to be weighed on leaving the site. LQL always weighs aggregate vehicles for trading standards purposes. That requirement does not apply to volumetric vehicles (as was being driven here) because there is no obligation to do so but more importantly no need to. LQL already uses its weigh bridge to spot check all of its vehicles including volumetrics as a matter of good practice and is satisfied that such practice is fit for purpose. That practice will continue and in any event it is of course open to LQL to check weigh every vehicle on every occasion before it is operated on the public road and that as it happens is indeed the current position. There is no evidence that LQL vehicles have ever been operated in an overloaded condition. LQL operatives and drivers are trained to ensure that vehicles are not overloaded as to their gross or axles weights.

No evidence was led that weight was an issue causative of or contributing to the collision, rather it was the un-roadworthiness of the vehicle and inappropriate speed at which it was travelling for the type of road.

Sgt [REDACTED] evidence related to the road worthiness of the vehicle and the manner of driving as important factors. He did not mention weight.

The Court also heard evidence that despite the driver's appropriate driver training he was speeding at the site, which gave cause for concern to a number of employees. The driver was also going to be subject to disciplinary proceedings as a result of that.

[REDACTED] Collision Investigator agreed with Sgt [REDACTED] In his report he concluded that the vehicle overturned whilst attempting to negotiate the bend at an inappropriate speed. He was unable to establish whether the driver misjudged the

severity of the corner or because he was unable to reduce the speed sufficiently to safely negotiate the bend or a combination of the two. The vehicle was only able to slow at a normal rate (due to the vehicles condition & 9% road gradient). If the driver did misjudge the corner there may have been insufficient reserve capacity to reduce the speed, more rapidly than normal.

went on to say in live evidence that the vehicle overturned and was going too fast for the bend. He was unable to say why the vehicle was going in excess of 30mph, a safer speed being no more than 20 mph. He was unable to say why the speed was too high, whether the driver misjudged the bend or he was unable to get enough speed off before the bend.

agreed a driver would have more foresight from the elevated position of the drivers cab and that there were clues along the road by way of street furniture and the road that a tight bend was coming. He agreed the vehicle negotiated the first bend without overturning. He assumed it was a safe speed for that bend and the later bend. He gave evidence the driver would have steered round the bend and then realised he was going too fast. The brakes did not fail in the sense they didn't work. The vehicle was capable of slowing down at a normal rate.

He did not know when or if the brakes were in fact applied on the witness evidence. The following matter was raised by the Court, 'What I [The Coroner] am looking for is more likely than not. The bottom line is that it was too quick; there is no evidence the brakes failed, so either the driver went too fast and there was no attempt to stop or he misjudged the bend, approached it too quickly & realised how sharp it was and did not have the brake reserve.' said, "I can't say which is more likely'. Witness said at the point he went over, there were definitely no brake lights illuminated.

There was no evidence given by the Collision Investigator or Sgt that the weight of the volumetric vehicle was a factor in the death of Mr Pickard. They were not asked about it nor did they comment or raise it in their written evidence.

Forensic Investigator, gave evidence. He said having undertaken a survey of the bend and where the lorry overturned at speed, there was consistency between speed data and evidence of bends to indicate the speed data was accurate. There is no evidence of speed when the vehicle overturned. The fact it overturned means it was travelling too fast for the bend.

The tightness of bend and height of centre of gravity and speed are all factors, he said. So it was going too fast for vehicle type at that location, it may only need to be going a few miles per hour faster than the threshold. There is no physical evidence of braking. It doesn't mean to say there was braking or wasn't. There is no evidence as to how hard the brakes were applied or when it started. So there is only a limited amount one can say other than it was too fast for its position and just beforehand, it negotiated a comparable bend.

The driver safely negotiated bend 1 and it implies the driver slowed down using his gears and also braked to a safe speed. Having driven along there, you expect someone to brake and then proceed through the bend.

The brakes were in essentially the same condition they had been the whole journey, so it should not have been a surprise to the driver. All we can say is the driver was able to negotiate all bends and junctions. I think we can say he knew how the vehicle performed.

██████████ went on to say 20 mph was a safe speed based on the fact the vehicle negotiated the previous bend.

It is significant that there were no questions of this expert or any evidence that the weight of the vehicle was relevant to the collision.

██████████ said volumetrics were randomly weighed as a sampling approach in line with acceptable practice and they were recorded on weekly sheets. Aggregate vehicles are weighed for trading standards purposes.

Whilst a question was put that overweight vehicles could 'cause problems', there is no evidence of that nor was there agreement with that unsupported proposition. The response was that volumetrics are difficult to overload. There was no admission that vehicles were being overloaded or the effect of such a vehicle.

The weigh bridge operator could not recall if the vehicle was weighed on the day in question but LQL is satisfied that vehicle had been weighed at under 28t at the commencement of the journey as it has a signed record to such effect. Nothing however turns on this.

On behalf of VOSA, ██████████ could not find any legal requirement for volumetrics to be weighed. ██████████ raised weight when he erroneously said the legal weight of the vehicle was 26t. There is no evidence overloading was a problem for LQL.

The relevant findings in the Court's Narrative were:-

Both Messrs ██████████ and ██████████ opined the vehicle was not roadworthy, only one brake fell within range, 5 slack adjusters were de-adjusted, so 5 adjusters were not functioning correctly. There was no evidence of the driver excessively using the brakes but evidence that he had used gears during descent. There was possible driver misjudgment or lapse but Mr ██████████ could not say these were more than possibilities.

Mr ██████████ concluded the vehicle overturned because it was travelling at an inappropriate speed but it was not possible to say why. ██████████ concurred with the evidence of Mr ██████████ no doubt the brakes were defective, if they were not defective there was less chance of the driver running out of brakes.

The Court concluded 2 factors were more likely than not:

1. Vehicle unroadworthy
2. Travelling at an inappropriate speed.

Consequently, we respectfully disagree that there is a risk that future deaths will occur unless all vehicles are weighed every time when leaving the site, because there is no evidence to support that proposition and it is in context quite unnecessary. It is noted that the Coroner's concerns are 'that not all of the Company's vehicles which travel on the public highway are laden with e.g. aggregates, are weighed on each occasion prior to their departure from the Company's premises.'

The Court wishes to create an obligation upon LQL that all of its goods vehicles including laden volumetrics are weighed prior to departure. Apart from it being impractical in the long run, there is no evidence to suggest that such action would reduce the risk of future deaths and it not something that can properly be inferred from the evidence. We submit that in context there is no such risk arising out of not weighing every goods vehicles or every laden volumetric vehicle that are otherwise in a roadworthy condition, properly driven.

Volumetrics are able to operate to design weights, being 28.5t in the case of vehicle MV03 GFU. LQL loads the vehicles. They do not rely on customers or third parties who might have a vested interest in under-declaring the weights. The company does have considerable experience as to the interrelationship of aggregate loaded in the main aggregate bay and the overall weights (Cement powder and water having maximum payloads dictated by the maximum capacity of their sealed containment). The only way these vehicles could be overloaded would be to deliberately overload them. There was no evidence of that and the vehicle being in an overloaded condition was never at any point during the Inquest suggested by any party. Moreover due to the design of the aggregate bins and the characteristics of the limestone aggregate used it is difficult to overload these vehicles. LQL will observe its legal obligation not to put a vehicle on the road in an overloaded condition. There is no legal obligation to check the weight of every load for good reason. If there were such a legal requirement haulage would grind to a halt and there would be long queues at every public weighbridge.

The Chief Coroners Guidance, para 24, states "it is not for the coroner to express precisely what action should be taken. A Report is a recommendation that action should be taken, but not what that action should be."

Hallett LJ, 7/7 Bombing Inquests *ibid.* p15, stated, "It is neither necessary nor appropriate, for a coroner making a report...to identify the necessary remedial action. As is apparent..., the coroner's function is to identify points of concern, not to prescribe solutions."

Paragraph 25 states, "Coroner's should be careful, particularly when reporting about something specific, to base their report on clear evidence at the inquest or on clear information during the investigation.."

Overall, there was no link between the weight of the vehicle and the collision, no expert evidence about or questioning of the experts as to the issue of weight and no evidence that weight was even a factor. Whilst a report may refer to 'anything' revealed in the investigation which gives rise to concern, it is submitted that has not occurred. The issue cannot be said to have arisen in the course of the coroner's investigation. Nor can the action be specified as it has been (Report para 6). The Court found the issues were the unroadworthiness of the vehicle and the inadequacy of the brakes. It therefore does not follow that the risk of future deaths will be addressed by going beyond the current law and creating an obligation to weigh every laden vehicle. It is for all those reasons quite unnecessary for any action to be proposed. That is not to say that LQL as a responsible operator would not weigh its volumetrics or any of its other goods vehicles on a regular basis. To reiterate the current practice is to do precisely what is being proposed but that is not to say LQL should be obligated to do so.

Since this incident LQL policy has been to conduct a torque test at each and every PMI. We would like to see such a test also introduced at the annual ministry test. Had this test been part of the ministry test procedure then perhaps the defective automatic slack adjusters would have been identified at the immediately preceding annual test.

Yours Sincerely,



Director  
Lightwater Quarries Ltd

