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10 June 2021

Dear Mr Brunton

Inquest Touching the Death of Roy Evans
Response on behalf of Ceredigion CC to Report under Regulation 28

We write on behalf of Ceredigion County Council ("CCC"), to whom you sent a Regulation 28 Report dated 16 April 2021 in relation to the Inquest held before you on 7 April ("the Regulation 28 Report"). The below letter constitutes CCC's response under paragraph 7(2) of Schedule 5 of the Coroners and Justice Act 2009 and under regulation 29 of the Coroners (Investigations) Regulations 2013, and discharges CCC's duties under those provisions.

CCC would like to start by assuring both you and the public of their commitment to doing everything they can to help ensure the safety of both their drivers and other road users. CCC and its transport managers have always had this at the heart of what they do, and as such there is a constant and ongoing system of review and improvement of all transport maintenance and management systems.

The Regulation 28 Report does not identify any specific systems or processes within CCC's transport maintenance and management department that are said to need improvement, and none of the evidence at the inquest highlighted any such issues either. If any specific such deficiencies had been identified in the two-and-a-half year police and coronial investigation, then we are sure these would have been brought to our attention.

The Inquest, of course, found that the "matters of concern" in the Regulation 28 Report did not cause or contribute to the sad death of Mr Evans. Although the Inquest was not able to determine exactly what had caused Mr Evans' fatal collision, it was able to establish that it was not any of these issues with the vehicle. There have been no incidents similar to Mr Evans' collision at CCC either prior to or since Mr Evans' death.

Corrections/Inaccuracies

Paragraph 39 of Chief Coroner's Guidance No5: Reports to Prevent Future Deaths 2020 suggests that any mistakes in relation to reports under Regulation 28 should be corrected in the response. We would therefore like to raise the following six inaccuracies/irregularities which we think it necessary to correct herein:

1. Regulation 28 not raised at Inquest

The issue of a Regulation 28 Report was not raised by you at all at the Inquest on 7 April or in any of the earlier correspondence regarding the Inquest. You did not give any mention of the fact that you were considering such a report and, crucially, did not invite any submissions/representations from the Interested Parties present regarding prevention of future deaths ("PFD").

Any coroner issuing a Regulation 28 Report is under a duty to consider representations before reaching a decision on this issue – see paragraph 8 of the Chief Coroner's Guidance No5: Reports to Prevent Future Deaths 2020. Despite our own considerable experience in this area, we are not aware of any other case where a report under Regulation 28 has been made without a Coroner asking for and considering such submissions.

Had you given us the opportunity to make submissions, then the points at 2.-6. below would have formed the basis of those submissions, and it is suggested that, having considered such submissions, no obligation under paragraph 7 of Schedule 5 of the Coroners and Justice Act 2009 would have arisen.

2. Evidence covering PFD already given at Inquest

You have already heard significant evidence at Inquest from the witness [redacted] dealing with issued relating specifically to PFD. This was not evidence that you asked for any clarification on or challenged in any way when that evidence was given.

That unchallenged evidence gave a comprehensive picture of the current position regarding vehicle maintenance at CCC. It also explained that the position going forward had been considered by both the DVSA and the Traffic Commissioner for Wales, who are satisfied with the measures CCC has in place.

At the end of that evidence, you appeared to accept that that evidence addressed any concerns you might have had:

[redacted]	I think that's all the questions I have sir, I hope that's clarified some of the points that we forgot to raise with [redacted], yes.
Coroner	Indeed, it will, [unclear speech 13:01:02] and [redacted] had said, simply, I don't know. We will have got the answers here, I was not aware that there'd been a public inquiry, but quite clearly as a result of that and from what you say [redacted], there'd been considerable and substantial changes.
[redacted]	Yes sir.
Coroner	Which is all well and good obviously, but were not in place on the day in question.
[redacted]	They've been enhanced, there was procedures in place, but they have been enhanced since then, yes sir.

Both Regulation 28 itself and paragraph 7 of the Chief Coroner's Guidance No5: Reports to Prevent Future Deaths 2020 make clear that the decision on whether to issue a Regulation 28 Report or not must focus on the current position and not the position at the time of the fatality: "*Coroners should consider evidence and information about relevant changes made since the death or plans to implement such changes. If a potential PFD recipient has already implemented appropriate action to address the risk of future fatalities, the coroner may not need to need to make a report to that body*". (emphasis added)

However, your Regulation 28 Report makes no reference at all to any of [redacted]' evidence, and instead focuses on a snap-shot position from almost three years ago, which you expressly accepted at Inquest (see above extract) was not the current position. That is not the correct approach to the test for issuing a report under Regulation 28.

3. Already dealt with by Traffic Commissioner

The issue of the suitability and adequacy of CCC's vehicle maintenance systems has been examined in detail by both an independent regulator, the DVSA, and an independent judicial authority, the Traffic Commissioner for Wales. The Traffic Commissioner held a Public Inquiry in January 2020. As a result of that Inquiry, the Traffic Commissioner made no recommendations or directions and found CCC and its Transport Manager to be in good standing and competence as a vehicle operator.

Given the above findings by the Traffic Commissioner, there ought to be no need for this issue to be examined *de novo*. Reliance on conclusions of specialist regulatory bodies by Coroners was endorsed by the Court of Appeal in R (Secretary of State for Transport) v HM Senior Coroner for Norfolk [2016] EWHC 2279. The Lord Justices in that case lamented the tendency of bodies with overlapping jurisdictions considering "*that [they] should [themselves] investigate the entirety of the matter rather than rely on the conclusion of the body with the greatest expertise in a particular area within the matter being investigated.*"

It appears that, unfortunately, this has also not been considered here when applying the test for issuing a report under Regulation 28.

4. Errors regarding evidence on indicator side repeaters

The factual basis for item c. in your "Matters of Concern" – that relating to indicator side repeater lamps – is erroneous for two reasons.

Firstly, during the examination of [redacted] into whether the absence of an indicator side repeater would continue an immediate prohibition, he accepted that he could not say whether it would constitute a prohibition in relation to the vehicle concerned:

[redacted]	If they are fitted with indicators, they need to work.
[redacted]	Okay so you are saying if they are fitted with indicators...
[redacted]	If they are fitted, yes.

[redacted]	Do you have any evidence they were fitted?
[redacted]	No, I don't.
[redacted]	The side indicators, thank you.
[redacted]	This is why a prohibition wasn't issued.

Secondly, [redacted] gave unchallenged evidence that the absence of an indicator side repeater was not classified as a "*safety critical*" defect, and it is therefore difficult to see how on any reading that could be considered an issue which could give rise to a concern that circumstances creating a risk of other deaths will occur.

5. <u>Prohibited from examining witnesses on these issues</u>

The Regulation 28 Report is based on factual findings on contentious matters on which you expressly prohibited us, as legal representatives for CCC (an Interested Person), from examining witnesses at the Inquest.

On 10 March 2021 you provided us with a list of the witnesses you would be calling for inquest (without having asked for witness requirements or agreement) – this said that the evidence of [redacted] (whose written report forms the basis of your Regulation 28 Report) would be read. On 29 March, we wrote to you to make you aware that the following conclusions of [redacted] were both considered contentious issues:

- "*Suspension defects detected should have rendered the vehicle not fit for service*."
- "*Maintenance documentation from 09th July 2018 and subsequent Email sent on 12th July 2018 indicates that a trailing arm defect was detected, but incorrectly diagnosed*."
- "*Maintenance documentation also indicates that indicator side repeater laps were misleading. These are listed as immediate prohibition within the categorisation of defects manual. It is unclear if these defects had been rectified."*

At that stage we were unclear if you sought to include these matters in the scope of your inquest, given that there was clear evidence that they were not causative of the death. We explained that we considered those conclusions of [redacted] contentious because they were inconsistent with the evidence given by [redacted] regarding the actions that the mechanic/foreman would have taken if there had been such defects present when they inspected the vehicle on 9th July 2018.

As a result, you said that you would call [redacted] to give evidence in person.

During the evidence of [redacted], we therefore sought to examine him in order to test the evidence on:

a) Whether the absence of side repeater indicators in itself did constitute an immediate prohibition under the Categorisation of Defects Manual;
b) The extent to which [redacted] could say with any certainty what the condition of the suspension would have been on 9th July 2018 (not least, because it had been in a fatal collision in between then and him examining it);

c) The extent to which he could say that the condition that the suspension was in on 9th July 2018 would have been an immediate prohibition (as opposed to a different defect categorisation), especially given what was recorded on the inspection report for 9th July and the actions of the mechanic and foreman undertaking the 9th July inspection.

As explained at 4. above, under examination in relation to point a), [redacted] accepted that he could not say that the absence of indicators on the vehicle concerned would have been an immediate prohibition. It is therefore perfectly possible and credible that, under examination into issues b) and c), [redacted] would likewise accept that he could not so conclude with any certainty.

However, having started to address issue b) and c) with [redacted], you directed that we could not examine [redacted] on these issues – not on the basis that the issue was not relevant to the inquest, but because you had already decided the issue before seeing that evidence tested through examination:

Coroner	... I am accepting, I'll tell you now, the evidence which has been put before the court that these three defects were prohibitive in nature.

[*the above comment was made when ruling that examination of the witness on these issues could not continue – before the witness had concluded their evidence*]

Rule 19(1) of the Coroners (Inquests) Rules 2013 mandates that "*A coroner must allow any interested person who so requests, to examine any witness either in person or by the interested person's representative*" (emphasis added). The subsection (2) exception to this rule is not applicable here, because you demonstrably considered these issues relevant – you made findings in respect of them in your summing up.

This position is reaffirmed at paragraph 12-65 of Jervis on (Coroners 14th Edition): (citing Re Bithell (deceased) [1986] 1 WLUK 114 as authority) "*All that said, it is nonetheless perfectly proper for legal representatives to test the evidence, and to suggest that a witness is wrong*."

In summary:

- We put you on notice that we wanted to explore specific issues with [redacted] as they were not accepted;
- You then called [redacted] to give live evidence;
- [redacted] accepted in evidence that a conclusion could not in fact be drawn in relation to one of the issues;
- You prohibited us from examining [redacted] on the other two issues;
- You said, prior to having heard all of the evidence from that witness on that topic, that you would be making a specific factual finding in relation to those issues;
- You relied on those factual findings in your summing up and Regulation 28 Report.

Clearly we should have been allowed to test that evidence through examination at the Inquest.

6. Invitations to provide this information previously were declined

The information you have now requested was already offered to you by CCC prior to the inquest.

On 20 August 2020, in response to the "Schedule of Faults" which formed the basis of Schedule 5 notices you served on witnesses (which required that those witnesses respond to allegations made against CCC), CCC offered to provide you with "*relevant and valuable additional explanation in relation to the specific questions you have raised, as well as the broader issues those entail*". Those "*specific questions*" covered the same points raised as your "matters of concern" in your Regulation 28 report.

That offer was turned down by you by email on 21 August 2020.

It is difficult to see how you can consider that further information on this topic is now essential to discharging your statutory functions, when you turned down CCC's offer of such information previously.

Evidence Given at Inquest

Although not given formally in response to the issue of PFD (as this was never raised by you at or prior to the Inquest), [redacted], the Transport Manager for CCC, gave evidence to you at the Inquest on 7 April 2021 which addresses all of the relevant issues relating to PFD. The relevant extract from that evidence is repeated below for your convenience:

…	… … …
Coroner	Yes, and can I ask you this, and if you don't know, say so. Clearly, this incident must have come to the attention to a number of people in the department.
[redacted]	Correct.
Coroner	Do you know if any steps have been taken to try to rectify the situation, so that this couldn't happen again?
[redacted]	Some of the existing procedures and processes have been enhanced. Obviously, there was processes in prior to this incident. However, they have been enhanced since the incident.
Coroner	Is it within your ability to say whether [redacted], with his very considerable experience on this machine, whether he would have taken it out if he'd had some defects, or would he have brought them all to the knowledge of the foreman? If it's possible for you to say.
[redacted]	Having looked at the vehicle file, there was previous incidences where if there was a defect identified, it was presented on that day to be rectified.
Coroner	Yes.

[redacted]	So, I am of the belief that if there was a defect on that day, he would have, as part of his check submitted if it was, he identified that the vehicle needed attention, be it a repair or a defect on that vehicle.
Coroner	Well, we've been told that he was, [over-talking 12:44:05] checks.
[redacted]	Yes, he was [unclear 12:44:08] yes Sir.
Coroner	So, there was no doubt in your mind.
[redacted]	No, no.
Coroner	He was not the sort of man who would say, 'Oh, well, that doesn't matter, I can take it out today.'
[redacted]	No, no, no Sir.
Coroner	[redacted], I think that's all I need to ask you. If you will wait a moment.
[redacted]	There's a number of questions from me Sir. [redacted], it might help if you had your statement in front of you.
[redacted]	I do, yes.
[redacted]	Paragraph, seven, just to clarify the point raised by my friend earlier, you've said there, that the inspection for this vehicle would be six-weekly, six-weekly safety inspection, that's right, isn't it?
[redacted]	Correct Sir, yeah.
[redacted]	And you've said, in your statement again, in that paragraph, that the items on the inspection sheet would have been checked at that inspection.
[redacted]	Correct Sir.
[redacted]	And that the foreman would have made the decision if the vehicle was still roadworthy and whether the repairs could be carried out at a future date.
[redacted]	Correct Sir.
[redacted]	So again, sometimes when there are issues identified with a vehicle, that doesn't render the vehicle unroadworthy, that's right?
[redacted]	No.
[redacted]	So, it is for the foreman to decide whether those, anything that is highlighted or raised by the mechanic, renders the vehicle unfit for service, that's right, isn't it?
[redacted]	Correct.
[redacted]	And so those issues would need to be rectified before the vehicle is returned to service.

[redacted]	Correct.
[redacted]	Or he may decide that those, do in fact mean that the vehicle is still fit for service.
[redacted]	Correct.
[redacted]	And could return into service and list those to be rectified at a future date.
[redacted]	Correct.
[redacted]	And the foreman and the mechanic would liaise between themselves in order to help the foreman reach that decision.
[redacted]	Yes.
[redacted]	And they are both, in your view, appropriately trained.
[redacted]	Yes, yes Sir.
[redacted]	Competent and experienced.
[redacted]	Yes, yes.
[redacted]	And indeed, the mechanic who checked it, whose name is on the most recent safety inspection, that four days before, was an MOT qualified mechanic. So he could test other vehicles for MOTs.
[redacted]	Yes, yes.
[redacted]	So, it really come down, doesn't it to a question of the professional view and opinion of that foreman, as to whether a vehicle is put back into...
[redacted]	Yes, on that day, a decision has to be made and I feel confident that that decision was made.
[redacted]	Excellent, now, we've heard that you are the listed person on the vehicle operator licence for the...
[redacted]	Correct.
[redacted]	...Council. There is a system, isn't there, called the Operator's Compliance Risk Score.
[redacted]	Yes, there is, yes Sir.
[redacted]	So, that is where you get a running monthly score of legal compliance on your vehicle operator's licence.
[redacted]	Correct.
[redacted]	So, anything it took by the DVSA would go into what your score was on that.
[redacted]	Correct.

[redacted]	And that would take into account, both roadworthiness issues, and so the sort of issues we're talking about here.
[redacted]	Yes Sir.
[redacted]	Whether the vehicle was fit to be on the road, and also, traffic issues, so tacho, weight, those sorts of things.
[redacted]	Yes.
[redacted]	And you get a score for each section, every month?
[redacted]	A combined score, yes Sir.
[redacted]	Yes, brilliant, and that score can be categorised, can't it, as either green, low-risk, amber, medium-risk or red high-risk.
[redacted]	Yes.
[redacted]	That's right, isn't it? And that is the score the DVSA and a coding that the DVSA give to licence, it's not something from the council.
[redacted]	No.
[redacted]	Have you reviewed the OCRS scores prior to attending today?
[redacted]	Yes, we've been green scoring since 2017. I believe we review that on a monthly basis, because it takes into account MOT passes.
[redacted]	So every month, I think it's from October 2017...
[redacted]	Yes.
[redacted]	You've got [unclear 12:48:40] everything between October 2017 to present, every single month is green.
[redacted]	For the [unclear 12:48:50] yes, correct.
[redacted]	Excellent, and in fact, a score of higher than ten, so it's a ten or below would be green, wouldn't it?
[redacted]	Yes, yes.
[redacted]	And it's the highest score, within that period, is 7.22.
[redacted]	Correct.
[redacted]	So throughout that period, well within the low-risk operator category, and that's a score given by the independent regulator at the DVSA.
[redacted]	Yes, yes.

[redacted]	Thank you. I'd like to talk through with you now some changes that have been made since this tragic accident. I think there may have been some confusion earlier with [redacted] about changes that have been made as a result of this accident. There have been a number of changes within the department since, we'll leave aside the confusing issue of whether those were as a result of findings here, but there is an ongoing system of improvement within the department, isn't there? Things Change within the department, don't they? Needs, the needs of the community.
[redacted]	Correct, legislation also changed, so we react on if there is a change in legislation. In particular, there was a change to the guide, to maintain roadworthiness. So, we change our processes to reflect these changes in the legal requirements.
[redacted]	Excellent, and improvements have been made as well, to tighten existing systems.
[redacted]	Yes.
[redacted]	So not to put fully new systems in place.
[redacted]	No.
[redacted]	But to tighten some of the systems we've been talking about today.
[redacted]	Yes Sir.
[redacted]	With relation to driver defect checks and the six-weekly and regular inspections in the TMU.
[redacted]	Yes.
[redacted]	So as part of that then, the driver defects are now audited, aren't they?
[redacted]	Yes, the driver defects are audited regularly, particular attention to driver reported defects. We had a system in place prior to this, it's been enhanced now, so there's greater awareness, there's a follow-up process that myself has to deal with and react to and to make the line manager/drivers aware of when defects haven't been reported correctly.
[redacted]	So just to clarify that then [redacted], when a driver reports in his defect sheet that something was okay.
[redacted]	Yes.
[redacted]	Then, when it goes for its six-monthly inspection, if something is picked up now that the driver should have picked up, there is now repercussions for the driver, isn't there?
[redacted]	Yes, indeed, there is.
[redacted]	So, he is then called up, isn't he, by you or...?
[redacted]	The line manager will be made aware of the situation, I provide them with the evidence, in terms of the photo or the item that was missed. As a reminder to the fitters now, we've got posters located in both our transport maintenance units in Aberystwyth and Glan yr Afon, that

	they need to mindful that when they are carrying out safety inspections, to ensure that if there is a driver-reportable defect that it needs to be followed in the correct procedure.
[redacted]	So that will help then with identifying whether drivers are carrying out those defect checks properly.
[redacted]	Correct.
[redacted]	Or whether they're picking up the sheet in the morning.
[redacted]	And just tick, tick, tick, yes Sir.
[redacted]	There are also extra checks, aren't there, now on the condition of the vehicles generally. I think there's only auditing.
[redacted]	Yes, so we are auditing, we've enhanced, we were previously carrying out gate checks, and we've enhanced that the gate checks happen every month...
[redacted]	I'm just going to interrupt you there, tell me what gate checks are?
[redacted]	Gate checks, so at the point of exit, at both depots, the vehicles are stopped, and we go through the driver's defect book. We'll go through the driver's hours book; we'll have a look at the condition of the vehicle. We'll also have a look at whether or not there's an obvious defect, if there's a bulb out or such like. These are done at both depots at Glan yr Afon and Penrhos depot. I regularly participate, so I have contact with the drivers and the line managers on a monthly basis.
Coroner	Sorry, can I just be clear about that. You say that every time a vehicle is taken out, that procedure...
[redacted]	No, no, so, every month, we audit a minimum of ten vehicles between the operating centres and we audit the vehicle and the driver of any, their defect book and the driver's hours book and the general condition of the vehicle and whether the driver's missing the defect book, stuff like...
Coroner	Thank you.
[redacted]	So the point of that, just to be clear, it's a random test...
[redacted]	It is indeed.
[redacted]	...that at some point, but the benefit there obviously, that anybody knows that at some point they could be checked.
[redacted]	It is random; however, we do keep a list of vehicles and show that we're not discriminating and picking on the same driver on every occasion, or the same vehicle on every occasion.
[redacted]	So, every driver is aware that at some point...
[redacted]	Yes, indeed.

[redacted]	...they could be pulled up.
[redacted]	Indeed.
[redacted]	And indeed, similarly with the fitters and the mechanics, they're aware that there is now this extra layer of protection where their work could be picked up.
[redacted]	Yes.
[redacted]	And greater level of responsibility with the mechanics for that.
[redacted]	Yes.
[redacted]	And presumably, if people are found, issues like retraining...
[redacted]	Yes, for example, if there is an item that is picked up, for example, a temporary repair that wasn't suitable, we, well, I, myself, have carried out toolbox trawls with the fitters, provided with photographic evidence to say that look, this sort of temporary repair needs to ensure that it is temporary to fulfil the repairs for the appropriate time until the full repair can be taken place. That could be a case of when the parts next order, so the next day.
[redacted]	Just to confirm as well, that the mechanics, fitters and foreman, are now trained and certified to a...
[redacted]	Correct.
[redacted]	A standard called IRTEC.
[redacted]	Indeed, the fitters have undertaken the Heavy Goods Inspection Standards and Procedures, provided by the Freight Transport Association, now [unclear speech 12:55:40] they then subsequently, of all the teams, the IRTEC qualification, which is the Industry of Road Transport Engineers Certificate, which is acknowledged throughout and across the industry.
[redacted]	So all these are not adding in, the vehicle is still checked every six weeks, and things still rely, of course, on the mechanics making decisions on the day, but what this does, I suggest, is add braces to the belt.
[redacted]	Indeed.
[redacted]	Is that correct?
[redacted]	Indeed.
[redacted]	Thank you. So those are all changes, [redacted], are they, that have taken place in the two-and-a-half coming up to three years since the incident.
[redacted]	That's right.
[redacted]	As a result of the prohibition notice served by the DVSA in relation to this specific vehicle, this sweeper vehicle. That triggered, didn't it, a referral to the Traffic Commissioner for Wales of the council's vehicle operator licence.

[redacted]	Correct.
[redacted]	So the Traffic Commissioner for Wales, with the help of evidence collected by the DVSA, and evidence submitted on behalf of the council, held a public inquiry in January 2020.
[redacted]	Correct.
[redacted]	To look into the council's vehicle operator licence.
[redacted]	Yes Sir.
[redacted]	You gave evidence at that.
[redacted]	I did indeed, yes Sir.
[redacted]	And indeed, the other aspect that that public inquiry looked at, was your suitability...
[redacted]	Yes Sir.
[redacted]	As the vehicle licence holder.
[redacted]	Correct.
[redacted]	The possible outcomes of that public inquiry were that the Traffic Commissioner is able to vary the existing licence.
[redacted]	Correct, yes, he's able to revoke, suspend, curtail, yes, he's able to make some drastic changes to the licence.
[redacted]	So, there are a number of changes, conditions, undertakings, etc., that the Traffic Commissioner was able to put on to that licence.
[redacted]	Yes.
[redacted]	Ultimately, he is able to suspend it.
[redacted]	Yes, correct.
[redacted]	And revoke the licence as well.
[redacted]	Indeed.
[redacted]	As a result of that hearing, that public inquiry in January 2020, the Traffic Commissioner took no action as a result of that public inquiry, didn't he?
[redacted]	Correct, yes, yes.
[redacted]	He didn't attach any formal conditions, to the vehicle operator's licence.
[redacted]	No.

[redacted]	And indeed, I think he remarked, didn't he, that it was very unusual.
[redacted]	Very unusual and that I still retained my good repute and professionalism throughout.
[redacted]	Yes, so he found that you were a good repute and professional competent.
[redacted]	Correct.
[redacted]	And that the council was a good repute and professional competent as well, in relation the operation of its entire fleet.
[redacted]	Yes Sir, correct.
[redacted]	So, the Traffic Commissioner, having heard a day's evidence and considered the position in the round, going forward, as of January 2020, he was reassured of the appropriateness of the council's systems in relation to its fleet management.
[redacted]	There was systems and processes submitted to the Traffic Commissioner, and he was satisfied with the submission that we provided him.
[redacted]	Similarly, [redacted], are you, as the holder of VO licence, satisfied now, obviously, there will continue to be changes...
[redacted]	Yes...
[redacted]	...and progress, but are you satisfied with the council's systems for...
[redacted]	I am.
[redacted]	Fleet management, and particularly maintenance going forward?
[redacted]	I am, compliance is paramount, it's a culture that we wish to endeavour and strive to achieve, but yes, I have every confidence and if I didn't, I wouldn't wish to be vehicle licence holder.
[redacted]	That's an ongoing...
[redacted]	Yes.
[redacted]	And indeed, I think last week, a new layer of management was put into the system...
[redacted]	Yes, correct.
[redacted]	...to help.
[redacted]	So there will be a transport maintenance manager, who will oversee the running of the two transport maintenance units and they will also be an operator licence holder as well to add and build to the resilience of the council's operator licence.
…	… … …

[redacted]	I think that's all the questions I have sir, I hope that's clarified some of the points that we forgot to raise with [redacted], yes.
Coroner	Indeed, it will, [unclear speech 13:01:02] and [redacted] had said, simply, I don't know. We will have got the answers here, I was not aware that there'd been a public inquiry, but quite clearly as a result of that and from what you say [redacted], there'd been considerable and substantial changes.
[redacted]	Yes sir.
Coroner	Which is all well and good obviously, but were not in place on the day in question.
[redacted]	They've been enhanced, there was procedures in place, but they have been enhanced since then, yes sir.
Coroner	There we are. Thank you, Mr [unclear 13:01:34].

The above evidence, which was given to you and accepted by you at Inquest, demonstrates that:

1. There already were systems in place for Preventative Maintenance Inspections to ensure that vehicles were properly maintained by CCC – the inspections for the sweeper vehicle involved in the accident were every six weeks. These inspections were carried out by trained and competent mechanics, and when they identified that vehicles had defects that made them unroadworthy, they were not allowed to be used until those defects had been rectified.

2. CCC seeks opportunities for continuous improvement in the delivery of its services and in the (almost) three years since Mr Evans' death, processes and systems have been reviewed and enhanced further, including the implementation of formal auditing processes in relation to compliance.

3. CCC's Operator Risk Compliance Score (a running score for compliance, maintained by the DVSA as an independent regulator) has been consistently well within the green, "low risk operator", category since October 2017 (when the scheme began).

4. There was an independent investigation into the suitability of CCC's fleet management and maintenance systems by both an independent regulator, the DVSA, and an independent judicial authority, the Traffic Commissioner for Wales. The Traffic Commissioner, assessing the position of CCC in January 2020 going forward, made no recommendations or directions and found them and the Transport Manager to be in good standing and competence as a vehicle operator.

"Fleet and Fleet Driver Management Systems" Document (Appendix 1)

The attached "Fleet and Fleet Driver Management Systems" document at Appendix 1 shows the comprehensive systems that CCC has in place, and when they were introduced, reviewed and/or updated. You are invited to read this document in full and to regard it as part of CCC's response.

Final Points

CCC had comprehensive and reliable vehicle maintenance/management systems in place prior to the fatality in 2018. They had a system of Preventative Maintenance Inspections for roadworthiness, and experienced and competent people in place to carry out those inspections. There were also driver daily defect checks. All of these were carried out in relation to the vehicle driven by [redacted]. No issue with the vehicle has been identified as causing or contributing to the collision. No specific issues regarding the systems in place in 2018 have been raised in the inquest process.

That said, CCC, as a responsible vehicle operator, has enhanced its systems since July 2018, as part of its ongoing system of review of its vehicle maintenance/management systems. Although both the DVSA and Traffic Commissioner have recently signed off on CCC's procedures, nonetheless CCC will seek to improve and develop those procedures still further going forward.

CCC remains fully committed to making its fleet of vehicles as safe as they can be.

It is CCC's and our view that the information herein, and the inquest evidence of [redacted] in particular, is more than sufficient to alleviate any concerns that circumstances creating a risk of deaths will occur in the future, and to confirm to the public that CCC has appropriate fleet management and maintenance systems in place.

The above letter constitutes CCC's response under paragraph 7(2) of Schedule 5 of the Coroners and Justice Act 2009 and under Regulation 29 of the Coroners (Investigations) Regulations 2013, and discharges CCC's duties under those provisions.

CCC would be grateful if, before publishing this response or making it more widely available, both you and the Chief Coroner would consider redacting the names of the individual witnesses from the above response letter. In our experience this is common practice, but we include the request herein expressly, pursuant to Regulation 29(8) Coroners (Investigations) Regulations 2013.

Yours faithfully

[sent electronically without signing]

Weightmans LLP
On behalf of Ceredigion County Council

Attachments: Appendix 1 – "Fleet and Fleet Driver Management Systems"

Ceredigion County Council
Fleet and Fleet Driver Management

1.0 Introduction

The following summarises the approach taken by Ceredigion County Council to the management of its fleet vehicles and drivers with a view of maintaining a safe and compliant operation.

The approach is underpinned by a culture of continuous improvement which focuses on taking proactive preventive measures and interventions as well as responding positively from lesions learnt and experience.

2.0 Training

Activity	Description	When introduced / reviewed / updated
Ceredigion Driver Awareness Training	Ongoing delivery of Ceredigion Driver Awareness Training (CDAT) to be completed prior to undertaking fleet driving and subsequently training to be repeated at least every 4 years.	Ongoing (pre July 2018)
Refresher Defect Check Training	DVSA good practice training videos shared with fleet drivers regarding the completion of daily defect checks.	January 2020
Fleet Driver E-learning module	Roll out of the Ceredigion Fleet Driver e-learning module to be completed annually.	February 2021
Driver Certificate of Professional Competency	Driver Certificate of Professional Competency (DCPC) for relevant professional drivers is maintained through an ongoing programme of training to ensure the 35 hours is completed within each 5 year cycle.	Ongoing (pre July 2018)

Minibus Driver Awareness Scheme	In addition to CDAT training, Minibus drivers are required to undertake MiDAS training prior to driving Fleet vehicles and this is subsequently to be renewed every 4 years.	Ongoing (pre July 2018)
Continuous Professional Development	Ongoing Continuous Professional Development of staff with the Transport Maintenance Unit which has included HGV Inspection Standards & Procedures training and IRTEC accreditation of Technicities and where appropriate / relevant MOT tester training	Ongoing (pre July 2018) IRTEC qualifications achieved January 2020 and March 2020 (two cohorts)
Driver Line Manager Training	Workshops advising driver line managers of their roles and responsibilities.	2020/21

2.1 Drivers

Activity	**Description**	**When introduced / reviewed / updated**
Driver Licence Checks	Driving Licence and DCPC (where appropriate) checks are undertaken twice a year of all fleet drivers.	Checks ongoing (pre July 2018) Frequency reviewed and increased to twice yearly January 2020
Gate Checks	Gate Checks undertaken on a random basis of at least 10 vehicles a month.	Ongoing (pre July 2018) Reviewed November 2019
Preventative Maintenance Inspections	Driver reportable defects identified as part of Preventative Maintenance inspections (PMI's).	Ongoing (pre July 2018) Reviewed December 2019
Driver documentation Audits	Audits of Vehicle and Plant Daily Checks and Defect Reporting Books and Driving Hours Books undertaken.	Ongoing (pre July 2018) Reviewed November 2019

Driver Infringements	Processes are in place for addressing any issues arising from identification of non-compliance by drivers including Driver Infringement Training, refresher training and independent driver assessments which are tailored to reflect issue arising. Processes include use of Corporate HR policies related to performance management and disciplinary process were deemed appropriate	Ongoing (pre July 2018)
Incident Reporting	Review of Incident Reporting process and lessons learnt.	October 2020
Corporate Driving Incident Group	Establishment of corporate Driving Incident Group which includes representation from the Council's Corporate Health and Safety Team to work proactively to put measures and interventions in place that support continual improvement and reactively discuss incidents arising to ensure a consistent approach.	March 2021
Corporate Driver Behaviour Group	Establishment of corporate Driver Behaviour Group to work proactively to develop measures and interventions to identify and support continual improvement with representation from corporate services including Human Resources, Health and Safety and Learning and Development teams.	October 2020
Driver Communications	Ongoing communications regarding vehicle and general Health and Safety matters through: ○ the On the Job staff newsletter features updates and reminders regarding all aspects of driving. ○ Good to Go ○ Tool box talks – driving related issues are discussed at the regular service took box talks with operational teams.	Ongoing On the Job launched March 2019 Good to Go launched October 2019 Ongoing (pre July 2018)

2.2 Vehicles

Activity	Description	When introduced / reviewed / updated
Daily Defect Checks	NIL return daily defect check process in place to first daily use of vehicle by a driver.	Ongoing (pre July 2018)
Preventative Maintenance Inspections	Preventative Maintenance Inspections (PMI) undertaken with frequency determined by vehicle / plant type and usage and, where appropriate, age / condition.	Ongoing (pre July 2018) Reviewed on an ongoing basis.
Standard Inspection Templates	Standard Freight Transport Association (Logistics UK) PMI templates used for the inspections with bespoke supplementary sheets for specialist vehicles / plant where appropriate	Ongoing (pre July 2018) Reviewed June 2019
Vehicle / plant release sign off	Documentation related to maintenance activities are signed and dated by the technician undertaking the work in addition to the Fleet Works Leader prior to release of vehicle / plant back into service.	Ongoing (pre July 2018) Reviewed June 2019
Lessons Learnt	Lessons learnt process in place in respect of any MOT / Annual Test failures which may arise across the Fleet. Driver reportable defects are identified as part of Preventative Maintenance inspections (PMI's) and these are recorded and reported to the Fleet Manager.	Ongoing (pre July 2018)
Maintenance Document Audits	Monthly audits of a vehicle related documentation including random sample of vehicle / plant Fleet Maintenance files are undertaken as well as checks of MOT/Annual Test and Tax Status. Audits are reviewed by the Fleet Manager who identifies and progresses any actions in relation to any issues identified. Fleet Management undertake monthly OCRS score checks and reviews	November 2019

Roller Break Tests	In addition to O Licence vehicles all Fleet HGVs (where vehicle / plant allows this testing) are subject to Roller Break testing at all 6 weekly PMIs which exceeds the requirement of 4 meaningful tests a year for O Licence vehicles.	Roller break testing for O Licence vehicles ongoing (pre July 2018) Frequency reviewed and increased as well as extension of roller break testing to non O Licence HGVs December 2019.
FTA (now logistics UK) Audits	FTA Vehicle Maintenance Systems Compliance Audits were undertaken at both Transport Maintenance Units operated by the Authority. These found operations and systems to be satisfactory and no recommendations were made.	March 2020
ISO Accreditation	Fleet management is working towards ISO Accreditation in relation its systems and processes.	Ongoing