Millmans Coaches Ltd trading as Grey Cars & Paul Mark Hamlyn White
[2023] UKUT 264 (AAC)

IN THE UPPER TRIBUNAL **Appeal No. UA-2023-000340-T**
ADMINISTRATIVE APPEALS CHAMBER

On appeal from the Decision of Kevin Rooney, Traffic Commissioner for the West of England dated 2nd March 2023

Millmans Coaches Limited trading as Grey Cars
Paul Mark Hamlyn-White

Appellants

Tribunal Judge Her Honour Judge Beech
Specialist Member of the Upper Tribunal Stuart James
Specialist Member of the Upper Tribunal Dr Phebe Mann

Hearing date: 10th October 2023
UA-2023-000340-T
Representation:
Appellant: Appellants indicated that they would not be attending the hearing.

DECISION

The appeals are DISMISSED

Subject Matter: Maintenance failings resulting in revocation; proportionality of decision; Good repute.

Cases referred to: 2002/217 Bryan Haulage (No.2); 2009/225 Priority Freight Bradley Fold Travel & Peter Wright v Secretary of State for Transport (2010) EWCA Civ.695.

REASONS FOR DECISION

1. This is an appeal from the decision of the Traffic Commissioner for the West of England ("the TC") made on 2nd March 2023 when he revoked the PSV operator's licence of the First Appellant ("the company") under s.17 of the Public Passenger Vehicles Act 1981 ("the 1981 Act") and found that the Second Appellant ("PHW") had lost his good repute as a transport manager and disqualified him from acting as such for one year from 31st March 2023 and until he had sat and passed the transport manager certificate of professional competence qualification.

The Background

2. The background relevant to the appeal can be found in the appeal bundle, the transcript of the hearing, the written decision of the TC and is as follows. The company was granted a standard international PSV licence in August 2002. The licence authorisation was for twenty vehicles with 17 vehicles in possession. There were two directors of the company: Duncan Millman (who played little if any part in the operation of the company) and Diane Millman. The transport manager was PHW. A previous licence held by the company had been revoked in 2002. The company had the benefit of various school transport contracts and provided private hire transport, also for schools.

3. The TC noted in his decision that the company's vehicles had incurred multiple prohibitions over recent years and that it had been called to a preliminary hearing in April 2021 due to an adverse maintenance investigation in January 2021. The TC accepted at that stage that significant improvements had taken place since the investigation and noted that drastic fluctuations in the operator's business brought about by Covid restrictions had made management more challenging. A new management structure was in place and there was evidence of effective systems. He issued a formal warning to the company and recorded the following undertaking:

   "A roller brake test will be undertaken in relation to at least every other preventative maintenance inspection".

4. There followed a number of prohibitions (PG9s):

   - 26.2.21 - DA52 received an immediate PG9 at its annual MOT test for a bolt missing on axle 2 nearside with obvious signs of movement
   - 14.9.21 – YN53 received an immediate PG9 for an empty brake fluid reservoir
   - 1.11.21 – GN5 received an immediate PG9 for having a steer axle tyre fitted which was more than 10 years old. The explanation was that this was fitted by mistake by a fitter
   - 23.2.22 – DA52 received an immediate PG9 at its annual MOT test for a positive hydraulic leak of brake fluid even without the brake applied.

The vehicle also failed on brake systems and components, headlamp aim, chassis condition, exhaust emissions and the exhaust system.

The Appellant had failed to undertake any Investigations into the three immediate PG9's issued at annual test.

5. On 4th August 2022, Vehicle Examiner ("VE") Williams undertook an unannounced maintenance investigation which was marked as "unsatisfactory" for the following reasons:

- The MOT final pass rate was 50% against a national average of 91%. A list of 26 annual test failures was included in the report.
- The prohibition rate on roadside encounters between 12.1.21 to 4.8.22 was 50% compared to the national average of 20%.
- Three vehicles were inspected during the fleet inspection and two were issued with immediate PG9s:
  WX03 – was fitted with a tyre that was cut and split and its cords exposed. The last PMI sheet in the vehicle file was dated 23.3.22. It was due a preventative maintenance inspection ("PMI") on 2.8.22 and should have been VOR'd. It was not.
  YJ53 – received an immediate PG9 and 4 delayed PG9s for door sensitive edge not working; axle 2 brake actuator lock nut loose; two seat belt buckles inoperable; contamination of seat. The last completed PMI sheet was dated 14.3.22.
- Five vehicle files were taken away for inspection. Four were missing PMI sheets since March 2022. The explanation given by PHW for the missing PMI sheets was that he had been too busy to complete them. He emailed the completed sheets to the VE that afternoon.
- 28% of PMIs were found to be overdue with no corresponding VOR.
- 21% of the brake tests were not performed at the same time as the PMIs.
- The company was in breach of its undertaking with regard to brake testing. Decelerometer tests had been carried out instead of roller brake tests ("RBTs") or brake tests had been missed entirely. The company's decelerometer was not working correctly and report print outs could not be downloaded.
- PMI sheets were not signed by the person inspecting the vehicle 27 times and on a few occasions, the wrong mileage had been inserted.
- The forward planner was missing one vehicle and PMIs had not been marked as completed since week 24.
- Whilst there was a VOR system, it was not being used.
- There was no PSV 112 reporting policy/procedure. On 12.7.22 MIL was involved in a fuel spillage on a road as a result of a fuel tank strap failing. 100m of road surface on the B3193 had to be resurfaced due to heavy fuel contamination.
- A driver defect reporting system was in place although the defects resulting in delayed prohibitions on YJ53 had not been reported.

6. The VE noted that the shortcomings he had identified were similar to those identified in 2021 and which had led to the TC calling the company to the preliminary hearing in April 2021. He concluded that the failings demonstrated a lack of overall effective control with major failings identified. The continued shortcomings showed that there had been little attempt by the company to comply with necessary guidance and the required systems and policies. The repeated shortcomings should have been identified by the company and its transport manager and they should have been rectified.

7. The joint response of Mrs Millman and PHW to VE Williams' report was as follows:

- Six older vehicles had been replaced with five newer ones (between 14 and 24 years of age) at a cost of £75,000.
- Despite the absence of PMI sheets, the work was being carried out and notes kept. Brake tests were normally undertaken using a decelerometer with RBTs taking place every other month. The rolling road had been out of commission for approximately three weeks. RBTs would now be undertaken on each PMI.
- Additional staff had been taken on in the workshop. Martin Janes was employed as a fulltime engineer although his background was not with PSVs and Alex Hamilton had been taken on to assist with the workshop administration and in the workshop. These were in addition to Harry Millman, Kevin Northam and PHW.
- A PMI would take place every time a vehicle was brought into the workshop.
- The absence of a vehicle from the forward planner was as a result of the purchase of a new vehicle in July.
- The company did have a robust VOR system. The maintenance investigation took place in August when the operation was effectively closed. There was no work in the diary and only one member of the workshop team was working. Keys to the three vehicles examined were kept in a locked VOR box. All VOR vehicles would now have a VOR sign placed in the windscreen and will be marked "VOR" on the fleet list.
- It would appear from the poor annual test fail history that Mr Sheppard, the fitter employed between November 2020 and November 2021 was not performing his duties in the correct manner. It was also apparent that the age of the fleet had an impact on his ability and inclination to maintain it. PHW had reverted to preparing vehicles for their annual tests.
- There was always an investigation when a vehicle failed its annual test and each failure discussed in depth. Mrs Millman had verbally reprimanded Mr Sheppard on three occasions. In future, investigations would be distilled into a written report.
- If defects are identified at PMI which should have been picked up during the driver walkaround check, the driver will be disciplined.

- Old tyres are no longer stored in the workshop but are kept behind the workshop ready for removal from site.
- The company's PG9 encounter percentage had improved to 40% since PHW had taken over personal responsibility for PMIs.
- Irtec training had been booked but had been cancelled due to COVID. It was hoped that this would be completed by two workshop members of staff.
- It had been a tumultuous time with the company having to deal with COVID added to the effect of losing Bruce Millman, Mrs Millman's husband who had sadly died and who was the driving force behind the company. With a better resourced workshop, a full set of contracts and updated fleet, the company would be compliant and excel in its business.

8. In the period allowed for the company and PHW to respond to the investigation report, two of the company's vehicles received further immediate PG9s:

    - 29.9.22 – YN53 – for a road spring, main leaf fractured, offside front axle 2, front spring eye broken.
    - 23.10.22 - WX03 for an insecure rear bumper which was broken and likely to become detached and was protruding and likely to cause injury. A delayed PG9 was also issued for a fuel leakage from the rear engine.

9. VE Williams' response to the above was unfavourable. He was unimpressed with the company's poor performance despite the previous unsatisfactory maintenance investigation with repeated shortcomings identified in August 2022. He considered that there had been little attempt by the company to comply with the necessary guidance and required systems and policies. The shortcomings should have been identified and rectified by the company and by PHW. Whilst the assurances and new policies/systems supplied by the company showed a willingness to improve, the seriousness of the issues found by him in August 2022, within two years of a previous maintenance investigation which also revealed serious issues caused the VE to conclude that the company was not doing enough to meet the necessary requirements.

<u>The public inquiry</u>

10. The public inquiry took place on 15th February 2023. Mrs Millman and PHW attended and were represented by Andrew Banks, solicitor of Stone King. Witness statements and a bundle of documents were submitted in the lead up to the hearing. Finances were dealt with as a preliminary issue and it was agreed that the company's vehicle authority should be reduced to seventeen. The evidence was summarised by the TC in this way:

    "*9. Mrs Millman adopted her statement. She told me that she had been in the business since 1991 but more in an administrative capacity. It was only after her husband's death* (May 2020) *that she took a wider role. She was attending an operator licence training course the following week. She*

had realised that her experience on the operational side was not as good as it could be. The easier option might have been to close the business in 2020 but she felt an obligation towards her staff and towards Devon Council. There was a real shortfall of providers in the area.

11. The company had issues with attracting and retaining skilled technical staff. One technician, Paul Marshall, had left in April 2022. PHW took on the inspections. With hindsight, juggling the engineering and operations roles was too much and she should have brought in another transport manager. They should have considered outsourcing the maintenance. They now had Alex Hamilton, a driver, assisting with inspection and the paperwork. They had invested in new vehicles. PHW had completed the Irtec course the previous day.

12. Technician Martin Janes had a light vehicle background. He had worked for a local grounds maintenance company looking after vans and pick-ups. I asked about the replacement vehicles and Mrs Millman accepted that they were still relatively old, ranging from 1999 to 2009.

13. PHW told me that he had been a driver. He had worked alongside Mr Millman in the workshop. He attended a three day basic inspection course in 2015 and refreshed it over the previous days. He hadn't been able to get the bookings for the roller brake testing. They had now moved to Adams Morey. Taking on the maintenance himself was "foolish" and "unwise". That would not happen again.

14. I asked about the prohibitions incurred at annual test. The missing U-bolt on DA52 .. in February 2021 had been fine when it was inspected and must have sheared on the way to test. His technician, Mr Shepherd had provided that explanation. PHW thought that it may have been loose.

15. The old tyre on the steer axled of GN05 had been the technician's error using the spare wheel from the back of the vehicle following a puncture without checking whether it was fit for service, symptomatic of Kevin Shepherd's falling standards. When Mrs Millman challenged him, he resigned on the spot. Mr Hamlyn-White told me that they now recorded tyre age during an inspection. It had always been the way that only new tyres were used on front wheels.

16. DA52 .. had been prepared to MOT in 2022 by Paul Marshall. (His) *background had been working for the RAC. He had been booked on an Irtec course in February 2022 but it had been cancelled as other course members have Covid. It had not been rebooked. … I was told that Mr Marshall had been insistent that he knew what he was doing. Following the failure, the vehicle had been scrapped. ..*

17. I asked then about the fleet inspection. A tyre on WX03 .. had been prohibited for splits in the tread with cords exposed caused by having been recut too deep. That again was Mr Marshall's fault. The policy was not recut minibus tyres. He had recut it without PHW's knowledge.

18. YJ53 had not been used since the end of the school term. They were aware that there were some seatbelt faults. It would have been inspected

and put right before the start of the new term. I suggested that the vehicle was likely to have been in service with broken seatbelts. PHW said that was not the case. They had been damaged on the vehicle's very last journey of the term along with other damage to the window surround and the carpet.

16. YN53 had been prohibited on 29 September 2022 because of a piece broken from the ring-eye end of the spring. The vehicle was used in a very rough route across Dartmoor.

17. The driver of WX03 hit a wall on the morning of 13 October 2022 just before DVSA inspected the vehicle at a school and prohibited it for an exterior body panel likely to cause injury and for a fuel leak, which PHW described as seepage from an injector pipe that was a quarter turn loose.

18. On 28 October 2022, Kevin Northam prepared VU06 for MOT. It was prohibited for a positive hydraulic leak. PHW told me that was seepage from a banjo bolt at the back of a calliper which he believed was caused by the rubber brake pipe flexing as the chassis moved causing wear. It was a tiny amount of brake fluid and PHW had not himself prepared the vehicle.

19. I asked about an incident referred to by the Examiner of a serious leakage of diesel causing the council to need to re-surface 100m of road. I was told that one of three fuel tanks had been removed from a Volvo coach. Then something in the road struck one of the remaining fuel tanks causing it to twist to the extent that diesel was pouring out of the filler neck which had been dislodged. The incident had not been notified to DVSA so they had not inspected the vehicle.

20. I challenged PHW on the appropriateness of him undertaking the "head of engineering" role when his qualification was a three-day course. I asked him about some of the investigations he had undertaken on front-axle brake imbalance. He told me that he had been told to investigate anything more than 30%. I pointed out that, on almost all occasions, both front wheels had locked so there was nothing anyone could do to get more effort out of a brake; the limiting factor was the friction between tyre and roller. PHW simply did not understand the basic physics".

11. In his closing submissions, Mr Banks accepted that in August 2022, the company had been in a state of flux. It had been naïve and a poor decision for PHW to undertake the maintenance. There were the options of employing another transport manager or sub-contracting the maintenance work. There had been training (the failure of Mr Janes to attend the Irtec course leading up to the hearing was understandable in the circumstances). There would be further training including on how to read a brake test printout. The newer vehicles were still of a considerable age. The company was prepared to install its own RBT and had produced the quote and related paperwork. The systems were now much better and the company had good intentions. Mr Banks submitted that the TC could trust the company to be compliant in the future. It had proved impossible to get an expert in PSV engineering and an undertaking was offered to invest further in training and recruitment. The company had been in business for 110 years. It had a number of employees

and PHW had accepted that the failings had arisen on his watch. Revocation would close the business and have an adverse impact on the local community. A suspension would be survivable if at a weekend or over Easter. A curtailment to sixteen would be survivable. The TC observed that it would appear that he was being told that any meaningful regulatory action would end the business and so he could not distinguish the impact of a curtailment affecting the operational fleet to some extent and revocation. The TC rose in order to give Mr Banks some time to take instructions and upon his return, the TC was informed that:

"In terms of the reduction in the authorisation and in terms of viability, Mrs Millman has reiterated to me that she indicated to you which was 16 vehicles is about what they need to be operating in order to make this a viable concern. If you'll recall at the outset, the initial voluntary surrender was for three licences, so if there's an additional licence on top of there, there'd be no margin whatever as a consequence of that, no expansion .."

Mr Banks offered an undertaking on behalf of the company that a suitably qualified external supervisor would attend once a week to oversee maintenance.

The TC's decision

12. The TC reminded himself of the 50% prohibition rate at the roadside between January 2021 and August 2022 and that since the fleet check performed in August 2022, further roadside encounters had resulted in two further immediate prohibitions being issued. Not one vehicle had been clear of defects. He recited some of the serious defects found. The MOT history was "*worst still".* He again recited some of the defects found. Since March 2021, only four vehicles out of twenty-two presentations had clear passes. The TC had no difficulty in finding that s.17(3)(aa)(i) of the 1981 Act (the undertaking to keep vehicles fit and serviceable) had been made out.

13. As for the remaining undertakings set out in s.17(3)(aa), the TC had no hesitation in finding that there had been breaches of the undertakings to keep records for 15 months and for an effective driver defect reporting system. The TC found that PHW had been too busy to fill out the PMI sheets between March and August 2022 and there were a number of the issues identified which should have been obvious to the drivers. The finding by VE Williams that 28% of the PMIs undertaken were overdue meant that the requirements of s.17(3)(a) of the 1981 Act (the statement that vehicles would be inspected at four weekly intervals) was also made out.

14. Turning to the good repute of both the operator and the transport manager (which the TC described as linked), he determined:

" *38. .. The root cause of the appalling state of this fleet I find to be gross incompetence within the workshop. I was told that the problem was retaining suitably skilled technicians. That may well be true. There can be few competent technicians who would want the challenge of maintaining such an elderly fleet and being associated with the MOT and roadside performance of it.*

39. Mr Hamlyn-White decided to take on the mantle. His qualifications? A driving licence, a three-day basic inspection course and some time helping the former director in the workshop. That he on numerous occasions dismantled a braking system and replaced seemingly perfectly good parts to try to get more brake efficiency out of a brake that has already locked would be funny if it was not so serious. Brake chambers have been changed on the brake with the higher reading, a compressor pipe is changed to try to improve brake effort, slack adjusters are changed on wheels that have locked. What a waste of time and money. He simply has no underlying mechanical knowledge nor an ability to apply simple GCSE physics. It is the equivalent to attending a three-day first aid course and then seeking to practice as a qualified nurse. It is reckless in the extreme and the outcome is clear to see.

40. His lack of understanding is further illustrated by his explanation of the immediate prohibition issued to WX03 .. for a defective tyre, having been recut too deep and exposing the cords. He told me that he had previously inspected that tyre in its recut state and the defect wasn't there; it had only been exposed by further wear. The point is that the tyre had been recut in that the grooves had been made deeper, exposing the cords at the base of the groove. The defect will have been present when Mr Hamlyn-White inspected it. He had clearly failed to identify it. More importantly, as transport manager, he simply did not understand what the defect was and how it had been caused."

15. The TC then considered the diesel spillage on 12th July 2022 which he described as a serious incident and which caused a major road to be closed and 100 metres of roadway to be resurfaced. The TC determined that the incident was one which should have been reported to the DVSA under s.20 of the 1981 Act. The section reads:

"(1) It shall be the duty of the holder of a PSV operator's licence, on the happening to any public service vehicle owned by him of any failure or damage of a nature calculated to affect the safety of the occupants of the public service vehicle or to persons using the road, to report the matter as soon as is practicable to the Secretary of State.

As a result of the failure of the company to report the incident to the DVSA, the TC found that the purpose of the legislation had been frustrated. The explanation now given that something on the road had caused a full fuel tank weighing between 100 and 200kgs to be dislodged was "*fanciful"* and "*terribly difficult to accept".* It seemed more likely that the spillage was caused or contributed to, by the fuel tank retaining strap being compromised. It was inevitable that the incident occurred because the tank was not properly secured. "*Poor workmanship again".*

16. The TC further determined that the recruitment of car and van mechanics to maintain a fleet of PSVs seemed to have been done in desperation. It was nonetheless a reckless act on behalf of both operator and transport manager and had led to vehicles operating in a dangerous condition.

17. The TC listed the positives: since the DVSA intervention, the inspections appeared to be broadly on time and the documentation generally sound; an

Irtec course had been attended. The technician would have attended but had very genuine reasons for not being able to do so; as at the date of the hearing, the systems were sound. The TC reminded himself of his decision at the conclusion of the preliminary hearing in April 2021 and concluded that whilst it seemed that a call to a hearing triggered compliance, five months later, one vehicle was encountered with a dry brake fluid reservoir and another failed its MOT for service brake operation, amongst other items. The improvement brought about by the DVSA and TC interventions seemed to be short lived. The TC continued:

"*It is unfortunate that Mrs Millman, even after I rose to allow her to take advice from her solicitor, insisted that any authorisation less than sixteen would make the business unviable. By reference to the Senior Traffic Commissioner's Statutory Document No 10, due in large part to the reckless decision allowing Mr Hamlyn-White to be "fleet engineer" for an ageing 16-vehicle fleet. I find this to be a case in the "severe" category. It requires that I take action that impacts on the operation. I may have been swayed to allow a small, that is, single-figure, authorisation to continue but Mrs Millman's position is that any incursion in to the sixteen vehicles is fatal to the business..".*

18. The TC concluded that the historical evidence suggested that he could not trust the company to be compliant in the future (the Priority Freight question). The deficit of competence of those in control, particularly the transport manager suggested that he could not. The evidence since August 2022 suggested that he could not. Good intentions were not enough to run a safe and compliant PSV operation.

19. The TC asked himself whether it was so bad that he needed to put the operator out of business (the Bryan Haulage question). He concluded that he could not allow a sixteen-vehicle operation to continue. The risk was simply too great. Every other vehicle inspected by the DVSA whilst in service was so dangerous that an immediate prohibition has been issued. Whilst the processes and paperwork had been bolstered since the VE's intervention, little had changed in on-road performance. "*How could it, when the person in charge of the fleet has no relevant qualification and demonstrated in the hearing a lack of even the most basic understanding of vehicle systems and the physics that lies behind them. This is an operation that, for the safety of school children in south Devon and other road users must be brought to an end. The good repute of the operator is lost".*

    (Revocation is mandatory under s.17(1(a) in those circumstances).

20. As for PHW, he had "*a high opinion of his own competence"* which was misplaced. The TC found him to be "*grossly incompetent within the workshop and grossly incompetent as transport manager in allowing those workshop arrangements to continue. His good repute is lost".* He was disqualified as a transport manager for one year and until he re-sat and passed the transport manager certificate of professional competence.

The appeal

21. By way of an Appellant's Notice filed on 23rd March 2022, the company and PHW appealed. Section 7 of the Notice, contained four identifiable grounds of appeal:

    (i) The TC should have answered the Bryan Haulage and Priority Freight questions differently. In making the concession that a single figure authorisation could have been allowed, the TC was conceding that the answers should have been that the operator could be trusted and should not be put of business albeit with a reduced fleet authorisation. He should by implication, have reduced the authorisation to the "single figure" and then allowed the company to decide if the number was commercially viable.

    (ii) In giving Mrs Millman the opportunity to consider the minimum authorisation that could be commercially viable, the TC put the company on the spot. What he should have done was to indicate a number that he had in mind allowing the company to respond to it.

    (iii) PHW was judged on his ability as an engineer rather than his competence as a transport manager. He had been responsible for the improvement in the systems acknowledged by the TC. Moreover, PHW's acceptance of previous poor performance indicated that he had competence as a transport manager.

    (iv) Insufficient weight was attached to the significant improvements to the systems that PHW had put in place prior to being called into the public inquiry. The TC had failed to properly apply the principles set out in the Senior Traffic Commissioner's Statutory Document No.10: the Principles of Decision-Making and the Concept of Proportionality and, in particular, Annex 3 (the Tribunal observes that there is no Annex 3 to the Statutory Document. It is unclear as to which of the Annexes A to F of the Document this refers to).

Discussion

22. The starting point is that this is a very serious case and it is of note that the TC's underlying findings about significant maintenance failings and the reckless decision making of the company and the transport manager are not challenged by either the company or PHW. The TC's conclusion that the case fell within the "severe" category of Annex C of Statutory Document 10 by reason of his findings that the reckless acts of the company and PHW had compromised road safety is not open to challenge and has not been. Having made that assessment, the TC was obliged to consider each of the suggested starting points for that category within Annex C which are: revocation and disqualification; suspension for an extended period of time that would materially affect the transport operation; a significant indefinite curtailment that materially affected the transport operation. It was clear and obvious to him from Mrs Millman's evidence that neither a lengthy suspension nor a significant curtailment were options available to him even if he deemed either to be potentially appropriate in the circumstances of the case. The use of the word *"may*" in paragraph 49 is of significance in that regard.

23. The call up letter addressed to the company set out in clear terms the powers that the TC had available to him in the event of adverse findings (which were not only inevitable but obviously so). The company and PHW should have appreciated that severe regulatory action was inevitable. Moreover, the company was represented by an experienced solicitor in road transport regulation. Even if there was any doubt in the minds of the company and PHW at the outset, that doubt would have been dispelled once the DVSA evidence had been carefully considered. The options available to the TC should therefore have been at the forefront of the minds of both Mrs Millman and PHW and Mrs Millman should have been in a position to answer the questions posed by the TC in the event that the TC found that good repute was retained and that the company could be trusted in the future and ought not be put out of business. The suggestion that the TC put Mrs Millman "*on the spot"* by asking her about curtailment is misconceived. The TC was required to ask the questions (otherwise there might be a suggestion that the TC had not considered all options) and the questioning along with the time given for her to consult Mr Banks was perfectly proper and reasonable. Moreover, the suggestion that the TC should have chosen a proposed level of vehicle reduction for the company to consider is also misconceived. If the company had considered that a substantial curtailment was survivable, then Mrs Millman should have said so. Indeed, the lack of any evidence of proactivity in the lead up to the hearing was startling. An operator that wished to demonstrate future compliance would have put together a suite of actions and systems to put before the TC. Instead, it was proposed that PHW who lacked the necessary qualifications and competence to be in charge of a workshop should remain so and another, unidentified transport manager should have been nominated in his place. It is not surprising in the circumstances, that the TC found that PHW was incompetent as an engineer and lacked competence as a transport manager. We are satisfied that no competent transport manager would have made the decisions that PHW had made.

24. But in any event, the complaints made about the TC's approach to regulatory action presupposes that the Priority Freight and Bryan Haulage questions were going to be answered or should have been answered in favour of the company. The Tribunal is satisfied that it was not plainly wrong for the TC to make the findings that he did. His findings that both the company and PHW had lost their good repute were proportionate and based upon the significant evidence of recklessness that was before the TC. The TC took the positive features into account, including the improvements in the systems but rightly found that those improvements had not resulted in safer vehicles being operated. Against the background of a previous DVSA investigation and a call up letter to a preliminary hearing which had resulted in only short-term improvements in the company's systems at that stage, he was plainly right to conclude that he could not trust the company to be compliant in the future. Revocation was inevitable. As is clear from the TC's decision on the company's application for a stay, he was "*firmly of the view that this operation presents a clear and present danger to the public".* This Tribunal agrees. The

company is fortunate that a serious accident had not taken place involving one of its dangerous vehicles.

25. In all the circumstances we are not satisfied that the TC's decisions were plainly wrong in any respect and neither the facts nor the law applicable in this case should impel the Tribunal to allow this appeal as per the test in *Bradley Fold Travel & Peter Wright v Secretary of State for Transport (2010) EWCA Civ.695.* The appeal is dismissed.

Her Honour Judge Beech
Judge of the Upper Tribunal
31st October 2023