

Neutral Citation Number: [2021] EWHC 2733 (QB)

Case No. QB-2020-
000184

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

B e f o r e:
MASTER VICTORIA MCCLOUD

BETWEEN:

ROSELYN AIGIBO OVU
(Administratrix of the Estate of Bernard Aziengbe Ovu, Deceased)

Claimant

-and-

LONDON UNDERGROUND LIMITED

Defendant

Counsel:

For the Claimant: Mr Christopher Walker of counsel instructed by Bindmans LLP

For the Defendant: Mr Peter Freeman of counsel instructed by Kennedys.

JUDGMENT

Keywords: fatal accident – personal injury – occupiers’ liability – negligence – duty of care – trespass – railways – alcohol – intoxication – coroners – Occupiers’ Liability Acts 1957, 1984 - Coroners and Justice Act 2009

Materials cited (whether not referred to in judgment):

Authorities:

Braithwaite v South Durham Steel Co. Ltd and Another [1958] 1 WLR 986

British Railways Board v Herrington [1972] AC 877

Revill v Newbery [1996] QB 567

Ratcliff v GR McConnell & E W Jones (CA) [1997] EWCA Civ 2679

Spearman (A Protected Party) v Royal United Bath Hospitals NHS Foundation Trust [2017] EWHC 3027 (QB)

Tomlinson v Congleton BC [2003] UKHL 47 at 26-27

Keown v Coventry NHS Trust [2006] EWCA Civ 39

Ahanonu v South East London & Kent Bus Company Limited [2008] EWCA Civ 274 (CA)

Tindall v Chief Constable of Thames Valley Police & Anor. [2020] EWHC 837 (QB)

Statutes and delegated legislation:

The Occupiers’ Liability Act 1957

The Occupiers’ Liability Act 1984

Coroners and Justice Act 2009

The Coroners (Investigations) Regulations 2013

Textbooks:

Clerk and Lindsell on Torts 23rd ed ch. 11

Accessible language summary (not part of ratio of judgment)

This summary has a Flesch score of above 50 and was written to ensure accessibility of the judgment to readers with average reading ability.

The Claimant sued the London Underground company because their relative Mr Ovu died after falling down stairs on a fire escape. It was late at night and he wandered on his own on a cold night, outdoors, onto the stairs. The staircase was in good condition. The Coroner had made recommendations about improving how the London Underground procedures worked when a person had walked onto the fire escape stairs and only one member of staff was working there. The judge had to decide whether the Deceased was a trespasser and whether London Underground company owed a duty to the Deceased to take steps to ensure his safety on the stairs in these circumstances. The Judge decided that the Deceased was a trespasser when he fell down stairs and died and that the London Underground company did not owe a relevant duty of care to him.

Master Victoria McCloud

1. With most things in the Law, cases have a triangular character, such that what is at once personal or private between the parties becomes, in the panopticon of the court, both a legal and a public matter. The relatively abstract nature of the law with which this case deals should not detract from the fact that at the heart of this case is the loss of a life of a young man, whose family is bereaved, after he fell to his death at a London Underground station.
2. This case relates to the law of Trespass and in part asks what the law means by ‘a trespasser’. Mr Bernard Ovu, aged 35, an IT specialist died near to the Docklands Light Railway platform of Canning Town London Underground Station on 22 January 2017 on a bitterly cold winter night after a fall and a head injury. The condition of the staircase where the Deceased fell is not alleged to have been dangerous nor is it said to have contributed to his fall. The trial took place in open court with Covid-19 protections and I think it can fairly be said that all concerned were satisfied that such was by far the preferable and most efficient mode of trial.
3. The issues to be tried go to the heart of what if any duty of care is owed by a party, here London Underground Limited, in the circumstances which I will outline here, and whether Mr Ovu was a ‘Trespasser’ at the time of his demise, and indeed what constitutes, even in principle, ‘a Trespasser’.

4. The case is an important one legally and is of interest to any common lawyer, including this judge because of its potential implications for users of the Underground, for the London Underground Railway itself and perhaps also for parties in analogous situations. I am grateful to both counsel for their exposition of the law and their helpful submissions.
5. The issues which, by my order of 15 January 2021, I directed to be tried before me were the following:
 - (a) If it is not admitted by the Claimant, was the Deceased a trespasser at the time of his death?
 - (b) Was a duty of care owed by the Defendant to the Deceased at the time of his death?; and insofar as necessary
 - (c) What was the extent of that duty of care?
6. There was a schedule of agreed facts, and a schedule of a few non-agreed facts but there was no need for me to resolve disputes of fact and no need therefore for oral witnesses.
7. The accident occurred in a non-public area of Canning Town tube station, and Mr Ovu went through some gates at the end of a platform at about 2.29am (this was a 24 hour station). He had had a rather erratic journey from Canada Water station via Stratford. His exact route or intended route, presumably towards home, is not wholly known but he lived in Kingston-on-Thames and may have therefore been in a general sense trying to travel in that direction. He had set off with a friend, and they travelled to the Rotherhithe area of East London, got into the tube station at Canada Water, where for reasons unknown the friend joined a Waterloo-bound Jubilee line train to the west but Mr Ovu became separated from him and boarded a train heading instead generally east towards Stratford. At Stratford he spent around 50 minutes wandering and went up to an unauthorised area of the station, chatted to individuals and staff and then returned to the trains and headed to Canning Town. I

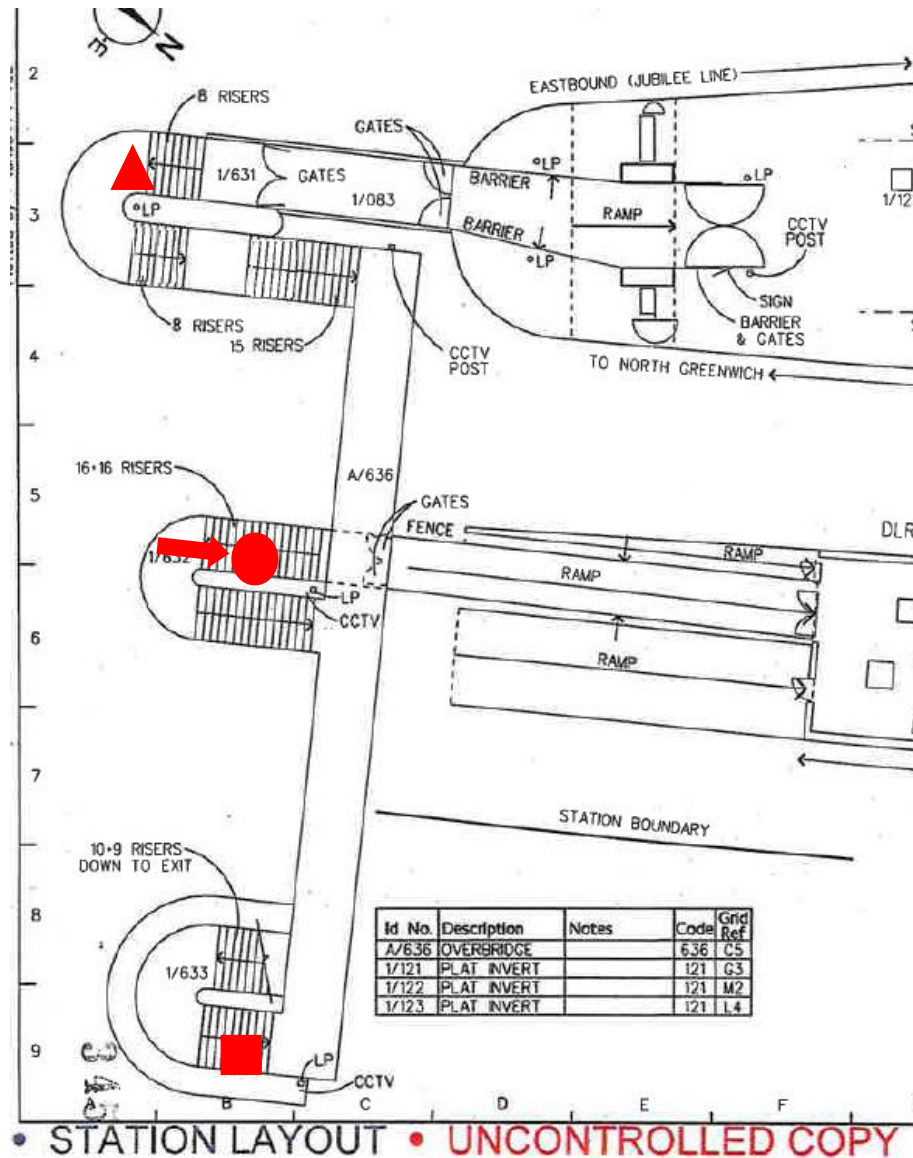
have included a map below¹ of the relevant stations. It was agreed that his behaviour was consistent with being intoxicated. A toxicology report at post mortem found significant blood alcohol (176mg/100ml) consistent with drunkenness.



8. The station plan of the relevant end of Canning Town is below. I had before me still images taken at key points during the evening from several of those cameras showing Mr Ovu in the period leading up to his death. It was not necessary for me to visit the locus. The triangle depicts the point at which Mr Ovu had passed the first substantial (one way) exit gates. The solid square depicts the final one way exit onto the street. The solid arrow and circle depict, respectively the direction of presumed

¹ Map image attribution: [Creative Commons Attribution-Share Alike 2.5 Generic, 2.0 Generic](#) and [1.0 Generic](#) license, attribution: Ed g2s (CC-BY-SA).

fall downstairs and the approximate location of the deceased when found, which was at the bottom of the stairs, with the gantry above. Those annotations are my own.



- The area upon which one focusses in this judgment is the emergency exit route from the station, which is in the form of a series of staircases leading up from the public platforms, to a raised walkway and then down to a final (outward opening) exit onto the street. To enter the emergency exit structure a passenger leaving the Jubilee line must first pass through some clearly marked emergency gates which are simple hinged barriers linked to a silent alarm back to the station control centre which on this night was staffed by just one person who was in charge of the whole station. CCTV records the location, and it appears on screen in real time, however to access

the CCTV recording so as to replay it if you are not sure, at the time of this incident it was necessary to contact British Transport Police (the station staff could not simply 'rewind' and replay it).

10. Some way beyond the hinged barrier is a much more substantial wire gate or door which is full height and opens outwards only. If a person exits through that they are then entering the staircase-and-gantry exit structure in the open air. If that is closed behind them then they cannot re-enter the station and their only viable exit route is to proceed towards a second equally substantial push-bar gate, also opening outwards-only, onto the street, which is Silvertown Way.
11. The still images from the CCTV showed Mr Ovu's route, timing, and actions in the period leading to his death. It was a freezing cold night, temperatures at times were down to -4 degrees Centigrade. He arrived at Canning town at about 01.56am and passed through the innermost barriers (from the platform heading out towards the emergency exit) at 01.59am, then shortly afterwards he passed through the second gates, entering the location shown with a solid triangle on the plan above (this was the first of the substantial, one way, gates) and headed into the exit structure. He is then seen heading up the fire exit stairs, walking across the gantry in the open air and is visible perhaps 'lurching' to one side. In the course of wandering within the exit gantry and staircases he at one point descended as far as the final, street exit gate and he is visible standing beside it at about 02.27 am. However he did not exit, as he could if he had pushed the gate, but turned around and went back up to the gantry. At times it is clear that it is a very cold night and the inquest which resulted found that there were signs of frost on Mr Ovu's clothing.
12. Back in the station control room the alarm had sounded to warn the sole member of staff (the customer services manager or "CSM") that someone had used the exit barrier. While Mr Ovu was wandering within the exit structure the member of staff went down and closed the first of the substantial exit gates, assuming Mr Ovu to have re-joined the platform, so that from that point if anyone was on the other side of it (as in fact was Mr Ovu) they would have one route out, and that was via the final emergency doors onto the street. At that point therefore Mr Ovu was left with one exit route. We have seen that Mr Ovu did in fact reach that exit gate but elected

not to use it, if indeed his state of intoxication left him really appreciating what it was at all which we cannot know.

13. It was part of the agreed facts that the emergency exit footbridge at Canning Town, although a non-public area, was known to the Defendant to be regularly used by fare-evaders and persons requiring somewhere to urinate/be sick/take drugs. Further that the Defendant's CSM presumed Mr Ovu to have "opened the gate to use the area behind as a toilet or to further vomit". It was also common ground that from 2.04 am when the CSM closed the emergency gates, Mr Ovu was unable to regain access through them to the Jubilee Line platform, though he tried to at 2.34 am (from the agreed chronology).
14. He stayed there for some time (about 11 minutes). He then went up the stairs again, part way along the gantry, commencing descent of a further set of stairs (the middle ones shown on the plan) which would lead to the Docklands Light Railway (DLR) platforms though there was a further closed gate there similar to that from the Jubilee line which would have prevented entry that way. That was the last time he was captured alive on CCTV. He appears to have fallen on the stairs at about 2.49am whilst going down towards the DLR platform and he was found deceased the following morning by a member of staff at 8.46am having suffered head injuries. He was at the foot of the stairs to the DLR platform. There were two flights and he was found at the bottom of the final set, at platform level. He was found to have died of the head injuries, though it may be that the freezing cold would not have helped.
15. There was a post mortem and an inquest. Cause of death was head injury and the verdict from the inquest was a narrative one. The Senior Coroner for East London issued a Regulation 28 Report under The Coroners (Investigations) Regulations 2013 making recommendations to London Underground. Not every inquest leads to such a report but where the Coroner feels there is concern of a risk of further deaths such can be issued (the duty arises under para 7(1) of Sch. 5 to the Coroners and Justice Act 2009²). The report says that there was a system of work in place to investigate

² Paragraph 7 of Schedule 5, Coroners and Justice Act 2009 provides coroners with the duty to make reports to a person, organisation, local authority or government department or agency where the coroner believes that action should be taken to prevent future deaths.

and resolve situations where a member of the public had gone through the exit barriers. The report recites the verdict that the processes were not followed. The member of staff did not follow the procedure which would have required him to check the exit structure beyond the barrier before he closed the (one way) gate so as to see whether there were people there. The fall, and death, were however found to be due to the state of the Claimant and cause of death was head injury.

16. The matters of concern raised in the Regulation 28 report included a lack of clarity as to the procedure to follow where a lone member of staff was in charge of a station and a passenger appeared to have passed through the exit gates, and as to the difficulty of accessing CCTV images to replay them because they were operated by the police and not the Defendant.
17. The unfortunate predicament in which the lone member of staff at Canning Town found himself was that to carry out the official process of checking the areas beyond the one-way gates, which were known to be used regularly by fare dodgers and drunk persons looking to vomit or urinate, he would have had to head out, alone, on to the exit structure in the early hours of the morning potentially to confront an unknown person or persons, and would be exposed to the risk that someone might close the gate after him leaving him with no route back save onto the street, abandoning the station for whatever time it would take for him to walk around and back into the station via the public entrance.
18. The claim is pleaded on the footing of breach of the occupier's statutory duty of care towards visitors and also in negligence at common law, and hence brings into play the statutory provisions of the Occupiers' Liability Acts, and also common law considerations. I queried whether (given the closure of the gate by the member of staff) this was a case such as that of *Tindall* in which I had given previous judgment, and another in which I am part heard at time of writing, where it was argued that acts done by a party who might not otherwise owe a duty of care comes under a duty by taking steps which 'make matters worse'. I was told that here there was indeed, as the Claimant's side saw it, a 'positive act' in the form of closing the gate, leaving Mr Ovu on the exit structure without checking for his presence (however the line of authorities cited in *Tindall* was not specifically cited to me).

Claimant's argument

Was Mr Ovu was a trespasser at the time of his death? Claimant's case.

19. It was common ground that Mr Ovu passed through the emergency gates without the consent, whether expressed or otherwise, of the Defendant, but this was not in the Claimant's submission the end of the matter in terms of whether at the time of the accident Mr Ovu was a trespasser. He had not chosen to leave the premises and his behaviour in seeking to re-enter the platform was consistent, it was said, with him having formed an intention to resume his journey towards home.

20. The closed gates had prevented him from giving effect to his intention to resume his journey and cease to be a trespasser. The law was not to the effect that the status of trespasser was merely defined by location and the absence of consent, rather Mr Ovu tried to get back in, and he thus remained in the 'restricted' area because the Defendant prevented him from leaving that area to resume his journey, and his intention was a material consideration. I was referred to *Spearman* which was a judgment by Mr Justice Martin Spencer. In that case due either to the effects of a brain injury or a hypoglycaemic attack the claimant left the treatment location and climbed several flights of stairs whilst in the Defendant's Accident and Emergency department, using an internal fire escape to get onto a flat roof, where he overcame a 1.4 metre barrier and thereafter either jumped or fell to the courtyard below sustaining serious injury. Counsel for Mr Ovu pointed out that in contradistinction to the facts of Mr Ovu's case, Mr Spearman (it seems) would in principle have been able to retrace his way into the A&E Department had he chosen to do but did not attempt to do so. The Defendant's approach to the case in *Spearman* was said to be similar to that of the Defendant here, namely that by leaving the treatment area he became a trespasser and the duty owed was solely that under the Occupier's Liability Act 1984. Yet per para. 56 of judgment it was said:

"... whether a person is or is not a trespasser is not solely to be determined by whether the place where they are is or is not an "authorised" place. A person's state of mind and intention is an important additional factor."

It was held that the Claimant had been mentally disturbed and that it was foreseeable that he was a part of a cohort of patients who might behave as he did in terms of entering areas not normally entered by patients: he had entered the off-limits area as a genuine mistake.

21. Counsel was careful to say that no part of the Claimant's argument in this case was that Mr Ovu could pray in aid his own state of intoxication (for example if through drunkenness he had mistakenly passed through the gates), but rather that (intoxicated or not) his intention was *'clearly to return to the platform, having used the restricted area for a purpose anticipated to the Defendant [ie urination or vomiting, possibly though this was not caught on camera] and he was only prevented from doing and from continuing on his journey so by the positive action of CSM Adeyeni closing the emergency gates'* (from C's skeleton).
22. Mr Ovu had evinced his intention to return to the platform by remaining beside the locked gates, unable to get back, for 11 minutes. By thus having an intention to return to the platform, Mr Ovu had ceased to be a trespasser, his state of mind being inconsistent with that and the physical location simply being a function of the fact he was prevented from returning to the platform by the actions of the Defendant's CSM. It was artificial therefore to say that he remained at all times a trespasser: location was not to be the sole determinant, per Martin Spencer J.
23. I was referred to the 1958 case of *Braithwaite* as a further illustration that the status of a trespasser is not solely due to location. In that case the Claimant was employed by South Durham Steel as a crane driver's mate and he was preceding a mobile crane along a railway line. Another line, in the ownership of the British Transport Commission (BTC), and not his employers, ran alongside and was very close by. At some point while walking he inadvertently put his foot a few inches over the sleepers, and was struck by oncoming traffic on the line when he was startled by a warning shout from the crane driver. BTC argued he was a trespasser at the moment of the accident, and that absent a reckless or deliberate act to harm him, no other duty was owed.

24. The court held that the Claimant had placed his foot onto the BTC's land and did not have permission to do so, but even so held that it was unrealistic and artificial on the facts of the case, where he was a licensee on part of the walkway and his encroachment was wholly inadvertent, to find that his involuntary encroachment onto the BTC's land made him a trespasser. Compare this with the quotation from *Herrington*, cited by the Defendant, which is quoted in the summary of the Defendant's argument below and is in apparently quite rigid terms.
25. If Mr Ovu was for 11 minutes trying to get back onto the platform and was prevented from doing so by the Defendant's own actions it would be nonsensical, the Claimant argued, to treat him as a trespasser if one applies *Spearman*, given Mr Ovu's intentions, ie his state of mind. The closure of the gate had caused Mr Ovu to go back the way he had come, onto the walkway, where later he sustained his fall. It was in those circumstances a bold argument, said the Claimant, that I should find the Deceased to have been a trespasser, and that then the sole duty owed when he died was that under the 1984 Act.

Was a duty of care owed to Mr Ovu? Claimant's case.

26. Irrespective of a finding on the Trespass issue, it was argued that in any event a duty of care was owed to him. Referring to Clerk and Lindsell 23rd ed it was said that the duties under the 1984 Act related to 'occupancy' duties, namely those arising from the state of the land, and that any duties arising from activity on the land fell to be considered under the general law of negligence. The learned authors accepted however that the wording of the Act and its reference to replacing the rules of common law, was not wholly clear, but the authors' view was that the preferable construction of the Act was to confine the ouster of common law to situations where a danger arose due to the occupancy of the land and the manner of its use, leaving claims in common law available for situations outside the ambit of occupancy duties. Occupancy, it was said by the learned authors and adopted by counsel, was a ground of liability and not a ground of exemption from liability yet this Defendant was

seeking to treat the Act in just such a way, using the wording as a species of exemption of any duty beyond that stated in the statute.

27. It was argued that the Defendant had foreseen and was well aware of situations where passengers have entered the fire escape route to urinate or vomit or for fare dodging and they had created a system of work to deal with that well known eventuality. It was the Defendant's own failure to follow that system that denied Mr Ovu the ability to re-access the Jubilee Line platform through the emergency gates without assistance and which left him on the escape structure and stairs, where eventually he fell to his sad death after trying and failing to get back onto the platform. Between 2nd June 2016 – 22nd January 2017, the emergency alarm to the barriers had been activated on 92 occasions and it was known by the Defendant that persons would often do so to go to the toilet or be sick (and not simply for the purpose of fare evasion). There were cameras and much of the footbridge area behind was on view as were the gates. When the tamper alarm on the emergency gates was triggered, a silent alarm was signalled on the Station Management Information System in the station control room and camera feeds were automatically selected on one of the monitors in the station control room.

28. The Defendant was plainly therefore both aware that customers often used the exit barriers and had put in place management and systems for dealing with that safely, demonstrating that the Defendant was aware that it had a responsibility to customers doing so and had planned ahead so as to manage that situation. What had happened was a failure to follow that system and in the result Mr Ovu died. Thus it was said that the Defendant's rule book on station management stated that, if a door were found to be open during a station security check, the area inside should be thoroughly searched before the door was locked and the Station Security Programme stated that where a door to a secure area is found open, a sweep should be made of the area before the door is closed and secured. The Defendant's own internal investigation report into Mr Ovu's death found that no sweep was performed by the CSM before securing the door.

29. The system of work which would have ensured his safety and ability to return to the platform was not followed and the significance of that was emphasised in the Coroner's Regulation 28 report. This was inconsistent with there being an absence of duty of care to the Deceased, including at common law.

Statutory duties of occupiers under the Occupiers' Liability Acts of 1957 and 1984

30. At the centre of the Claimant's case was the basic argument that the Defendant owed a duty of care to Mr Ovu as its passenger and that that applied at common law, so that this is not 'just' a statutory Occupier's Liability Act case. To that end it was stressed that the duty alleged arose not from so-called 'occupancy' duties under the Acts but rather because at all material times he was a member of the public using the Defendant's transport services, something which did not come to an end merely because he was in a restricted area of the station at the time of his death.

31. In particular under the 1957 Act s1(1) a duty was owed to: "visitors in respect of dangers due to the state of the premises or to things done or omitted to be done [on the premises]" and section 1(1) of The Occupiers' Liability Act 1984 was almost identical in the case of trespassers. These concerned the safety of the premises and dangers due to things done or omitted to be done on the premises, but activities or omissions on the premises not in themselves affecting the safety of the premises were not within the scope of the Acts. The Defendant's position (which will be considered below) was said to be framed notably in relation to rebutting a case under the Acts and not, at least prominently, to rebutting the Claimant's primary case which was framed in negligence at common law.

32. I was referred to *Revill*, where a trespasser was shot through the door of a shed by the owner who had been alerted to his presence and discharged a gun, not specifically intending to hit the Claimant. In the judgment of Neil LJ, the relevance of the Section 1(4) of the 1984 Act did not preclude but simply defined the extent of the common law duty of care to trespassers arising from "activities on the land" namely the statutory duty "take such care as is reasonable in all the circumstances of the case to see that he [the trespasser] does not suffer injury on the premises by reason of the danger concerned."

33. Here, and looking at Mr Ovu's situation relative to the *Revill* facts, where a duty was found to exist, the Defendant had gone to the lengths of having in place a system of work to deal with people passing into the restricted area, as they appear to do regularly, and it had positively assumed responsibility in this instance by intervening to close the gates, not following the policy of checking for the presence of possibly intoxicated people before doing so, and thereby unknowingly prevent Mr Ovu from getting back to the platform.

34. Counsel argued that in *Spearman* the Court had been critical of any attempt to narrow common law duties by reference to "occupancy" duties within the restricted meaning of the 1957 Act (para. 61 of judgment). Here the Defendant was (wrongly) denying a duty of care towards the management of individuals on the exit system after using the exit doors. This approach was said to be inconsistent with the approach taken in both *Revill* and *Spearman*.

Extent of duty. Claimant's case.

35. The Claimant's position was that the Defendant owed a duty to devise and implement suitable and sufficient control measures to reduce the risk of an accident or injury to members of the public using that transport system, of which Mr Ovu on the Claimant's analysis was one such at the time of his death. In the alternative (giving effect to the common duty under s.2(2) of the 1957 Act towards visitors) the Defendant owed an "activity" duty to act so as to ensure that Mr Ovu was reasonably safe in using the station [and, in securing the emergency gates in the circumstances pleaded, it breached that duty] (this is described by the Claimant as a framing of the applicable duty in a form derived from the statutory wording of Occupier's duties under the 1957 Act). And in the further alternative, by a different framing making use of the words of the 1984 Act s.1(4), the Claimant would describe the common law duty (in so far as it is found that Mr Ovu was a trespasser), to be a duty to act so as to ensure that the Deceased "was reasonably safe from danger using the station" and that in securing the emergency gates in the circumstances pleaded, it breached that duty. (I am treating this framing as intending to echo the

statutory words which would strictly be that the duty “is to take such care as is reasonable in all the circumstances of the case to see that he does not suffer injury on the premises by reason of the danger concerned” [and that in securing the emergency gates in the circumstances pleaded, it breached that duty].

Defendant’s argument

Was the Claimant a Trespasser? Defendant’s case.

36. The Defendant’s submission was that Mr Ovu was a trespasser at the time of his death. He had passed through alarmed emergency gates, and it was not in dispute that that was not a place where the public had permission to be (other than one takes it in an emergency, which this was not). It was admitted in the Reply that when he went through the gates he did so without consent, express or implied, from the Defendant. It was a simple case, therefore, of trespass from that point on.

37. I was referred to *Herrington*, per Lord Morris:

“The term ‘trespasser’ is a comprehensive word: it covers the wicked and the innocent: the burglar, the arrogant invader of another’s land, the walker blithely unaware that he is stepping where he has no right to walk, or the wandering child – all may be dubbed as trespassers.”

Mr Ovu was on that definition a trespasser, argued the Defendant. His state of mind could not change that, even if he had passed through the emergency barriers by mistake or even if (as is also pleaded) he passed through them deliberately but had an intention to return to the platform when passing through them (or later, at the time he tried and failed to return to the platform).

38. The difficulty which would be caused by a subjective approach to trespass which takes into account the mind of the trespasser was said to be illustrated by the statement of the Defendant’s HSE Senior Manager in a railway context. [p. 62, paras. 10-19] to the effect that almost every trespasser could say that they were not trespassers because they had some intention to return to the platform and that could not sensibly be said to cause them to cease to be a trespasser as soon as they formed the relevant mental intention.

39. *Spearman* was to be distinguished: Mr Spearman was a ‘vulnerable patient’, hyperglycaemic, confused, mentally unstable with a phobia of hospitals who was in the defendant’s hospital for treatment and supervision by them. Martin Spencer J. found him to be a patient and a lawful visitor whereas in this instance it was said Mr Ovu was neither a lawful visitor once he was on the escape system, nor (obviously) a patient. (Though note that the Claimant argues that Mr Ovu remained a *passenger* trying to head home even once he had exited the platform (intending to return), rather than a patient, and as noted, also argues that he was not a trespasser, being someone who had formed the intention to re-join the platform).

Was a duty of care owed to the Deceased? Defendant’s argument.

40. The Claimant was not a lawful visitor said the Defendant, and it therefore did not owe to the Deceased the common duty of care, pursuant to the 1957 Act.

41. The only duty of care that could theoretically be owed by the Defendant to this Deceased as a trespasser would, said the Defendant, be pursuant to the 1984 Act namely:

“1.-(1) The rules enacted by this section shall have effect, in place of the rules of the common law, to determine –

(a) Whether any duty is owed by a person as occupier of premises other than his visitors in respect of their suffering injury on the premises by reason of any danger due to the state of the premises or to things done or omitted to be done on them; and

(b) If so, what that duty is.

(2) N/A

(3) An occupier of premises owes a duty to another (not being his visitor) in respect of any such risk as is referred to in subsection (1) above if

(a) he is aware of the danger or has reasonable grounds to believe that it exists;

(b) *he knows or has reasonable grounds to believe that the other is in the vicinity of the danger concerned; and*

(c) *the risk is one against which, in all the circumstances, of the case, he may reasonably be expected to offer the other some protection.*

*(4) Where, by virtue of this section, an occupier of premises owes a duty to another in respect of such a risk, **the duty is to take such care as is reasonable in all the circumstances of the case to see that he does not suffer injury on the premises by reason of the danger concerned.***

42. It was said that since the 1984 Act makes clear in its opening sentence that it has effect *“in place of the rules of common law.”*, it replaced the common law and was the sole source of any duty of care to a trespasser.
43. For there to be any duty therefore the argument was that a Claimant must satisfy all three criteria of sub-paragraph (3), and in this instance there was no reasonable ground to believe that the staircase posed a danger (nor is it said there was any problem with the staircase per se, such as its state of repair, it was a normal type of staircase of the type that many people every day). Since it was not possible to establish that the staircase posed a danger over and above that to be expected of any staircase the second limb of para (3) could not be satisfied either. Lastly it was said that in any case the Defendant did not have any reasonable grounds to believe Mr Ovu would use the staircase (or at least, if given the evidence that people frequently used the exit stairs and walkway to vomit or urinate, the Defendant had such reasonable grounds, the very fact that they had not come to any harm mitigated against there being thought to be some danger arising from it).
44. Lastly even if the claimant could satisfy the first two limbs of paragraph (3), the risk of a person falling on a standard staircase, of the type used by millions of Tube passengers every year, was not one against which the Defendant should be expected to offer additional protection.

45. I was referred to *Ratcliff* at paragraphs 36 – 37. That case concerned injury resulting from a dive into a swimming pool but, picking it up at paragraph 37:

37. *Mr Lissack sought to portray the danger here as a hidden one or something in the nature of a trap. In my judgment it was nothing of the sort. Even if the defendants knew or had reasonable grounds to believe that students might defy the prohibition on use of the pool and climb over the not insignificant barrier of the wall or gate, it does not seem to me that they were under any duty to warn the plaintiff against diving into too shallow water, a risk of which any adult would be aware and which the plaintiff, as one would expect, admitted that he was aware. Had there been some hidden obstruction in the form of an extraneous object in the pool or a dangerous spike, of which the defendants were aware, the position might have been different. Though even so I am doubtful whether the defendants needed to do more than they did, namely to prohibit use of the pool except during certain permitted hours in the summer. Even in the case of a lawful visitor there is no duty to warn of a danger that is apparent (Staples v West Dorset District Council (1995) P1QR 439).*"

46. Here, it was said, this was a normal staircase and there could be no duty to warn people about the dangers of falling down stairs. To do so, or, worse, to have to take special steps to ensure the safety of drunk people on staircases on the transport network, would be to impose an immense burden and if it was said that such a duty applied to this exit staircase (and ones like it) then the duty owed to trespassers would be greater than that owed to the many people using the other staircases on the London underground on a daily basis, as lawful visitors.

47. In addition to the above s1(6) was referred to namely "No duty of care is owed by virtue of this section to any person in respect of risks willingly accepted ..." and in this instance Mr Ovu willingly drank to excess and willingly chose to use the stairs, and willingly went through gates which could potentially be closed behind him (as in fact happened).

48. In sum, quoting the Defendant's skeleton "*Adults must be responsible for their own actions. It would be disastrous for society and contrary to public interest, if adults ...*

could get intoxicated and incapable, relying on a duty of care on others to ensure no harm befalls them, or to compensate them when it inevitably does.”

If there is a duty, the extent of that duty of care? Defendant’s case.

49. Per Lord Reid in *Herrington* [899E]:

“It is always easy to be wise after the event and in judging what ought to have been done one would have to put out of one’s mind the fact that an accident had occurred and visualise the position of the occupier before it had happened. Quite probably, this would not be the only point on his land where trespass was likely. One would have to look at his problem as a whole.”

It was said that when one ‘looks at the problem as a whole’, this Defendant would not owe a duty to warn, or to assist a lawful visitor in relation to the ordinary dangers arising from use of a standard staircase in the public areas of the station, and it would be wrong to hold that there was therefore a duty (greater than that towards non-trespassers) to warn trespassers about identical staircases in non-public areas let alone take other steps (this not being a staircase in disrepair or otherwise abnormally dangerous).

50. Similarly any duty to the Deceased did not extend to keeping the emergency barriers open for him to return, and in fact on the contrary it was reasonable to close them to prevent an intoxicated passenger returning to the danger of falling onto the tracks.

51. I was cautioned in the terms set out by Lord Justice Laws in paragraph 23 of *Ahanonu*:
“The judge ... has in effect sought to impose a counsel of perfection Such an approach distorts the duty to take reasonable care. There is sometimes a danger in cases of negligence that the court may evaluate the standard of care owed by the defendant by reference to fine considerations elicited in the leisure of the court room, perhaps with the liberal use of hindsight. The obligation thus constructed can look more like a guarantee of the claimant’s safety than a duty to take reasonable care.”
Hence any notion that the Deceased was entitled to have personnel constantly scanning CCTV monitors and setting out in groups to find him before it was possible to

fall down an ordinary staircase would be just such an unrealistic counsel of perfection which, if imposed, would as counsel put it “render the network unworkable”.

Decision

52. On the agreed facts I must decide the following three issues:

- (a) was the Deceased a trespasser at the time of his death?
- (b) Was a duty of care owed by the Defendant to the Deceased at the time of his death?; and insofar as necessary
- (c) What was the extent of that duty of care?

Was the deceased a Trespasser at the time of his death?

53. The Acts of 1957 and 1984 do not use the expression ‘trespasser’ or ‘trespass’ but speak in terms of visitors or persons who are not visitors, in law. The 1984 Act expressly adopts the concept of visitor from the 1957 Act, and thereafter deals with the position of anyone who is not such a visitor. In turn the 1957 Act in s.1(2) indicates that *“for the purpose of the rules so enacted the persons who are to be treated as an occupier and as his visitors are the same [...] as the persons who would at common law be treated as an occupier and as his invitees or licensees.”*

54. This is instructive because the status of ‘visitor’ as defined in the 1957 and 1984 Acts entails the status of invitee or licensee, at common law. We shall see in a moment whether the case law cited to the court means that there are circumstances where a person who is a non-invitee or non-licensee can nonetheless not be a trespasser, or can in effect become a visitor under the Acts, according to their own intentions, as the Claimant argues.

55. There does not seem to me to be a sensible reason – and nor did the Claimant argue – to draw a distinction between ‘trespassers’ and those referred to as non-visitors under the 1984 Act but I should look at what the common law says are the defining features of a trespasser because the question posed is, in terms, whether the Deceased was a trespasser when he died.

56. One starts with *Herrington*, a House of Lords case: “The term ‘trespasser’ is a comprehensive word: it covers the wicked and the innocent: the burglar, the arrogant invader of another’s land, the walker blithely unaware that he is stepping where he has no right to walk, or the wandering child – all may be dubbed as trespassers.”

What the above examples in the quotation have in common are two key ingredients namely (i) lack of permission or invitation whether express or implied, and (ii) being in a location where one has no such permission to be. One must look to any subsequent decisions to see whether later cases have signalled a more nuanced approach as the Claimant argues along the lines in *Spearman*.

57. The case of *Spearman* in 2011 poses something of an apparent challenge to the non-subjective approach in the rather older case of *Herrington* decided in 1972 and I must consider its implications carefully: does *Spearman* effectively confirm that the status of a trespasser is not solely a matter of location and permission but may be affected by the state of mind of the person entering upon the (restricted) land?

58. Mr Spearman was a man who suffered a hypoglycaemic attack – which affects one’s mental state very considerably – and had been taken to Accident and Emergency department of the Defendant hospital by ambulance. Separately, as a young man he had suffered a brain injury in a traffic accident and had been left, it appears, with something of a phobia of hospitals. His occasional hypoglycaemic attacks when they took place left him ‘confused, and the combination of this with his existing brain injury made him vulnerable’ (para 10.) In particular the learned judge said this at para. 9 after recounting an historic incident at Heathrow airport when Mr Spearman had started cleaning a lawfully held shotgun in public (the bold emphasis is my own):

“Andrew Spearman says: ‘Jamie was oblivious to the fact that the police were surrounding him or that his actions would cause alarm to others. Jamie lacked empathy for his surroundings or an appreciation of the threat that certain activities or environments would pose him. Jamie would become fixed on the objective he was trying to achieve, and once he had decided to do it he became blinkered by doing that task such that he would not appreciate the whole picture’. **In my judgment, this**

comment is pivotal in understanding what happened when the Claimant sustained the accident which is the source of this claim.”

59. On the day of the accident Mr Spearman suffered a ‘particularly bad’ hypoglycaemic attack. An ambulance was called and Mr Spearman was ‘virtually comatose’ with a Glasgow Coma score of 4 (para. 13). Administration of glucose solution improved his condition but his score was still not normal on arrival at hospital (the GCS was 10) and was very resistant to the notion of being taken to hospital. Whilst in hospital he spoke of wanting to ‘go up a level’ which did not make sense to staff and per Martin Spencer J this indicated that the Claimant was either still confused or that confusion was returning.
60. After having been left for barely a minute or so, it appears the Mr Spearman removed the drip cannula from his arm, got out of a high-sided trolley, passed through various doors and up various stairs, and ultimately on to a flat roof which was used from time to time by people to catch the sun or it seems to watch cricket, and which was protected by a 1.4m high inwards-leaning fence around the perimeter as a safety measure to prevent falls. It appeared that Mr Spearman had climbed the fence using furniture and had then jumped or fallen, sustaining grave injuries.
61. As is the case here, one of the issues for the judge to decide was whether at the time of the accident the Claimant was a trespasser or a visitor for the purposes of the Acts of 1957 and 1984. The Martin Spencer J. in *Spearman* held that the defendant owed the Claimant a duty of care under the 1957 Act to take reasonable steps to ensure that the premises were reasonably safe for him as a vulnerable patient who was confused and mentally unstable at the time that he was in the Emergency department of the hospital. It follows from the decision that the 1957 Act applied that Mr Spearman was in the circumstances held to be a visitor.
62. The learned judge’s reasoning in so concluding has to be considered carefully because at para. 56 he states that “... *in my judgment whether a person is a trespasser or not is not solely determined by whether the place where they are is or is not an ‘authorised’ place. A person’s state of mind and intention is an important*

additional factor. If a patient, who is a lawful visitor to a hospital ... has finished his or her treatment and is leaving, he or she does not cease to be a visitor in general until they leave the hospital premises. The position may be different if they deliberately enter an area marked 'no entry' or 'private' or know that they are entering a part of the hospital where they have no right to be. But if the patient simply makes a mistake and goes the wrong way, it could not possibly be suggested that such a person was a trespasser."

63. How is one, if at all, to reconcile the apparent relevance of state of mind or intention, per Martin Spencer J., with the apparently strict approach in *Herrington*? In my judgment the answer is to be found by considering the position in *Herrington* a little more closely than solely the rather stark words of Lord Morris quoted above. We must recall that *Herrington* concerned a child who trespassed onto some electrical railway lines which were quite near to land where children habitually played. There had been a fence in place to make it clear where the occupier's land (and indeed the danger itself) were, but through poor maintenance the fence had fallen into such disrepair that it did not deter small children from going onto the railway land. The analysis in *Herrington* concerned the question whether (in the era before the 1984 Act) any duty was owed to trespassers, and the decision in that regard was, broadly, that (per Lord Morris at 907E) that 'common sense and ordinary intelligence' – alongside concepts of common humanity – should direct the position. The circumstances were (per Lord Morris at 904C) that "*it is a matter of ordinary common knowledge that children will roam and will explore. If a fence marks a boundary an adult who climbs over it will appreciate what he is doing. A small boy who finds a part of a fence so dilapidated that there is no real obstacle to his progress will not or may not know that he is at once a 'trespasser' if he goes in.*" (And he then surmised that there might be situations of an analogous sort for adults). Having reviewed a series of valuable historic decisions Lord Morris stated at 907E: "*I think that the railways board would see that in the circumstances of this case there was a likelihood that some child might pass over the broken down fence and get on to the track with its live rail and be in peril of serious injury. Even though the child would be a trespasser ought it not to be their 'plain duty' to repair the fence?*". At

909G the Defendant was held to owe a duty to take steps to exclude or to warn, or otherwise avert the danger.

64. In *Herrington*, for the class of victim in question, a child, the lack of a fence meant that the child was unaware of entering an area without permission but he was a trespasser nonetheless and the liability of the defendant was founded on what amounted to a breach of a duty to maintain the fence so as to protect or warn vulnerable children who might otherwise become trespassers by entering the area where there was a danger on the land. In the case of *Spearman*, the claimant had entered with permission, unlike the child in *Herrington*, but had then wandered into an area for which he no longer had permission, but without any indication to him that would (for him as a foreseeable class of visitor namely a confused and ill patient) have warned that he was now exceeding the limits of his licence. He was held not to be trespassing in those circumstances. The mental element in *Spearman* seems to me to be best described as asking whether in the circumstances of a lawful visitor, that class of person with those characteristics could reasonably have been aware of the limits of the licence he had. Mr Spearman simply did not know he was off limits, and that was a function of the lack of signage and his own vulnerabilities which were commonplace in the hospital environment and actually known to the staff. One might be tempted in a sense also to read into *Herrington* a degree of relevance of 'mental state' insofar as the court there made reference to what appears to be a duty to at least warn people of particular dangers before they become trespassers.
65. My judgment therefore is that Martin Spencer J's approach is not inconsistent with that in *Herrington* if one considers that the position of a person who is already a visitor and who has no way to know, in the circumstances and with his characteristics, what the limit of the licence actually is, is in a somewhat different position to that of a person who at no stage has any permission to enter at all, but where some particular danger lurks on the land and no step is taken to at least warn of it before the person trespasses.
66. In *Spearman* the judge considered that "*The position may be different if they deliberately enter an area marked 'no entry' or 'private' or know that they are*

entering a part of the hospital where they have no right to be.” In my judgment the crucial difference in the case of Mr Ovu is that firstly, he entered the off-limits area having passed very clear barriers and signage (and cannot, and does not pray in aid his own intoxication), and secondly that having at that stage become a trespasser merely changing his mind and wishing to re-enter the platform is, whilst plainly a mental state, not comparable to the case of a person who is unaware they have or are about to exceed their licence or unaware (as in *Herrington*) that they will be entering a dangerous area. The reference therefore by Martin Spencer J to a person’s state of mind and intention being an important additional factor must be read in that light on the facts of *Spearman* and cannot be read in my view as intending to import a broad notion of intentionality into the law of trespass.

67. Adopting that approach, Mr Ovu entered the restricted area as a trespasser, was well aware of the fact that he was ‘off limits’ due to barriers and signage, and in my judgment even assuming he later intended to cease to be a trespasser, or even if one assumes he intended from the start to enter and then return soon afterwards, that mental state intention did not change his status from being a trespasser to being a licensee or invitee. In relation to the argument that at all material times he remained a passenger, even if one assumes such to be the case that does not seem to me to take matters further: the status of passenger defined the scope of his licence in terms of use of the premises and he had exceeded that licence as he well knew.

68. The case of *Braithwaite* accords in my judgment with the above approach. On the facts there was no warning of the dangers of oncoming trains and per Edmund Davies J at 990 *“his encroachment of a few inches over or upon the sleepers of the commissions line was wholly inadvertent and involuntary and the result of his startled turnabout as a result of the warning shout”*. We see there the involuntary nature of act underpinning a finding that there was no trespass, and we see in *Spearman* what amounts to an involuntary act in that the grossly unwell claimant not only was impaired but had no notice of the fact he was (possibly) off limits. One cannot conclude therefore from *Braithwaite* any more than from *Spearman* that such a limited application of a notion of mental state or awareness can stretch to

cover the case of a knowing trespasser who may have later changed his mind and decided to leave.

69. I therefore answer the first question in the affirmative: the Deceased was a trespasser at the time of his death. He was not a lawful visitor because he had exceeded the well signposted limits of his permission and there is nothing on the agreed facts to suggest that the signage or barriers were (unlike the fence in *Herrington* or the unmarked doors in *Spearman*) were such as to mean that he could not be aware of the limits of his licence.

Was a duty of care owed by the Defendant to the Deceased at the time of his death?

70. It is I think obvious and uncontentious that (whether or not some further or additional duty may have been owed to the Deceased), my conclusion above that he was a trespasser at the time of his death implies that at the very least the duty to non-visitors under the Occupier's Liability Act 1984 applies namely: where there is any danger due to the state of the premises or to things done or omitted to be done on them there is a duty to take such care as is reasonable in all the circumstances of the case to see that the trespasser does not suffer injury on the premises by reason of the danger concerned, if the occupier is aware of the danger or has reasonable grounds to believe that it exists *and* knows or has reasonable grounds to believe that the other is in the vicinity of the danger concerned, *and* the risk is one against which, in all the circumstances, of the case, he may reasonably be expected to offer the other some protection. (The above wording is intended to summarise the effect of the 1984 Act).

71. That partly answers both questions (b) and (c), ie the question of existence of a duty and its scope simply taken from the 1984 Act. It does not address the wider case of the Claimant, and that was that the law permits a duty of care at common law outside or in parallel with the Statutory duties towards trespassers or visitors and that on the facts of this case based on the words of the 1984 Act s.1(4), and also at common law, the Claimant owed Mr Ovu a duty to act so as to ensure that the Deceased "was reasonably safe from danger using the station" and that in securing the emergency gates in the circumstances pleaded, it breached that duty.

Do the Acts exclude any other possible duties at common law towards trespassers?

72. I must first consider whether the law in principle permits a duty towards a trespasser to co-exist at common law alongside the duties set out in the 1984 Act. We see from s1(1) of the 1984 Act that the rules enacted by that section have effect, in place of the rules of the common law, **to determine whether any duty is owed by a person as occupier of premises other than his visitors in respect of their suffering injury on the premises by reason of any danger due to the state of the premises or to things done or omitted to be done on them** and, if so, what that duty is.

73. Does s.1(1) operate to replace rules of the common law in respect of duties which may be owed to non-visitors, in all instances? Both the 1957 and 1984 Acts refer to the ousting of the common law in similar terms but it is instructive to consider that in *Spearman*, where the Claimant fell under the 1957 Act, the Hospital was held to owe a duty of care in parallel with that under the 1957 Act. I was taken to discussion of the interpretation of the 1957 Act in Clerk and Lindsell 23rd ed on this point. The learned authors concede there that the phrasing of the Act could be read as meaning that the legislation applies to replace the common law in respect of any injuries caused by negligence on the part of the occupier of land. However the learned authors conclude, in my view persuasively, that the reference to ‘danger due to the state of the premises or to things done or omitted to be done on them’ is intended to echo the prior common law on ‘occupancy duties’ that is to say negligence (by activity, omission or state of premises) which give rise to a danger due to the state of the land itself, and not to ‘activity’ duties such as the holding of (say) a dangerous event such as a firework display, which on the authors’ analysis falls to be determined outside the Acts. The authors refer (at note 10 in the extract provided to me from 11-04 to 11-07) to Lord Hoffman in *Tomlinson v Congleton* at 26-27 in relation to the 1984 Act to the effect that the fact that a person may get into danger on a given piece of land is not itself a peril due to the state of the premises, and that even if the occupier’s acts or omissions may concurrently affect his safety this does not widen the ambit of the Act. Supporting that we see *Revill v Newbery* in which the reckless shooting of a trespasser was not something governed, for liability purposes, by the 1984 Act but was a matter for the common law.

74. In the same note the authors cite *Keown v Coventry NHS Trust*³ where trespass was admitted such that the 1984 Act applied. A child playing on a fire exit fell and was badly injured. The fire exit was not in disrepair but at first instance the Recorder held that there existed a "danger due to the state of the premises" and rejected an argument by the Trust that there could not be a danger in the absence of a faulty state of repair and he said that, in coming to this conclusion, he had particularly in mind, *"the height to which a person using the steps could climb and the fact that any fall from virtually any part of the fire escape was likely to carry with it a serious risk of injury"*, that the Trust was aware of the circumstances giving rise to the danger, knew that children played in the grounds and that there was a risk of their coming into the vicinity of the fire escape and that the risk of suffering injury by reason of the danger due to the state of the premises was a risk against which the Trust might reasonably be expected to offer some protection. Liability was upheld. On appeal the Court of Appeal reversed the decision holding that, even in the case of a child in those circumstances (and a fortiori in the case of an adult: see *Keown* at para. 11 per Longmore J) the threshold for a 'danger due to the state of the premises' (etc) was not met. Per Lewison J at 28 *"Thus in order for the threshold question to be answered in the affirmative it must be shown that the premises were inherently dangerous."*

75. I conclude therefore that in principle the duties under the 1984 Act apply only to dangers of the sort referred to in the extract from Clerk and Lindsell (and in the authorities cited there) and do not restrict the possibility of liability for breaches of duties in relation to harms from matters not due to dangers arising from 'occupancy duties' – ie the state of the premises and the effect on that of activities or lack thereof. In principle therefore there is nothing to prevent in an appropriate case some duty of care at common law in parallel with the duties to trespassers under the 1984 Act.

76. Was there a duty of care at common law towards the Deceased to ensure that the Deceased "was reasonably safe in using the station" per para 12 (v) of the Reply to Defence? Looking at the other parts of the Particulars, at common law was there a

³ Neither Tomlinson nor *Keown* were expressly referred to before me but they were referred to in the footnote to the extracts from Clerk and Lindsell placed before me and I have therefore considered them.

duty “to use reasonable skill and care in securing the emergency gates” (para 9(10) Reply), and “to devise and implement suitable and sufficient control measures to reduce the risk of an accident or injury to members of the public using that transport system... to the lowest level reasonably practicable”?

77. In turning to this issue, one has to have firmly in mind that when asking whether a particular duty of care is owed, one must ask **what risk is it that is being protected against**, specifically (per Thorpe LJ for the court in *Ratcliff* at 27). To start at the other end of the telescope so to speak, and to ask in the abstract what the duty may be is to give rise to a risk of a counsel of perfection especially with the benefit of hindsight in the ‘leisure of the court room’ – per Laws LJ in *Ahanonu* at 23. If one comes under a duty at common law then it is a duty to take reasonable care in all the circumstances but one must know what risk the duty, if any, seeks to mitigate against. It is important (also per Thorpe LJ in *Ratcliff* at 27) to see whether the claimant himself was aware of the risk of injury because it was obvious. The risk in that case was that when diving into a swimming pool one may hit one’s head on the bottom. The risk was said to be obvious unless the claimant took care to make sure there was enough water to dive into, which he did not. Furthermore – and continuing with Thorpe LJ’s judgment at 28 - a judge must ask what a defendant would actually be expected to do if it did owe a duty.

78. What happened in this case was that Mr Ovu apparently slipped and fell on a standard staircase which had no particular defects or unusual dangers of condition. It was much like any other staircase on the Underground whether in public or non-public areas. The harm which befell Mr Ovu was a blow to the head occasioned by the fall, and the risk which he encountered was the ordinary risk of using a staircase, a risk obvious to any adult especially after a few drinks. In my judgment the extent of any duty of care in relation to the risk of a fall on the stairs was to ensure that, in accordance with the 1984 Act, the stairs did not present a particular danger in relation to their state in respect of dangers meeting the criteria in s.1(3), and I would probably go so far as to say that if hypothetically on that evening the Defendant’s staff had been making use of the stairs for their own purposes for some activity such as an impromptu social event and had in the process negligently harmed the

Claimant such as by tripping or pushing him, then they may have owed a duty at common law in that regard in parallel with the 'occupation' duty of the 1984 Act.

79. In this instance all we have is a staircase, in normal condition, on which Mr Ovu fell. Nothing was being done on it or to it. There are no measures that the Defendant could *sensibly* be expected to have taken which would prevent a fall on an ordinary staircase in good condition, given the obviousness of the risk of a fall on any stairs and the enormous implications if it were to be necessary to – somehow – intervene to protect transport users from that normal everyday risk. One cannot for example say that the duty was to take care by preventing access to any steps, or by accompanying passengers, or by policing the competence of users to ensure they were briefed on using steps, or requiring safety equipment to prevent falls, and such would be impractical in modern society in a vast transport system. In *Ratcliff*, per Thorpe LJ at 37, even simply warning users of the steps (such as by a sign saying "Warning, danger of falling down stairs!") would not be a step required given that "*... even in the case of a lawful visitor there is no duty to warn of a danger that is apparent*"

80. Thus the proposed duty to "devise and implement suitable and sufficient control measures to reduce the risk of an accident or injury to members of the public using that transport system... to the lowest level reasonably practicable" sounds enticing as a general public good, yet it moves into the realm of a degree of unreality where the issue in question relates to protecting the public from the normal risks of every day activity.

81. What about the possible "duty to use reasonable skill and care in securing the emergency gates". In this instance there is no nexus between closing gates and someone slipping and falling on steps: this was not an injury caused by - say - slamming the gate and trapping a finger and nor was the closure of the gate a step which meant that Mr Ovu was 'trapped' and obliged to use the particular staircase he chose to use: he was free to leave at any time via the exit and different stairs which opened onto the street, and indeed he had actually gone as far as that gate and elected not to leave. I am not in this case expressing any view on the different

set of facts if a situation arose where a person was in fact trapped once they became a trespasser.

82. The closure of the gate did not introduce some new hazard or amount to an intervention which arguably made matters more dangerous than they were with the gate open (there was discussion of the analogy with my own judgment in *Tindall* on the subject of whether a duty arises due to an intervention on the ground which changes the risks, but in this instance the risk of a fall on a staircase has no relationship with the state of the gate: it neither lessened nor worsened the risk of a fall whether by changing the state of the premises or by being a dangerous activity carried out by the Defendant).

83. In my judgment on the facts of this case and bearing in mind the risk to be protected against, the only reasonable framing of a duty of care falling upon the Defendant could be that provided for under s.1(1) of the 1984 Act, which would arise if the triggering criteria of s.1(3) were met, and that whilst there may be different circumstances where common law duties arise and the law does permit parallel common law duties where the risk and damage does not fall within the scope of the Act, this case does not give rise to such further duties in relation to the specific risk here.

84. My answers to the issues therefore are:

(a) Mr Ovu was a trespasser at the time of his death.

(b) A relevant duty was not owed to him in respect of the risk in question namely falling down stairs and sustaining injury because:

i. I have held that there is no basis for a separate common law duty in this instance; and

ii. a duty under the 1984 Act s.1(4) arises in relation to the stairs only if they posed a danger due to their state (or activities/lack thereof affecting their state), and provided the criteria in s.1(3) were also satisfied. In my judgment the closure of the gate did not give rise to such a danger, nor did the admitted failure to follow internal procedures in relation to checking the exit area after an alarm. The

stairs were not dangerous due to their state in and of themselves. The position is in a sense close to that in the *Keown* case cited in Clerk and Lindsell above.

85. In relation to the Reg. 28 report, I do not consider that the fact that such recommendations were made impacts upon the existence of a duty of care or its scope, and nor does the prior existence of a policy to search the area beyond the gates in such circumstances. The function of a Coroner's Reg. 28 report is to improve safety and prevent deaths, which is a public good but the function of the Coroner is not to determine the different question of a duty of care at common law. Likewise the prior existence of a policy to check the exit structure does not establish that the duties contended for here applied as a matter of law.
86. The decision here will of course disappoint Mr Ovu's family but I hope some solace can be gained from the Coroner's recommendations and the changes to communication and policy which took place as a result whereby the Defendant's staff will now always either check the area, check the CCTV replay or contact the police if they are working alone and feel unsafe to check the exit structure themselves. During the trial I expressed some concern for the CSM who was faced with working alone at night and being expected to check the exit structure, on his own and with the potential of becoming locked out and having to exit the station onto the street, leaving the station unattended while he came back via, one assumes, the public entrance. The outcome of the Reg. 28 report means that now the system has changed so that a CSM cannot find him or herself in that position and will be able to return to the platform. The HM Inspector Assistant of Railways found that the Defendant had failed in its duty to assess the risks to employees in the position of this CSM working alone and that he had been unable safely to follow the employer's procedures. It cannot be ideal, though I say so entirely obiter, for staff to be in the position of working alone: on that night the CSM should, it appears, have had 2 other members of staff with him (I glean this from the interview with him in the bundle) but one was on paternity leave and there was no cover for the other.

13/10/21