THE HIGH COURT

[2024] IEHC 167

[Record No. 2019/469CA]

BETWEEN

SUSAN REDMOND

PLAINTIFF/ APPELLANT

AND

TALLAGHT UNIVERSITY HOSPITAL

DEFENDANT/RESPONDENT

JUDGMENT of Mr. Justice Mícheál P. O'Higgins delivered on the 13th day of March 2024

1. This is a claim for personal injuries that arises from an accident at work on 23 August 2016. The plaintiff is now retired but, at the time of the accident, was working for the defendant as a sterile technician in the Central Sterile Services Department (CSSD) of Tallaght Hospital in Dublin.

2. The case was dismissed in the Circuit Court and this is the plaintiff's appeal from that decision. Without prejudice to the issue of liability, the parties have reached agreement on quantum. Accordingly, this judgment is only concerned with liability.

3. The CSSD is responsible for disinfecting and sterilising all surgical instruments used in the hospital. Surgical items are placed into wire mesh baskets or trays and are stored on

metal racks that are arranged along the wall opposite the sterile washing machines. The instruments within the trays are washed in the washing machines and later sterilised in separate machines called autoclaves. Later in the process, the cleaned instruments are grouped in customised packages as specified by hospital surgeons for individual medical procedures.

4. In this case, the plaintiff sustained injuries when stacking the washed trays on the storage rack opposite the washing machines. The storage rack in question has four shelves and the accident occurred when the plaintiff was placing a tray full of instruments on to the shelf. The instrument trays are fitted with retractable handles at each end which can be lifted up for use or dropped down to facilitate stacking. Lifting the trays by their handles makes it easier for employees to keep their fingers away from the body of the tray and the metal instruments inside. The sides of the tray are made of wire mesh woven into a grid. Each tray bears a barcoded identification label that enables the system to track the usage and location of each tray.

5. Under the system operated by the defendant, CSSD staff must inspect each tray of instruments closely each time the tray is used. Any tray that is not perfectly clean must be removed from circulation for further cleaning and sterilisation. Cleanliness and hygiene standards are central pillars of the whole system, as one would expect in a hospital setting. Defective trays are replaced and not repaired.

6. The court heard evidence from the plaintiff, Susan Redmond, a work colleague, Ms. Fiona Bowden, and Consultant Engineer, Mr. Barry Tennyson. The defendant called evidence from Ms. Jacinta Burke, Sterile Services Manager, Mr. Martin Wall, now Manager of the CSSD and Dr. Lorcan O'Flannery, Consultant Engineer. For reasons of brevity, I do not propose to outline in great detail the evidence from each witness. I will confine my review to the main points emphasised by the factual witnesses.

Evidence of the plaintiff

7. The plaintiff is a great grandmother and is now 71 years of age. Her accident occurred on 23 August 2016 when she was about eight months off retirement. She had been working in the hospital since before 1997 and worked there when it was the Meath Hospital in Heytesbury Street and then she moved over to Tallaght. She initially worked in the catering section and later worked in the CSSD. She had been team leader in CSSD for several years.

8. The plaintiff said that, on the day of the accident, the department was very busy. She was lifting a metal tray of instruments onto the storage rack that can be seen in the engineer's photographs. She believed the tray she was carrying was a "Major Orthopaedic" set which was very heavy. There were three stacks of trays already positioned on the middle shelf, situated like the trays in photograph 4. However, the stacks of trays that were already in position were higher than the arrangement seen in photograph 4. The only place with a gap for her to leave the tray was on the top of the middle stack. There was no room to put the tray on the stack to the left or to the right, as they were full to the top and were already five trays high. There was a small gap above the middle stack, and she decided that was where she would place the tray. There was very little room to land the tray on the rack.

9. The plaintiff said that she placed the tray on top of the fourth tray in the middle stack and noticed that the stack was not steady. She reached in with her hand to try to make it steady. While doing this, she got a sharp pain to the finger of her left hand, causing her to let go of the side of the tray and, as a result, the weight of the tray came down on top of her finger and caused a crush injury. She believed her finger got caught between the top (fifth) tray and the (fourth) tray beneath. She managed to lift up the tray and get her finger out. While she was not sure, she believed the sharp prick to her finger came from a loose wire on the tray, rather than from a metal instrument contained within the tray. She said that, from time to time, wires and trays would become loose.

10. The plaintiff told a work colleague, Ms. Bowden, about her accident and showed her the injury shortly after it occurred. She relayed to Ms. Bowden how the injury had happened, and Ms. Bowden told her to make sure to clean her finger properly.

11. The plaintiff later went back to work. She did not report the accident formally until two days later, when she reported it to her manager, Ms. Burke. I will return to that issue presently.

12. The plaintiff was cross-examined by Mr. Bourke SC for the defendant. The plaintiff confirmed that she had been a team leader for several years and was on the safety committee. She confirmed that she and other work colleagues had received training and manual handling at least every three years. She accepted that, in 2014, all team leaders were involved in an exercise of weighing the medical sets. It was put to her that the weight of the orthopaedic set was 5.4 kilograms. The plaintiff was not sure about weight but said that the tray she was carrying at the time of the accident was heavy. She accepted she had been nineteen years at this task and had no issues with lifting or storage issues before this.

13. It was put to the plaintiff that, before an employee places the tray down, they should look to see where they are going to put it and employees must ensure that everything is flat before placing a tray on top of another tray on the rack. It was put to her that, had she done this properly, she would have spotted if there had been a wire sticking out. The plaintiff said that everything looked normal at the time, but something was sticking out that caused the tray to be unsteady.

14. It was put to her that it could not be correct that there was nowhere to put the tray. The plaintiff said that they were very busy that day. It was put to her that the defendant's barcode reports did not support that position and showed there were no staff shortages that day. The plaintiff suggested there may have been loaned-in sets in from the day before still on the rack.

15. It was put to the plaintiff that she could easily have sourced a trolley or called over a colleague. The plaintiff said they were simply too busy. It was put to her that, if there was any issue about there being no space on the rack, she could have placed the tray on the inspection tables. The plaintiff said the norm is to keep the Major Orthopaedic sets together. It was put to her that each employee is required to assess the situation before placing a tray on the rack, and that whilst it is the norm to keep the trays together, employees have to use their common sense and take basic steps if there is a shortage of space.

16. The plaintiff was asked why she did not report the accident immediately. It was put to her that, as team leader, she was obliged to report it straight away. It was also put to her that if there is an injury resulting in the slightest bit of blood, it is a very significant issue, as it compromises the integrity of the sterile operation. On this basis, the plaintiff was pressed as to what she had done with the compromised tray as, on her evidence, there had been blood on her finger. The plaintiff said that she put it back into the hatch to be recleaned. It was put to her that no tray was ever reported as defective and nor had the system picked up any trays being returned through the hatch for cleaning. The plaintiff stood over her claim that she returned the tray through the hatch.

Evidence of Ms. Fiona Bowden

17. Ms. Bowden confirmed that she had been 20 years in Tallaght in September. Ms. Bowden was a technician, and the plaintiff was team leader in the section. As to training, she confirmed that they had been given manual handling courses. She said that they got training from the manager, Ms. Burke who brought them through each work area. She could not remember exactly what they were told but recalled being told that different medical sets have different weights. The Major Orthopaedic sets would be the ones they would use most often estimating their weight as being between 5 and 5.5 kilograms, and the minor sets as being

lighter. She confirmed that they often carried out this task. In the period that she was there, the system of work never changed – they still emptied and stacked them in the same way.

18. Ms. Bowden was brought through the plaintiff's accounts by reference to photographs 3 and 4, namely that the plaintiff was laying the fifth tray on top of the fourth, and the two stacks to the left and right were slightly higher than the stack she was placing the tray on. The witness confirmed that she sometimes had to do that. She said that, similar to the plaintiff, if you have enough room, you get the tray in – you do your own risk assessment. She said that the handles fell down and worked well. She herself never sustained nicks or cuts.

19. Ms. Bowden confirmed that she remembered the plaintiff showing her her injured finger. She thinks this was in the post-sterilisation room, a corridor off the cleaning room. She was not sure if she was working the same shift with the plaintiff at the time, but she was definitely at work. The plaintiff told her she had hurt her finger and had caught it underneath the basket when unloading the washer. From memory, there was not much of an injury but a few days later the plaintiff showed her her finger again and it was swollen.

20. Ms. Bowden was not cross-examined by the defendant.

Evidence of Mr. Barry Tennyson, Consultant Engineer

21. The final witness for the plaintiff was the engineer, Mr. Tennyson. Mr. Tennyson gave evidence broadly in keeping with his report. Counsel brought him through the photographs and the plaintiff's description of the accident. She had explained to him that the bay involved had three stacks and that the accident happened when she was placing the tray on the middle stack and the stacks to the left and right were full. He said that the plaintiff was 5 feet 2 inches tall. Working from the plaintiff's indication that there were five trays on the shelf in the middle stack, this would mean the tray was approx. level with her nose when the tray was in its final position. The plaintiff explained to him that the tray she had just placed on the stack was rocking and, therefore, she had to adjust it by squeezing her hand into the

gap. It was while doing this that she felt a prick to her finger and pulled out her hand, resulting in the top tray crushing her finger.

22. Mr. Tennyson gave his opinion that the tray was not compatible with the shelving system because the two drop-down handles require employees to turn the tray, and this made the task awkward. In his view, the stacking arrangement was too cramped and unnecessarily so. There was a lack of storage room in the facility.

23. As to training, Mr. Tennyson felt that there was no training for the specific task of stacking the shelves. He said that a proper risk assessment would have identified a lack of storage. A competent risk assessor would have made proper inquiry. He said the trays are not designed to be stored on top of each other. The trays were often overly full of instruments, meaning they could be unstable when stacked. He confirmed he did not find any issue with the wire trays themselves.

24. In cross-examination, it was put to him that the storage in question involves open shelving for hygiene purposes. Therefore, the guide rail system that Mr. Tennyson was advocating was simply not appropriate. He disagreed. It was put to him that the general-purpose shelving, such as that seen in the photographs, needed to be easily cleaned because, as with any storage system, dirt can accumulate in the bars. He indicated that he could see from the photographs that there was a storage problem in the facility. The storage shelves are not wide enough. Mr. Tennyson was critical of the risk assessment that was carried out which he suggested was generic. Overall, he felt the stacking arrangement was crude.

Evidence of Ms. Jacinta Burke, Sterile Services Manager

25. The first witness for the defence was Ms. Burke. She had been the Sterile Services Manager since 2010. She gave extensive evidence as to the training that was offered to the plaintiff and her colleagues. There was training given with respect to unloading the washing machine and placing the items in storage. The training was not generic, but rather was

specific to the department. The training was redone every three years. There was very great focus on risk assessments. Mr. Martin Creagh did the risk assessment, but she was also involved. It was incorrect that this only covers the unloading of the washing machines – it also covers employees walking over to the shelf and placing the tray onto the shelf.

26. She confirmed that a Major Orthopaedic set weighed 5.3 kilograms and that a minor set would be somewhat less. She was asked if they had had any concerns or complaints over the years about employees having to place sets onto the shelving. She said there had been no complaints, even though they had staff and safety meetings. She was asked to comment upon the plaintiff's evidence that the shelf was completely full. Ms. Burke said that would be *"extremely unusual"* and that if space was an issue, an employee would just bring up a table.

27. She confirmed that the plaintiff was a team leader and a health and safety representative. There was a strict protocol that, if there was any accident, it must be reported immediately. There had been no report made of the plaintiff receiving a puncture injury or laceration. If there was such an event, everything would stop as you would immediately go to occupational health. Such an occurrence was taken extremely seriously because it could potentially compromise the entire safety setup. The washing machines do not kill all germs, so it was very serious if there was a blood incident. The sterile kits involved would have to be decommissioned immediately and scanned back into the system for cleaning and sterilisation.

28. In cross examination, she confirmed that the plaintiff had become team leader in 2005 and was a valued employee. She had an exemplary record and a vast amount of experience. She had had no disciplinary issues and had made no legal claims of any nature in the past.

29. It was put to Ms. Burke that the plaintiff's case always was, and is now, that she caught her finger between two trays. She was asked as to when she formed the view that the plaintiff's account was under a cloud of suspicion. Ms. Burke denied doubting the plaintiff's

account of the accident. However, she did not recall the plaintiff mentioning the puncture injury to her finger when she reported the accident to her two days later.

Evidence of Mr. Martin Wall, Manager of the CSSD

30. The second witness for the defendant was Mr. Wall who is now the Manager of the CSSD. He gave extensive evidence as to the barcoding system and the safety protocols.

31. Mr. Wall gave evidence that he ran a nonconformist report for the day in question and, on that day, there was no Major Orthopaedic sets returned through the hatch or otherwise. He was brought through a number of system report printouts which the system automatically generated. He confirmed there was no report of a damaged instrument or tray. When asked to comment upon the plaintiff's description of the accident, he said that it would be unusual for the storage area to be cramped in that fashion. The only time this would happen was if they were very short staffed, and sterile sets were not being turned around. He confirmed that, from his read of the records, there was a normal complement of staff on that day and they were not short staffed.

32. In cross-examination, Mr. Wall fairly acknowledged that the plaintiff was a person of integrity, and he was not in any way calling into question the honesty of her account.

Evidence of Dr. Lorcan O'Flannery, Consultant Engineer

33. Dr. O'Flannery gave evidence in accordance with his detailed report. He disagreed with Mr. Tennyson that there was something wrong or unsafe about employees having to turn the trays before placing them on the storage rack. He disagreed with Mr. Tennyson's position concerning the need for guide rails and he relied on the various points made in his report as to why the storage rack was appropriate.

34. Mr. Tennyson had advised him that the plaintiff was wearing latex gloves at the time of the accident. He said that at the joint inspection, the focus was on the wire that caused the prick injury to the finger. He could not understand how a competent technician would keep a

defective basket in circulation. The whole issue of a blood injury in a hospital setting is a red flag that one would expect the plaintiff to be aware of. He could see no fault whatever in the type of shelving and did not agree with the criticism as to lack of guide rails. In his view, the shelving was entirely appropriate for the task. While it was a simple system, the storage system was practical and efficient. The whole sterilisation operation involved a large operation of thousands of trays. He endorsed Mr. Wall's statistics as to the extensive operation that was involved, and the excellent safety record enjoyed by the department. All in all, the system was designed to pick up wherever there is human error.

35. Each side provided helpful written submissions, and these were supplemented by way of oral submissions at the conclusion of the hearing.

Submissions by the plaintiff

36. Mr. Fitzgibbon SC for the plaintiff was critical of the manner in which the defendant had defended the case. The line of questioning advanced by the defendant had, at best, strongly implied that the accident as alleged by the plaintiff did not happen. It was most unsatisfactory that a plea of dishonesty or a plea as to a false claim had not been pleaded in an upfront way in the defence, as it should have been. Counsel suggested this was not done because the defendant, in those circumstances, would face a far higher burden of proof and would be subject to substantial aggravated damages in the event of failing to prove fraud or dishonesty on the part of the plaintiff. The court should treat the defendant's defence for what it was in real terms and assess the defence against a higher burden of proof.

37. The doubt and insinuation cast upon the plaintiff's version of events was highly objectionable, not just from an absence of proper pleading, but because of the very significant weight of contemporaneous evidence supporting the claim. In that regard, counsel said there were several independent pointers tending in favour of a conclusion that the accident

occurred in the manner described by the plaintiff. Counsel relied upon the plaintiff's unimpeachable record of employment with the defendant, the absence of previous claims, the contemporaneous reporting of the accident to Ms. Bowden, and a number of other nuggets of corroborative evidence which, it was urged, reinforced the legitimacy of the plaintiff's claim.

38. Counsel submitted that both witnesses as to fact called by the defendant, Ms. Burke and Mr. Wall, expressed under oath, and without hesitation, that the plaintiff was telling the truth. Not one witness in the entire proceedings actively challenged the veracity of the plaintiff's evidence.

39. The only form of challenge to the plaintiff's account arose in relation to Mr. Wall's evidence as to the automated system of tracking the sterile sets and trays. Mr. Wall was asked to check the tracking system because of retrospective *"concerns"* which arose around the time of the Circuit Court hearing in 2019, rather than at the time of the accident itself. These concerns appear to have arisen from the plaintiff's inaccuracies as to the times of her work shift on the accident date and of reporting the accident, as given in the Circuit Court hearing.

40. Counsel submitted that it would be remarkable if a court preferred the evidence regarding the tracking system to the direct evidence given by the plaintiff and her witnesses, particularly where the defendant's witnesses agreed that the plaintiff was a person of integrity.

41. As to the specifics of breach of duty alleged, the plaintiff gave evidence that the tray could sometimes arrive from theatre in a messy condition, and not neatly stored within the tray. After washing, the tray had to be stacked with the other Major Orthopaedic sets in a designated rack in one of only two open shelving units located against the wall. Consistent with the engineer's photographs, the designated space could be almost full, as arose on the accident date as described by the plaintiff.

42. The other point not seriously challenged was that the plaintiff, in endeavouring to place her tray onto the middle stack, had to lift it from about chest tight to head height, while rotating some 90 degrees to fit it into the space, reach into the back with her right hand, holding the rear handle of the tray and then place the tray directly onto the stack of trays. On any view, this was awkward and unsafe.

43. It was the plaintiff's evidence that, as happened from time to time, the tray she placed on the middle stack was not steady. Accordingly, she was required to reach into the *"couple of inches"* gap on either side of the tray, effectively unsighted, to adjust and secure its resting position. While carrying out this task, the plaintiff felt a prick to her left index finger, which she believed was from either a loose wire on the tray or something else. This, understandably, caused her to release her grip on the tray and her finger was thereby caught between the two trays with sufficient force to cause a crush and evulsion fracture.

44. Mr. Fitzgibbon SC submitted that, when one considers the plaintiff's description of the accident and the engineering evidence of Mr. Tennyson who concluded that the system of work and absence of proper risk assessments were unsafe in several respects, the working arrangement captured in the photographs was manifestly unsafe. Even to a lay person, the engineer's photographs depict a task with crooked trays sitting one on top of another in a very confined space, all of which points to an unsafe system. For all these reasons, it was urged that the plaintiff should succeed on liability.

Submissions by the defendant

45. Mr. Bourke SC made oral submissions on behalf of the defendant. For reasons of brevity, I will confine this summary to the core points made by defence counsel. Firstly, it was submitted that, when one steps back from the case, this was an unwitnessed injury to the plaintiff's hand. That being so, the defendant was perfectly within its rights to invite the court

to assess whether any inconsistencies in the plaintiff's account call into question whether the accident occurred in the manner alleged. It was for the plaintiff to prove that the accident happened in the manner she suggests and there was nothing unreasonable or improper in the defendant requiring the plaintiff to prove her case.

46. The defendant pointed to a number of discrepancies in the plaintiff's evidence which, it was urged, individually and cumulatively called into question the plaintiff's account. Many of these points involve objective and unchallenged evidence produced by the automated system, and are, therefore, persuasive in their own right.

47. Mr. Bourke relied on the evidence of Mr. Wall who gave his evidence based on detailed audit reports that he had generated. His evidence was that no baskets or trays were repaired or replaced as a consequence of a defect such as a protruding wire in the six months after the incident. Secondly, he gave unchallenged evidence that no baskets or trays were returned through the hatch, as alleged by the plaintiff. He also gave evidence that no orthopaedic sets could re-enter the system and be put back through the washer without having been logged on to the system. The plaintiff had not complained about a protruding wire or any sort of a sharp object in the contemporaneous records.

48. Thirdly, counsel urged that the plaintiff was a team leader who had drawn blood in circumstances where the drawing of blood is a significant issue requiring immediate reporting and liaising with occupational health. The plaintiff herself accepted that such an event should have been reported, particularly when dealing with a sterile room environment.

49. Fourthly, despite having allegedly suffered an injury at 2.00pm, there was documentary evidence before the court presented by Mr. Wall that the plaintiff continued working with further sets, the last recorded set being at 3:11pm and finished her shift at 4.00pm. Yet, she had made no reference to any incident or defective tray. Nor had she made any reference to any prick injury or drawing blood, despite the strong safety protocol that was

in place. All of this was very surprising, particularly in the context of the plaintiff's duty as a team leader and safety representative.

50. More generally, it was urged that the plaintiff's recall of the incident was vague and inconsistent. In cross-examination, the plaintiff initially said she reported the accident the following day, but when the contemporaneous records were put to her, she accepted that it must have been two days later. The plaintiff had given evidence that she was not wearing gloves, which contradicted what she told her own engineer at the joint inspection. The plaintiff gave evidence that, on the day of the accident, she was working on the shift from 11.30am to 8.00pm. However, when cross-examined, she accepted that she was working from 7.00am to 4.00pm and that the system recorded her removing a large orthopaedic set from the washer on only one occasion, namely around 8.00am.

51. In relation to the core part of the plaintiff's claim concerning insufficient storage space or "overcrowding", it was urged that this issue was not properly pleaded. Nor did it feature as a significant issue at the joint engineering inspection. It was also inconsistent with the evidence of Mr. Wall that there was a crossover of shifts at the time; therefore, both shifts were present and thus it was unlikely the defendant was short-staffed on the day in question.

52. Counsel emphasised the unchallenged evidence that the sterile services unit processed approx. 1.5 million sets without any such accident. Moreover, the preponderance of the evidence indicated that the defendant took the issue of staff safety very seriously and had introduced appropriate training and risk assessment procedures which the plaintiff herself had acknowledged. All told, it was submitted the defendant's system of work was demonstrably safe.

53. Finally, by way of fallback submission and without prejudice to the defendant's overall position on liability, counsel submitted that, even at the height of the plaintiff's claim, she was guilty of significant contributory negligence in failing to benefit from her knowledge

and experience as a team leader, having carried out the task for some nineteen years, failing to carry out her own risk assessment of the task at hand and failing to source an additional storage trolley or inspection table on which to safely place the tray. For all these reasons, counsel submitted the claim should be dismissed.

Analysis

54. The first issue I want to deal with is the complaint by the plaintiff's counsel that it was wrong and inappropriate for the defendant to defend the case in the manner in which they did. In my view, this point is without merit. The manner in which the case was defended was reasonable and forensic. The defendant was fully entitled to put it up to the plaintiff to prove her case, particularly in circumstances where the accident itself had not been witnessed or reported to management at the time of its occurrence. Moreover, there were aspects of the plaintiff's evidence account that were vague and uncertain and, in my view, it was perfectly legitimate for the defendant to probe and test these issues. The cross-examination of the plaintiff and her witnesses was full and fair and, at no stage, descended into badgering or discourtesy. The fact that the defendant's two main witnesses acknowledged that the plaintiff was a decent, honest and valued worker does not, in my view, invalidate the defendant's defence of the action, or preclude the defendant from advancing the case that there were frailties in the plaintiff's overall account. For all these reasons, I reject the complaint made by counsel that the defendant's conduct of the case was objectionable or inappropriate.

55. The second issue I want to comment upon is the plaintiff's own evidence. I found the plaintiff to be a reasonable witness who did her best to give credible and truthful evidence. I found that there was a strong vein of consistency in her account on certain core issues, including her account as to the storage task she was presented with on the day of the incident. However, there were certain aspects of the plaintiff's evidence that I found to be unclear and

uncertain. Her recall of dates and times was poor. When she was cross-examined about her claim that she had placed the orthopaedic set back into the hatch for sterilisation, her answers were uncertain and rather vague. Her recall on these issues was quite poor and I felt, at times, that she was guessing, rather than recollecting specifically what had happened.

56. Very importantly, however, I found the plaintiff to be an honest and credible witness. At times during her evidence, she made concessions and acknowledgments against her position and, in the view of the court, engaged properly with questions during cross-examination. She readily acknowledged that she was a very experienced employee, and she knew from training that, if an orthopaedic set looked extremely heavy, employees were trained to call over another member of staff to assist with the task.

57. Turning then to the mechanism of the accident itself, the starting point for the consideration of liability is the question whether the court accepts the plaintiff's evidence about the storage rack being overcrowded and the plaintiff being obliged to place the tray into a very tight spot. For shorthand purposes I will refer to this as the *"overcrowding"* issue.

58. In the defendant's written and oral submissions, objection is taken to the overcrowding issue being in the case *at all.* The defendant submits that no such case was made by the plaintiff in her pleadings and that the closest the plaintiff comes to pleading this issue is particular (j) of the updated particulars of negligence. The defendant says that the contemporaneous accident reporting makes no reference to the overcrowding of shelves being an issue. Nor did this feature at the joint engineering inspection. The defendant says it is also difficult to reconcile with the evidence of Ms. Burke and Mr. Wall.

59. I will deal firstly, with the pleadings objection. In my view, this is not a valid objection by the defendant. Para. 7 of the plaintiff's indorsement of claim pleads in straightforward terms that, on the day of the accident, the plaintiff removed the tray from the washer when she felt a prick to her left index finger. She immediately pulled her finger back

but, because of the weight of the tray that she was holding, it came down on her left index finger before she could remove it fully and, as a result, her finger was crushed. To my mind, that is perfectly consistent with the plaintiff's core account. In the next paragraph of the indorsement claim, it is specifically pleaded that *"there was little room for manoeuvre and her fingers would have to go into tight spaces"*. Thereafter, it is pleaded that, initially, the plaintiff thought nothing of her injury and got on with her job. However, by 25 August 2016, the condition of her finger had deteriorated, the tip was very sore, and she reported it to her supervisor. Again, that is all consistent with the plaintiff's essential account. These core aspects are also consistent with the description of the accident at para. 4 of the indorsement of claim, albeit there is no express reference to the overcrowding issue within that paragraph.

60. In addition, the plaintiff delivered further particulars of negligence and breach of duty and breach of statutory duty on 17 October 2017. Particular (A) alleges that the defendant permitted a practice to exist whereby trays were stacked perpendicular to the shelf, thus requiring an awkward twisting manoeuvre when reaching to the back in a confined space created by the adjacent stack. Moreover, particular (J) expressly pleads that the defendant failed to leave sufficient gaps between the trays so that the hand could be withdrawn safely.

61. The complaint of overcrowding and tight storage space also features heavily in the report of the engineer, Mr. Tennyson. In his first report of 2 November 2017, he comments extensively on the shelving and the awkwardness of the task. At para. 4 he says the practice in Tallaght was to stack the plates perpendicular to the shelf, thus requiring an awkward twisting manoeuvre when reaching to the back in a confined space created by the adjacent stack (photo 9). This was made all the more awkward considering that the trays can be stacked seven trays high and only one inch apart. He stated his view there was a foreseeable risk of hand crush injury.

62. In his report he describes the circumstances of the accident as relayed by the plaintiff. The account given is entirely consistent with the account the plaintiff gave in evidence and, to my mind, places centre stage the issue of tight storage space. In para. 10 he states that the plaintiff released the handles and had to reposition the tray to get it to sit properly. The report then continues "*there was no room at the top or the side to retrieve the back handle that had dropped as it was designed to*". Then in his criticisms of the defendant's system of work at para. 11, Mr. Tennyson says *inter alia* that "*the accident was caused by the failure to leave sufficient gaps between the trays so that the hand could be withdrawn safely".*

63. While I take the defendant's point that the overcrowding/tight storage space issue could have been spelt out more clearly in the civil bill, I think there are sufficient pleas in the pleadings and in the particulars for the plaintiff to be able to say that the defendant was fully on notice of this feature of the plaintiff's case. The additional particulars served on 17 October 2017 are very clear and, in my view, put the issue beyond doubt. For all these reasons, I hold that the defendant's pleading objection is unsustainable. I hold that the tight storage space/ overcrowding issue is sufficiently spelt out in the pleadings and, in fact, has been a consistent thread running right through the plaintiff's case.

64. Turning now to the substance of the issue, it seems to me that the plaintiff's own evidence on the overcrowding issue largely went unchallenged. I have no hesitation in accepting the plaintiff's account that, on the day in question, she was presented with a situation where she was trying to store a heavy item at head height in a very confined space - a task that was awkward and challenging. I accept the plaintiff's evidence, and I find as a fact, that on the accident date in question the area was busy and there was only space in the middle column on the storage rack to place the tray. I accept the plaintiff's evidence, and find as a fact, that the gap that was left in the storage rack was tight and that it was very difficult for the plaintiff to manoeuvre the tray into position, considering: the tightness of the space,

the fact that she was effectively *"flying blind"* when readjusting the tray, the considerable height the task was being performed at, the weight and heaviness of the tray and the overall awkwardness of the task.

65. I accept the plaintiff's evidence that there was virtually no room between the adjoining stacks and there was also very little room between the top or the middle column and the top of the rack. In addition, I accept the plaintiff's evidence, and find as a fact, that she noticed the stack was not steady and this necessitated her putting her hand back in to adjust and steady the tray. I accept her evidence, and find as a fact, that she felt a prick into her finger and instinctively pulled her hand back and the heavy tray came down on her finger before she could remove it, resulting in the crush injury indicated by the medical reports.

66. Insofar as the evidence of Ms. Burke and Mr. Wall was to the effect that it would be very unusual for the storage area to be overcrowded in this fashion, I note that neither witness, to their credit, insisted that this was never the case and both allowed of the possibility of staff shortages and trays being present on the storage rack from the previous day, albeit they felt this was very unlikely on the day in question. It should be noted, however, that the plaintiff was the only witness who gave evidence who was actually present for the accident. Even though it is unchallenged, the court is of course not bound to accept the plaintiff's evidence in that regard. However, I found this aspect of the plaintiff's evidence to be persuasive and consistent and she steadfastly maintained the position in cross examination that the rack was full and she was dealing with a tight space.

67. One factual matter that was very much put in issue was the plaintiff's claim that she suffered a prick type injury to her finger and that this was what prompted the instinctive withdrawal of her hand, resulting in the crush injury. The plaintiff was clear in her evidence that the preface to sustaining the crush injury to her finger was the prick injury. While she was not altogether clear on what caused the prick injury, it seems to me there is very strong

corroborative evidence available to support the conclusion that she suffered a prick injury. The court was provided with a medical note from Tallaght Hospital dated 25 August 2016 relating to the plaintiff's attendance with a clinician, Ms. Anna O'Leary at 10.53am. Under the heading "Presenting Complaint" Ms. O'Leary notes the following:

> *"Presented to ED following workplace incident. Caught finger between two metal trays 2 days ago. Presents with painful swolling [sic] left index fingertip".*

Then at the foot of the medical note the following is stated:

> *"On exam left index finger is red and swollen. Exquisitely tender on the medial side of the tip of the finger. Pain also at the distal joint. Reduced ROM. Pain on both flexion and extension. Evidence of a small puncture within the tip of the index finger on the lateral side of the finger".*

68. The attendant's note from Ms. O'Leary is not just consistent with a crush injury to the plaintiff's finger having occurred two days earlier, it is also consistent with the plaintiff having suffered a small puncture within the tip of the index finger as a result of the prick injury that she described in her evidence.

69. In addition, there are a number of other independent pointers which, individually and collectively, corroborate the plaintiff's account of the accident and her description of the injury. Firstly, the accident report form dated 25 August 2016 describes the incident as *"caught between two basket*" [sic]. In the medical findings box the following is stated: *"Review of OCC, injury. Crushed index finger (L) index finger 2 x 7.. Orthopaedic set = v. heavy sore + tender + swelling +*". The note is signed by a treating consultant by the name of Mulligan.

70. Secondly, in the first report of Mr. John Quinlan, Consultant Orthopaedic Surgeon dated 27 September 2016, the following account is provided in the accident details:

"This lady was lifting a heavy orthopaedic set off the loader to stack on top of another set. Something stuck into her left index finger tip from the set. As a result she dropped the set and her left index finger got caught between the two sets. She washed and dressed her own finger and continued working".

In the same report Mr. Quinlan notes the injuries that were sustained as follows:

"Avulsion fracture of the ulnar aspect of the distal interphalangeal joint of the left index finger."

71. Whilst the accident description in a medical report is obviously self-confirmatory and therefore of limited probative value on the question of liability, it nonetheless reinforces the strong sense of consistency running through the various contemporaneous and near contemporaneous reports of the accident. All of this reinforces the court's view of the plaintiff's evidence.

72. As I mentioned earlier, I found that the plaintiff's evidence was less than clear on the question as to what she had done with the orthopaedic set after the accident, and specifically whether she returned the tray through the hatch, back into the system for further cleaning. I found Mr. Wall to be a good and fair witness and he stated from his review of the audit reports that no trays were returned to the earlier phase of cleaning through the hatch, as was alleged by the plaintiff. However, even accepting that to be so, Mr. Wall's evidence does not exclude the possibility that the tray was returned for cleaning without being monitored on the system. For the tracking system to track an item, somebody needs to scan it in. While the system was automated, the system was nonetheless dependent upon human intervention. That being so, the possibility of human error or oversight cannot sensibly be excluded. The likelihood that this is what occurred is increased in circumstances where, as I accept, the

plaintiff did not report the blood injury at the time or bring to the attention of management on the day that a recall issue had occurred.

73. It may be that the plaintiff was not inclined to draw attention to herself, for fear of this triggering what would have been a relatively serious blood inquiry. Whatever the cause of her not reporting the blood injury, in my view her failing in that regard is not determinative of the liability question. This is because, by that stage, the injury had already occurred. Nonetheless, in light of the plaintiff's particular role as a representative on the safety committee and her status as team leader in the department, it was less than impressive that she did not alert management to the issue at the time that it happened, particularly because a blood injury could endanger patients as well as staff.

Dispute between the engineers

74. In the view of the court, it is not necessary to dwell too long on the differences in views offered by the respective engineers. Both Mr. Tennyson and Dr. O'Flannery gave evidence which was helpful to the court. As part of his criticism of the defendant's system, Mr. Tennyson suggests the accident was caused by the failure to install tray guides or slides in the storage shelf. He argued that this would eliminate an unsteady stack of trays containing irregular objects. This was disputed by Dr. O'Flannery. He was satisfied there was a safe system of work and that the metal grid shelving storage was appropriate and fit for purpose. He felt that while the storage rack was reasonably basic it was straightforward and suitable. In his view, guide rails would not work with trays of different weights, heights and sizes. In fact, his view was that guide rails were not suitable and represented a hygiene risk because they are more difficult to keep clean because there are different sides and ledges incorporated into their design.

75. Dr. Flannery pointed out that the orthopaedic trays are supplied free of charge to the hospital by their surgical instrument suppliers whenever new instruments are purchased. This type of tray is a standard piece of medical equipment that has been used by hospitals for many years. Borrowing the figures provided to him by the defendant's representatives, he stated that the hospital processes approx. 36,000 standard trays every year and a further 25,000 larger trays for single items - an average of 167 trays every day. The defendant points to these statistics as being significant because, according to the unchallenged evidence, there have been no previous accidents of a similar nature.

76. It is proper and appropriate that the court should take all of these matters into account, including the statistics concerning the defendant's impressive accident-free record. However, engineering experts can only offer opinion evidence to assist the court, based on an established or agreed or assumed body of facts. While the engineering evidence is important, the first port of call is the *factual* description of the incident itself. Since the court accepts the plaintiff's evidence that she had to carry out her task in such a tight and confined space, and that this was the dominant factor that led to the accident, the evidence of the respective engineers falls to be considered against that established factual backdrop.

77. In the view of the court, it is not necessary to address all areas of dispute between the engineers. Nor is it necessary for the court to address all of Mr. Tennyson's criticisms of the defendant's operation, including the type of equipment provided, the level of training or the design of the storage rack. Nor is it necessary to get into the debate concerning whether the defendant should have provided shelving units with guide rails or separate compartments.

78. Instead, I am going to confine my observations to the issue as to the provision of sufficient storage space for the orthopaedic trays. Accepting as I do the plaintiff's evidence that the designated space on the rack was full, or virtually full, this means that the system of work on that particular day was unsafe because it exposed employees such as the plaintiff to

an unnecessary and foreseeable risk of injury. The defendant must have been aware that this was an awkward, challenging and repetitive task that had to be performed at head height. The task involved the carrying of a heavy metal item weighing over 5kgs which had to be manoeuvred in to position in circumstances that were far from ideal. In my view, it was foreseeable that an employee might have to reposition the tray to get it to sit properly.

79. Based on the evidence, I hold that the plaintiff had to perform the readjustment task in an area of very confined space in circumstances where there was no room at the top or to the side to retrieve the back handle of the tray that had dropped, as it was designed to do. I accept Mr. Tennyson's evidence that, on these facts, the defendant's system of work was unsafe and exposed the plaintiff to unnecessary risk of injury. Working in such a tight and cramped area, it was foreseeable in my view that an accident would happen along the lines described by the plaintiff. In my view, either a redesign of the stacking arrangement or greater provision of storage space would have avoided this accident. I accept the evidence of both the plaintiff and Ms. Bowden that in all the time they were there, the system of work had not changed.

80. Separately, while perhaps not as critical as the points made above, it does seem to me that the risk assessment carried out by the defendant could and should have directed more attention to the storage element of the procedure. I accept the defendant's evidence that a risk assessment was carried out but in the view of the court it was more focussed on the issue of manual handling and failed to dedicate sufficient emphasis to the storage phase of the operation.

81. I am satisfied for all these reasons that, on the particular day in question, the common law duty of care not to expose the plaintiff to unnecessary harm was breached by the defendant. In addition, owing to the insufficiency of storage space provided, I am satisfied that the plaintiff has established material breaches of the following provisions of s 8(2) of the Safety, Health and Welfare at Work Act 2005:

- (a) Managing and conducting work activities in such a way as to ensure, so far as is reasonably practicable, the safety health and welfare at work of its employees;
- (c) Ensuring, so far as is reasonably practicable, the … provision … [of storage] plant and machinery that are safe and without risk to health;
- (e) Providing systems of work that are planned … and revised as appropriate so as to be, so far as is reasonably practicable, safe and without risk to health;
- (h) Determining and implementing the safety, health and welfare measures necessary for the protection of the safety, health and welfare of its employees when identifying hazards and carrying out a risk assessment.

82. Having said all of the above, it does seem to the court that this was a singularly unusual set of facts that conspired on this particular day that resulted in the storage rack being virtually full at the time that the plaintiff had her accident. I accept the otherwise impressive evidence of the defendant's witnesses concerning the accident-free history of the department. I also accept the strong body of evidence produced by the defendant in a general sense concerning the care and attention paid by the defendant to the whole issue of hygiene and patient and staff safety.

Contributory negligence?

83. It was put to the plaintiff in cross-examination that she was guilty of negligence and contributory negligence. This was a theme also developed by the engineer Dr. O'Flannery in his evidence. Senior counsel in cross-examination put to the plaintiff that she had been carrying out this task for some nineteen years and that she was an experienced team leader and a safety representative on the defendant's safety committee. In addition, the plaintiff's colleague, Ms. Bowden, in her evidence accepted that employees were required to carry out their own risk assessment of each lifting task and further that, when putting down an

orthopaedic set, employees were required to make sure they had enough room. In the light of all the evidence in the case, it seems to me that there should be a significant finding of contributory negligence made against the plaintiff.

84. I hold that the plaintiff, in view of her position and experience, should have realised that the storage rack was full or nearly full. She should therefore have sourced an additional storage trolley or placed the tray on an inspection table. Better again, in view of her own position and experience, she should have alerted management to the necessity to clear away some of the metal trays from the shelves of the storage rack.

85. In assessing what percentage of contributory negligence should apply, it seems to me the court should take into account that this was a reasonably repetitive lifting task which the plaintiff and her colleagues had to carry out, and which also involved a degree of monotony and repetition where employees were almost doing things "by rote". This aspect of the task may have contributed to the plaintiff not pausing to assess and heed the fact that the storage rack was full and may have contributed to the plaintiff storing the item in an unthinking fashion, and not sourcing an alternative table.

86. In the view of the court, it would be unfair and disproportionate to dismiss the entirety of the plaintiff's claim based upon her failure to carry out the necessary risk assessment prior to sustaining her injury. Nonetheless, a substantial finding of contributory negligence is warranted. Based upon the evidence that I have heard, and taking account of the storage deficits and statutory breaches, I will make a one-third finding of liability as against the plaintiff. I hold that the defendant should bear the primary responsibility and be adjudged two-thirds responsible for this accident.

87. As the parties have reached agreement on quantum subject to liability, I will hear submissions on the terms of the final order and on the question of costs.

Appearances: Niall Fitzgibbon SC and John Nolan BL instructed by Kent Carty Solicitors LLP for the plaintiff.

Conor Bourke SC and Barry Browne BL instructed by State Claims Agency for the defendant.

Signed: Mícheál P. O'Higgins