Neutral Citation No: [2020] NIQB 38 *Judgment: approved by the Court for handing down (subject to editorial corrections)**	*Ref:* **MAG11117** *Delivered:* **18/03/2020**

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

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QUEEN'S BENCH DIVISION

_____

2017 No. 110615

JAMES MAXWELL

Plaintiff;

-and-

CHC GROUP LIMITED

and

AGRI FOOD AND BIO SCIENCES INSTITUTE

Defendants.

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MAGUIRE J

Introduction

[1] The plaintiff in this case is James Maxwell. He is a man aged 67. On 10 November 2014 he was involved in an accident while at work as a steam boiler operative. At the time, the plaintiff was employed by the first named defendant, CHC Group Limited ("CHC"), at the premises of the second named defendant, Agri Food and Bio Scientists Institute ("AFBI").

[2] The accident happened in the early morning - 07.15 hours to be precise - during hours of darkness. The plaintiff had arrived at work in the Stormont area of Belfast at AFBI at around 07.00 hours and one of his first tasks was to go and check a particular boiler. In order to access the boiler, the plaintiff had to negotiate a passageway at the end of which was a set of steps which he had to go down.

[3] The plaintiff at the time of the accident had been working for his employer CHC at the AFBI premises for some 14 years or so. He was aware that the steps had 2 to 3 months earlier been cordoned off by a chain which had been placed across them at the end point of a passageway which was on his route to the relevant boiler. The chain had been put in place to prevent smokers using the area at or about or below the steps as the place to go in order to have a smoke. A sign had been erected

on the chain to the effect that there was to be "no unauthorised entry". This sign, it is common case, did not apply to the plaintiff as he had to use the steps in order to make his way to the boiler in question. In fact, there were others who likewise were authorised to use the steps, such as persons accompanying the plaintiff for the purpose of his work at the boiler and persons who were part of the AFBI estates office staff.

[4] It appears from the plaintiff's evidence that on the morning in question there was no lighting in the area of the passageway which led to the steps. There were three lights along the passageway to the staircase, but for reasons unknown it appears likely, if the plaintiff's account is correct (and the court has no reason to doubt it), that none of the three was working. Two of the lights were conventional lights whereas the third was some form of emergency light. The plaintiff said he approached the steps *via* the passageway in the dark. As he candidly admitted at the hearing, he unfortunately simply forgot about the chain being across the passageway at the top of the steps and as a result in the darkness he tripped or fell over the chain and ended up at the bottom of the first flight of steps, so injuring himself. In these proceedings the plaintiff seeks damages in respect of the injuries he received in this accident.

[5] It is unnecessary to describe the plaintiff's injuries as the parties have been able to reach agreement upon the following:

(a) Quantum has been agreed in this case.

(b) An element of contributory negligence on the part of the plaintiff has likewise been agreed.

(c) It is further agreed that the award to the plaintiff, after a reduction for contributory negligence, should be £35,000, with the CRU to be payable by the defendant or defendants which are liable.

[6] The issue which has not been agreed and which was the subject matter of the hearing before the court was whether one or other of the two defendants, or both, were liable to pay damages. In other words, while the plaintiff is bound to succeed on the basis described above, the court is being asked to decide whether CHC should pay or whether AFBI should pay or whether each should pay to some extent.

The plaintiff's pleaded case

[7] It is necessary to refer briefly to the plaintiff's Statement of Claim which is directed at both defendants. It is based on the proposition contained in paragraph 4 that the damage to the plaintiff was caused by reason of "the negligence and breach of statutory duty of the Defendants and each of them".

[8] There are then set out particulars of negligence and later particulars of breach of statutory duty of the defendants. There is no attempt to differentiate between the defendants in relation to the particulars provided.

[9] In relation to the particulars of negligence some 16 allegations are made. These are:

> "(a) Allowing and permitting the Plaintiff to be in and about an area which was dangerous and unsafe in the circumstances.
>
> (b) Failing to carry out any or adequate risk assessments in relation to the working operations and the place of work.
>
> (c) Causing and permitting a chain to be placed in a dangerous location at the top of the stairs.
>
> (d) Failing to assess the danger created by placing a chain at the top of the stairs.
>
> (e) Causing the chain to be a dangerous obstruction on the stairs.
>
> (f) Failing to highlight the chain and warn the Plaintiff about the presence of the chain.
>
> (g) Causing and permitting the stairs to be dark.
>
> (h) Causing and permitting a bulb to be broken.
>
> (i) Failure to maintain and repair bulbs adequately or at all.
>
> (j) Failure to inspect the area adequately or at all.
>
> (k) Allowing and permitting the plaintiff to be in and about an area which was dangerous and unsafe in the circumstances.
>
> (l) Failing to ensure that traffic routes in the workplace were safe.
>
> (m) Failing to provide the Plaintiff with a safe place of work.

(n) Failing to provide the Plaintiff with a safe system of work.

(o) Failing to have any or adequate regard for the safety of the Plaintiff.

(p) Causing or permitting the Plaintiff to sustain personal injuries, loss and damage".

[10] There are only two breaches of statutory duty referred to in the Statement of Claim. These are:

(a) Breach of Regulation 5 of the Workplace (Health, Safety and Welfare) Regulations (Northern Ireland) 1993. This deals with the maintenance of the workplace and of equipment, devices and systems.

(b) Breach of Regulation 12 as aforesaid. This deals with the condition of floors and traffic routes.

The Evidence

The Plaintiff

[11] The court found the plaintiff to be a somewhat vague witness even though there was no dispute that the accident that befell him occurred broadly in the manner which he had described. In answering questions, this witness often chopped and changed in his responses and he left the court with the impression that he was fearful of saying very much with confidence or with certainty. His evidence is, accordingly, to be treated with caution.

[12] The main points relevant to what the court has to decide, which emerged from the plaintiff's evidence, were as follows:

- He said he checked the boilers a number of times per day.

- He said he had not noticed whether the lights in the passageway worked or not prior to the accident.

- He thought, however, that the day of the accident was the first time he had noted that the lights were off but he later contradicted this by saying that he in fact thought they were off for a period of about a week.

- He said more people than him used the passageway and staircase.

- At no stage had he reported the lights being off to anyone. He had not reported this to CHC; and nor had he reported it to AFBI.

- He thought that if he was to make a report in relation to the lights being off that report would be to AFBI's estates office.

- He had had visits from personnel within CHC once or twice a year. When the visits took place a check was made in respect of his working environment to highlight anything which was dangerous.

- In more recent times he had become directly employed at the same premises by H and J Martin, but this change post-dated the accident.

- There had been changes made since the accident. In particular, gates had been put on at the relevant end of the passage or walkway and the chain removed. Reflective nosing was also applied to the stairs of the steps.

- In his opinion there was no longer a hazard at this area.

- He had been in contact with an employee of CHC called Anita Poole. After the accident she had visited him when he was in hospital and he told her what had happened. As a result she had prepared an accident report form.

- In fact it turned out that he was related to Anita Poole and three other members of the senior management of CHC. However, he denied in any way trying to place AFBI in a bad light.

- While he was quoted in the accident report form as having said that the lights had been "out for years" he initially, when asked about this, said he could not remember, though he later amended this by accepting that he probably did tell Anita Poole that the lights had been out for years.

- He said he had no "lone worker" training prior to the accident. He said he had been to various training courses run by CHC but that none of these impinged directly on the matters which affected the accident.

- He accepted that he should probably have had a torch with him so as to deal with a situation of this kind. However, he did not indicate that he had been trained to this effect.

- He said he had not been trained to report faults in the lighting by CHC. Nor had he been trained by AFBI similarly.

Anita Poole

[13] Anita Poole at the relevant time worked for CHC and seems to have concerned herself with issues of health and safety in relation to CHC's employees,

like the plaintiff, who worked at a third party's (here AFBI's) premises. She was called on behalf of CHC. The plaintiff was her uncle.

[14] This witness described the system operated by CHC which was characterised by her as involving random visits to third party premises with a view to checking the working environment of CHC's employees. In the case of the plaintiff, she said she visited AFBI's premises twice a year approximately.

[15] She offered the view that the premises at AFBI were not regarded as dangerous premises but that she had carried out risk assessments in the context of the position at AFBI of the plaintiff as a CHC employee working with boilers. She did what she described as "generic risk assessments". According to this witness's evidence, other members of CHC's senior management, in particular a Mr Dale Poole (both a relative of hers and of the plaintiff's) also visited the AFBI site on occasions.

[16] This witness told the court that her central interest was to seek to define what hazards existed in the workplace that she was assessing. To do this she walked around and inspected. If she saw something which required action she said she would report it to AFBI and/or CHC. She said she had last visited the site prior to the accident in June 2014 – 5 months before. On that occasion she had gone to the boiler to which the plaintiff had been going at the time of accident. She had not noticed any problems in the vicinity or in the access to the boiler. In particular, at that time she said there was no chain in place across the passageway at the head of the stairs. This, she said, was placed in position by AFBI staff about two months prior to the plaintiff's accident. She had not been made aware by anyone that it had been so positioned. In her view, with hindsight, it was clear that the chain represented a trip hazard as it was strung at too low a level and was too close to the steps themselves. It would have been better for the chain to have been at least at waist level and further back from the steps. Notably she gave these views after having visited the scene of the accident later on the day when it had occurred. At that time she said she was in contact with and attended together with members of the AFBI staff. She said she told them that the lights and chain needed fixed as a matter of urgency.

[17] After the accident it is clear that a new steam boiler operative had to be appointed to replace the plaintiff and she told the court that later when she went to check the premises to ensure all was in order the chain had been withdrawn from use and the lights had been repaired and, additionally, fluorescent nosing had been applied to the individual stairs.

[18] A problem with the evidence of Anita Poole was that even though she said she had fully risked assessed the area in question in advance of the accident in June 2014, she was unable to provide the court with records of the outcome of that assessment. The court therefore had no risk assessment document which dealt with the precise areas connected to the accident and there was no direct mention, in

advance of the accident, of any problem at or about this location. For example, there was no document which had been discovered by CHC which dealt with the issue of what one of their workers should do in the event of a failure of lights on access ways. This was so, notwithstanding that it is self-evident that the route which was being used by the plaintiff at the time of the accident in hours of darkness could only be safely used with the assistance of an adequate form of artificial light.

[19] It is right to observe that Ms Poole appeared to the court to be frustrated by the absence of records which she believed existed in relation to her visit to the AFBI premises in June 2014, but at the same time the legal representatives of CHC were adamant that they had provided discovery both to the plaintiff and to AFBI of anything which was relevant.

[20] Finally, there was no doubt that this witness did compile an accident report form after the accident. As already noted, the report contains some notably extravagant claims on the part of the plaintiff as to the length of time the relevant lights had been out in the passageway.

Michael McLaughlin

[21] This witness was called by AFBI. He is a well-known consultant engineer and had visited the site for an inspection on 11 October 2018 (nearly four years after the accident). Also at that inspection was a Mr Declan Cosgrove, a consulting engineer who was engaged by the plaintiff.

[22] In the course of dialogue between the two experts, Mr McLaughlin said that he was told by Mr Cosgrove that the cause of the lights not being on was a fault with the timer. Mr McLaughlin queried as to whether the plaintiff had tried on the day of the accident to switch on the lights but he was told by Mr Cosgrove that the plaintiff had not. The plaintiff was then quoted by Mr Cosgrove as saying that there was a policy not to turn on the lights when it was dark.

[23] This evidence appears to do little credit to the plaintiff as what he appears to be saying makes little sense, especially as a switch or switches to turn on the lights may be found at the location. The court can only suppose that the plaintiff's memory, after such a long gap in time, had failed him.

[24] Mr McLaughlin placed emphasis in his evidence on the plaintiff's position as a "lone worker" at the AFBI premises. He relied on this notion basing himself on an official HSE guidance document on this subject of May 2013. The court can appreciate that it is right that the plaintiff worked alone at the AFBI premises and away from his employer's base. However, the plaintiff was adamant that by the date of the accident he had not received any substantive lone worker training. In respect of the court's consideration of the documentation contained in the trial bundle it would appear that there is no basis for believing that the plaintiff did in fact receive substantive lone worker training. However, there are fleeting references in the

documents seen by the court as to CHC being aware of this concept and of them mentioning it.

[25] In respect of this aspect of the matter, the court doubts whether the concept of the lone worker can legitimately be viewed as being of substantive importance to the court's conclusions in respect of the issue now before it. While the court accepts that the basic thinking behind the lone worker concept makes reasonable sense so that, for example, a lone worker should communicate to another person where he is going to be and should carry a mobile phone in case he should need some assistance, these issues are not at the centre of the case.

[26] The court accepts Mr McLaughlin's proposition that in a situation such as that of the plaintiff one would have expected him to be carrying a torch during hours of darkness but it appears that he was not doing so, or if he did carry one, he did not use it. The court could find no documentation in the trial bundle indicating that CHC had identified any risk in connection with his apparent failure to carry a torch. Nor is there any material in the papers which would demonstrate that CHC had provided him with a torch.

Stephen Cousins

[27] Mr Cousins was called on behalf of AFBI. He is the manager of the AFBI estate at Stormont. He began working in this job in or around July 2014 just after the visit Anita Poole said she had undertaken in respect of the plaintiff's place of work in June 2014.

[28] The main points made by Mr Cousins were as follows:

- That there was no policy that he was aware of that AFBI had of not switching on lights or not using lights.

- That there was a policy introduced 2 to 3 months prior to the plaintiff's accident designed to prevent staff from smoking in the area at or beyond the staircase which had been cordoned off by a chain. The witness explained that since 2005 there was a general no smoking policy in government buildings, save at designated places. However, staff in defiance of that policy used undesignated places such as at the location described above for smoking. This led to steps being taken as described. The chain across the passageway at the top of the steps with a sign on it was therefore put in place.

- That the plaintiff was spoken to about the use of the chain prior to the decision to put it in place. This was done because there was an awareness that he would have to use the passageway and steps and therefore needed access to them and to the boiler beyond them.

- That he and his colleagues took health and safety issues seriously and he accepted that a failure to do so might result in someone getting hurt.

- That accordingly there was a need not to create accidentally any form of trip hazard.

[29] This witness in a frank exchange during cross-examination, by Chris Ringland BL for CHC, accepted that the siting of the chain where it was placed had been a mistake because it was strung too low (inviting trips) and was at the top of a set of steps so representing a particularly dangerous trip hazard.

[30] The witness went on to accept that there had not been any or any proper risk assessment of this development in the workplace. He also accepted that if there had been such an assessment this may well have highlighted the risk to the point where it would have been likely that the use of the chain would have been abandoned.

[31] Another concern which Mr Cousins accepted was valid was that there had not been due consideration given to alternative means of dealing with the problem caused by the smokers which was under consideration. He accepted that putting in a gate was the most obvious way of achieving the objective, though he felt that a downside of this option was that it would be likely to take some considerable time to put in place.

[32] Other possibilities, he accepted, would have involved drawing the attention of staff to possible sanctions if they failed to adhere to the no smoking policy and the need to smoke only in designated areas. In respect of this, he said he thought it would not work but admitted this approach had not been tested.

[33] Given the location of the chain the witness conceded that it was vital that the adjacent lights worked during hours of darkness.

[34] Mr Cousins took the court on a journey which explained how members of staff at AFBI could report faults and achieve repair of same. In accordance with this procedure the lights in question, which appear to have given rise to the plaintiff's accident, were repaired some four days after the accident by a contractor following a report (which may have come from either Ms Poole or a member of the AFBI staff).

[35] As the plaintiff was not a member of the AFBI staff Mr Cousins pointed out that the procedure would have been for him to report a defect such as lights being out to AFBI staff who would then activate the process of obtaining the necessary repair.

[36] At the end of his evidence Mr Cousins stated that there was a system for inspecting the lights in the building periodically. He indicated that there were records of such inspections but he could not account for the fact that in the discovery made by AFBI to the plaintiff and to CHC no such records had been produced.

The court's assessment

[37] For the purpose of the issue which the court is required to decide it makes the following assessment:

(1) There was a failure by AFBI staff to act with due care when deciding to put the chain arrangement in place at the top of the steps some 2 to 2½ months prior to the accident. The main defects in the plan were that the chain was slung too low and was placed too close to the edge of the steps.

(2) As a result, the plan when put into action had the effect of creating a potential hazard in the form of the risk that a person may trip over the chain. The danger thus created is increased in the light of its location at the top of the steps.

(3) In these circumstances it was clear that an important priority was to ensure that the nearby lights operated properly during hours of darkness as any failure in this regard was bound to exacerbate the risk of serious injury. This pointed up the need for a proper system of inspection to be in place. There is no evidence that in fact a working system was in place.

(4) The plaintiff clearly had been aware of the chain but had forgotten about it and, given its low slung position, tripped over it and fell down the stairs in the darkness so causing his injury. This points to contributory negligence on his part.

(5) There had been no risk assessment carried out by AFBI in respect of the new arrangement introduced by them arising from the problem of smokers using undesignated areas.

(6) The court is satisfied that the placing of the chain should have been subjected by AFBI to a risk assessment but this did not occur.

(7) The court believes that most likely all of the lights were out but in any event even if the emergency light was not out it seems clear that the area had been placed in darkness so creating circumstances in which the accident occurred.

(8) There is no evidence that CHC provided the plaintiff with a torch which, arguably, it should have done. If a torch had been provided it might have avoided the accident. The point is, however, moot as there

is no specific pleading in the plaintiff's Statement of Claim or elsewhere directly impugning either defendant in respect of this issue.

(9) The court is satisfied that CHC did inspect the area in June 2014 and found no apparent defect. In fairness to Anita Poole, at her June 2014 inspection there was no chain to see, as it had yet to be installed.

(10) CHC had no system for dealing with changes to the working environment which arose in between the two standard inspections which were carried out. Either its worker on the ground should have had, as one of his duties, the making of reports to CHC of any such changes, or CHC should have had a member of its management designated to carry out this function either by liaising with its worker on the ground and/or the AFBI management. While the plaintiff was consulted by AFBI about the proposed change, he made no report about the proposed new arrangements to his employer. No other member of staff had been identified by CHC as a person who performed this function.

(11) It follows from the above that the court accepts that CHC was unaware of the change in the working environment introduced by the chain prior to the accident but this state of ignorance should not have been allowed to occur and CHC ought to have had in place a reasonable system for making itself aware of changes to the workplace. Reliance only on two inspections per year was not enough, given the non-delegable nature of the duty.

(12) The steps taken by CHC in the aftermath of the accident appear appropriate.

[38] In the light of the above, the court is of the view that:

(a) AFBI clearly failed to carry out, as the body in primary occupation of the workplace, any or any sufficient risk assessment of the positioning of the chain across the passageway. In addition, the court is not satisfied that there was any working system for inspection of lights to ensure that they were working. Further, AFBI failed to give its attention to the way in which the chain was slung and as a result slung it too low and too close to the staircase. In these circumstances it was not disputed by Rory Donaghy BL for AFBI that at least a portion of the liability in this case must fall upon them. In any event, the evidence of Mr Cousins, in the court's assessment, may reasonably be viewed as an acceptance that there were serious flaws in the process leading to the inception of the new arrangements.

(b) The court also is of the opinion that CHC failed in its duty to ensure a safe workplace for the plaintiff. This failure can be traced to the absence of any instruction to the member of its workforce based at AFBI or to any of its staff in continuous contact with him or AFBI to draw to senior management's attention, as should have occurred, the introduction of a new arrangement which affected the worker's day to day activities. There is no evidence that CHC had in operation a system which placed this obligation on its worker on the ground or indeed on any other member of its staff. In the absence of any such obligation, CHC was disabling itself from carrying out its duty to provide a safe working environment for its employee. Causally, this affected the course of events, as if a risk assessment had been carried out of the change in the work environment, it seems highly likely that, based on Anita Poole's analysis, the flaws in the proposed change would have emerged with the ultimate consequence that the accident would not have occurred.

[39] The court does not believe that, on proper analysis, this is a 50/50 case. The author and originator of the flawed changes to the work environment were AFBI, which also had primary responsibility for the lights. This should be reflected in the court's allocation of responsibility for the accident. Accordingly, the court will hold that it is just and equitable that AFBI should be 75% responsible for the accident and CHC 25%.

CHC's Pleadings Point

[40] At the end of the evidence in this case, counsel for the defendant raised a pleadings point on behalf of CHC. In essence, he submitted that AFBI in their defence had not raised a case against CHC whereas CHC in its defence had raised a case against AFBI. Accordingly, he argued AFBI should not be able to rely on a case which had not been particularised and thus any case directed at his client on the part of AFBI should be dismissed.

[41] The court has considered this point. It expresses its surprise that this point had not been made at the outset of the proceedings, especially in circumstances where the court had been presented with the situation that, as a result of discussions between the parties, the issues had been narrowed in the way referred to at paragraph [5] above. If this was a good point, the logical time for it to have been taken would have been before any evidence was heard.

[42] Be that as it may, counsel relies on Order 16 and, in particular, Rule 8 (6). This reads:

> "Where defendants are sued as tortfeasors liable in respect of the same damage [which is this case] they should be treated as opposite parties and no notice need

> be served under this rule but any such defendant, if he intends to support the claim for contribution or indemnity to rely on facts or particulars not pleaded by the plaintiff or any contractual right, must furnish particulars thereof in writing to the other parties".

[43] As the court understood counsel's argument, it was that AFBI's case against his client involved a transgression of the above rule in that it relied on matters which ought to have been particularised in writing in advance of the hearing.

[44] The court is not attracted to this argument which, in view of the way the case ran, seems to be relying on a mischief which in reality had little, if any, purchase on the facts before the court.

[45] At no time prior to the making of this submission was there any suggestion that CHC felt that it was taken by surprise or wrong footed by the way the case had developed before the court. Indeed, in the unlikely event that this had been the position, the court could easily have taken steps to ensure that any potential unfairness could have been met by suitable remedial steps.

[46] In the court's view, if it now accepted this point and ruled that AFBI was unable, on procedural grounds, to advance the case it wished to make against CHC, this would run counter to the requirements of fairness and would be inconsistent with the over-riding objective found in Order 1 Rule 1A.

[47] The court, therefore, places no weight on this submission. The court would also point out that the basis upon which it has attributed a measure of liability upon CHC in this case relates to a matter which has been pleaded in the plaintiff's Statement of Claim.