Neutral Citation No. [2011] NIQB 67

Ref: **GIL8254**

Judgment: approved by the Court for handing down
*(subject to editorial corrections)**

Delivered: **24/08/11**

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

QUEEN'S BENCH DIVISION

BETWEEN:

LEANNE SMITH AS PERSONAL REPRESENTATIVE AND ADMINISTRATRIX OF THE ESTATE OF DAVID JOSEPH McLOUGHLIN (DECEASED)

Plaintiff;

-and-

RODNEY WILGAR T/A WILGAR CONTRACTS

Defendant.

GILLEN J

Cause of action

[1] The plaintiff in this matter is the partner of David Joseph McLoughlin (Deceased) and the administratix of his estate. She sues by virtue of the Fatal Accidents (Northern Ireland) Order 1977 on her own behalf and by virtue of the Law Reform (Miscellaneous Provisions) Act (Northern Ireland) 1937 on behalf of the estate by reason of the death of the deceased on 6 December 2005 in the course of his employment with the defendant. The inquest on the death of the deceased found that the pattern of his injuries was consistent with him having fallen off a ladder and struck his head on the ground. The severity of his injuries indicated he was at a considerable height on the ladder when he fell.

Facts not in issue

[2] Certain of the facts pertinent to the issues in this case that I have to decide were either agreed or were not seriously in dispute in these proceedings.

[3] It was clear that at the time of his death the deceased was an employee of the defendant as a painter and decorator engaged in painting the gable wall of property at Garland Hill, Belfast when he fell from the ladder causing his death. The defendant Rodney Wilgar at that stage employed five men (including the deceased and an apprentice). The defendant himself was rarely on the site apart from mornings (for example when the accident occurred) and some afternoons as he was generally pricing other jobs at other sites. However he had a foreman there permanently working namely Jason Agnew.

[4] At this time of his death the deceased was 27 years of age. Helpfully the parties had agreed the proposed quantum at £39,020 subject to my approval. Hence this case was heard only on the issue of liability.

[5] The deceased had been employed with the defendant for between six and twelve months (there was some dispute as to the exact period but this was not of any relevance) as a painter and decorator. Prior to working with the defendant, the deceased was a long term insulin dependent diabetic who on occasions had suffered hypoglycaemic attacks (hereinafter called "hg attacks"). Medical records before me recorded such attacks had occurred on the following dates:

- January 1985
- January 1987 when he was on a ladder at the time
- August 1997
- June 1999
- April 2000
- July 2000 when he had been involved in a road traffic accident
- July 2001
- December 2003 when he fell from scaffolding
- October 2004.

On one occasion, three months before the accident whilst working with the defendant, the deceased had, in the presence of amongst others Jason Agnew, taken a dizzy turn after work. Jason Agnew had given him a tin of coke and, as Jason Agnew described," he came round".

[6] It therefore was undisputed that the deceased had failed to control his diabetes from time to time rendering him vulnerable to hg attacks which had caused him to fall.

[7] Accordingly I am satisfied from the evidence of Dr Nelson, a consultant dealing with diabetes who gave evidence in this case on behalf of the defendant, that this deceased was unsuited to working at heights as a painter or decorator because of his history of diabetes and of hg attacks.

[8] On the day of his death, the deceased had been working on the gable wall on a 20 foot long ladder which was secured by being wedged under a garden shed at the side of the property. The work involved the painting of the fascia/soffit around the top of the wall. I am satisfied that after his fall there was evidence that the ladder had not moved and remained securely in position. At the particular place where the ladder was placed at the time the deceased fell, it was therefore unnecessary to foot the ladder given the secure wedging against the shed. The ladder was neither based on infirm surface nor placed at a dangerous angle for the base to rest.

[9] The accident occurred at approximately 9.15 am. The deceased had started work about one hour prior to that.

Statutory duty

[10] The statement of claim alleged a number of breaches of statutory duty, some of which had been repealed and others which were not relied on at the hearing. Those relied on were as follows.

The Management of Health and Safety at Work Regulations (NI) 2000 (hereinafter called 'The 2000 Regulations")

[11] Under Regulation 3, every employer must make a suitable and sufficient assessment of the risks to the health and safety of its employees to which they are exposed while at work. Risk assessment is a cornerstone of modern health and safety law. What is "suitable and sufficient" broadly requires a systematic examination of the workplace, examining the hazards present and the likelihood of them arising. The extent of this assessment will vary with the complexity of the operation. The risk assessment is intended to identify the measures to be taken to comply with the employer's statutory duties.

[12] These regulations owe their origin to the European framework Directive (89/391/EEC). The underlying philosophy of the Directive is of creating uniform levels of health and safety protection throughout for Member States so ensuring that competition does not take place at the expense of worker protection. The Directive sets out a clear hierarchical approach to an employer's strategy on the basis of the principles of prevention under Article 6(2) of the Directive. These principles are set out in Schedule 1 to the 2000 Regulations and are as follows:

> "(a) Avoiding risks;
>
> (b) Evaluating the risks which cannot be avoided;

(c) Combating the risks at source;

(d) Adapting the work to the individual, especially as regards the design of work places, the choice of work equipment and the choice of working and production methods, with a view, in particular, to alleviating monotonous work and work at a pre-determined work-rate and to reducing their effect on health;

(e) Adapting to technical progress;

(f) Replacing the dangerous by the non-dangerous or the less dangerous;

(g) Developing a coherent overall prevention policy which covers technology, organisation of work, working conditions, social relationships and the influence of factors relating to the working environment;

(h) Giving collective protective measures priority over individual protective measures; and

(i) Giving appropriate instructions to employees.

[13] A leading authority on the interpretation of the English Regulations comparable to the 2000 Regulations in Northern Ireland is a decision of the Court of Appeal (Civil Division) in Allison v London Underground Ltd [2008] EWCA Civ. 71. In that case the plaintiff was a tube driver who developed tenosynovitis due to the prolonged use of a brake controller which had been modified. The modification was not the subject of expert advice and no special instructions were given to drivers as to how they should position their thumb in relation to the chamfered end.

[14] Emphasising that the statutory duty was higher than the duty existing at common law and imposed on the employer a duty to investigate the risks inherent in his operations Smith LJ said at paragraph 57 et seq:

> "How is the court to approach the question of what the employer ought to have known about the risks inherent in his own operations? In my view, what he ought to have known is (or should be) closely linked with the risk assessment which he is obliged to carry out under reg. 3 of the 1999 Regulations (*comparable to the 2000 (NI) Regulations*). That requires the employer

> to carry out a suitable and sufficient risk assessment for the purposes of identifying the measures he needs to take to comply with the requirements and prohibitions imposed upon him by or under the relevant statutory provisions. What the employer *ought* to have known will be what he *would* have known if he had carried out a suitable and sufficient risk assessment. Plainly, a suitable and sufficient risk assessment will identify those risks in respect of which the employee needs training. Such a risk assessment will provide the basis not only for the training which the employer must give but also for other aspects of his duty, such as, for example, whether the workplace is safe or whether work equipment is suitable.
>
> (58) ……. Risk assessments are meant to be an exercise by which the employer examines and evaluates all the risks entailed in his operations and takes steps to remove or minimise those risks. They should be a blue print for action. I do not think that Judge Cowell was alone in underestimating the importance of risk assessments. It seems to me that insufficient judicial attention has been given to risk assessments in the years since the duty to conduct them was first introduced. I think this is because judges recognise that a failure to carry out a sufficient and suitable risk assessment is never the direct cause of an injury. The inadequacy of a risk assessment can only ever be an indirect cause. Understandably judicial decisions have tended to focus on the breach of duty which has lead directly to the injury."

[15] Before passing on to a further aspect of statutory duty in this case, I record that Regulation 13 of the 2000 Regulations enjoins an employer to take into account the capabilities as regards health and safety of each employee in entrusting tasks to that employee.

The Health and Safety (Work at Heights) Regulations (NI) 2005(hereinafter called "the 2005 Regulations ")

[16] Regulation 5 of the 2005 Regulations requires every employer to ensure that any person engaged is competent to work at height and schedule 2 enjoins an employer to provide sufficient work equipment, training and instruction.

[17] Where relevant regulation 6 of these 2005 Regulations provides:-

"**Avoidance of risk from work at height**

6.-(1) In identifying the measures required by this Regulation, every employer shall take account of a risk assessment under regulation 3 of the Management Regulations.

(2) Every employer shall ensure that work is not carried out at height where it is reasonably practicable to carry out the work safely otherwise than at height.

(3) Where work is carried out at height, every employer shall take suitable and sufficient measures to prevent, so far as is reasonably practicable, any person falling a distance liable to cause personal injury.

(4) The measures required by paragraph (3) shall include –

(a) His ensuring that the work is carried out –

(i) from an existing place of work; or
(ii) in the case of obtaining access or egress using an existing means,

which complies with Schedule 2, where it is reasonably practicable to carry it out safely and under appropriate ergonomic conditions; and

(b) Where it is not reasonably practicable for the work to be carried out in accordance with sub paragraph (a), is providing sufficient work equipment for preventing, so far as is reasonably practical a fall occurring.

(5) Where measures taken under paragraph (4) do not eliminate the risk of a fall occurring, every employer shall –

(a) So far as is reasonably practicable, provide sufficient work equipment to minimise –

(i) the distance and consequences; or

(ii) where it is not reasonable practicable to minimise the distance, the consequences of a fall; and

(b) Without prejudice to the generality of paragraph (3) provide such additional training and instruction or take other additional suitable and sufficient measures to prevent, so far as is reasonably practicable, any person falling a distance liable to cause personal injury."

[18] Regulation 7 of the 2005 Regulations requires an employer, in selecting work equipment for use in work at height to select such equipment as has characteristics which are appropriate to the nature of the work to be performed and is the most suitable work equipment having regard in particular to the purposes specified in regulation 6.

[19] Regulation 8 dictates that every employer shall ensure that Schedule 7 of the 2005 Regulations is complied with in the case of a ladder. Schedule 7 of the Regulations provides where relevant:

"1. Every employer shall ensure that a ladder is used for work at heights only if a risk assessment under Regulation 3 of the Management Regulations has demonstrated that the use of more suitable work equipment is not justified because of the low risk and:

(a) the short duration of use; or
(b) existing features on site which he cannot alter . . ."

[20] The Health and Safety Executive ("HSE") in June 2005 produced a document "Safety in the Selection and Use of Ladders" which drew attention to the need to ensure that the most suitable access equipment is selected and used safely. Subsequent to this accident in 2007 the Health & Safety Executive produced a document "Safe Use of Ladders and Stepladders" which indicated that the selection process as to whether not a ladder was the most suitable

access equipment required the employer to take into account the hierarchy of controls including:-

- "Firstly to avoid work at height where possible.
- Then to prevent falls from height; and, failing that, to reduce the consequences of a fall.
- Where work at height is necessary you need to justify whether a ladder or stepladder is the most suitable access equipment compared to other access equipment options.

You do this by using risk assessment and the hierarchy of controls".

[21] Whilst the latter HSE document was published after this accident, it does no more in my view than review what is clear from the Regulations mentioned above and the need to employ a hierarchy of controls before using a ladder in jobs such as this.

[22] I conclude this summary of the legal principles applicable by referring to Bhatt v. Fontain Motors Limited [2010] EWCA Civ 863. This case arose out of an accident when the plaintiff was injured in a fall from a ladder at work. The issue in the case centred on the application of the English 2005 Regulations which are comparable to the Northern Ireland 2005 Regulations. At paragraph 28 Richards LJ said:-

> "I agree that one needs to start with the regulations rather than with the claimant's conduct. The regulations are directed at avoiding or minimising the risks inherent in working at height . . . If work at height cannot be avoided, the risks must be minimised by, inter alia, the selection of work equipment which is appropriate and meets the other requirements of regulation 7(2) . . . If he (*the employee*) falls while using inappropriate equipment in circumstances where he would not have fallen if appropriate equipment had been provided, it is difficult to maintain that he was wholly to blame on the basis that the fall would not have occurred if he had followed the prescribed system for the use of the inappropriate equipment."

At paragraph 34, the judge continued:-

> "The defendant's breaches of the regulations placed the claimant in a situation of risk to which he would not have been exposed if the regulations had been complied with. What happened is the very kind of event that the regulations are aimed at preventing."

Was the defendant aware that prior to the accident the deceased suffered from diabetes and /or was subject to HG attacks?

[23] A crucial factual element in this case was my determination as to whether or not the defendant knew or ought to have known directly or vicariously that the deceased suffered from diabetes and/or that he was subject to dizzy spells.

[24] I am satisfied that the defendant was so aware for a number of reasons. First, Mr Peter Cargo, an uncle of the deceased, gave evidence before me that he regularly socialised with the defendant Rodney Wilgar at the Four Winds Bar each Saturday afternoon. He recalled that some time prior to the accident he had mentioned to Mr Wilgar that the deceased was looking for a job as a painter and decorator. Crucially he deposed that he had mentioned to Mr Wilgar that the deceased was a diabetic though it was his assertion that the condition was controlled. Mr Wilgar in evidence for the defendant recalled the conversation in the bar about the job with Mr Cargo but denied any recollection of mention of the deceased being a diabetic .Shortly thereafter he employed the deceased. I preferred the evidence of Mr Cargo in this regard. I believe that he gave his evidence honestly and impressively in the witness box. He did not seek to embellish his evidence by indicating that he had told Mr Wilgar about the HG attacks and it seemed to me to be likely that, for the protection of his nephew as well as not wishing to mislead someone who was doing him a favour, he did mention the diabetic condition of the deceased. I am satisfied that Mr Wilgar has either forgotten this conversation or is being less than frank about it simply because he now recognises that he did not give sufficient attention at the time to this matter.

[25] Secondly I heard evidence from Chris Gordon who had employed the deceased as a painter and decorator prior to his employment with the defendant. Mr Gordon struck me as a straightforward honest individual. His evidence was that he had been well aware of the deceased being a diabetic because he had witnessed the deceased injecting himself both at lunchtime and at tea breaks. Indeed the deceased had specially enquired if anybody in the employment at that time was squeamish about needles. I find it curious that the deceased would not have employed the same approach when working during the period of six months/one year with Mr Wilgar and I therefore find it inconceivable that the need for the deceased to have injected himself with needles would not have come to the attention of Mr Wilgar or at least his foreman Mr Agnew. It is not without significance that the medical records revealed that on the second day of his employment with Mr Wilgar he had been off work to attend a diabetic clinic. I find it inherently unlikely that Mr Wilgar would not have asked him why he was taking time off work so soon after commencing. Any further doubt about my belief that it must have been obvious to the employees that he was injecting himself were dispelled

when I heard the evidence of Mr McGuinness, another employee with the defendant, who had been working with the deceased on this job and had seen him taking insulin injection on occasions whilst at work.

[26] The evidence of Mr Agnew, an experienced foreman with the defendant, further convinced me that the defendant was directly or at least vicariously well aware of the condition of the deceased. Mr Agnew told me that if he had known the deceased was a diabetic it would have concerned him to the extent that he would have informed Mr Wilgar about it and he would not have wanted the deceased to work at heights. This echoed the evidence of Mr Wilgar who also told me that had he known the deceased was a diabetic he would have mentioned this to Mr Agnew and would have made enquiries precisely about the effect on him of his diabetes before allowing him to be exposed working at heights. Mr Agnew frankly admitted that he knew that diabetes would be a danger for someone working at heights.

[27] I am satisfied that Mr Agnew was being less than candid when he denied that he was aware that the deceased had such a condition. He admitted witnessing a dizzy spell that the deceased had suffered prior to the accident as referred earlier in this judgment at paragraph [5]but denied being aware that this was connected to the diabetes of the deceased. However it emerged in cross examination that this very issue had been raised with him at the inquest into the death of the deceased. There was an agreed record of the evidence of that inquest and in particular his answer to a question from his solicitor Mr Caldwell about the earlier incident. The extract from the inquest contained in my papers recorded Mr Agnew's answer as follows:

> " . . . After work one day David had a bit of a turn. We were going to go home but he sort of came to a pause. I gave him a tin of coke and he came round. He told us afterwards. Nothing was mentioned to Rodney about it. It was about three months before the accident. He took a wee turn. He was standing at his car and we were talking to him and he could hear us but he couldn't talk back or he couldn't move. We gave him a tin of Coke and he recovered. We were going to call the ambulance. Afterwards he was laughing about it and he told us that he had diabetes. He was OK after the Coke."

[28] Mr Agnew had simply no answer to this admission that he had earlier made at the inquest which of course was in complete contradiction to his evidence before me. I have no doubt that Mr Agnew as the foreman and the man in charge of the deceased was well aware of his diabetic condition and that he had suffered at least one HG/dizzy attack prior to the accident. I find it

highly unlikely that he would not have mentioned this to Mr Wilgar given his evidence as noted by me at paragraph 24 above.

[29] Taking all this evidence individually or indeed cumulatively I believe that the defendant knew or ought to have known that the deceased suffered from diabetes and that he was subject to dizzy attacks before the occasion of his death.

Conclusions

[30] I am satisfied that had Mr Wilgar carried out a suitable and sufficient assessment of the risks of this job to the health and safety of the deceased to which he was exposed while at work, he would have provided a scaffolding tower for him. He failed to do this despite being armed with the knowledge that the deceased was a diabetic and had taken at least one dizzy turn. Mr Wilgar told me that he did carry out a safety assessment but of course even on his own case he did not take into account the fact that the deceased was a diabetic because he claimed that he did not know this. Not only do I reject this evidence about his lack of knowledge as to the deceased's condition, but I am not persuaded that he carried out any assessment at all. Photographs of the scene of the accident shortly after it occurred revealed a ladder, different from that on which the deceased was positioned, at the back of the house placed on grass without any wedging or anyone to foot the ladder. The evidence of Mr McGuinness was that there was no need to foot this ladder because it was on firm ground. It was never suggested to Mr McGuinness by defendant counsel in cross-examination that he was wrong about this albeit Mr Agnew later denied that footing had not occurred. This evidence in itself is indicative of a slapdash approach to risk assessment by Mr Wilgar and a clear underestimate by him of the importance of risk assessment. In any event, he accepted that he did not take into account the diabetes of the deceased – he denied knowing about it – and since I do not accept this that rendered the assessment for this deceased in breach of Article 3 of the 2000 Regulations. This exposed the deceased to a risk to which he should not have been exposed. Someone who is suffering from diabetes, and particularly someone who has a history known to the defendant through Mr Agnew of a dizzy attack, should not have been allowed to climb a ladder in these circumstances. The defendant did not adapt the equipment to the needs of the individual using it and thus replace the dangerous with the non dangerous. Consequently the defendant did not examine and evaluate all the risks entailed in this operation, or take steps to remove or minimise those risks by the use of a tower scaffold. In short there was no blue print for action under the provisions of the 2000 Regulations.

[31] I have determined that there were breaches of regulations 6(1), 7 and 8(e) together with schedule 7 of the 2005 Regulations in that the defendant has failed to select appropriate equipment or to demonstrate that the use of more suitable work equipment, namely a tower scaffold, was not justified because of

low risk. Allowing a diabetic who has had a dizzy spell in the past to use the ladder is not a low risk operation whatever the duration of the use. In circumstances where the deceased was suffering from this condition, a moveable ladder was not appropriate to the nature of the task to be performed and was not the most suitable work equipment. The breach exposed the deceased to an unacceptable risk. The defendant failed to invoke the hierarchy of controls at his disposal before using a ladder. I am satisfied that that was the cause of the deceased falling because on the probabilities a tower scaffold would have provided protection against, and minimised the risks of, a fall.

[32] The defendant did have in his possession two aluminium mobile towers. A tower scaffold could have been used in this instance in the space available. The engineer called by the defendant, Mr McLoughlin, whilst asserting that the use of a ladder was a safe and proper system, conceded that a proper work platform could have been stabilised and a mobile platform could have been put up albeit it would have taken some time to do this. Hence I am satisfied that it was reasonably practicable to have provided such a mobile tower. I pause to observe that the evidence of Mr McLoughlin concerning the safety of a ladder was predicated on there being no belief by the defendant that the deceased was a diabetic.

[33] Even if the scaffolding available to the defendant was too big or the gap too small for its use - as asserted by the defendant -, a suitably sized scaffold tower could have been hired for £40 per day according to Mr Murray the civil engineer called on behalf of the plaintiff and as admitted by Mr Wilgar. I consider such an expense would have been an appropriate investment if it was necessary.

[34] In coming to this conclusion I am conscious that the advent of the mobile scaffolding into this case was a late entrant appearing first on the amended statement of claim of 14 June 2011 and not having been raised by Mr Murray the consulting engineer on behalf of the plaintiff until a late stage in his reporting. I am satisfied that Mr Murray's late adoption of this matter was caused by a lack of awareness on his part of the relevant statutory provisions and case law which eventually was drawn to his attention, in my view properly, by the plaintiff's solicitor.

Negligence

[35] Apart from the breaches of statutory duty, I am also satisfied that the facts that I have found ground a finding of negligence on the part of the defendant for failing to:

- make an adequate risk assessment,
- properly consider the deceased's condition and previous history of hg and or dizzy attacks

- provide proper, safe and suitable work equipment and in particular a tower scaffold
- take steps to minimise the dangers of working at heights for this individual workman

Causation

[36] I am satisfied that on the balance of probabilities, the provision of a mobile scaffold tower would have afforded sufficient protection for this deceased against a fall from a ladder due to a hypoglycaemic attack and the failure to do so or to otherwise assess the danger to this workman of working at heights was the likely cause of this death. The absence of any call or shout prior to the fall as evidenced by Mr Agnew coupled with the failure on the part of the deceased to make any attempt to jump clear from the shed area at the time of his fall - again as evidenced by Mr Agnew and the position of the deceased after his fall - and the unlikelihood of the ladder having slipped or moved during the fall by virtue of its post accident position all persuade me that on the balance of probabilities this was an instance where the deceased suffered yet another hypoglycaemic attack as opposed to a slip due to overreaching etc . The consequences of this could have been prevented on the probabilities by the presence of a scaffold tower with appropriate barriers.

Contributory Negligence

[37] The deceased was clearly aware that he had a substantial history of HG attacks including falling from a ladder and scaffolding in the past. He ought to have been aware that in climbing a ladder 20 feet high he was embarking on a manoeuvre where there was a real risk of falling with dire consequences. At 27 years of age I regard him as sufficiently old and of adequate experience to have recognised this danger. I am not satisfied that he had given the full details of these previous falls to Mr Wilgar. Whilst I have found frailties in Mr Wilgar's evidence, nonetheless I am satisfied that had he been told that this man had actually fallen from ladders or scaffolding before(as opposed to ignoring the previous incident of his dizzy turn) , then either he would not have been given the job or else mobile scaffolding would have been provided.

[38] Whilst therefore I am fully satisfied that the defendant's breaches of the Regulations and negligence were causative of the accident nonetheless I am satisfied that the deceased was guilty of contributory negligence. Thus although the defendant carries principal responsibility for exposing the plaintiff to a risk to which he should not have been exposed, the deceased bears substantial responsibility for neglecting to draw specifically to his attention his previous history of falls. In my view the deceased was one-third to blame for the injuries leading to his death.

[39] I therefore make an award of two-third of the damages to which the plaintiff is entitled. The proposed figure will now be considered by me having heard further submissions from the plaintiff's Senior Counsel.