SHERIFFDOM OF LOTHIAN & BORDERS AT EDINBURGH

IN THE ALL-SCOTLAND SHERIFF PERSONAL INJURY COURT

Court Ref: PIC-PN1086-23

NOTE BY SHERIFF D R G KEIR

in causa

ANGELA KELLY

Pursuer

Against

DUNDEE CITY COUNCIL

Defenders

Pursuer: Smith, Advocate; Digby Brown LLP

Defender: Logue, Solicitor; Clyde & Co (Scotland) LLP

Edinburgh 25 October 2024

Note

[1] This is an action for damages as a result of an accident at work on 6 May 2022. While the pursuer was ordinarily employed by the defenders as an administration assistant, she was working for them that day as a receptionist at Dundee International Sports Centre where a local election count was taking place. Towards the end of her shift, she was walking through the main hall at DISC when she tripped and fell and sustained injury.

[2] A proof proceeded on 22 and 23 October 2024. Parties had agreed quantum at £5,027.40 inclusive of interest and the proof was restricted to liability.

[3] The pursuer called the following witnesses to give evidence:

(i) The pursuer
(ii) Alana Fyffe
(iii) Stephen Kerr
(iv) Susan Bruce
(v) Courtney Bayne
(vi) Dr Darren Green

[4] The defenders called the following witness to give evidence:

(i) Lisa Archibald

The evidence

The pursuer

[5] She had been based at the reception area at DISC on 6 May 2022. She entered the main hall at around 1500 hours to speak to Lisa Archibald about whether she could leave for the day. She tripped on tape that was holding down some cables on the floor. She identified the area where she fell with reference to the image of the hall (page 38 of the Joint Bundle). The tape was red and had lifted away from the floor. She fell and hurt her hands and knees. She was helped back to her feet by two women who were standing nearby. She denied that she had been rushing at the time of her fall. She had subsequently completed an Accident Report form (page 31 of the Joint Bundle) on 23 May 2022 where she wrote "tripped over loose tape covering electrical wires".

Alana Fyffe

[6] Alana Fyffe was also an employee of the defenders assisting with the election count at DISC. She was working in the main hall on the day of the accident. She had seen cabling in a separate part of the hall similarly taped down. She considered that the tape was coming way at the edges. She left the building at around 1045.

Stephen Kerr

[7] Stephen Kerr was another employee of the defenders working at DISC that day and was working alongside the pursuer as a receptionist. He found out about the pursuer's accident later the same afternoon. He had tripped over the same cables earlier that day between around 1200 and 1400 hours. He described it as a mound of wire protected by

tape. He accepted that the tape had held the cables down securely at the time of his trip. He had reported his trip to an unknown female facilities assistant.

Susan Bruce

[8] Susan Bruce was employed by the defenders as a Senior Health & Safety Manager. She had around 22 years' experience in health and safety and held NEBOSH qualifications in that regard. She had been standing in the hall at DISC at the time of the accident. She heard but did not see the pursuer fall. There was a cable that had been taped down on the floor in the vicinity. She did not know what caused the pursuer to fall. She had glanced at the cable and tape afterwards and it did not appear to have been disturbed.

[9] Prior to 6 May 202, she had carried out a risk assessment in relation to the layout of the hall which had focused on the identification of hazards and areas of significant risk. The proposed layout upon which that assessment was based was detailed in a plan lodged in process (page 37 of the Joint Bundle). The cable in question had not been identified as a risk as she had been unaware there would be cables in that area until the morning of 6 May 2022. She had understood that the cables would be run behind furniture and therefore kept out of the way of foot traffic. When she attended the hall on 6 May 2022, she discovered that the layout had been altered with specific reference to a group of desks in one corner of the hall (as shown more clearly in the image of the hall on page 38 of the Joint Bundle). There were cables running along the floor that had been secured with red and white hazard tape. She carried out a dynamic risk assessment and inspected the tape. She was satisfied that the risk of tripping had been sufficiently controlled by the use of the tape. She had also checked the condition of the tape throughout the day and had not noted any significant degradation.

[10] She accepted that where a risk assessment identified a significant risk from trailing cables, that risk would have to be managed, for instance by the use of cable covers. She considered that the use of the tape performed the same function as a cable cover.

[11] She agreed that if the tape had become detached then it would have presented a significant trip hazard. She accepted that her preference would have been to remove the risk posed by the cables completely, in line with the HSE recommended "hierarchy of controls" approach to managing risk. That had been the intended plan based on the original layout of the hall. Had she found out about the change in layout earlier, her advice would have been to remove the cables entirely.

Courtney Bayne

[12] Courtney Bayne worked for the defenders as a Health & Safety Advisor. She had around 6 years' experience in health and safety and held NEBOSH qualifications in that regard. She had been standing beside Susan Bruce at the time of the pursuer's fall. She had helped the pursuer to her feet and got her a chair. The pursuer stated that she had tripped on a cable. She looked at the cable and did not notice anything. She had subsequently completed a Health & Safety Incident Report Form (page 34 of the Joint Bundle) and a RIDDOR form (page 32 of the Joint Bundle) in respect of the accident.

Lisa Archibald

[13] Lisa Archibald worked for the defenders as their Elections Manager. She had held that role since 2006. With reference to the image of the hall (page 38 of the Joint Bundle), she highlighted the desks in the top right corner which constituted the management area where access was restricted. It was decided that the original layout of that area (as detailed in the plan on page 37 of the Joint Bundle) should be changed as it did not provide

sufficient privacy for the information displayed on the screens on the desks. She thought this decision may have been taken on the Monday prior to the count but accepted that the decision may have been taken earlier than that. The layout changes were not discussed with Susan Bruce. She accepted that privacy screens or partitions could have been used to address the privacy issues identified as alternatives to changing the layout of the desks.

Dr Darren Green

[14] Dr Green was a forensic investigator for Burgoynes Consulting. He had held health and safety roles in industry before joining Burgoynes and also held NEBOSH qualifications.

[15] He had listened to the factual witnesses give their evidence. He agreed with Susan Bruce about importance of following the HSE recommended "hierarchy of controls" with regard to managing risk. He considered that the initial plan to have the cables located under furniture was appropriate as it eliminated the risks associated with trailing cables. However, he would have expected that to be recorded in the risk assessment document. Once the layout of the hall changed, the original risk assessment was no longer valid and an updated assessment should have been carried out. While he noted that Ms Bruce had carried out a dynamic risk assessment on the morning of the accident, he did not view the use of tape as an appropriate control mechanism. It was foreseeable that tape could become worn during the course of the day or be lifted when it came into contact with footwear. He agreed with Susan Bruce that if the tape became detached, it would present a significant tripping hazard. The use of a cable cover instead of tape would be more reliable as it would retain its original structure throughout the day.

Decision

Assessment of the evidence

[16] In terms of my assessment of the evidence, I considered that all of the witnesses were generally credible and reliable and doing their best to assist the court.

Liability

[17] Focusing on liability, it was agreed that the pursuer had fallen in the hall on 6 May 2022. I accept the pursuer's account that the reason for her trip/fall was the hazard tape covering the cables that had become loose. The pursuer gave her evidence in a straightforward manner without embellishment. Her evidence was consistent with the contemporaneous account of the accident noted in the Accident Report form.

[18] I consider that the critical issue for parties was the presence of the cables on the floor of a traffic area and whether or not they should have been there at all.

[19] There was no dispute that the defenders owed the pursuer a duty of care at common law as her employer. The standard of care is one of reasonable care. The issue for determination is whether the defenders breached that duty of care. Following the Enterprise and Regulatory Reform Act 2013, it is well understood that the statutory duties relied upon by the pursuer remain relevant as evidence of the standards expected of employers in civil cases. It is equally well understood that as part of those duties, a reasonably prudent employer will conduct a risk assessment in connection with its operations so that it can take suitable precautions to avoid injury to its employees.

[20] A failure to carry out a risk assessment can only give rise to liability at common law if a suitable and sufficient risk assessment would probably have resulted in a precaution being taken which would probably have avoided the injury.

[21] In this case, the pursuer criticised the defenders' failure to carry out a further risk assessment following the change to the layout of the hall that included the positioning of cables running across the floor of a traffic area. These cables posed a foreseeable risk of injury. Had there been a further risk assessment, the cables and the tape securing them would not have been present at the time of the pursuer's accident.

[22] The defenders submitted that the pursuer's case rested on a counsel of perfection. It was not enough for the pursuer to simply identify precautions that might have assisted with the benefit of hindsight.

[23] The problem with this submission is that it ignores the risks the defenders had previously identified and the precautions implemented to address those risks. Critically, it also ignores the evidence of their own Health and Safety Manager, Susan Bruce.

[24] As per Ms Bruce's evidence, the risks associated with trailing cables had been identified at the time of the original risk assessment. On the basis that the cables in question would be running under furniture, she was satisfied that they did not pose any hazard to pedestrian traffic and no further steps were required to control the risks associated with their presence.

[25] However, the layout of the hall changed and that brought the foreseeable risk of injury posed by trailing cables back into the equation. While it is unclear exactly when the layout changed, I accept the evidence of Lisa Archibald (an employee of the defenders) that it was not later than the Monday of the week of the count/accident (6 May 2022 with the election itself having taken place on 5 May 2022) but it may have been earlier. As such, the defenders were aware of the layout change several days before the accident but they failed to take any action, such as notify Susan Bruce who, as a result of that failure, was unable to update the risk assessment.

[26] By the time Ms Bruce became aware of the layout changes and the presence of the cables on the morning of the accident, the control measures were a fait accompli. Hazard tape had already been applied to the cables and Ms Bruce carried out a dynamic risk assessment based on what she found that morning.

[27] Ms Bruce was candid about the presence of the cables. She was clear that if she had found out about them at an earlier stage, her advice would have been to remove the cables entirely. This is consistent with both her own and Dr Green's evidence about the need to follow the HSE's well-known "hierarchy of controls" approach to managing risk and eliminate a specific risk if possible, failing which to consider what alternative control measures might be appropriate. It is also consistent with her evidence about the foreseeable risk of injury posed by trailing cables on the floor of a traffic area.

[28] Lisa Archibald was equally clear about the rationale for the layout change which led to the presence of the cables on the floor and her acceptance that the privacy issues identified could have been addressed by the use of privacy screens or a partition which would have left the layout unchanged. Moreover, she was clear that the layout change occurred at least several days prior to the accident and there was a failure to notify Ms Bruce of that change. As such, this was not a case where there had been unforeseen changes made at the last minute on the day of the accident whereby a dynamic risk assessment of the type conducted by Ms Bruce might have been appropriate.

[29] Against that background, I am satisfied that a prudent employer exercising their duty to take reasonable care towards their employees, such as the pursuer, ought to have identified the foreseeable risk of injury posed by the trailing cables prior to 6 May 2022. Had they done so, as per the evidence of Ms Bruce, that foreseeable risk of injury would have been avoided by taking the reasonable step of removing the cables from the traffic

area. The defenders failed to do so and as a result there were trailing cables covered in tape present on the floor in a traffic area on 6 May 2022 which caused the pursuer's accident.

[30] The pursuer has therefore proved on the balance of probabilities that the defenders were in breach of their duty to take reasonable care towards her.

Contributory Negligence

[31] Turning to the issue of contributory negligence, the onus lies on the defenders to prove that the pursuer's actions fell below the standard of a reasonable person in the position of the pursuer. The defenders submitted that the cables were there to be seen and the pursuer should bear some responsibility for her accident. I do not agree. There was no reliable evidence that the pursuer was rushing or otherwise not paying attention as she walked across the hall. There was also no reliable evidence that she had deliberately ignored any instructions about entering a restricted area. I therefore conclude that there was no evidence to support a finding of fault on the part of the pursuer and accordingly make no deduction for contributory negligence.

Conclusion

[32] The defenders have breached their duty of care towards the pursuer and are therefore liable to make reparation to her. Decree for £5,207.40 is granted in favour of the pursuer.

Sheriff
Douglas Keir

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Sheriff Douglas Keir
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