Case Law Review: the significance of recent cases

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Three cases:

- Hugh kindly asked me to speak
- Discussed topics
- Decided on significant recent court cases
Introduction

• *Meus*: manual handling

• *Barry*: manual handling

• *Davis*: prosecution

One other topic:

• Are courts awards increasing?

A paper on the HSR Website, [www.healthandsafetyreview.ie](http://www.healthandsafetyreview.ie)
The *Barry* case

- Lifting a box from above head height – twisting movement – injured

**Judge said:**
- Trained not to stack trollies above head height and put heavier goods lower
- This was not followed in practice
- Rejected employer’s help and step ladder arguments
- Awarded €88,000. Apportioned liability two-thirds, one third.
The *Meus* case

- Induction training – conflict over manual handling training
- Lifting heaving boxes of suitcases from above head height
- Drop to ground – injured when picking up

**Judge said:**
- Training not give
- Even if it was it was inadequate
- 100% liability
- Award €85,000
Messages from the judiciary

There are a number of messages from the judiciary in the two judgments:

• Risk assessments must be task specific
• Training must be adequate to enable an employee to perform his/her duties safely, with the training comparable to the task to be performed
• DVDs and slideshows, while a useful training tool, must be relevant to the task to be performed
• Training must be delivered in a form, language and manner that the employee (person being trained) understands
• Training must be followed up by supervision to ensure the employee is using the correct manual handling techniques
• There is no point in managers offering help if that puts them at risk, as that is not a solution to the problem
• Expecting employees to ask colleagues for help if the colleagues are busy is not a defence
• Workers should not be expected to lift from above shoulder level
• Judges are not impressed when plaintiffs (injured workers) engineers go out to inspect store rooms and find them cluttered. This confirms injured workers’ claims that the workspace was cluttered.

Lessons for employers and safety advisors: challenge lawyers.
Davis prosecution

• Guest in hotel bedroom died from carbon monoxide poisoning
• Davis charged with manslaughter and he and his company charged with failing to protect persons not in his/its employment
• Prosecution case was that Davis had converted the hotel boiler to allow for the use of liquid petroleum gas rather than natural gas without reading the instructions and without testing the boiler.
O’Higgins in defence

- Expelled gas from boiler circulated back, feeding up through vertical service ducts
- Garda detective inspector agreed ducts had never been fully fireproofed
- Argued if a ventilation shaft had been working it would have expelled all gases
- No ventilation shaft because of appearance and cost – “incredibly ugly”

**Judge’s question:** was Davis grossly negligent?

Jury acquitted.
Are court awards increasing?

- *Davis v HSE*: €5,000 over *Book of Quantum*
- *Meus* again: €10,000 above *Book of Quantum* maximum

I am hearing increasingly that awards are increasing.

Thank you for coming and listening.

Any questions and I would welcome your views on the question: are courts awards increasing?
Case Law Review: 
the significance of recent cases

Organisers: Stepex FM Ireland
Venue: RDS, Ballsbridge, Dublin 4
Speaker: Herbert Mulligan, Editor, Health & Safety Review
Date: March 4th, 2015
When Hugh kindly asked me to speak at this event we discussed what would be a relevant topic. That was some months ago. We agreed on significant recent court cases.

By good fortune there was a very significant judgment recently in a case taken by a Ms Meus against Dunnes Stores. It concerns manual handling training. Another recent interesting case was the prosecution of Richard Davis and his company Davis Plumbing and Heating Contractors, which was taken following the death of a guest at an hotel in Kinsale.

The two cases are significant for different reasons. To my mind the Meus case is more significant as it concerns the perennial workplace issue of manual handling. Taking the judge’s comments in the Meus case and in another manual handling case, Barry v Dunnes Stores, employers and safety advisors have clear judicial guidelines on manual handling training and management.

Apart from these three cases I want to raise a question and ask your views. Are court awards increasing?

**THE MEUS and BARRY CASES**

The two judgments highlight the importance of risk assessment, relevant task specific training, the limitations of video training, the need to train workers in a language they understand and the importance of post-training supervision. For employees the judgment in the Barry case, in which the injured worker was held to be one-third responsible for the injuries she suffered highlights the importance of saying no when asked to perform unsafe tasks.

**The Barry case**

In the Barry case, Ms Barry, a shop assistant in a large supermarket, was injured when lifting boxes which were stacked well above her head height.

She reached up to one of the boxes not knowing what was inside it and pulled it forward to take it down. As the weight of the box came into her arms, which were stretched above her head, she realised it was too heavy for her to manage. She called out to a colleague to help but the colleague was handling another box.
As a result she had to take the weight of the box into her arms and put it down quickly on a table that was close by. This required her to perform a twisting movement. A few minutes later she felt pain in her back which soon started to radiate into her left buttock and down her left leg.

In her judgment, Ms Justice Irvine noted evidence that staff were trained not to stack trolleys above eye level for safety reasons and to put heavier goods on lower levels. However she said that on the occasion of the accident the company’s safety practice was not followed. She said her finding in this regard was supported by evidence from an engineer for the injured worker that when he inspected the store he found trolleys stacked to a height of up to eight feet.

Dealing with a suggestion from the store manager that if the worker had called him, he would have helped, Ms Justice Irvine said he would have put himself at risk. Dealing with a suggestion that the worker could have used a step ladder, the judge said the worker should never have required a step ladder and even if she had used one it could only be used to gauge the weight of the box. Her comment that the only way the box could have been taken down safely was by two tall men of equal height as shown in the training video highlights the need for training videos to be relevant.

Apportioning liability, Ms Justice Irvine said that notwithstanding these findings, the worker should not have tried to lift the box down. She apportioned liability, holding the employer 70% responsible for the accident and injured worker 30% responsible.

The *Meus* case

In the *Barry* case Ms Justice Irvine dealt with one specific aspect of manual handling: lifting above shoulder level. In the *Meus* case, while liability turned on what Mr Justice Barr held was inadequate training, he dealt with a wide range of health and safety issues thrown up in the context of the Manual Handling Regulations.

The worker was required in the course of her work as a shop assistant to fetch a large number of boxes from a storeroom. The boxes weighted between 13kg and 15kg and contained a number of suitcases of varying sizes. On the day of the accident the boxes in the storeroom were stacked above her head height and she had to knock them off the top of the pile and let them fall to the ground before putting them on a trolley. She filled one trolley, but suffered a back injury while loading a second trolley.

It is interesting, that as in the *Barry* case the worker was lifting boxes from above head height. Another interesting aspect of case, as in the *Barry* case, is that the store room was cluttered.
Summarising the evidence and delivering judgment, Mr Justice Barr highlighted a number of training issues, supervision and risk assessment.

**Training: records**

The training given to Ms Meus when she joined the company, was the judge said, one of the key issues. She had signed a card, which was “apparently a record of the training” given to her at that time in August 2006. The card indicated that all the training took place on one day, August 26th 2006. The types of training stated to be given were induction, alcohol sales, hygiene, chemical, health and safety and manual handling.

Ms Meus admitted the signatures were hers, but denied receiving all of the training set out in the card. She stated she received induction training, which comprised a tour of the shop premises. She specifically denied receiving health and safety and manual handling training. She said she was told to sign the card and that is what she did.

The company contested the denial. The health and safety manager, who signed the card for the health and safety and manual handling modules of the training, gave evidence that he trained a group of new employees, including Ms Meus. When questioned about other trainers not signing the card, he said he signed it in respect of the training actually given by him.

**Training: adequacy**

In relation to manual handling training the health and safety manager said he gave a demonstration of good lifting technique, using an A4 box of paper for the exercise. When questioned about this he accepted that the demonstration was not remotely comparable to lifting a large box. In the circumstances he accepted that the training was not adequate.

He said he adopted the crouch and lift technique. He showed the group a slideshow dealing with manual handling, followed by two DVDs on health and safety aspects, including one on the manual handling of loads. Ms Meus denied “point blank that she was shown any slideshow or any DVDs”.

Dealing with the contested evidence, Mr Justice Barr said Ms Meus struck him as a truthful witness. He accepted her evidence that she was not shown any slideshows or DVDs, although she was given a tour of the shop premises and a handbook. In these circumstances, he said, “she did not receive any adequate training in respect of her employment”.

Continuing, he said that even if he was wrong in this conclusion, the training given “was inadequate to enable her to perform her duties safely”. The demonstration given was in relation to lifting a box
of A4 paper. This was not “remotely comparable to the lifting exercise” Ms Meus had to do in the course of her duties.

An important point, which employers and health and safety advisors need to ensure lawyers address when defending cases is the judge’s comment that the DVDs were not proved in evidence. It may also occur to safety professionals that that it might be a good idea to get another employee who was on the training course to give evidence about the course. It is one thing to assert something has been done: in court it is necessary for defendants to prove it.

*Training: delivered in a language and manner that is understood*

Ms Meus was given a handbook, which included two pages on manual handling. She told the court that she had difficulty in understanding it due to her poor English. At the end of the training session the health and safety manager said he did not ascertain if all the new recruits actually understood the presentation.

Earlier the judge had heard evidence that employers are required by section 10 of the SHWW Act 2005 to provide instruction, training and supervision in a form, manner and language that the employee is reasonably likely to understand. Commenting on this Mr Justice Barr said no attempt was made to enquire if Ms Meus understood the instruction allegedly given to her in relation to manual handling.

*Supervision*

The health and safety manager said that after the training he had not checked to see if Ms Meus was adopting the correct lifting technique and that he did not follow up on the training.

Commenting on this the judge said there was no proper follow up to the training given. Nobody checked to make sure Ms Meus understood the basic requirements of safe manual handling. If there had been adequate follow up and supervision, the company would have learnt that she was using an incorrect and dangerous method of lifting items. This should have been spotted and corrected.

*Risk assessment*

No risk assessment had, Mr Justice Barr held, been carried out in relation to the lifting duties of Ms Meus in the men’s department. If one had been, it would have shown that she was required to carry a large and bulky box of significant weight. The risk of back injury would have been evident. No such task specific risk assessment was carried out and the employer was in breach of regulation 10 of the General Application Regulations 1993 and section 10 of the SHWW Act 2005.
**Ask for help**

Mr Justice Barr rejected an argument put forward by the employer that Ms Meus should have asked for help. He accepted her evidence that her colleagues were busy with their own duties. She could not, he said, keep asking her colleagues to come to the storeroom to help her. She had to do the best she could to load the trolley and “cannot be faulted for failing to seek assistance”.

**The Meus case: liability**

Having found that the training was inadequate, that there was no follow up supervision, that there was no risk assessment, Mr Justice Barr held that the employer was liable for the accident. He found that the employer was in breach of:

- Regulation 10 of the General Application Regulations 1993 to carry out a risk assessment (the accident happened in April 2007, five months before the General Application Regulations 2007 became law)
- Its common law duties
- Section 10 of the SHWW Act 2005 in relation to instruction, training and supervision
- Regulations 13 of the General Application Regulations 1993 in relation to training

**The message from the judiciary**

There are a number of messages from the judiciary in the two judgments:

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- Expecting employees to ask colleagues for help if the colleagues are busy is not a defence
• Workers should not be expected to lift from above shoulder level
• Judges are not impressed when plaintiffs (injured workers) engineers go out to inspect store rooms and find them cluttered. This confirms injured workers’ claims that the workspace was cluttered.

The other lesson to be drawn by employers and safety advisors is to challenge their lawyers to put in proof evidential items, such as the DVDs in the Meus case. If the DVDs, which the health and safety manager said in evidence had been shown had been proved to the court it may have led to a different conclusion by the judge. Better still, it will occur to some observers, that if others who were on training courses were called to give evidence of the course, a judge would have to take account of that evidence.

KINSALE HOTEL CASE

The really interesting point in this case is the defence Michael O’Higgins, S.C., put forward. The approach taken by Mr O’Higgins in defending the case is reminiscent of the classic route cause analysis approach of health and safety experts. Keep on asking questions and peeling back until all the possible causes of the accident have been identified.

Mr Davis, a plumber was charged with manslaughter. He was acquitted after defence senior counsel, Michael O’Higgins argued that his client was a scapegoat and that there would be an element of fairness if other people were in the dock.

In what might be described as a route cause analysis defence of his client, who was charged, after an hotel guest died from carbon monoxide poisoning, with manslaughter and under health and safety legislation with offences relating to the conversion of a gas boiler, Mr O’Higgins put it to the jury that if the hotel had taken advice and put up a chimney stack system, if ducts had been sealed, if the system had been operated as designed with a fan to blow the gases out, his client would not be in court. “If a lot of other people had been doing what they should have been doing nobody would have gotten sick, nobody would have died”.

The fatal accident

 Earlier the court heard that a young woman was found dead in a bedroom in the Trident Hotel in Kinsale at 2pm on Sunday, January 9th 2011. The court heard that the woman and her sister, who shared the bedroom, had been at a hen party.
Giving evidence the deceased’s sister told the court that they got back to the hotel at about one o’clock in the morning. During the night they were feeling unwell and a doctor was called. The doctor treated the girls with an injection for the winter vomiting bug. The next thing she remembered was waking up in Cork University Hospital with members of her family around her and being told that her sister was dead.

Setting out the case for the prosecution senior counsel Brendan Grehan said the cause of death was established as acute carbon monoxide poisoning. Counsel said that the State’s case was that a few days before the fatal accident a new boiler had been put into use in the hotel and that it had been converted to allow for the use of liquid petroleum gas rather than natural gas. The alteration was effected by the insertion of a chip.

Counsel said the plumber had spent 20 minutes at the boiler. He did insert the chip, but it would appear “he never read the instructions” and he was not otherwise aware that he had to do more. Two particular parts of the boiler had to be readjusted and the plumber carried out no adjustments whatsoever. Because he did not carry out adjustments it was the source of the carbon monoxide that lead to the young woman’s death. Counsel said it was the prosecution’s case that the plumber ought to have tested the boiler and that in not doing so “he was guilty of gross negligence”.

**The charges**

The plumber was charged with manslaughter, because of what prosecuting counsel said was criminal negligence and not out of any intention to cause injury.

He was also charged with two offences under section 12 of the SHWW Act 2005, which provides that every employer shall manage and conduct his undertaking in such a way as to ensure, in so far as reasonably practicable, that in the course of work individuals at the place of work who are not his employees are not exposed to risks to their safety, health and welfare. The plumber’s company was also charged with the same offences under section 12.

**Evidence**

Evidence was given that the plumber initially told the gardai that he had tested the boiler but he later told them he had not done so. The court also heard that the plumber was not registered with the Register of Gas Installers of Ireland, though three other plumbers in his company were registered.
The court heard that the plumber told the gardai that he was sick about what happened and would “have to live with it for the rest of his life”. The plumber told the court that he was told by the suppliers of the boiler that it was an easy chip conversion and that all he needed to do was to change the chip.

Later two managers of the suppliers of the chip confirmed telling the plumber it was a matter of changing the chip. However they denied giving instructions on the conversation process.

**The defence casts doubt**

During the presentation of the prosecution case, Mr O'Higgins cross-examining prosecution witnesses constructed a case for the defence.

Cross-examining a civil engineer called as an expert witness by the prosecution, Mr O'Higgins suggested that the expelled gas from the downstairs boiler area circulated back, not only returning but then feeding up through the ducts through vertical service ducts overhead. He said that a smoke test in the aftermath of the fatality demonstrated that the carbon monoxide from the boiler rose through the service ducts. The engineer agreed that it did not just drift up, it was sucked up. Answering Mr O'Higgins’s question that the service ducts had never been fully fireproofed, a detective inspector agreed they were not sealed.

Mr O'Higgins also suggested to the engineer that if a ventilation fan in the attic had been working it would have expelled all the gases. The engineer replied, “Maybe not all”. During the case it emerged that a ventilation shaft, which the fire officer had been assured would be part of the building, had not been erected.

Questioning one of the owners of the hotel about the ducts, Mr O'Higgins elicited the information that the primary reason the ventilation duct was not erected was because the owners were concerned about the visual impact. The owner described it as “incredibly ugly”. There were also cost considerations.

Mr O'Higgins described these factors as a perfect storm related to ventilation and unsealed ducting which allow poisonous gases to rise into the hotel bedroom where the young woman died. The prosecution countered that the death would not have occurred if the plumber had made the necessary adjustments.
Judge’s directions to the jury

Giving directions to the jury, Judge Sean O’Donnabhain said the purpose of the defence’s cross-examination of witnesses is “to raise a reasonable doubt”. That was the purpose of the questions about the defects in the blowers, in the fan and with the heating system, all of which were outside the control of the plumber. The State’s case was that the plumber was grossly negligent.

Posing questions that the jury should ask themselves, such as did the plumber have a duty of care to people in the hotel to do the job in a manner that was safe? In the judge’s opinion, yes. Was the plumber negligent, in that he did not read the instructions, the judge said “perhaps yes”. But the question for the jury was: “was he “grossly negligent?” The kernel of the defence case was that the commissioning of the boiler was not the only matter in causing the young woman’s death and that the jury should consider the various defects in the building which has nothing to do with the work done by the plumber. The judge also noted that though doctors had been called during the night no one from the hotel went to the bedroom until about 2pm.

The jury returned a verdict of not guilty on all counts against both the plumber and his company.

ARE COURT AWARDS INCREASING?

For about the last year or so there have been suggestions that courts are making awards in excess of the parameters set in the Book of Quantum. This is a question on which I would welcome your views.

I will mention two recent cases. In Daly v Health Service Executive where an award of €75,000 was made for general damages, the award was over €5,000 over the maximum award for a back injury resulting in significant ongoing injuries provided for in the Book of Quantum. In Meus v Dunnes Stores, which we have already discussed, the judge awarded €80,000 for general damages, a sum €10,000 above the maximum provided for in the Book of Quantum.

You may have cases from your own experience.

That is about it. Thank you for coming and listening.

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