High Court of Ireland Decisions

Judgment

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[2019] IEHC 79

THE HIGH COURT

[2015 No. 8433 P]

BETWEEN

GERALDINE O'GRADY

PLAINTIFF

AND

ABBOTT IRELAND

DEFENDANT

JUDGMENT of Ms. Justice Eileen Creedon delivered on the 11th Feburary 2019;

Background
1. These proceedings were commenced by way of personal injury summons by the plaintiff in which she makes a claim for damages in respect of serious personal injuries, loss, inconvenience and expense incurred as a result of the negligence, breach of duty including breach of statutory duty under the Safety Health and Welfare at Work Act 2005, the General Application Regulations made thereunder, the Occupiers Liability Act 1995 and contract on behalf of the defendant its servants or agents.

2. At all material times the plaintiff was an employee of the defendant. She says it was an express and/or implied term of the contract of employment between the plaintiff and the defendant that the plaintiff would be provided with a safe place and system of work. In particular, she says that on or about the 24th day of July 2014, the plaintiff was carrying out her duties pursuant to her contract of employment with the defendant at the defendant's factory premises known as Abbott Ireland Vascular Division, Cashel Road, Clonmel, in the County of Tipperary, when the plaintiff stepped into a lift, the door of the lift struck the plaintiff on the head and as a result the plaintiff suffered serious personal injuries, loss, damages, inconvenience and expense.

3. The plaintiff says that in the circumstances the defendant failed to provide the plaintiff with a safe place and/or system of work. She says that the lift which is the subject matter of these proceedings, did not emit a verbal warning that the doors were closing and/or otherwise warn a user that the doors were closing. Further, she says the doors themselves were an excessive width and a danger to users. She says the sensors of the lift were not properly placed and/or did not function correctly. The plaintiff sets out further and better particulars of the injuries occasioned by the alleged wrong of the defendant at para. 5 of the personal injury summons.

4. She confirms *inter alia* that she sustained a haematoma to the right temporal area of her head. An MRI scan did not identify any bony injury to her skull. Post - incident she had tenderness over the right temporal area but no swelling. The plaintiff indicates that she has suffered post - concussion syndrome together with post-traumatic stress disorder. She says that her sleep continues to be disturbed and she suffers from flashbacks. The plaintiff's general practitioner has prescribed antidepressant medication. The plaintiff had to take time off work and has been advised to undergo cognitive behaviour therapy.

Evidence

5. The plaintiff gave evidence on her own behalf. She confirmed that she is the quality control lead coordinator with Abbott Ireland Ltd. She confirmed that that role involves the scheduling and coordinating of a group of quality control staff members to support with testing and audits of the product for Abbott Ireland in the DES segment of the business, that is to say the Drug Eluting Stent segment of their business in Clonmel. She said that she has a team of people that work with her and that she coordinates the quality control support in various areas on the site in Clonmel for both audits on the process and checking that the product is made to specification. She referred to the events the subject matter of this claim which occurred on Thursday the 24th July 2014. She said that at that time she had the same job, that she was a quality control lead coordinator. She confirmed that there had been a slight expansion in her duties due to significant numbers of redundancies the previous year. She confirmed that she was on the evening shift that day. The shift would run from the hours of 4:30 p.m. to 1:00 a.m. She said that she was due to go on two week's holidays the following day. She confirmed that the incident occurred in what she described as "the secondary pack area". She said that this is the area where the product has gone to the steriliser and is coming back for another packing which is referred to as the secondary pack, to get it ready to send out to the customer.

6. She said this is an area of the factory that she took over responsibility for as quality lead the year before but that it would not be an area that she would frequent. She said that she would mainly communicate with that area by email or telephone. She said that she normally worked in the DES suites, the production suite, where her desk would be located. With regard to the secondary pack area, she indicated that she would go down there about once a month but that she would not go there as part of her day to day duties.

7. She confirmed that on the evening of the 24th July 2014, she went down tto the secondary pack area to have a conversation with a Mr. Jim Roche. She indicated that Mr. Roche was to take over as acting lead coordinator for the two weeks that she was going to be on annual leave. She indicated that she went down there at about half past 8 in the evening. She described two lifts that she was used to using, one which she described as a people lift, which opened from the middle and had voiceover warnings, and the second another freight lift which went down to the criblet area which opened to one side and again had voice over warnings. Ms. O'Grady indicated that she went down to the secondary pack area on the evening in question to speak with Mr. Roche and she was taken through a set of photographs to identify that area when giving her evidence. She described how she had a conversation with Mr. Roche and as they were concluding their discussion they were walking along the corridor. She said that Mr. Jim Roche was continuing into the warehouse and that she continued to the lift to go back up to her work area.

8. She indicated that she pressed the button which was on the left hand side of the lift, and the door opened. She said that she then turned back to make a final comment in the conversation to Mr. Roche. She said that she then went to walk into the lift and at that stage she said that unknown to her the door had started to close. She said therefore that when she went to go into the lift, the door struck her on the side of the head. She said it struck her on the temple area of the right side of her head. She said that the door struck her with its leading edge as she was entering the lift. She identified the area in question by reference to photographs. When asked what type of contact it made with her head she indicated that it was a very strong contact when it banged off her head. She said the door struck her head and then the door went back into the open position.

9. She said that after the impact she continued on up onto the next floor and described what happened at that point to include the medical attention that she received. She described the lump on her head and the headaches that she experienced the following morning. On Monday she went to work at 2:30pm but was asked to just simply write a short report on the accident and to go home and commence her holidays. She described the fear she had about taking her flight on her holidays because she was concerned about blood clots. She saw the company doctor, who reassured her, and she proceeded to go on holiday.

10. She indicated that the holiday was not a success due to ongoing headaches and the bruising to her face. She went on to describe her condition upon her return to work which included headaches and loss of concentration. She stated that the headaches persisted for three months. She stated the bruising lasted for about three weeks and the lump for about six weeks. She further indicated that sleeping became a big problem for her and that consequently she had to take sleeping tablets.

11. She said that she also started suffering from flashbacks to the accident. She indicated that the flashbacks persisted to the present time that is the hearing of this current case and that she might wake up once a month or every few weeks. During the year of the accident, matters had improved by Christmas when the antidepressant medication began to take effect. The flashbacks became less frequent to once every few weeks and then maybe once a month. Most recently, coming up to the court case, she has been waking up every night. She confirmed that she never would have described herself as an anxious person before the accident of July 2014. She referred to a previous stressful time in 2012 when she had been a witness to court proceedings on behalf of Abbott Ireland and had taken a week off work.

12. She said that after the accident, she went on reduced hours and did not get back to normal hours until the middle of November of that year. She described how she thought on the evening of the accident that she was going to die and how that ultimately

affected her confidence at work. She said that currently she is able to cope at work; she is doing full hours but that she does not consider herself as strong as she was before but that with the help of the medication she is coping. As for her non - work activities she indicated that she does not have the same level of energy or enthusiasm that she would have had before the accident. She also gave evidence about the efforts she has made to reduce the medication that she is on.

13. One such effort was availing of the company's employee assistance programme which entitles every employee to six counselling sessions which are free and fully confidential. She said that she commenced those sessions at the end of October. However, she ceased those sessions when she said that she was informed that if she took litigation against the company the Company would be entitled to access the notes of her counselling sessions with the company counsellor. She indicated that she felt an immense sense of betrayal as a result of this. Towards the end of her direct evidence about her own culpability in terms of her actions that day, she indicated that she was used to always hearing the door closing very loudly saying "door now closing" and she indicated that she had expected that she would hear that.

14. In cross - examination the plaintiff confirmed that she pressed the button to wait for the door to open, that she had turned back to pass a comment to her colleague Mr. Roche, and in that sense she was looking away from the lift in the direction of her colleague. It was put to her that she was turned away from the lift as she entered the lift and that she was in fact facing the other direction. She said yes that she was turned to her colleague passing a comment and then she turned to enter the lift. She confirmed that she was having a conversation looking in the other direction as she went into the lift. She said that she was having a conversation and that she then turned to enter the lift just as it struck her. She was asked whether at any stage prior to being struck by the lift had she her eye on the door. She answered that when she pressed the button the door was closed. The door then opened and she turned back to pass her comment and then went on to enter.

15. It was further put to her that at no stage before she was hit on the head or walked into the lift door did she have her eye on the door and she agreed that no she was not watching the door. She said that she was waiting to hear that it was going to close. When it was put to her that she had walked into a door when she was not looking at it she indicated that she walked into the lift and did not hear the door closing. She said that she had an assumption that the sensor on the lift would stop the door closing and that she would hear the voice over and none of this happened as she walked into it. She said she had been working in Abbott for approximately sixteen or seventeen years and had been used to using and dealing with a lift that always would tell her the door was opening and the door was closing.

16. It was further put to her that there was a timeframe during which a lift door will remain open, and then it would start to close and it was put to her that if she were to occupy that timeframe by having a conversation while looking the other way, it would be prudent to check whether the lift was closing before she walked forward and hit her head off it. She said that because she had not heard any warnings, that she was not aware that it had started to close and that she assumed that it was still open and that is why she went to enter the lift.

17. Mr. Jim Roche was called to give evidence on behalf of the plaintiff. He was with the plaintiff at the time of the incident. He works as a quality control inspector with Abbott Ireland. He gave his recollection of the incident, saying that he recalled that the plaintiff came down to give a handover to him because he was going to be the stand - in quality control lead while she was on holidays. He indicated that he had a conversation with her in the corridor and that they both walked back towards the lifts. His recollection was

that he was going to the bathroom which was around that way and that she would have been going back to the lift.

18. He said that she had pressed the button for the lift to come down and that as he was walking away she turned to make another comment to him which he does not recall. She turned back to go into the lift. He says there was then a collision between her and the lift. He could not give any precise details as to the nature of the impact. He said that as she was turning to go into the lift, the door was coming from behind her and there was a collision. He confirmed that there was no voiceover on that particular lift at the time. He described it as a big sturdy lift suitable for carrying goods.

19. In cross - examination he accepted that he uses this lift on a regular basis. He agreed that the lift in question is a lift which is in regular and frequent use by Abbott employees including himself. He confirmed that some employees just use the lift on their own whilst some use it to carry freight or material. He confirmed that in his seventeen years working in Abbott, he had never heard of any incident involving that lift and that he had had no incident with that lift himself.

20. He confirmed that all employees received training and instruction in respect of reporting any issues or concerns from a health and safety perspective within the company. He confirmed that there was a system within the company whereby if there is any issue with equipment malfunctioning there are systems whereby employees go and report that. In that context, he indicated that he had made a statement in respect of the incident, the subject matter of this litigation. He was referred to that statement and confirmed again in his evidence how the plaintiff was standing in front of the lift, that he was standing over to her left. He said that the plaintiff had pressed the lift button and they had continued their conversation. He said he saw the lift open, he thought the conversation was over, she was about to go into the lift when she said something else. He confirmed in his evidence that the plaintiff turned to speak to him before she turned to enter the lift. He said that as she turned to enter the lift the doors began to close at the same time and she banged into the doors. He agreed that as she was walking towards the lift door that she was looking to her left and she turned back to the lift as the doors were closing. He confirmed in his evidence as per his statement that the doors had opened before she looked away.

Engineering Evidence
21. Mr. Michael Fogarty, engineer, gave evidence on behalf of the plaintiff. He confirmed his qualifications and the fact that he had carried out an inspection at the premises of Abbott Ireland on the 10th July 2017. He confirmed that there were two sets of doors. There are the car doors and there are the landing doors. He confirmed that the car doors travel with the lift once the lift door closes, while the landing doors remain on the landing.

22. With regard to the sensor he confirmed that the sensor was marked "E" on the photographs produced to the court and is attached to the car door. He confirmed various measurements stating that it would have been the outer door which would have struck the plaintiff and that that door has a thickness of 40mm. He indicated that after that there is a further space of 20mm before the inner car door on which the sensor is positioned. He said that therefore the sensor is in effect located 60mm inside the outer door. He agreed in his evidence that on these lift doors that is normally where the sensor is located, that it is centrally located in the doors. He went on to say that in his opinion because it is located a distance inside Panel B being the outer door, that you would have to get your head or your body at least 60mm inside of the edge of the outer door which he called the "danger zone" to activate the sensor. On that basis he proposed that if the sensors were located on the outside of the doors outside Panel A

then you would activate the sensor before you got into what he termed the "danger zone".

23. In giving his opinion in evidence he agreed that the position of the sensor is the normal position that sensors are located on these doors. He expressed his view that on 90% or 95% of occasions the sensor will pick up the presence of a person and retract but not on all occasions. He stated that it is effective most of the time, 90% of the time, but that there are occasions when it is not effective and on that basis indicated that he did not think that it was a very good location for the sensor.

24. A number of maintenance/engineering reports had been discovered to the plaintiff which were referred to this witness. The reports indicated that there was an issue found with the landing door and that the equipment was adjusted and the unit returned to normal service. The first report referred to in relation to this says that an adjustment was made to the door closing spring on the ground floor landing. A further report was referred to for two weeks later on the 4th July 2014 which says "Carry out M1 routine service visit on the lift. Had to tighten up closing spring on ground floor landing door". A similar report in respect of the 29th August 2014 states that "Had to give attention to closing spring on ground floor landing entrance." Mr Fogarty said that he did not know anything about those incidents.

25. Mr Fogarty was also asked about the presence of a voiceover on the lift. He expressed the view that if a person is expecting a voiceover and they are used to a voiceover, and are listening out for a voiceover and are not hearing it, then they are more likely to just assume the door is not going to close and get caught out by the fact that there is not a voiceover when in the normal course of their work, they are more accustomed to an elevator with a voiceover.

26. The witness was referred to his report and in particular to the final paragraph where he sets out his conclusions. In his conclusions he indicated that the plaintiff was not provided with a safe means of access and egress. He stated that the defendant was negligent and in breach of the statutory duties as set out in s. 8 and s19 of the Safety, Health and Welfare at Work Act 2005 in terms of risk assessment. He proffered the opinion that if there was a risk assessment carried out which highlighted that some of the elevators had the voiceover warning and some of them did not, in his opinion a control measure would have been put in place to put in the voiceover on the elevators with a view to consistency.

27. In cross - examination he was asked about the CE mark on the lift in question. He was asked whether that informed users that the lift was in compliance with all current European standards. When pressed on the issue, the engineer said that he had not paid a lot of attention to the CE marking on the door. He indicated that he felt from looking at the positon of the sensor on the elevator, from listening to the plaintiff's description of how this accident occurred, that he could understand how it could occur. He gave the opinion that the location of the sensor, which was in the middle of the door inside the outer edge of the door, had contributed to the accident. However, he also accepted that any elevators which he had looked at in the course of his professional work had the sensor in the centre of the door where this one is positioned. He further confirmed that the door was compliant with best practice worldwide.

28. He was then questioned about the mechanics of the occurrence of the accident. He said that normally if a person is standing straight they will get the impact on the right shoulder with the door coming from the right. So, he indicated that the plaintiff would at least have to have been leaning forward at the time of the accident to have received the impact on her right temple. The witness accepted that the sensor has to be on the inner door because the outer door cannot be operating independently of the inner door, or a person using the lift runs the risk of stepping into space. However, he proffered the

opinion that you could have a motion sensor like they have in shopping centres in respect of automatic doors, but he indicated that he had never seen such an arrangement on lifts.

29. He was asked how the defendant could prevent somebody injuring themselves if they walk into a door when looking behind them. He proffered the opinion that if the voice over warning was on this lift similar to that on the lifts the plaintiff was more familiar with he believed it was unlikely that the accident would have happened. He accepted that there was no malfunction of the lift. He was not in a position to express any opinion in respect of the maintenance reports on the closing spring mechanism of the door or its relevance if any as he had not considered that aspect.

30. Mr. Hackett who is a Service Engineer with Otis gave evidence on behalf of the defendant. He is an engineer with Otis which he described as a worldwide lift and escalator company. He has been with that company for 20 years. He had been an installation engineer for approximately thirteen years. He has been a service engineer for seven to eight years. He confirmed that in accordance with the contract with Abbott Ireland that Otis attend four times a year for service, and any time in between that when they are called for a specific incident.

31. When asked about his experience of lifts generally and those having voiceovers and those not having voiceovers, he broke it down roughly 60 - 40, and estimated that 40% of lifts he has dealt with have voiceovers.

32. He was referred to the opinion given by Mr. Fogarty engineer that there might be two sensor arrangements on a door like this, one for the cabin door and one for the landing door and asked if he had come across such an arrangement in his experience. Mr Hackett indicated that in his experience he had never come across a double sensor arrangement of that type. He was asked from his experience and by reference to the lifts with which he has been involved, how the sensor arrangement on this door compared with other lifts that he had dealt with. He indicated that there are two types of arrangements in his experience, the arrangement that pertained in the lift in question and an arrangement that pertained in older types of lifts where there would have been a beam which is situated approximately 500mm up from the finished floor level of the lift. This he described as the older type arrangement.

33. He was further asked about the closing spring of the main door prior to and post this accident. He confirmed that the closing spring is used to close approximately the last 20mm or thereabouts of the door. He indicated that if there is an issue with the closing spring, then that effects the functioning of the lift in that the electric contact is not made and the lift does not operate at all. He confirmed that if there is any interruption of the safety circuit, no matter where it is on the lift, the lift will not operate at all, nothing will happen. He confirmed that he had inspected the lift after the incident complained of and found no issue with the lift at that time.

34. In cross - examination he was asked whether there was a connection between any possible difficulties with the closing spring mechanism of the door and the operation of the sensor. His evidence was that the sensors only came into play when the lift is in operation or a part of the lift is in operation, i.e. when the doors are moving. He said that from his experience, if there is a difficulty with the electrics as a result of the closing spring mechanism, then the lift will not be operational at all and the doors will not be opening and closing at all.

35. With regard to voiceovers, his evidence was that his understanding is that the idea of voice activation systems originally was to warn people inside the lift, particularly those who might be either blind or visually impaired. He indicated that the sensor is working at all times when the door is moving. He indicated that the minute the door

starts to close the sensor is in operation. He was referred to the evidence given by Mr. Fogarty engineer in respect of what he had termed a "danger area" where the door is closing and the sensor will not operate because the person who is entering is not close enough to the sensor. He confirmed that from his experience, the positioning of the sensor was the industry norm.

36. Mr. Hackett was taken through various other routine service visits and call outs and it was put to him that the call outs had a bearing on the landing door gate closer and were relevant. It was his evidence however that these were heavily used lifts and that call outs occur regularly. On re - examination he confirmed that any difficulties with the closing spring mechanism are only relevant in respect of the last 10 to 15mm of the door closing.

Evidence given by Mr. McGrath on behalf of Abbott Ireland the defendant in the case

37. Mr. McGrath is a facilities and calibration supervisor with the company. He clarified that part of his role would be responsibility for setting out the correct maintenance programmes for the facilities equipment onsite and ensuring that those programmes are adhered to. He confirmed that there are five lifts in total on site in Abbott Ireland in Clonmel, County Tipperary. He confirmed that they have a programme with a company called Otis to maintain those lifts. He indicated that there are two arms to that programme. There is the fixed maintenance element which is a quarterly visit to undertake a number of checks on the lift and identify and confirm that the lift is working correctly and if not, to identify anything to the company and repair it. He indicated that the second arm of that programme is to provide a callout service in between those quarterly visits in the event of anything occurring with a lift.

38. He was asked when Otis inspected the lift following the incident and he indicated that Otis inspected the lift on the 5th August 2014. He indicated that on that date Otis were present on site for a call out for one of the other lifts and were brought to this particular lift to verify or otherwise what the company themselves had found, which is that all safety devices on the lift were working correctly. Mr. McGrath confirmed that on the day of the accident an engineer called John Walsh who was a delegate of their facilities department but working for another maintenance company was onsite and upon being made aware of the incident he examined the lift to verify or otherwise whether all of the safety devices on all doors of that lift were all working correctly. He provided a memo to the company which was contained in the discovery to the plaintiff. Mr. McGrath was asked that as a result of receiving the memo from Mr. Walsh, whether any immediate action was required to be taken, and he confirmed that no immediate action was required.

39. Mr. McGrath confirmed that the company has a system called "Lifecycle". It allows all employees the opportunity to make suggestions or raise issues on safety enhancements regarding anything onsite. He confirmed that subsequent to the accident, as a result of a suggestion from staff, all lifts were standardised and a voiceover was installed on any of the lifts that did not have it, including the lift which is the subject matter of this incident.

The Arguments - Plaintiff

40. The plaintiff directed the court to the statutory duty of the employer under the Safety Health and Welfare at Work Act, 2005. The plaintiff says in terms of any breach of statutory duty, the plaintiff's engineer gave evidence of breaches of s. 8 and 19 of the Safety Health and Welfare at Work Act, 2005.

41. The plaintiffs quote s. 8(1) of the Safety Health and Welfare at Work Act, 2005, which provides as follows: -

"Every employer shall ensure, so far as is reasonably practicable, the safety, health and welfare at work of his or her employees".

The plaintiff says that s. 8(2) of the 2005 Act sets out generally but not exhaustively matters which an employer's duty extends to. In particular, the plaintiff says s. 8 (2)(c) provides that the employer's duty extends to: -

"(c) as regards the place of work concerned, ensuring, so far as is reasonably practicable—

(i) the design, provision and maintenance of it in a condition that is safe and without risk to health,

(ii) the design, provision and maintenance of safe means of access to and egress from it, and

(iii) the design, provision and maintenance of plant and machinery or any other articles that are safe and without risk to health;"

The plaintiff goes on to say that s. 2(6) of the 2005 Act defines the phrase "reasonably practicable" as follows: -

"For the purposes of the relevant statutory provisions, "reasonably practicable", in relation to the duties of an employer, means that an employer has exercised all due care by putting in place the necessary protective and preventive measures, having identified the hazards and assessed the risks to safety and health likely to result in accidents or injury to health at the place of work concerned and where the putting in place of any further measures is grossly disproportionate having regard to the unusual, unforeseeable and exceptional nature of any circumstance or occurrence that may result in an accident at work or injury to health at that place of work."

The plaintiff goes on to quote s. 19 (1) of the 2005 Act which provides as follows: -

"Every employer shall identify the hazards in the place of work under his or her control, assess the risks presented by those hazards and be in possession of a written assessment (to be known and referred to in this Act as a "risk assessment") of the risks to the safety, health and welfare at work of his or her employees, including the safety, health and welfare of any single employee or group or groups of employees who may be exposed to any unusual or other risks under the relevant statutory provisions."

The plaintiff refers to its own engineering evidence which indicates that the defendant employer ought to have carried out a risk assessment which ought to have highlighted that as some of the lifts had a voiceover warning and some of them did not, that an appropriate control measure ought to have been to put in place a voiceover on all of the lifts. They say that this was not done and that it has been done since.

The plaintiff then further opens the Safety Health and Welfare at Work Act, (General Application) Regulations 2007. The plaintiff says that the 2007 Regulations expanded and particularised further the employers' obligations under s. 8 (1) to ensure so far as reasonably practicable the safety health and welfare at work of his or her employees.

The plaintiff opens in particular Regulation 11, which provides *inter alia* that: -

"An employer shall ensure that—

(h) mechanical doors and gates—

(i) function in such a way that there is no risk of accident to employees,"

42. The plaintiff said that Regulation 28, which replaces Regulation 19 of the Safety Health and Welfare at Work (General Application) Regulations 1993, sets out the specific duties of an employer with regard to the use of work equipment. Regulation 28 provides *inter alia* : -

"An employer shall ensure that—

(a) any work equipment provided for use by employees at a place of work complies, as appropriate, with the provisions of any relevant enactment implementing any relevant Directive of the European Communities relating to work equipment with respect to safety and health,

(c) the necessary measures are taken so that the work equipment is installed and located and is suitable for the work to be carried out, or is properly adapted for that purpose and may be used by employees without risk to their safety and health,

(d) where it is not possible fully to ensure that work equipment can be used by employees without risk to their safety or health, appropriate measures are taken to minimise any such risk,

(e) sufficient space to reduce such risks is provided between moving parts of work equipment and fixed or moving parts in its environment,

(k) employees have safe means of access to, and egress from, and are able to remain safely in, all the areas necessary for production, adjustment and maintenance operations,".

43. The plaintiff further opens Regulation 32 which it says deals with control devices and provides *inter alia* : -

"An employer shall ensure that -

(b) control devices are located outside danger zones except where necessary,"

The plaintiffs go on to refer to s. 2 (6) of the Safety Health and Welfare at Work Act 2005, which defines what is meant by reasonably practicable. The plaintiff says that in order to satisfy the reasonably practicable test, the employer must have done the following: -

(a) identified the hazards;

(b) having identified those hazards assessed the risks to the safety and health likely to result in accident or injury to health;

(c) after identifying those hazards and assessing the risk, put in place the necessary protective and preventative measures.

44. The plaintiff says that the employer is only excused from not taking any further measures where it is: -

"grossly disproportionate having regard to the unusual, unforeseeable and exceptional nature of any circumstance or occurrence that may result in an accident at work or injury to health at that place of work."

The plaintiff says that the Supreme Court recently in the decision of *Thompson v. Dublin Bus* [2015] IESC 22, considered whether the duty under Regulation 19 of the Safety, Health and Welfare and Work (General Application) Regulations 1993 was an absolute one or not. In that case a bus driver had been driving his bus over a number of ramps. On one of those ramps, the pneumatic suspension of the bus malfunctioned causing a loss of "cushion effect" and thereby causing an injury to Mr. Thompson's neck and lower back. In the High Court, the following matters were accepted: -

> (a) There was no evidence to suggest that the plaintiff was driving too fast;
>
> (b) There was sufficient evidence to establish that a proper regime of inspection and maintenance was carried out by the first named defendant;
>
> (c) The construction of the ramps, which had been undertaken by the second named defendant, conformed to best practice;
>
> (d) The plaintiff did suffer personal injuries as a result of the suspension failure which resulted in an ongoing physical deficit.

45. In the High Court, the trial judge found that although the defendant, Dublin Bus, had discharged its common law duty in ensuring that there was in place a good and proper maintenance system in relation to the bus, that nevertheless pursuant to Regulation 19 of the 1993 Regulations, that liability was strict and therefore the plaintiff ought to succeed. The court found that there was: -

> "In practical terms an absolute duty on employers in respect of the safety of equipment [provided] for the use of their employees".

The High Court relied on the previous judgment of Keane J. (as he then was) in *Everett v. Thorsman Ireland Ltd.* [2000] 1 IR 256.

On appeal certain provisions of Regulation 19 (now repealed by the 2007 Regulations and replaced with Regulation 28) considered by the Supreme Court were 19 (a) and (c): -

> "It shall be the duty of an employer to ensure that -
>
> (a) The necessary measures are taken so that the work equipment is suitable for the work to be carried out or is properly adapted for that purpose and may be used by employees without risk to their safety and health.
>
> (c) where it is not possible fully to ensure that work equipment can be used by employees without risk to their safety or health appropriate measures are taken to minimise any such risk."

46. The Supreme Court analysed the provisions of Regulation 19 and also the Framework Directive (89/391/EEC). There was a second directive on work equipment, namely Directive 89/655/EEC. The 1993 Regulations transposed the provisions of the aforesaid directives into Irish law.

47. Having considered the provisions of the Directive Dunne J. delivering the unanimous judgment of the Supreme Court, found that there was not an absolute or strict duty on the part of an employer to ensure the safety health and welfare of the worker. A specific breach of duty had to be proven.

48. Dunne J. found the following extract from the Advocate General Mengozzi's opinion in the case of *European Communities v. the United Kingdom of Great Britain and Northern Ireland* [2007] ICR 1393 to be of assistance to the court in analysing the issue of whether the regulation imposed an absolute duty or not. Advocate General Mengozzi examined the nature and duty imposed by Article 5 (1) of the Framework Directive, which provides that: -

> "The employer shall have a duty to ensure the safety health and welfare of workers in every aspect related to the work."

As follows: -

> *"I have already stated that the provision sets out the duty incumbent on the employer to guarantee the safety and health of workers. It is now necessary to define specifically the substance and extent of that duty, which, as we have seen, is formulated in absolute terms.*
>
> *In that context, I agree with the parties that this definition must be established in the light of all the provisions of the framework directive, and, in particular, Article 6 thereof, which defines the employer's general obligations, although it seems to me possible to derive some material indicators from the wording of the text of Article 5(1) itself.*
>
> *First of all, it seems to me clear that that provision requires the person subject to the duty to take positive action, consisting in the adoption of measures designed to pursue the objective of protecting the safety and health of workers.*
>
> *Secondly, since the duty in question consists in 'ensuring' that this interest is safeguarded, those measures must be appropriate and sufficient for that purpose. In other words, in view of the wording of Article 5(1) of the framework directive, the duty which that provision places on the employer requires, in my view, the adoption of all necessary measures to ensure the safety and health of workers in every aspect related to their work.*
>
> *That finding is further confirmed by the first subparagraph of Article 6(1) of the framework directive, according to which '[w]ithin the context of his responsibilities, the employer shall take the measures necessary for the safety and health protection of workers…'.*
>
> *Thirdly, the objective of protection which Article 5(1) of the framework directive is designed to secure makes it necessary to interpret the duty placed on the employer as being essentially a duty of prevention. That duty therefore takes the form both of anticipating and assessing risks to the safety and health of workers resulting from the undertaking's activities and of determining and taking the requisite preventive measures.*
>
> *Fourthly, since technical progress and developments in the production systems may result both in the creation of new risks to the safety and health of workers and in the diversification and improvement of protective measures, the employer's duty to ensure safety must be interpreted as an evolving responsibility, requiring constant adjustment to circumstances which may affect the quantum and extent of the risks to which workers are exposed as well as the effectiveness of the measures required to prevent or reduce them.*

To that effect, Article 6(2)(e) of the framework directive stipulates that, in adopting preventive measures, the employer must adapt 'to technical progress'

Finally, it is clear from the general criteria for prevention laid down in Article 6(2)(b) —which, as we have seen, requires the employer to evaluate 'the risks which cannot be avoided'—and Article 6(2)(f) —which requires the employer to replace 'the dangerous by the non-dangerous or the less dangerous'—that the general duty to ensure safety laid down in Article 5(1) of the framework directive does not extend so far as to require the employer to provide a totally risk-free working environment.

The analysis set out above allow of the conclusion that, pursuant to the duty of safety laid down in Article 5(1) of the framework directive, an employer is required to prevent or reduce, so far as possible and taking into account technical progress, all of the risks to the safety and health of workers that are actually foreseeable.

Translated into terms of liability, the above considerations imply that both the occurrence of foreseeable and preventable risks to the safety and health of workers and the consequences of events which constitute the realisation of such risks will be attributable to the employer, since both are a result of a breach of the general duty to ensure safety as defined above.

Conversely, the occurrence of risks that were unforeseeable and/or inevitable and the consequences of events which constitute the realisation of such risks will not be attributable to the employer on that same basis."

49. Dunne J. found that Regulation 19 of the 1993 Regulations was not expressed in absolute terms. The court opined that it was open to member states to impose more stringent requirements than those found in the directives. The Supreme Court found that Regulation 19 (3) of the 1993 Regulations did not do so.

50. The Supreme Court found that as there is not an absolute duty, that it was necessary for the plaintiff to identify a specific breach of duty under the Regulation. The High Court trial judge had found that there was no such breach as Bus Éireann had in place a proper maintenance system.

51. The Plaintiff in this case argued that it should be noted that the Supreme Court considered the 1993 Regulations and not the 2007 Regulations. The plaintiff says that the language of Regulation 11 of the 2007 Regulations is much more emphatic than Regulation 19 of the 1993 Regulations. The latter referred to an employer taking the "necessary measures" to ensure safety" and where safety could not be ensured, to take "appropriate measures" to minimise the risk.

52. The plaintiff says that in the case of Regulation 11 of the 2007 Regulations, the language is starker. The employer "shall ensure" that mechanical doors and gates function in such a way that "there is no risk of accident" to employees. The plaintiff says that it is not a question of taking necessary or appropriate measures. The plaintiff says that the duty is absolute and strict.

53. The plaintiff goes on to say that in the case of Regulation 32 of the 2007 Regulations, the language is not as strict as same provides that an employer shall ensure that all "control devices" are located outside danger zones except where necessary. Having said that, the plaintiff says that it is difficult to envisage why the

sensor could not be located on the landing doors in addition to or in substitution of the sensor on the car doors. The plaintiff also says that it should be noted that the definition of "reasonably practicable" contained in section 2(6) of the 2005 Act which was not contained in the original 1989 Act was not considered by the Supreme Court.

54. It is submitted by the plaintiff that whether a strict liability test applies as in the case of a breach of Regulation 11 (h)(i) or the reasonably practicable test under section 8 (1) the defendant is liable on either front. The plaintiff submits that in the present case, the defendant employer breached its statutory duty under the 2005 Act and the General Regulations as follows: -

Absolute statutory duty

55. The plaintiff says that if it is accepted that there is an absolute duty as set out in Regulation 11 (h)(i) that the employer shall ensure that the function of mechanical doors presented "no risk" of injury, then the absence of an outer sensor and/or voiceover is an automatic breach of the statutory duty and the Court does not need to consider the reasonable practicable test.

Reasonably practicable test

56. The plaintiff submits that the defendant employer is in breach of the reasonably practicable test by the failure to locate a sensor at the outer doors and the failure to maintain a uniform application of voiceover warnings. The plaintiff says that the plaintiff's engineer gave evidence that the accident could not have occurred had the sensor been located on the outer door in terms of the reasonably practicable test it is clear that the defendant employer failed to meet this test in the following respects: -

> (a) The defendant employer failed to identify the risk of the outer door striking an employee within the 60mm danger zone. The defendant also failed to identify the risk of confusion on the part of employees when using lifts with and without warning voiceovers.
>
> (b) Having failed to identify that risk it failed to take any protective measures.
>
> (c) If it had identified that risk a number of protective measures could have been taken to protect the employee. In particular, had the sensor been placed on the outer door, the accident would not have occurred. Alternatively, had a voice warning been installed the accident would not have occurred. Thirdly, had the defendant adopted a consistent approach to voice warnings on their lifts, then the employee would not have assumed the presence of a voiceover on the lift she was using.

57. The plaintiff says that the placement of the sensor on the inner door but not the outer door has not been shown to be disproportionate to the risk of being struck. The plaintiff says that it must be borne in mind that the plaintiff's engineer evidence which is not disputed, was that there was a 10% risk of persons being struck by the lift door. The plaintiff says that this is in the context of a factory that has between 1200 and 1500 employees.

58. The plaintiff says that there is nothing to suggest that it was disproportionate for the defendant employer to have an additional lift sensor on the outer doors. The plaintiff says that there is no suggestion that it is inconvenient to have a lift sensor on the outer door. The plaintiff says that there is no suggestion that it is disproportionate in terms of cost. The plaintiff says it must be remembered that this is not a high - rise building, and that this is a lift which is being used both to transport persons and goods.

59. The plaintiff further says that as reflected in the opinion of Advocate General Mengozzi, there is an evolving responsibility on an employer to constantly adjust the workplace in order to minimise risk of injury and to bring into the workplace "technical progress and developments". The simple and uniform provision of a warning voiceover is one such measure that ought to have been considered. It has been considered since but unfortunately for the plaintiff, not at the time of the accident.

60. Finally, the plaintiff says that as regards the location of the controlled device, when one considers Regulation 32 of the Safety Health and Welfare at Work (General Application) Regulation, 2007, same provides that an employer shall ensure that "control devices are located outside danger zones except where necessary". The plaintiff says that the sensor is not located outside the danger zone but within the very danger zone. The plaintiff submits that this again is a clear breach of the Regulations. She also submits that in the circumstances the defendant employer has failed to take all reasonable and practicable measures to ensure the safety health and welfare of their worker the plaintiff herein and accordingly is liable to compensate the plaintiff in relation to her injuries.

The Arguments - Defendant

61. In response the defendant says that: -

> (i) The duty owed by an occupier to a visitor is to exercise reasonable care in all of the circumstances "having regard *inter alia* to the care which a visitor may reasonable expect to take for his or her own safety" to ensure that a visitor to the premises does not suffer injury or damage by reason of any danger existing thereon.

62. A plaintiff to succeed in an action for alleged breach of section 3 must therefore establish that the feature on which he/she came to harm constituted a danger in respect of which the occupier failed to take reasonable care in all of the circumstances.

63. Further, the defendant says that it is trite law that an occupier is not an insurer of a visitor in respect of any harm that might befall him. The danger to be reckonable for the purpose of s. 3 must be unusual. The distinction, per Peart J. in the case of *Lavin v. Dublin Airport Authority plc* . [2016] IECA 261 at para. 46: -

> *"The distinction between an unusual danger and a usual danger is important even in the context of s. 3 of the 1995 Act. A fixed staircase can be the cause of injury to a person descending same, since it is not difficult to lose one's step for any number of reasons, and fall. Such a danger is however a usual danger that any adult would anticipate and take care to avoid by, perhaps, holding the handrail provided, or ensuring that he/she is not carrying anything likely to cause loss of balance. It is the sort of danger that exists by reason of the nature of the staircase itself without any defect existing. On the other hand, the fixed staircase might have a defect that the invitee/visitor could not anticipate or be aware of. For example, the handrail might not be securely fastened to the wall, and may give way when used for balance, causing the person to fall. That would be an unusual danger, and therefore one in respect of which the occupier has a duty to guard or warn against, failing which he will be liable for any injury that ensues."*

The plaintiff says that that case involved a fall on an escalator. The court allowed the defendants appeal and dismissed the plaintiff's case. It concluded that there was no unusual danger in the escalator. Peart J. described that the escalator: -

> *". . . it was a properly designed and properly functioning escalator which conformed to the required British Standard. Both engineers were agreed upon that. No fault was found to exist in it. In that sense it is no different to the fixed stairs referred to above."*

In that case, the plaintiff had come to harm while attempting to adjust her carry-on bag while on the moving escalator and whilst not holding the handrail provided. The court acknowledged that in any situation it could be suggested that a different circumstance may have resulted in a different outcome. That was not however the test. The court was satisfied that the escalator did not comprise a danger within the meaning of section 3 and that there had been no want of reasonable care on the part of the defendant.

64. The defendant said that a similar conclusion in the context of an automated door claim was reached by the Court of Appeal in the case of *O'Flynn v. Cherry Hill Inns Ltd T/The Oliver Plunkett Bar* [2017] IECA 211. The plaintiff, having walked through a door in a public house, put her hand back to restrain the door she felt would be closing behind her. The tip of one of her rings entered the rebate of the door frame and was crushed and severed. The claim was promoted against the publican as occupier of the premises. Irvine J. reiterated that an occupier was not the insurer of the welfare of a visitor and that the duty was not one to take all steps as might be necessary to ensure that a visitor would not be injured. The appeal was allowed and the plaintiff's claim rejected. Irvine J. had some particular observations to make on the obligation of a visitor and particularly as regards the use of a door: -

> *"From infancy we are warned of the risk of injury from closing doors. The education of toddlers concerning this particular type of danger probably starts when they first encounter the safety latch on the kitchen press.*
>
> *Beyond the home, doors are part of everyday life and automatic doors are no exception. They are commonplace in buildings of every nature. Automatic doors are encountered in every type of public building including hospitals, schools, courts and offices. As adults we know we must avoid leaving our fingers between the leading edge of the door and the door frame as it closes. Likewise, we are only too aware of the consequences of placing our fingers near or within the recess of the hinged side of a door. To propose that an adult should be considered blameless, and I use the word blameless in the legal sense in which that word is understood, for an injury sustained when, having proceeded through an automatic door, they blindly placed their hand behind them in a manner such that their fingers were placed in the hinged recess of the door is in my view untenable."*

In the present case, the defendant submits that each of these decisions is particularly apposite to the circumstances of the within claim. The lift at which the incident occurred had not malfunctioned and was in accordance with all relevant standards. The defendant said it had been in constant use on a daily basis at the factory premises of the defendant from 2005. There had been no prior incident. This incident occurred in circumstances where the plaintiff ignored the basic premise of looking where she was going. She was familiar with the operation of the lift and aware that the door had opened prior to turning around to make the comment and then moving forward. The defendant says that as stated by Irvine J. in the O'Flynn case: -

> *"We are all guilty from time to time of doing things without paying sufficient attention to the consequences of those actions in terms of potential risk. When we do so and sustain injury as a result we are to blame and we must absorb the consequences of our conduct unless we can demonstrate that some other party was in some respect culpable".*

65. With regard to the Safety Health and Welfare at Work Act 2005, the defendant says that this Act creates duties and obligations not only for employers but also for employees. The general duties of an employer are described at section 8 which puts the obligation on an employer to "ensure so far as reasonably practicable the safety health and welfare at work of his or her employees." The defendant also refers to the case of *Thompson v. Dublin Bus* [2015] IESC 22 in which the Supreme Court held that the duty so imposed on an employer was not absolute. They refer to the facts of the case and

confirm that the defendant was found not liable in circumstances where it had a system of inspection and maintenance in place. They say that section 19 of the Act requires an employer to identify the hazards in the place of work under his or her control and carry out appropriate risk assessment. The defendant says the employer is not an insurer. They say that liability cannot and should not be visited upon it in the absence of evidence of some malfunction or defect in the equipment used. They say that the lift in the incident case had not malfunctioned, was in compliance with European standards, and bore a CE mark to confirm the position in that regard. They say it had been in operation at the premises since 2005 in regular and constant use and absent any prior incident or complaint. The defendant says that the fact of steps taken subsequent to the incident the subject of the within proceedings as a matter of law, is not evidence and cannot be offered as evidence of negligence on the part of the defendant.

66. They further say the obligation as regards the health and safety of persons at work is not limited to an employer under the 2005 Act. The defendant says that s. 13 of the Act imposes extensive statutory duties on employees to include the obligation at s. 13 (1) (a) to take reasonable care to protect his or her safety, health and welfare and the safety health and welfare of any other person at work. The defendant says the incident was caused by inadvertence on the part of the plaintiff for which she as a matter of common sense and in accordance with s. 13 of the Act of 2005, must bear full responsibility.

Decision

Facts

67. The court finds the facts as follows: - The plaintiff had worked in the factory since in or around 1999. She was not generally based in the secondary pack area but she said she did however attend that area from time to time and by her own evidence about once a month. She said that she attended on that occasion to speak to Jim Roche in respect of handing over her work obligations in advance of her going on leave.

68. The plaintiff having had a conversation with Jim Roche, walked with him along the corridor towards the warehouse lift.

69. She called the lift by pressing the button with her right hand. Mr. Jim Roche was over her shoulder to the left.

70. At that point the lift door opened in accordance with her own evidence and that of Jim Roche. The plaintiff observed the doors opening, after the doors opened, the plaintiff turned and looked over her left shoulder to make a concluding comment to Mr. Roche.

71. She turned back towards the lift and walked forward making contact with the closing door of the lift. The impact was to the plaintiff's right temple.

72. The plaintiff conceded that she saw the door opening before turning back to Mr Roche and was not looking at or in the direction of the door when she moved to enter the lift.

73. This particular lift had been in position since around 2005 and bears the CE mark which confirms that it is in conformity with the relevant European standards.

74. There was no malfunction of the lift.

75. Abbott Ireland had a system in place for the inspection of lifts. All lifts were examined quarterly and at any other time when issues arose.

76. Evidence was given in respect of a number of call outs in respect of this particular door before and after the accident in question. These call outs had been in connection with the closing spring mechanism of the door which it was established relates to the final few millimetres of electrical contact required in order that the door closes securely. The Otis Engineer confirmed that if there was any issue with the spring mechanism on the door the electrical circuit would be broken and the lifts would not function at all to include opening and closing of doors. This was not contradicted by the plaintiff.

77. It was accepted by both sides that voiceovers on lifts occur in about 40% of lifts nationally and the requirement of a voiceover is not a legal or industry requirement.

The law

78. The plaintiff in her claim alleged *inter alia* breach of statutory duty under the Safety Health and Welfare at Work Act 2005 and the General Regulations made thereunder and the Occupiers Liability Act, 1995.

79. As an employee of the defendant company she was on the premises in the course of her work and the characterisation of the plaintiff under the Occupiers Liability Act 1995 would be under section 3 of the Act that of visitor. The duty owed by an occupier to a visitor is to exercise reasonable care in all of the circumstances and to ensure that a visitor to the premises does not suffer injury or damage by reason of any danger existing thereon.

80. A plaintiff, to succeed in an action for an alleged breach of section 3 of the Occupiers Liability Act 1995 must establish that the feature on which he or she came to harm constituted a danger in respect of which the occupier failed to take reasonable care in all of the circumstances.

81. The Safety Health and Welfare at Work Act 2005 implemented the 1989 EU Framework Directive on Safety and Health at Work and consolidated the amendments to the Safety Health and Welfare at Work Act 1989. The 2005 Act encompasses all the regulations and improved codes of practice that had been made under the 1989 Act. The Safety Health and Welfare at Work (General Application) Regulations 2007 (the General Application Regulations) replaced, simplified and updated the 25 then existing sets of regulations and orders. They apply to all places of work and replace in particular the Safety Health and Welfare at Work Act (General Application) Regulations 1993 (the 1993 Regulations) save for Part X and the 12th Schedule to the 1993 Regulations in respect of the reporting of accidents and dangerous occurrences which remained in force at the time.

82. Nine general principles of prevention derived from the 1989 EC Framework Directive are set out in Schedule 3 of the 2005 Act as referenced in s. 8 of the 2005 Act. These principles of prevention are a hierarchical framework of control measures or risk elimination and reduction measures.

83. The general principles of prevention as provided for by Schedule 3 are: -

(i) The avoidance of risks;

(ii) The evaluation of unavoidable risks;

(iii) The combating of risks at source;

(iv) The adaption of work to the individual especially as regards the design of places of work, the choice of work equipment and the choice of

systems of work with a view in particular to elevating monotonous work and work at a predetermined work rate;

(v) The adaption of the place of work to technical progress;

(vi) The replacement of dangerous articles substances or systems of work by safer, less dangerous articles, substances or systems of work;

(vii) The giving of priority to collective protective measures over individual protective measures.

(viii) The development of an adequate prevention policy in relation to safety health and welfare at work which takes account of technology, organisation of work, working conditions, social factors and the influence of factors relating to the working environment.

(ix) The giving of appropriate training and instruction to employees.

84. Under section 8 (1) of the 2005 Act, employers must do whatever is reasonably practicable to ensure the safety health and welfare of their employees. According to section 2 (6), this should be interpreted as follows: -

"For the purposes of the relevant statutory provisions, "reasonably practicable", in relation to the duties of an employer, means that an employer has exercised all due care by putting in place the necessary protective and preventive measures, having identified the hazards and assessed the risks to safety and health likely to result in accidents or injury to health at the place of work concerned and where the putting in place of any further measures is grossly disproportionate having regard to the unusual, unforeseeable and exceptional nature of any circumstance or occurrence that may result in an accident at work or injury to health at that place of work."

Section 8 (2) of the 2005 Act extends the employer's duties without prejudice to section 8 (1) of the Act. It sets out generally but not exhaustively matters which an employers' duty extends to which were referenced above by the plaintiff in their arguments.

85. The core duties imposed on employees are set out in section 13 (1) of the 2005 Act and include *inter alia* a duty to take reasonable care to protect their safety, health and welfare and the safety health and welfare of anybody who may be impacted by their acts or omissions at the workplace.

86. With regard to the Safety Health and Welfare at Work (General Applications) Regulations 2007, the plaintiff opened three specific regulations. They are Regulation 11, Regulation 28 and Regulation 32.

Absolute statutory duty

87. This issue of absolute duty was considered by the Supreme Court in the case of *Thompson v. Dublin Bus* [2015] IESC 22. In that case the Supreme Court considered the 1993 Regulations. The plaintiff in this case argues that the wording of the 2007 Regulations which postdate that decision renders the duty of an employer an absolute duty.

88. The Supreme Court in the case of *Thompson v. Dublin Bus* [2015] IESC 22 in considering the 1993 regulations, determined it was not an absolute or strict duty on the part of the employer to ensure the safety health and welfare of the worker. It was held that a specific breach of statutory duty had to be proven. The defendants are now arguing however that the 2007 Regulation creates such an absolute duty. They point to

what they term "the starker" and "more emphatic" language of the 2007 Regulations in particular regulation 11. They say that regulation 19 of the 1993 Regulations referred to an employer taking "necessary measures" and "appropriate measures" while the 2007 regulations state that an employer "shall ensure" that mechanical doors and gates function in such a way that "there is no risk of accident to employees".

89. It is clear from a reading of the 2005 Act and the 2007 regulations that the primary duties of the employer are contained in S8 of the Act which sets out the reasonably practicable test. Further the difference in language between the previous regulation 19 and the current regulation 11 is not such that would justify a reinterpretation of the duty of care. Section 8 (1) states that an employer "shall ensure" and Regulation 19 states that "Every employer shall identify the hazards in the place of work under his or her control…." This language was considered by the Supreme Court in the *Thompson* case and was determined to not create an absolute duty. Having considered the 2005 Act and the 2007 regulations this Court is satisfied that the language in the 2007 regulations and in particular regulation 11 is not such that it alters that position and falls well short of establishing an absolute duty on employers and accordingly rejects the plaintiff's argument that there is an absolute duty on the employer.

Reasonably practicable test

90. The reasonably practicable test is set of in S8 of the 2005 Act and has been set out in full above.

91. While particular regulations were opened to the court, Regulation 11, Regulation 28 and Regulation 32, there is a specific regulation also in respect of escalators and travellators.

92. The 2007 Regulations have a specific regulation with regard to elevators and travellators in Regulation 15. Regulation 15 sets out as follows: - "An employer shall ensure that escalators and travellators—

> (a) function safely,
>
> (b) are equipped with any necessary safety devices, and
>
> (c) are fitted with easily identifiable and accessible emergency shutdown devices."

93. The plaintiff says that the defendant employer is in breach of the reasonably practicable test by its failure to locate a sensor on the outer doors and the failure to maintain a uniform application of voiceover warnings.

94. With regard to the positioning of the sensor it was suggested by the plaintiff's engineer that the sensor was within the "danger zone". The defendants put forward that the 60mm between the outer door and the activation of the sensor was a "danger zone". Directive 89/655 defines "Danger Zone" as any zone within or around work equipment in which an exposed worker is subject to a risk to his health or safety. It is not clear to the court whether the lift comes within the definition of work equipment given the separate regulation dealing with escalators and travellators and whether as such the position of the sensor is within a danger zone as defined. In any event the court is not required to determine that question as the expert engineering evidence from the plaintiff's engineer accepted that the positioning of the sensor was the industry norm and while an alternative similar to automatic doors was suggested there was no evidence that this was a viable alternative that would meet required safety standards. Evidence was given by the Otis Service Engineer that based on his experience, sensors are automatically activated once the lift is in operation and the doors are opening and

that the location of the sensors on the inner door was standard industry norm. Taking the plaintiffs case at its highest point, the court is not satisfied that the evidence supports the proposition that the location of the sensor created a 60 mm danger zone and finds that the employer was not in breach of the reasonably practicable test by its failure to locate a sensor on the outer doors.

95. With regard to the inconsistency in respect of voiceover messages, the court is conscious that voiceover messages are only contained in 40% of lifts nationally and that this is not an industry requirement. In that regard, the court notes the comments of Irvine J. in the case of *O'Flynn v. Cherry Hill Inns Ltd. T/A The Oliver Plunkett Bar* [2017] IECA 211. In particular, the comments of the learned appeal judge she says: -

> *"Beyond the home, doors are part of everyday life and automatic doors are no exception. They are commonplace in buildings of every nature. Automatic doors are encountered in every type of public building including hospitals, schools, courts and offices."*

This Court is of the view that the same could be said of lift doors, that lift doors with or without voiceovers are encountered by people constantly and regularly and that it is not reasonable to consider any adult blameless should they enter through a lift door without paying proper attention to it and subsequently sustaining injury.

96. Further under the Health Safety and Welfare at Work Act 2005, section 13 imposes extensive statutory duties on employees to include the obligation at section 13(1)(a) to take reasonable care to protect his or her safety health and welfare and the safety health and welfare of any other person at work.

97. Having considered the duties of the employer under section 8 of the 2005 Act, the reasonably practicable test under section 2, the relevant regulations, the facts of the case to include the circumstances of the accident and the safety regime and measures taken by the employer the court is satisfied that the employer has fully discharged its duties and is not in breach of the reasonably practicable test by its failure to maintain a uniform application of voiceover warnings.

98. Similarly, having considered the Occupiers Liability Act 1995 and more generally the employers common law duties the court is satisfied that the employer has discharged its obligations to exercise reasonable care in all of the circumstances to ensure that the plaintiff did not suffer injury or damage by reason of any danger existing thereon.

99. Having considered the law and facts in this case the court is satisfied that the incident was caused by inadvertence on the part of the plaintiff for which she must bear responsibility, and in those circumstances dismisses the plaintiff's claim.

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