Neutral Citation Number: [2018] EWHC 3407 (QB)

Case No: HQ17P03366

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
QUEEN'S BENCH

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 10/12/2018

Before :

JEREMY JOHNSON QC, SITTING AS A DEPUTY JUDGE OF THE HIGH COURT

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Between :

GARY CHISHOLM	**Claimant**
- and -	
D & R HANKINS (MANEA) LIMITED	**Defendant**

- -
- -

Daniel Lawson (instructed by **Stewarts Law LPP**) for the **Claimant**
Winston Hunter QC (instructed by **DWF LLP**) for the **Defendant**

Hearing dates: 26th to 29th November 2018

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Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

....

Jeremy Johnson QC, sitting as a Deputy Judge of the High Court:

Introduction

1. Each year workers are killed or seriously injured as a result of contact with high voltage overhead power lines ("OHPLs"). Such accidents can be prevented by following straightforward advice from the Health and Safety Executive ("HSE") to avoid, wherever possible, carrying out work within 10 metres of OHPLs (and, where that is not possible, to implement rigorous safety precautions).

2. On 11 February 2016 the Claimant, Mr Chisholm, then aged 42, was cleaning out the trailer of his tipper truck in Block Fen Drove, Cambridgeshire. He did so by tipping the trailer to let the remnants of his previous load run out. The trailer touched, or came into very close proximity with, OHPLs. Mr Chisholm suffered an electric shock with consequential serious injuries, including a below knee surgical amputation of his right leg, extensive burning to a large proportion of his body resulting in severe scarring, a spinal process fracture to L2 and psychological injury. He seeks damages in negligence against his employer, D&R Hankins (Manea) Limited ("Hankins"), for personal injuries and special damage provisionally claimed in a sum exceeding £4m.

3. By an order dated 11 April 2018 the issues of primary liability and contributory negligence are to be tried separately as preliminary issues. A hearing of the trial of the preliminary issues took place on 26-29 November 2018.

The issues

4. Mr Chisholm's case is that the accident was caused by the negligence of Hankins. He pleads a number of particulars of negligence and breach of statutory duties, but his case in summary is that Hankins failed to adopt and enforce a safe system of work for cleaning out the trailers of tipper trucks. There was, he says, an insufficient risk assessment, a failure to provide adequate training and instruction as to the risks of working in the vicinity of OHPLs and the need to maintain a safe horizontal exclusion zone from OHPLs, a dangerous tipping mechanism which allowed the trailer to continue to tip when the driver was not at the controls, and a failure to take appropriate steps when another driver had a similar accident as a result of raising his trailer into contact with OHPLs on the same road. Any finding of contributory negligence for failing to see the OHPLs should be very modest.

5. Hankins contends that it had a safe system of work in place which prohibited the tipping of the trailer when carrying out cleaning. If Mr Chisholm had complied with the express instructions he had given then the accident would not have happened. Moreover, OHPLs are an obvious hazard, as Mr Chisholm well knew. They were there to be seen. He should not have tipped his trailer when directly underneath OHPLs. He chose the worst possible location to tip his trailer. Other, safe, locations were available. He was the author of his own misfortune and no liability should attach to Hankins. In the alternative, a finding of a significant degree of contributory negligence should be made.

The evidence

6. There is a wealth of documentary and witness evidence. There are a large number of factual conflicts in the evidence, but many of those are not ultimately relevant to the issues that I have to resolve. The volume of material assists greatly in the resolution of the issues.

7. Documentary evidence: There are reasonably high quality photographs of the scene showing the immediate aftermath of the accident. These in themselves broadly show how the accident occurred. They also provide a good indication of the view that Mr Chisholm had from his cab when engaging the tipper (and which correspond with the evidence given by Mr Chisholm, and an important eye witness, Matthew Fox). Tachograph and telephone records give a reliable indication (subject to a point on timings) of Mr Chisholm's movements during the day and his use of a telephone shortly before the accident. Hankins' internal records provide an indication of the steps taken to assess and control the risks to its employees and the systems of work that were in place, although these need to be considered as against the extensive and conflicting evidence of a number of different witnesses. Training records provide some indication of the instruction and tuition that individual drivers, including Mr Chisholm, received, which again fall to be considered in the light of the witness evidence. There is also extensive material to show what guidance was available to employers to address and control the risks to tripper drivers, including in particular the risk from OHPLs.

8. Claimant's witnesses: Evidence was given by Gary Chisholm, David Dewsbery, Jody Read, Ben Prime, Karl Gilbert, Matthew Amps, Trevor Robinson, Steve Riley, Roderick Chisholm and Matthew Fox.

9. They were all drivers who had worked for Hankins, with the exception of Mr Fox who was an eye-witness to the accident and a driver for another company.

10. Matthew Amps was a self-employed driver who spent the vast majority of his time working for Hankins. Nothing he said was materially inconsistent with the thrust of the evidence given by the other Claimant witnesses who were employees of Hankins. However, I do not treat his evidence as being, in itself, indicative of the system of work adopted or instructed by Hankins. That is because he was self-employed and was driving his own vehicle. I take the same approach in respect of Trevor Robinson who only worked for Hankins for 2 months, 2-3 days a week, during a sugar beat season.

11. Roderick Chisholm is Gary Chisholm's father. He had employed his son in the early years of his son's career and, later, he too had worked for Hankins. He is understandably distressed by the accident and it may have been unsurprising if that had coloured his evidence. I did not, however, detect that. I found his evidence to be wholly credible. Mr Hunter QC challenges his evidence that he too had stopped on one occasion in the location where the accident occurred. I do not attach any significance to that evidence. Roderick Chisholm also provided helpful and important background evidence, particularly in relation to his son's career and experience. Nevertheless, I have not found it necessary

to rely on his evidence in order to resolve any of the material factual issues that arise.

12. The other drivers all gave evidence as to the training they received from Hankins, the systems of work that were in operation, and their own practice when it came to the cleaning of tipper trailers in order to avoid contamination of loads, including the extent to which they tipped the trailer. Many of them were highly experienced drivers. There was a strong challenge to evidence as to the amount of debris that one driver said he would sometimes need to remove from his trailer, but that is not ultimately a matter I need to determine. I considered that they were all essentially honest witnesses and that they were not attempting to deceive on any material issue. That said, some (but not all) of the drivers displayed a degree of complacency in relation to health and safety. They did not all welcome giving up the occasional Saturday to attend training courses and some displayed varying degrees of contempt for the idea that they could be given instruction in relation to matters in which they were highly experienced. This is likely to affect the reliability of their evidence as to the instructions that they were given, simply because some of them may not have been paying particularly close attention.

13. <u>Defence witnesses:</u> Evidence was given by Ricky Howlett, Andrew Hankins, Rosemary Hankins, Colin Dunn, Chris Sallis, Simon Nunn, James Benton and Stephen Chambers.

14. Ricky Howlett had primary responsibility for health and safety. He was also a qualified driver and did some driving himself. He gave helpful evidence, but his discharge of his health and safety duties is best assessed by reference to the contemporaneous documentation.

15. Mr Hankins was a director of Hankins. He had provided Mr Chisholm with his induction training. He made a number of concessions which were against his and Hankins' interests. He was an honest witness, although I have disagreed with his view of what all drivers would have understood from their training (as to which see paragraph 48 below).

16. Colin Dunn, Chris Sallis, Simon Nunn, James Benton and Stephen Chambers were drivers who worked for Hankins. They too gave evidence as to their own practice when it came to the cleaning of tipper trailers in order to avoid contamination of loads, including the extent to which they tipped the trailer. Simon Nunn had an accident which was similar to Mr Chisholm's accident and which I address in more detail below.

<u>The facts</u>

Mr Chisholm's background and work history

17. Mr Chisholm left school at 16 and worked as a mechanic for his father for 5 years. He then qualified as a LGV driver. He held a Certificate of Professional Competence ("CPC") which entitled him to work in quarries and required him to undertake annual CPC training. His work involved the collection, transport

and delivery of aggregates, driving a cab with an articulated tipping trailer. It was not necessary for him to clean out his trailer between loads.

18. In 2003 Mr Chisholm started work as a tipper driver for Hankins. Aside from a 2 year period between 2005 and 2007 when he worked for another company, he continued to work for Hankins until the date of his accident in 2016. He therefore spent a total period of 12-13 years working for Hankins.

19. When working for Hankins Mr Chisholm was required to collect a variety of loads, including sand and grain. On a typical day he would leave the Hankins site by 4am. He would spend the day delivering loads all over the country, but principally in the Cambridgeshire, East Anglia, and East Midlands areas. He was often required to go to the Bardon Aggregates quarry on Block Fen Drove, on average once a week. He was therefore very familiar with that road which is a single track carriageway running for a distance of about 1½ - 2 miles between the A142 and the Bardon quarry.

20. Mr Chisholm did not typically return to Hankins between loads. He would deliver one load, and then collect a new load from a different site. He was (when there was a change in the nature of the load he was carrying) required to clean out the trailer between loads so as to avoid contamination. He was not always permitted to do this at the collection or delivery sites. Rather, he sometimes had to find a convenient place between the delivery site and the collection site. This was typically a layby by the side of the road. There was a particular spot on Block Fen Drove which he would use to clean out the trailer before collecting from Bardon quarry.

21. In 2016 Mr Chisholm was driving a Scania Heavy Tractor Articulated cab, fitted with a bulk haulage tipper semi-trailer. The tipper trailer was controlled by a "power take-off" ("PTO") control, which was a lever to the right hand side of the driver's seat. The PTO control was detented. That meant that once it was set the trailer would continue to rise even if the driver let go of the control: the PTO would not automatically revert to neutral. This enabled the driver to leave the cab whilst the trailer was still being raised. Other cabs had a "standard" PTO control which would automatically return to neutral if the driver let go of the control, so that the trailer would stop lifting.

22. In the 12-13 years during which Mr Chisholm worked for Hankins he had no accidents and there was only one occasion on which he was given a warning. That warning was because of a complaint that he had not worn protective equipment at a site. There is, however, clear evidence that he was regarded as a diligent and competent employee who complied with instructions and took appropriate care to ensure safety. In its evidence to the HSE following the accident Hankins said:

> "Gary has always been a very good and confident employee. He works very hard, looks after his vehicle and has excellent paperwork in place. The only occasion when there has been any cause for concern with Gary was when it came to the Company's attention in May 2015 that Gary was not wearing the appropriate level of PPE. This concern was raised with

> Gary verbally and a letter was subsequently sent to Gary by Mr Howlett advising that appropriate PPE must be worn and site rules followed at all times. The issue never arose again."

The danger from OHPLs

23. Mr Chisholm and all other drivers who gave evidence said that OHPLs are an obvious hazard for tipper truck drivers. All agreed it was necessary to check for obstructions, including power cables, before tipping. All agreed that they should avoid bringing the tipper trailer into contact with OHPLs. None of the drivers appeared to have a clear and confident awareness of the safe distances from OHPLs that should be observed, although two of Hankins' driver witnesses were aware of the need to keep some distance away.

24. The danger from OHPLs, and the precautions that must be taken before working in the vicinity of OHPLs, is explained in detail and in clear and straightforward terms in three documents published by the HSE: (1) A guide to workplace transport safety, (2) Guidance Note GS6 and (3) Agriculture Information Sheet No 8.

25. The first of these documents provides advice for employers on what they need to do to comply with the law and reduce risk. There are specific sections on tipping and on OHPLs:

> "**Tipping sites**
>
> 161. Tipping should take place in well-lit areas on ground that is level and stable and clear of overhead hazards such as power lines… Also see the "Overhead power lines" section (paragraphs 170-171).
>
> …
>
> **Overhead power lines**
>
> 170. The most effective way to prevent vehicles coming into contact with overhead lines is by not carrying out work where there is a risk of contact with, or close approach to, the wires. The law requires that work may be carried out in close proximity to live overhead lines only when there is no alternative and only when the risks are acceptable and can be properly controlled. See HSE publications *Avoiding danger from overhead power lines* and *Working Safely near overhead power lines* for more information."

26. The first of the references in paragraph 170 is to Guidance Note GS6 (Fourth edition) "Avoiding danger from overhead power lines". It was published in March 2013 but does not fundamentally change guidance that was provided in previous editions. It is primarily aimed at employers who might be planning work near OHPLs where there is a risk of contact with the wires. It describes

the steps that should be taken to prevent contact with OHPLs. It states that every year people are killed or seriously injured as a result of contact with OHPLs and that these incidents often involve machinery such as tipping trailers.

27. It provides the following guidance:

> "2. …An overhead wire does not need to be touched to cause serious injury or death as electricity can jump, or arc, across small gaps.
>
> 3. One of the biggest problems is that people simply do not notice overhead lines when they are tired, rushing or cutting corners. They can be difficult to spot, eg in foggy or dull conditions, when they blend into the surroundings at the edge of woodland, or when they are running parallel to, or under, other lines.
>
> …
>
> 9. The law requires that work may be carried out in close proximity to live overhead lines only when there is no alternative and only when the risks are acceptable and can be properly controlled. You should use this guidance to prepare a risk assessment that is specific to the site….
>
> …
>
> 11. Good management, planning and consultation with interested parties before and during any work close to overhead lines will reduce the risk of accidents. This applies whatever type of work is being planned or undertaken, even if the work is temporary or of short duration. You should manage the risks if you intend to work within a distance of 10m, measured at ground level horizontally from below the nearest wire.
>
> **Remove the risk**
>
> 12. The most effective way to prevent contact with overhead lines is by not carrying out work where there is a risk of contact with, or close approach to, the wires.
>
> …
>
> **Working underneath overhead lines**
>
> 23. Where work has to be carried out close to or underneath overhead lines, … and there is no risk of accidental contact or safe clearance distances being breached, no further precautionary measures are required.
>
> 24. However, your risk assessment must take into account any situations that could lead to danger from the overhead wires. … If this type of situation could exist, you will need to take precautionary measures.

25. If you cannot avoid transitory or short-duration, ground-level work where there is a risk of contact from, for example, the upward movement of… tipper trailers…, you should carefully assess the risks and precautionary measures. Find out if the overhead line can be switched off for the duration of the work. If this cannot be done:

• refer to the Energy Networks Association (ENA) publication *Look Out Look Up! A Guide to the Safe Use of Mechanical Plant in the Vicinity of Electricity Overhead Lines*. This advises establishing exclusion zones around the line and any other equipment that may be fitted to the pole or pylon. The minimum extent of these zones varies according to the voltage of the line, as follows:
- low-voltage line - 1 m;
- 11 kV and 33 kV lines - 3 m;
- 132 kV line - 6 m;
- 275 kV and 400 kV lines - 7 m;

• under no circumstances must any part of plant or equipment… be able to encroach within these zones. Allow for uncertainty in measuring the distances and for the possibility of unexpected movement of the equipment…;
…
• make sure that workers… understand the risks and are provided with instructions about the risk prevention measures;"

28. The second of the two references at paragraph 170 of the guide to workplace transport safety is to Agriculture Information Sheet No 8, "Working safely near overhead electricity power lines". That states:

"**Control measures**
…
• The safest option is always to avoid working near OHPLs if you can. Creating alternative access routes or work areas to avoid OHPLs is often the easiest and cheapest option.
…
Where you cannot avoid working near OHPLs, you will need to carry out a risk assessment and implement a safe system of work.
…
Safe work activities
Risks can be reduced if the following activities are not carried out within a horizontal distance of at least 10m from OHPLs. These distances should be measured from the line of the nearest conductor to the work, projected vertically downwards onto the floor and perpendicular to the route of the line [and a diagram shows that what is meant is the horizonal distance between the power line and the place where the work is to be done]. The activities are:

> …
> • tipping trailers…
> …
> If you cannot avoid carrying out any of these work activities closer than 10m, consult your DNO for advice. If the line cannot be moved or made dead you will need to assess the risks and agree a safe system of work. This may involve the erection of barriers to keep machinery a safe distance away from OHPLs, and other precautions as described in the HSE guidance note Avoidance of danger from overhead electric power lines…"

29. The key message is that the risk from OHPLs can be avoided altogether if work is not done within a horizontal distance of 10m from OHPLs.

30. Paragraph 25 of Guidance Note GS6 (see paragraph 27 above) refers to a publication of the Energy Networks' Association on behalf of electricity companies entitled "LOOK OUT – LOOK UP! A Guide to the Safe Use of Mechanical Plant in the Vicinity of Electricity Overhead Lines." Again it is written in very clear and straightforward terms. The body of the document runs to just 5 pages, including large diagrams. It says:

> "**2 EXCLUSION ZONES**
>
> • …any contact can result in serious or fatal injuries.
>
> • Electricity at high voltages can also jump gaps with no warning whatsoever, so it is also dangerous to let your plant approach too close to a line.
>
> • The distance that electricity can jump depends on the voltage of the line. The higher the voltage, the further you must stay away from the line… This distance is called the EXCLUSION ZONE…"

31. The guidance then sets out diagrams showing the exclusion zones for different lines, the zone for 11kV lines being 3 metres. It then says:

> "Please note that these are absolute minimum distances that should under no circumstances be infringed. ***If you do – it could prove fatal.***" [Emphasis in original]

Hankins' risk assessment

32. Hankins had completed a risk assessment which is headed "Location/Activity: Manea Depot." The activities listed include "Tipping Trailers". It says under the heading "Consequence":

> "Unsafe tipping can result in vehicle turnover or contact with overhead obstruction and cables."

33. Under the heading "Existing Controls" it says:

> "All drivers briefed on the tipping code of practice."

34. This is a reference to the document that I describe at paragraph 55 below.

35. Under the heading "Recommended Controls" it says:

> "Annual retraining in line with TASCC regulations."

Hankins' pleaded system of work

36. Hankins (in its Defence, and also in evidence it provided to the HSE) describes the system of work that it says was in place for cleaning trailers between loads:

> "The instructed and required method of cleaning was with a long-handled brush and a hand-held shovel both of which were carried on the tractor unit for such use. The contents of the trailer once [swept] up were to be stored in a sack or bag and returned to the depot for disposal.
>
> There was absolutely no need to activate the tipping mechanism and to do so for the purposes of cleaning the trailer was not only contrary to the Defendant's system of work, it would potentially be a disciplinary matter…"

37. Hankins also says (in its response to the Particulars of Negligence):

> "…The Claimant was expressly forbidden to use the tipping function for cleaning of the trailer."

38. This system therefore completely avoided the need for tipping when cleaning the trailer. If this system had been adopted by Mr Chisholm then the accident would not have happened.

The system of work that was adopted in practice

39. This was not, however, the system adopted by Mr Chisholm. He would routinely (albeit not invariably) find a convenient layby, where he could tip the trailer in order to let any remnants from the previous load run out, before then sweeping out anything that still remained. So too did Mr Dewsbery, Mr Read, Mr Prime, Mr Gilbert and Mr Riley who were each employed by Hankins to drive tipper trucks. They gave evidence that they regularly (or, in Mr Prime's case, "occasionally") tipped their trailers in order to clear out the

remnants from a previous load. All of them said that they had never been instructed that this was prohibited. They tipped their trailers on Block Fen Drove. Mr Prime, for example, said that he tipped his trailer further up the road from the site of the accident. He confirmed in evidence that at that point the OHPLs ran above the left hand roadside verge, and he would park on the right hand side, so the horizontal distance between his vehicle and the OHPLs was approximately the width of the road.

40. All witnesses accepted that it was necessary to check for obstructions. None of them gave evidence of being instructed as to precisely how they should check for obstructions, including, specifically, whether it was necessary to get out of the cab and walk around the vehicle. Mr Chisholm said that he was not instructed in how to check for overhead obstructions. As to how he in fact checked, he said "usually just a glance."

41. Mr Dewsbery said that if it was an area that he was familiar with then he would not specifically check. But if he was tipping in an area that he had not used before then he would "have a look round and see if it was okay...[I would] get out and have a look." If he saw that there were powerlines that he was going to hit then he would not tip.

42. Mr Read said that as he pulled up he would have "a glance around" and that after engaging the PTO he would jump out of the cab and "I guess you'd be looking around. You'd just… check." Mr Prime said "It would just be a general glance without getting out the cab, we were familiar with the road, so you'd sort of be complacent with it."

43. Mr Fox did not work for Hankins but he regularly drove along Block Fen Drove and was, himself, the driver of a cab with a tipper trailer. He said that he regularly saw drivers tipping their trailers in laybys on Block Fen Drove. He also said:

> "it wasn't unusual at all. It's something that most tipper drivers do at some stage. If they say they don't, then they're probably really good at sticking to the rules or they're not telling the truth."

44. Simon Nunn and James Benton did sometimes tip their trailers (albeit only a modest amount) in order to assist with the cleaning out process. Indeed that is how Mr Nunn's accident occurred (when the trailer tipped more than he intended).

45. Colin Dunn and Chris Sallis said (and I accept) that they did not ever tip the trailer as part of the cleaning/sweeping procedure. However, in Chris Sallis' case he only worked on aggregates so the issue did not arise. Chris Sallis and Stephen Chambers also says that they never saw anyone else tipping their trailers for the purposes of sweeping out. They were not challenged on that evidence. It is difficult to reconcile their evidence with Mr Fox's account, which I do accept, as to what he saw on a regular basis on Block Fen Drove. However, Mr Sallis may not have appreciated that sweeping out was taking

place, and Mr Chambers mostly carried sugar beet – there is no evidence that he regularly used Block Fen Drove.

The instruction and training that was provided to Mr Chisholm

46. <u>Initial induction:</u> Mr Chisholm says that when he first went to work for Hankins he underwent an induction lasting about half an hour to an hour and was given documentation. He said that the induction concerned the procedures relating to work at Hankins. He did not recall being given any instruction on procedures relating to tipping. Rather, his recollection was that it concerned the documentation that was required for the movement of foodstuffs which he had not transported in his previous career. The documentation that he was provided with has not been produced and there is no evidence as to precisely what it contained. It would be consistent with Mr Chisholm's evidence if it had comprised trade documentation relating to the transport of foodstuffs provided by the United Kingdom Agricultural Supply Trade Association ("UKASTA"). When Mr Chisholm returned to working for Hankins in 2007 he did not undergo a new induction.

47. Mr Hankins says that he provided Mr Chisholm with his induction training. Hankins' pleaded case is that Mr Chisholm was expressly prohibited from tipping when cleaning his trailer away from Hankins' premises (see paragraphs 36-37 above). Evidence was given by Hankins to the HSE to the same effect. In his written statement Mr Hankins said:

> "Under no circumstances was it necessary nor permitted to tip the truck when carrying out the cleaning or sweeping out process. That was the system of work and all drivers would have understood that from their induction with the company."

48. In his oral evidence, Mr Hankins maintained that he had explained to Mr Chisholm that he should clean out the trailer by using the brush and that no part of his explanation of the system of work to Mr Chisholm involved a need to tip the trailer. However, he candidly accepted that he did not explain that tipping the trailer was prohibited. Ultimately, he maintained his view that drivers "would have understood" from the initial induction that it was not permitted to tip the truck when carrying out the cleaning process. So far as Mr Chisholm is concerned, however, I conclude that he did not understand that tipping the trailer was prohibited. He had not been told it was prohibited. It was an obvious way of clearing out the trailer and many other drivers did it.

49. After Mr Chisholm's accident a document entitled "important safety memo" and dated the same day as the accident, was sent from Mr Howlett to all of Hankins' drivers. It says:

> "Following a very nasty incident today we feel that it is appropriate to remind everyone about their duties to ensure that all safety precautions and procedures are rigorously followed before, during and after tipping your trailer, especially when tipping near to power lines.

> You must always ensure that you are on level, secure ground and clear of any obstructions and that you are able to tip without endangering yourself or those around you.
>
> Always remember to check all around and above BEFORE starting the tipping operation.
>
> Maintain your own safety and that of others at all times."

50. It is commendable that Mr Howlett took swift action in response to the accident. This document was obviously written before there had been detailed consideration of the circumstances of the accident. I therefore do not base my ultimate findings as to the system of work that was permitted on this document alone. Nevertheless, there is nothing in this document to suggest that Mr Chisholm should not have been tipping his trailer. Rather, the document implies that tipping was permitted, including, remarkably, tipping "near to power lines", so long as the trailer was on level and secure ground and clear of obstructions and that the operator felt that he was able to tip without danger.

51. An instruction that was promulgated after Mr Chisholm's accident, but which was said to reflect the intended safe system of work before the accident, states:

> "DO NOT fully raise the trailer body under any circumstances and ensure a full check round is completed before starting the process of cleaning the trailer body to avoid contact with any obstructions such as overhead cables, gantries, trees or buildings"

52. This does not suggest an unqualified blanket prohibition on tipping of the trailer body. Rather, it implies that it is permissible to tip the trailer body by a certain (unspecified) amount so long as it is not "fully" raised. The obligation to carry out a "full check round… to avoid contact with… overhead cables" strongly suggests that tipping, at least to some extent, was contemplated and permitted.

53. <u>Provision of written documentation:</u> Each year a form was completed in respect of each of Hankins' employed drivers indicating that the driver had read a series of documents. The circumstances in which this form was completed were hotly contested. On analysis, however, the dispute was more apparent than real.

54. Ultimately, none of the drivers suggested that their signatures were forgeries and in respect of some of the forms it was clear that the driver had not only signed the form, but had also completed some of the content (including annotated ticks or circles to indicate that they had read individual documents). Rosemary Hankins, who administered the forms, had in some instances dated them and inserted the driver's details. That is not particularly surprising and is of no significance. In some instances Mrs Hankins annotated the ticks or circles to indicate that the drivers had read the individual documents. Her

evidence was that she only did so after "going through the forms" with the driver and recording their responses. For his part, Mr Chisholm maintains that it was a "30 second exercise" and he was given no opportunity properly to read the form. Having seen and heard the drivers, and Mrs Hankins, give evidence I find that it is highly likely that it was a somewhat perfunctory exercise. Mrs Hankins regarded it as "a paperwork exercise, when all said and done." Many of the drivers were experienced, confident in their abilities, and candidly complacent when it came to matters of health and safety. That said, I am satisfied that they each voluntarily signed the document, that it was open to them to ask for copies of the documents (and that if they had done so the documents would have been provided) and that Hankins was entitled to rely on their signed assurance that they were familiar with the content of the documents.

55. As to the documents that Mr Chisholm (and others) had signed as having read, the only one that has direct relevance to the issues in this case is a document entitled "UKASTA Code of Practice for the Safe Operation of Tipping Vehicles." It is a list of 15 do's and don'ts. Paragraph 3 states:

> "ALWAYS follow the site operator's instructions. Never tip a vehicle without receiving a clear instruction, CHECKING FOR OVERHEAD CABLES and other obstructions before raising the body."

56. This form is purportedly signed by Mr Chisholm alongside the date 2 January 2008. A further signature appears alongside the date 30 August 2008. It is also marked as being "updated" on 30 August 2009 and 17 September 2011. Mr Chisholm does not now recall signing the document. He does not, however, deny that he did so and there is no basis for a finding that the signature has been forged. I find that the document was provided to Mr Chisholm and signed by him. Although he was adamant that he never "double signed" the form, it is likely that this was due to a misunderstanding. He clearly did not "double sign" the form on any single occasion. Rather, he signed it on 2 January 2008, and then re-signed (and it was re-dated) on 30 August 2008.

57. By the time this document was provided to Mr Chisholm he had been driving for Hankins for 3 years. He was well familiar with the system of work that he had adopted. The instruction that it was necessary to check for overhead cables and other obstructions before raising the body did not tell Mr Chisholm anything he did not already know. The same goes for the instruction that it was necessary to follow a site operator's instructions. Those are both statements of the obvious. It is unsurprising if they did not particularly register with Mr Chisholm. As to the instruction "Never tip a vehicle without receiving a clear instruction", the natural reading of the document is that that applies when working on a site and therefore under the jurisdiction of the site operator. There is nothing to suggest that Mr Chisholm understood (or should have understood) that to be of universal application, so as to apply outside agricultural premises (this being a UKASTA document) and so as to prohibit tipping under any circumstances without a clear instruction from a third party. In any event, Hankins itself accepts that tipping (albeit only to a small degree)

was permitted when cleaning and in circumstances where there would be no third party to give an instruction.

58. <u>Courses:</u> Hankins did not itself directly provide any training courses. In March of each year from 2010 Mr Chisholm attended, on a Saturday, a compulsory CPC course for HGV drivers. Each of these courses was scheduled to last for up to about 7 hours, but there was evidence that they did not always last as long as that. The last training session before the accident was in March 2015. There are also some other, ad hoc, entries in Mr Chisholm's training record. His full training record is as follows:

"Jan 2008	UKSTA Code of Practice for the Safe Operation of Tipping Vehicles
April 2009	EPIC Training. Safe procedures of Quarry loading.
March 2010	CPC. Driver Hours & Tachograph Regulations
Sept 2010	TASCC. AIC code of practice Driver Training.
March 2011	CPC: Walk Round checks and safe loading.
Sept 2011	TASCC. AIC code of practice Driver Training reviewed.
March 2012	CPC. Safe, defensive & economical driving. Safe load handling
March 2013	CPC. Health & Safety in Road Transport.
March 2014	TASCC. AIC code of practice Driver Training
March 2014	CPC/MPQC Training. Safe procedures of Quarry loading.
March 2015	CPC. Drivers Hours, WTD & Tachograph regulations."

59. An employer's duty of care is not delegable. It is not an answer to a negligence claim based on inadequate training to show that the employee received training from a reputable body, unless that training was itself adequate to discharge the duty of care.

60. Here, the evidence as to what was taught at these courses is unsatisfactory. There are certificates of completion of the courses, but they do not disclose anything as to the content of the course beyond what might be inferred from the title.

61. A large number of documents have been disclosed that are said to emanate from CPC courses. They run to almost 400 pages and they appear all, or

mostly, to be powerpoint slides. Ten of these slides relate to tipping operations. They say that it should be "clear overhead" before tipping, that vehicles should not touch any cables, and that the driver should not leave the cab when tipping. None of the slides refer to the need to maintain an exclusion zone around OHPLs, or to the possibility of electricity arcing. There is no evidence that these slides were shown to Mr Chisholm at any particular course. However, he accepts that he attended courses where this sort of material was shown, and that he was well aware of the need to ensure that the area was free from obstructions when tipping.

62. Training given to other drivers: There were disputes about the training that had been given to drivers other than Mr Chisholm and, in particular, the extent to which they had been instructed not to tip their vehicles when cleaning out. There was a conflict in this regard between, on the one hand, Mr Read, Mr Prime, Mr Gilbert and Mr Riley and, on the other hand, Mr Howlett. That is not, however, of any real relevance to the issues in the case. What matters is the training given to Mr Chisholm, not the training given to others. Even if Mr Howlett is right, it is clear that the instruction to Mr Read, Mr Prime, Mr Gilbert and Mr Riley was not enforced. Mr Chisholm was far from alone in the practice that he adopted for cleaning out his trailer, and in his case the agreed evidence is that he was not told that he should not tip the trailer. Whether or not it was contrary to an instruction given during their induction, a number of other drivers adopted a similar approach.

63. Conclusions in respect of training: Mr Chisholm was not prohibited from tipping his trailer for the purpose of cleaning. He was not instructed as to the minimum exclusion zone that should be observed around OHPLs. He was aware that you could get a electric shock from touching OHPLs, but he did not know that getting too close to them (but without actual contact) could cause the same thing. He did not know how high his trailer went when tipped. He was instructed that he should check for obstructions before tipping, but he was not given any instruction as to how he should do that.

Previous incidents

64. In its evidence to the HSE Hankins had claimed that this was the first incident that had been reportable under RIDDOR and that Hankins prided itself on having such a low number of accidents. There had, however, been a number of previous incidents, including two which, on the face of it, should have been reported under RIDDOR, one of which was similar to the accident that befell Mr Chisholm.

65. In around 2003 Simon Nunn stopped on Block Fen Drove to clean his trailer. He set the PTO to tip, intending, he says, only to tip a small amount. He then left the cab, thinking that the PTO had returned to neutral so that the trailer had stopped tipping. In fact, unbeknownst to him, it was continuing to tip and it struck OHPLs that were immediately above. He rushed back to the cab and reversed the tipping mechanism. In doing so the trailer pulled a live wire out of the transformer. Mr Nunn was not electrocuted, quite possibly because he was in the cab, effectively a Faraday shield. He recognises, with no overstatement, that he was "very lucky." It is difficult to see why this incident

was not reportable under RIDDOR. More importantly, it was a clear demonstration that (1) drivers were (or may have been) tipping in order to clean their trailers, (2) drivers were not (or may not have been) observing safe exclusion zones from OHPLs, and (3) a PTO mechanism that continued to operate when the driver left the cab might give rise to danger. It does not appear that any steps were taken, or lessons learned, as a result of this fortunate and narrow escape.

66. There is evidence of three accidents in 2014-15 when drivers hit obstructions whilst tipping.

67. So far as Mr Chisholm is concerned, he accepts that he was aware, at least in general terms, of these incidents. He was aware that they further demonstrated that which he well knew - the need to check for obstructions before tipping.

<u>The accident</u>

68. On 11 February 2016 Mr Hankins arrived at Hankins' site sometime before 4am. His tachograph shows that he was "working" at 3.59am. He left the site at 4.10am with a trailer loaded with wheat. He drove to Tilbury, a distance of 85 miles. He arrived at 6.12am and delivered the wheat. He then drove to a farm at Bishops Stortford, loaded with wheat, and delivered that to a mill in Peterborough. He then went to a farm near Huntingdon, loaded with wheat and delivered that back to the mill in Peterborough. By the time he left Peterborough it was 3.15pm.

69. He rang the office to receive his next tasking and he was instructed to go to Bardon Aggregates on Block Fen Road to pick up some sand which he would then take back to Hankins' site (so that it could be delivered the following day). That would then be the end of his working day. He was under a little pressure of time because of his tachograph hours, and because the Bardon quarry closed at 4.30pm (and there may have been a queue). However, he says, and I accept, that he was not under undue time pressure and time considerations did not have a significant impact on his actions.

70. This would be the last trip of the day. It was necessary for him to clean out the trailer because his previous load had been wheat and his new load was to be sand. Otherwise, the sand would be contaminated by remnants of the wheat.

71. He exited the A142 onto Block Fen Drove. It was still light and the weather conditions were good. As I have said, he was familiar with the road and he had a favoured spot where he would clean out the trailer. On this occasion he was unable to use that spot because of road works. He drove a little further before pulling into a slight layby on the right hand side of the road. Up until the point where he pulled in there was an 11kV OHPL running along the right hand side of the road. At about the point where he pulled into the layby this OHPL crossed over the road and ran along the left hand side of the road. If he had been paying careful attention to the OHPL he would have noticed that. However, his primary attention is likely to have been on pulling into a layby that he had not previously used.

72. From the position where Mr Chisholm parked his cab, looking forwards, it seemed as if the OHPLs were running along the left hand edge of the road, so alongside the verge on the other side of the road from here he had pulled in. As it appears to me from the photographic evidence it would not have been apparent to Mr Chisholm, looking forwards, that the cables had crossed from right to left.

73. So, once he was parked, even if he had looked carefully from his position within the cab he could not have appreciated that the OHPLs ran immediately above his trailer (as Mr Fox confirms – see below). Mr Chisholm, perhaps understandably, does not now recall specifically checking that there were no obstacles. He fairly accepts "I might not have checked", but he also says, and I accept, that he was aware of the OHPLs running alongside the left hand verge of the road. Because he had parked on the right hand side of the road he thought he was well clear. He was not aware that they had crossed the road immediately above his trailer. He thought they had crossed "much further back". It is not necessary to make a finding as to whether he was right about that. The road bends so it is possible that OHPLs cross and re-cross the road. As against that Mr Hunter QC points out that a HSE inspector recorded that when she visited the site the only place where the OHPLs crossed the road was at the location of the accident (it is not clear whether the inspector was only considering the location of "the site" or whether she was referring to the entire length of Block Fen Drove).

74. In his statement to the HSE Mr Chisholm said that he was aware of OHPLs on the right hand side. However, he explained in evidence, and I accept, that he was there mistaking his left and right and that he had meant that he was aware of them running alongside the left hand side.

75. At 3.57pm the tachograph records that Mr Chisholm was no longer "driving" and that he was now "working". Mr Chisholm's evidence is that this means that he had parked the cab and engaged the handbrake.

76. Mr Chisholm's cab was fitted with a hands free mobile phone that was supplied by Hankins. Although Mr Chisholm does not now recall, lately disclosed telephone records demonstrate that he was having a telephone conversation shortly before he parked his vehicle. It is suggested by Hankins that he may have been distracted, and so may not have observed the OHPLs crossing the road as he brought the vehicle to a stop. The records show that at 3.49pm a colleague, David Broker, had telephoned Mr Chisholm (there were earlier calls, too, but they are not significant). This call lasted 6 minutes and 26 seconds. It therefore finished at 3.55pm or 3.56pm. If the tachograph timings and the telephone timings are both precisely accurate, such that they are synchronised one with the other, it follows that the call ended a minute or two before he parked. If they are out of sync then the call may have finished earlier, or it may have finished as Mr Chisholm was parking (with the result that Mr Chisholm may have been distracted). It is simply not possible to make a finding one way or another. It does not, however, make a practical difference because, whatever the underlying reason, the relevant point is that Mr Chisholm did not fully check that the area was free from obstructions.

77. An issue arose as to whether Mr Chisholm removed the sheet covering the top of the trailer after parking on Block Fen Drove. Mr Hunter QC points out that the tachograph shows that he parked at 3.57pm. The emergency call to the police was made at 4.06pm. He suggests that there is a period of time that is left unaccounted for and that it is likely that this is explained by Mr Chisholm removing the sheet. I am not satisfied that any safe inference can be drawn from the timings. There is no evidence that the times recorded for the 999 call and the times recorded by the tachograph are both accurate so that they can be safely compared to a precision of seconds or a small number of minutes. Even if the period was as long as 8 minutes that is not grossly inconsistent with the sequence of events that Mr Chisholm undertook (engaging the PTO, walking to the back of the trailer, releasing 4 mechanisms, returning to the cab, putting the PTO in neutral, and leaving the cab again). Mr Chisholm may also have been completing a telephone call at the time he parked (if the timings in the telephone records and the tachograph records are not synchronised). He also says that he may have completed some paperwork. The timing point alone is not a safe basis for any inference to be drawn.

78. If Mr Chisholm had removed the sheet then he would have needed to climb a ladder attached to the trailer. He would then have stood on a gantry adjacent to the trailer from where he could roll up the sheet. He is six feet six inches tall. His head would have been some distance above the top of the trailer. The OHPLs would have been a relatively short distance above his head, and would have stretched out into the distance. They would have been clearly visible. Mr Chisholm says in terms he did not remove the sheet at that point. He says that if he had done so he would have seen the power lines. Although he does not now remember doing so, he says he must have removed the sheeting immediately after his delivery in Peterborough. I agree that is likely to be the case.

79. Having parked the vehicle and, as I find, before exiting the cab, Mr Chisholm then engaged the PTO and started raising the trailer. He got out of the cab on the right hand side of the vehicle, stepping on to the verge immediately adjacent to the vehicle. The trailer was continuing to rise because of the detented PTO (although, unlike in Mr Nunn's case, this was intended by Mr Chisholm). He says, and I accept, that his vehicle would have obscured the OHPLs. He did not see them. He went to the back of the trailer to open the tailboard. As he walked down the side of the trailer the view of the power lines would have been obscured by the trailer. Mr Chisholm's focus is likely to have been on the ground which was an uneven verge. If he had stood at the back of the trailer, and looked away from it in the direction from which he had driven, he would have been in a position to see the OHPLs and to see that they crossed the road immediately above the trailer. However, at this point he had already engaged the PTO to raise the trailer. He would have had no particular reason to look back up the road. Rather, his attention was on the back of the trailer because he needed to release the tail gate so that any remnants within the trailer could fall out. He then went back to the cab to stop raising the trailer. Again, he was not able to see the OHPLs because he was on the right hand side of the vehicle, and the power lines were to the left of the vehicle.

Having put the PTO in neutral he left the cab to walk back to the tailboard of the trailer. At that point, as he puts it, "I got zapped."

80. Seconds before the accident, Mr Fox, who was a colleague of Mr Chisholm, drove past Mr Chisholm's parked lorry. He first saw it from a distance of a quarter to half a mile away. He could see that the trailer was raised, or was being raised. As he got closer he could see that the tailgate was open and Mr Fox concluded that Mr Chisholm was cleaning out the trailer before going to the quarry. He says that it was common to come across lorry drivers cleaning out their trailers near to the quarries. He does not express any surprise at seeing the trailer raised. This adds further support for the conclusion that, in practice, drivers did often clean their trailers by tipping and were aware that each other did so.

81. As Mr Fox passed he saw Mr Chisholm in the cab operating the PTO. He could see that the trailer was touching, or was very close to, the power lines. He sounded his horn to warn Mr Chisholm. Aware of the danger of an electric arc, he sped up to get away from the immediate vicinity. Seconds later he saw Mr Chisholm, in his wing mirror, go up in flames.

82. Mr Fox says:

> "If Mr Chishom had looked up he may have seen the power line but it is unlikely that he would have realised how close it was to his lorry as it was closest to the opposite side of the trailer to where Mr Chisholm was standing and to him the overhead lines would have appeared to be at least a trailer's length away.
>
> …
>
> I didn't actually realise the power lines cross the road at the point where Gary's accident occurred as they remain on the same side of the road prior to the accident spot and the angle of overhead power lines is deceiving to the eye."

Primary liability

The PTO control

83. Mr Lawson argues that the PTO control was not reasonably safe because it did not return to neutral when the operator let go of it. Accordingly, the tipper could continue to rise (or fall) after the operator let go of the PTO. Mr Nunn's accident (albeit involving a malfunctioning or obstructed PTO, rather than a detented PTO) demonstrates one potential consequence: the trailer might rise to a much higher level than desired and strike an obstacle. Another well recognised risk of tipping is that the trailer might topple (in which case the driver is safest to remain in the cab). Advice given by the HSE in its workplace transport publication (see paragraphs 24-25 above) is that straps should not be used to hold controls in position – see paragraph 168:

> "Drivers should:
>
> …
>
> - Not leave the control position when raising or lowering the body and not apply straps to hold the controls in position;"

84. The guidance does not state in terms what the rationale is for this advice. I infer from the context that a primary concern is to reduce the risk of injury in the event that the trailer topples. As against that, the detented PTO does not seem to me to be inherently dangerous. It does not require the driver to leave the control position, it merely enables that possibility. Moreover, it might be suggested that there is the potential benefit (I stress that I do not find that this is a benefit, or that any benefit outweighs the risks) that it may enable the driver to leave the cab during tipping in order to have a better view of the trailer and any possible obstacles.

85. Mr Lawson relies on the Supply of Machinery (Safety) Regulations 2008. Chapter 3 of schedule 2 to the 2008 Regulations states:

> "3. SUPPLEMENTARY ESSENTIAL HEALTH AND SAFETY REQUIREMENTS TO OFFSET HAZARDS DUE TO THE MOBILITY OF MACHINERY
>
> Machinery presenting hazards due to its mobility must meet all the essential health and safety requirements described in this section (see point 4 of the General Principles at the start of this Annex).
>
> 3.1. GENERAL
>
> 3.1.1. Definitions
>
> (a) "Machinery presenting hazards due to its mobility" means:
>
> machinery the operation of which requires either mobility while working, or continuous or semi-continuous movement between a succession of fixed working locations, or
>
> machinery which is operated without being moved, but which may be equipped in such a way as to enable it to be moved more easily from one place to another.
>
> (b) "Driver" means an operator responsible for the movement of a machine. The driver may be transported by the machinery or may be on foot, accompanying the machinery, or may guide the machinery by remote control.
>
> …
>
> 3.3. CONTROL SYSTEMS
>
> …

> 3.3.1. Control devices
>
> The driver must be able to actuate all control devices required to operate the machinery from the driving position, except for functions which can be safely actuated only by using control devices located elsewhere. These functions include, in particular, those for which operators other than the driver are responsible or for which the driver has to leave the driving position in order to control them safely.
>
> …
>
> Where their operation can lead to hazards, notably dangerous movements, the control devices, except for those with preset positions, must return to the neutral position as soon as they are released by the operator."

86. Mr Lawson submits that the PTO was a control device that could lead to dangerous movements but that it did not return to the neutral position as soon as it was released by the operator. I am prepared to assume (without deciding) that he is right about that. On that assumption it follows that the manufacturer of the PTO was in breach of regulation 7(2)(a) read with regulation 2(2). It does not, however, follow that Hankins were in breach of the common law duty of care that it owed to Mr Chisholm. There is no evidence that Hankins purchased the PTO from anyone other than a reputable supplier, or that it was anything other than an off-the-shelf proprietary product. It was not incumbent on Hankins to check that their supplier was complying with the 2008 Regulations, and Mr Lawson did not suggest as much. The issue is whether the PTO was unsafe.

87. It is difficult to see why a detented PTO would be chosen unless it is to allow a driver to leave the control position when raising or lowering the body, and that is directly addressed (and warned about) in the HSE guidance. Certainly, no explanation was given by Hankins in evidence as to why a detented PTO was used. However, I am not satisfied that it has been demonstrated that the PTO was itself dangerous. It follows that the claim based on the PTO fails.

Risk assessment

88. Mr Lawson relies on the duty to carry out a risk assessment recognised by the Supreme Court in Kennedy v Cordia (Services) LLP [2016] UKSC 6 [2016] 1 WLR 597 *per* Lord Reed and Lords Hodge JJSC (with whom all of the other Justices agreed) at [110]-[111]:

> "110. …it has become generally recognised that a reasonably prudent employer will conduct a risk assessment in connection with its operations so that it can take suitable precautions to avoid injury to its employees... The requirement to carry out such an assessment… forms the context in which the employer has to take precautions in the exercise of reasonable care for the

> safety of its employees. That is because the whole point of a risk assessment is to identify whether the particular operation gives rise to any risk to safety and, if so, what is the extent of that risk, and what can and should be done to minimise or eradicate the risk. The duty to carry out such an assessment is therefore… logically anterior to determining what precautions a reasonable employer would have taken in order to fulfil his common law duty of care.
>
> 111. It follows that the employer's duty is no longer confined to taking such precautions as are commonly taken… A negligent omission can result from a failure to seek out knowledge of risks which are not in themselves obvious…

89. Here, there was no specific assessment of the risks associated with cleaning out trailers whilst parked on the highway. That was an activity that gave rise to risk, particularly as it was reasonably foreseeable that drivers would tip their vehicles to assist with the cleaning process. The job of cleaning out trailers ought to have been the subject of risk assessment. The failure to do so was a breach of duty.

90. Hankins did make an assessment of the risks associated with tipping. Mr Lawson points out that the risk assessment refers only to the Manea site. I accept, however, that the assessment can be taken as a general assessment of the risks associated with tipping which was of general application and was not limited to the Manea site. I accept the submission of Mr Hunter QC that it would have been impracticable to have carried out separate risk assessments for every site where a driver might carry out a tipping operation.

91. In order to undertake a reliable risk assessment Hankins was obliged to "seek out knowledge of risks which are not themselves obvious." That is so as a matter of general common law obligation. It ought, at the very least, to have consulted readily available guidance, particularly the guide to workplace transport safety and the section in that guidance on "tipping". That section identifies the risks not just of contact with OHPLs, but of coming into close proximity with OHPLs. It cross-refers to the other specific guidance in relation to OHPLs that I have identified at paragraphs 26-31 above.

92. As it was, the risk assessment simply referred to "contact" with OHPLs. It did not identify or consider the risk of coming into close proximity with OHPLs. It then identified that the controls of the risk were limited to drivers being briefed on the tipping code of practice. Again, however, that document does not address the risk of coming into close proximity with OHPLs.

93. The relevant guidance was available and should have been considered, certainly following Mr Nunn's accident. Mr Howlett explained that it was considered following Mr Chisholm's accident. There was no good reason for not considering it after Mr Nunn's accident.

94. In any event, Mr Howlett, who was the person primarily responsible for health and safety at Hankins, accepted that he was "aware before the accident that you should keep a 10 metre exclusion zone." He accepted that avoiding contact with OHPLs was not sufficient to control the risk of electricity arcing and he therefore accepted that the risk assessment did not adequately deal with that risk.

95. It follows that there was no sufficient assessment of the risks and of the need to instruct drivers to maintain an exclusion zone from OHPLs when tipping. This was a further breach of duty.

System of work

96. It would have been a safe system of work if drivers had been instructed not to tip their vehicles when cleaning and if this instruction had been enforced. However, this was not done, at least not in relation to Mr Chisholm. I find that Mr Chisholm was never told that he must not tip his trailer when cleaning it out. It was therefore necessary (as an alternative to an instruction not to tip) for Hankins to adopt a safe system of work for tipping.

97. It would also have been a safe system of work if drivers had been instructed to maintain a 10 metre exclusion zone from OHPLs when carrying out tipping. Mr Hunter QC says that this was impracticable because (1) it would have severely limited the locations where tipping could be carried out, and (2) it would rely on drivers being able to make fine distinctions as to whether a distance was 9½ metres (and therefore unsafe) or 10½ meters (and therefore safe). I disagree. The vast majority of locations where a driver might carry out tipping are not within 10 meters of an OHPL. Where they are within 10m of an OHPL then there is nothing impracticable in either (a) the driver having to move to a separate location, or (b) the driver being instructed to take very particular and careful precautions (as explained in the guidance). Moreover, the whole point of a 10 metre exclusion zone (which allows for a margin of error) is to avoid drivers having to make precise estimations of distances. The alternative that was adopted was to require drivers to make their own assessment of whether tipping was safe, but without giving them the information necessary to make that assessment. That was not a safe system of work.

98. It was further suggested that the guidance was more concerned with earth works and other works of that nature. However, the guidance specifically refers to tipper trailers (see paragraph 25 of Guidance Note GS6) and I can, in any event, see no good reason why it should not be applied to this type of activity.

99. If it really was thought impracticable to require a 10 metre exclusion zone then there are other alternatives that could have been adopted (including different exclusion zones for different types of OHPL, with a minimum 3 metre exclusion zone for 11kV lines). However, this would have required careful analysis and assessment. This simply was not done. The system of work that was in place was unsafe and in breach of Hankins' duty to Mr Chisholm.

100. Mr Lawson relies on regulation 4(3) Electricity at Work Regulations 1989. That states:

> "Every work activity, including operation, use and maintenance of a system and work near a system, shall be carried out in such a manner as not to give rise, so far as is reasonably practicable, to danger."

101. Breach of this regulation does not, in itself, give rise to a right of action in damages – see s69(3) Enterprise and Regulatory Reform Act 2013. The conclusions set out above on breach of duty are not based on the 1989 Regulations. Those regulations are, however, entirely consistent with the common law obligations and it is likely that if Hankins had given sufficient thought to its statutory obligations then, in this respect, it would have complied with its common law duty of care to Mr Chisholm.

Causation

The PTO control

102. The claim based on the PTO control fails. The question of causation does not therefore arise. However, even if the PTO was unsafe, I am not satisfied that it has been shown that this was a material cause of the accident. If a "standard" PTO had been in place then Mr Chisholm would not have been able to leave the cab whilst the tipping was taking place. He would, though, still have tipped the trailer. The trailer would still have touched or gone very close to the OHPLs. It may be that Mr Chisholm would not, at that instant, have suffered an electric shock and that he would have been protected by the Faraday shield of the cab. However, even if that is right, it is likely that he would have suffered a shock as soon as he stepped from the cab to the ground (at least, the contrary has not been demonstrated). Mr Lawson argues that there would have been damage to the trailer at the point of contact with the OHPL and that Mr Chisholm would have noticed this and would not have then stepped from the cab. This, however, involves a degree of speculation without any expert evidence or other evidential basis. Moreover, even if causation of the injuries in a "but… for" sense could be established, that would be largely adventitious. The nature of the PTO in this case did not, in the circumstances of this case, materially increase the risk of the trailer coming into contact with the wires and was not a material cause of the accident.

Risk assessment and implementation and enforcement of safe system of work

103. If a sufficient risk assessment had been carried out into the task of cleaning then it would have been appreciated that it was reasonably foreseeable that drivers would tip their trailers. This would then have resulted in drivers being expressly forbidden from tipping their trailers, or from doing so beyond a very limited degree.

104. If a sufficient risk assessment had been carried out into the dangers posed by OHPLs then the need not just to avoid touching OHPLs, but also to maintain an exclusion zone, would have been identified. This would or should have

resulted in drivers being instructed to maintain an exclusion zone. The likelihood is that drivers would have been instructed to maintain a horizontal exclusion zone of 10 metres from all OHPLs (possibly with caveats if that was absolutely impossible). That is the simplest clearest and easiest way of managing and controlling the risk and it is likely to have been the method adopted if the risk had been identified. It would, however, have been open to Hankins to adopt different exclusion zones for different types of OHPL. That could still be a safe system of work, but it would then be necessary to give clear instruction and training to drivers as to the different exclusion zones. The appropriate exclusion zone for the OHPLs that are relevant to this case would have been 3 metres.

105. Accordingly, if Hankins had adequately assessed the risks and had adopted a safe system of work it would have instructed drivers not to tip their trailers when cleaning (or not to do so beyond a very small amount) and/or to maintain a horizonal exclusion zone from all OHPLs of at least 10 metres when tipping (or else to maintain exclusion zones according to the type of OHPL, with 3 metres being the appropriate distance in this case).

106. Mr Howlett suggested in his evidence that Mr Chisholm did not take too kindly to instruction or additional training. However, Hankins fairly stressed in its evidence to the HSE that it regarded him as “always” having been “a very good and confident employee” and that there was only one occasion in the many years he had worked for Hankins when there had been any cause for concern (see paragraph 22 above). I am therefore entirely satisfied that if Mr Chisholm had been given a clear instruction that he must not tip his trailer when cleaning then he would have obeyed that instruction. The accident would then not have happened. Similarly, if he had been given a clear instruction that he should maintain a 10 metre (or even a 3 metre) exclusion zone then he would not have tipped his trailer. I do not have precise measurements of the distances at the scene of the accident, including in particular the horizontal distance between the OHPLs visible from the cab, and the cab. However, from the photographic evidence it is reasonably clear that this distance is unlikely to have been significantly more than the width of the road, and that is certainly substantially less than 10 metres. Whether the distance is less than 3 metres might be a little more difficult to assess, but it is not necessary to make a definitive finding. What is important is what effect an instructed exclusion zone of 3 metres would have had on Mr Chisholm. I am satisfied that he would then have appreciated that it was necessary not just to avoid contact with the wires, but to maintain an exclusion zone of at least 3 metres. He would have realised that the wires he could see from his cab may well have been within a horizontal distance of 3 metres. He would then either have simply chosen somewhere else to park, or else would have paid much more attention to the OHPLs, either on his approach to the layby, or by getting out of his cab after parking. In either event he would have noticed the danger and would not have tipped his vehicle in that location.

107. I am therefore satisfied that Mr Chisholm has established that Hankins’ breaches of duty were a material cause of his accident.

108. It follows that Mr Chisholm succeeds in his claim.

Contributory negligence

Principles

109. Section 1(1) Law Reform (Contributory Negligence) Act 1945 states:

> "Where any person suffers damage as the result partly of his own fault and partly of the fault of any other person or persons, a claim in respect of that damage shall not be defeated by reason of the fault of the person suffering the damage, but the damages recoverable in respect thereof shall be reduced to such extent as the court thinks just and equitable having regard to the claimant's share in the responsibility for the damage."

110. It is therefore necessary to make a broad assessment of the claimant's share in the responsibility for the damage he sustained (as opposed to the claimant's responsibility for the accident – see Jackson v Murray and another [2015] UKSC 5 *per* Lord Reed at [20]). That assessment requires consideration of "the relative importance of [the claimant's] acts in causing the damage apart from his blameworthiness." There are two aspects in apportioning liability as between the parties, "namely the respective causative potency of what they had done, and their respective blameworthiness" (Jackson at [26]).

111. Mr Hunter QC recognises that where there has been a breach of a statutory duty owed by an employer to an employee, it is not usual to make a high reduction in the award of damages on grounds of contributory negligence. Here, however, he says the position is different. He relies on the observations of Latham LJ in Sherlock v Chester City Council [2004] EWCA Civ 2001 at [32]:

> "There may well be some justification for that view in cases of momentary inattention by an employee, but where a risk has been consciously accepted by an employee, it seems to me that different considerations may arise. That is particularly so where the employee's skill and the precaution in question is neither esoteric nor one which he could not take himself."

Assessments made in other cases

112. Mr Lawson has drawn my attention to two cases where the courts have made findings as to the degree of contributory negligence of employees who suffered injuries as a result of contact with OHPLs.

113. In Berry v Star Autos (transcript 26th July 2013) the claimant was using a crane to unload a portacabin from the back of a lorry. The crane came into contact with OHPLs causing damage to the claimant. In Milroy v British Telecommunications PLC [2015] EWHC 532 (QB) the claimant was working from a mobile platform when his head touched, or came close to, an OHPL. In both these cases the accident occurred in part because of breaches of duty by

the employer and in part because of the employee's failure to notice and avoid the OHPL. To that extent there are similarities with the present case.

114. However, the assessment of contributory negligence is highly fact specific and depends on an assessment of the relative culpability and causal potency of the actions of the employer and employee. The particular circumstances of this case (including, in particular, factors relating to the employer's breach of duty) are different from those in Berry and Milroy. It would not be appropriate to adopt the assessment made in either of those cases. Rather, it is necessary to apply well-established principles to the particular facts of this case.

Application of the principles to this case

115. Does s1(1) of the 1945 Act apply? The issue is whether the accident was partly due to failure on the part of Mr Chisholm to take reasonable care for his own safety.

116. I have explained that Mr Chisholm could not have appreciated, from the view he had from his parked cab, that the OHPLs ran above the trailer. Equally, however, he could not know, from that view, that there were no obstructions above the trailer. He knew that he needed to check for obstructions, including OHPLs.

117. Mr Chisholm was very familiar with Block Fen Drove. He knew that there were OHPLs. As he drove along Block Fen Drove he could have seen the OHPLs which were highly visible. He had the opportunity, as he chose a place to park, and as he parked, to check for obstructions. If he had taken that opportunity he would have seen the OHPLs. He would have chosen a different place to park, or would have manoeuvred his cab and trailer so that they were well clear of the OHPLs.

118. If he had not checked for obstructions on his approach to the layby (for example if he was distracted by a telephone conversation, or if he was focussing on manoeuvring his vehicle into the layby) then he could, having parked, have got out of the cab and walked around the cab and trailer to check the area was free from obstructions and OHPLs.

119. Again, that would have resulted in him choosing a different place to park. In all the circumstances Mr Chisholm breached the instruction he had been given to check that the area was free of obstructions before tipping. That amounted to a failure to take reasonable care for his own safety and it was a partial cause of the accident.

120. Assessment of contributory negligence: Mr Chisholm's failure to check for obstructions was an immediate and substantial cause of the accident. Hankins' breaches of duty were less immediate but they were multiple breaches which were substantial causes of the accident. I do not consider that it is possible meaningfully to distinguish between the parties in respect of the causal potency of their conduct.

121. There is, however, a significant distinction between their respective blameworthiness.

122. So far as Mr Chisholm is concerned, although he had ample time to check for obstructions, his failure to do so (and his engagement of the PTO without appreciating that he had failed to check), was a momentary lack of concentration or focus. It was the end of a 12 hour working day, much of which had been spent driving. Mr Chisholm was a hard working and diligent employee. Clearly he should have checked more carefully. However, his blameworthiness for the accident is very limited compared to that of his employer.

123. It is inevitable that from time to time drivers will suffer momentary lapses in concentration or focus. It is precisely for that reason that it is so important that the employer rigorously risk assesses dangerous tasks and implements and enforces safe systems of work. Hankins had every opportunity, over a period of years, to ensure that it discharged its duty to Mr Chisholm. There was very clear and easily accessible guidance from the HSE as to the steps that should be taken. Those steps were easy to implement. They would have involved no, or no significant, resource or cost. It was simply a case of telling drivers not to tip when cleaning and/or to always maintain a 10 metre separation from OHPLs when tipping (with perhaps a caveat as to what they should do if that was absolutely unavoidable). When Simon Nunn had his accident there was an obvious need to review the system of work that was in place. There was an ongoing failure to do so.

124. As to the submission made by Mr Hunter QC (see paragraph 111 above) I do not consider that it is particularly relevant that liability results from breaches of a common law duty rather than a statutory duty. As it happens Hankins were also in breach of statutory duties, it is just that those breaches do not directly give rise to a liability in damages. More importantly, however, the duties that were here breached were duties which were designed to prevent the very thing that occurred, namely momentary inattention on the part of a normally hard working and attentive employee. This is not a case where, as in Sherlock, the employee has "consciously accepted" a risk.

125. In all the circumstances, having regard to Mr Chisholm's share in the responsibility for the damage (after considering the respective causal potency of the parties' conduct, and their respective culpability), I think that it is just and equitable to reduce Mr Chisholm's damages by 25%.

Outcome

126. Hankins breached its duty of care to Mr Chisholm by failing sufficiently to risk assess the tasks of cleaning the trailer and tipping the trailer, and also by failing to implement and enforce safe systems of work in respect of those tasks, even after another employee had a similar accident. Those failings were a material cause of the accident.

127. Mr Chisholm therefore succeeds in his claim, but damages will be reduced by 25% because he did not check that the area was safe before tipping his trailer.