SHERIFFDOM OF LOTHIAN AND BORDERS AT EDINBURGH
IN THE ALL-SCOTLAND PERSONAL INJURY COURT

[2019] SCEDIN76

PN2694/18

JUDGMENT OF SHERIFF R D M FIFE

in the cause

CHRIS KING

Pursuer

against

COMMON THREAD LTD, a company registered under the Companies Acts (SC271900) with a place of business in Scotland

Defender

Pursuer: Bennie, Advocate; Digby Brown, Glasgow
Defenders: Murray, Advocate; Clyde & Co LLP

Edinburgh, 20 August 2019

[1] A proof in this action proceeded on 30, 31 July and 1 August 2019. The pursuer claims damages when his left thumb was trapped between a door and a doorframe while working with the defenders as a therapeutic support worker on 17 November 2015. Damages were agreed at £25,000. The proof was restricted to liability.

[2] The following authorities were referred to by parties:

1. *Gilchrist* v *Asda Stores Ltd* [2015] CSOH 77;
2. *Dehenes* v *T Bourne and Son* [2019] SC EDIN 48;
3. *Spencer-Franks* v *Kellogg Brown and Root Ltd and others* [2008] UKHL 46;
4. Fire (Scotland) Act 2005;
5. *Robb* v *Salamis (M&I) Ltd* [2006] UKHL 56;

6. Excerpt from Provision and Use of Work Equipment Regulations 1998;

7. *Hide* v *The Steeplechase Co (Cheltenham) Ltd and others* [2013] EWCA Civ 545;

8. *Kennedy* v *Chivas Brothers Ltd* 2013 SLT 981;

9. *Cockerill* v *CXK Ltd and another* [2018] EWHC 1155 (QB);

10. *Mason* v *Satelcom Ltd* [2008] EWCA Civ 494

11. Section 69 of Enterprise and Regulatory Reform Act 2013.

[3] The sheriff, having resumed consideration of the cause, finds the following facts to be admitted or proved:

Findings in fact

[4] On 17 November 2015 the pursuer was working in the course of his employment with the defenders as a therapeutic support worker at their residential care facility for young persons, aged between 5 and 18 years, at Cobblehaugh Cottage ("the Cottage").

[5] The Cottage had space for three looked after young persons and had three bedrooms. On the evening of 17 November 2015 only one young person, CB, was a resident. CB was 15 years of age.

[6] The Cottage was staffed by 2 therapeutic support workers at any time. On 17 November 2015 the pursuer commenced a 24 hour shift at 10.00 hours. From 08:00 hours to 16:00 hours a manager or senior support worker would usually also be present.

[7] CB's bedroom was opposite an office. Support workers would sleep overnight in the office or in the lounge. The distance from the front entrance to CB's bedroom was around 5m. The two other bedrooms were at each end of the building.

[8] At around 23:00 hours on 17 November 2015 Liam Booth was the second member of staff on duty. He was engaged in paperwork or other duties at that time.

[9] At around 23:00 hours on 17 November 2015 the pursuer was providing support to CB. CB had had a troubled childhood and found night-time difficult. During the course of the evening CB said he was unhappy and on several occasions that he wanted to go home. The pursuer gave him reassurance and guidance. CB went outside the Cottage for a few minutes and was then encouraged to return inside by the pursuer.

[10] The pursuer accompanied CB back to his bedroom. He continued to reassure CB. CB was sitting on his bed with his back resting on the wall and his feet on the bed. CB's bed was located to the left side of the bedroom as one enters. The pursuer was present in CB's bedroom for between two and three minutes. CB had a low mood and demeanour. The pursuer said he was going to bed and said goodnight to CB. CB replied: "just get out." CB was not aggressive. CB did not raise his voice. The pursuer again said goodnight.

[11] The pursuer exited the room. He opened the door with his right hand and left the room, pulling the door closed with his left hand.

[12] As the pursuer pulled the door towards a closed position, suddenly and without warning CB kicked the inside of the door causing the door to slam shut. The pursuer heard the sound of the door slamming shut. The pursuer's left thumb was trapped between the door and the door frame. The pursuer sustained a crush injury to the terminal phalanx of his left thumb.

[13] The door to CB's bedroom was not a certified fire door but had some fire resistant features. The door was fitted with a perko door closer ("PDC") which consisted of a chain that connected the door to a spring. When the door was opened the spring was tensioned and stored energy. When the door was released by the person opening it, the spring contracted and pulled the chain, causing the door to close.

[14] The PDC closed CB's bedroom door when it was released at a distance of more than 11cm from a fully closed position (in a straight-line measurement). When CB's bedroom door was released from a distance of less than 11cm from a fully closed position (in a straight-line measurement) it closed to the point that the latch met the door frame and stopped at 1.5cm from a fully closed position. If the door was released less than 11 cm from a fully closed position the PDC had insufficient momentum to cause the latch to retract and the door to close fully. The PDC operated as was intended and was not defective on 17 November 2015.

[15] The Scottish Fire and Rescue Service carried out a fire safety audit of the Cottage on 12 June 2015. The recommendation of the audit was that any PDCs be replaced by overhead hydraulic door closers capable of closing the door automatically from all angles of opening or an equivalent measure. The fire audit report stated all bedrooms within the Cottage should be fitted with fire doors. Fire doors should be full self-closing. CB's bedroom door was not a fully self-closing fire door. The PDC was non-compliant for a fire door.

[16] The pursuer was instructed by the defenders to keep doors within the Cottage fully closed. The pursuer's understanding was that all doors were fire doors and that closing the doors would slow down the spread of fire.

[17] The pursuer had known CB for some months prior to the incident. The pursuer had a good relationship with CB, giving him support. The pursuer described CB as having normal teenage behaviour. CB could be quite stroppy at times: he would not engage; he would swear; he would name call; he would verbalise his annoyance; he would storm out of a room.

[18] The incident on the evening of 17 November 2015 was the only occasion during his employment with the defenders that the pursuer witnessed a door being slammed. The pursuer did not see CB acting physically at any time and he had no reason to anticipate CB would act physically. There was no other evidence of CB being physical at any time.

[19] The door was suitable for the specific task of the pursuer closing the door. The door was not defective. There was no record of any fault to the door to CB's bedroom.

[20] The Scottish Fire and Rescue Service did not specify a date by which any PDCs be replaced. There was no requirement for the defenders to replace the PDCs by 17 November 2015. There was an expectation by the Scottish Fire and Rescue Service that any PDCs would be replaced by the time of the next annual fire safety audit in around June 2016.

Findings in fact and in law

[21] The PDC fitted to CB's bedroom door was not defective. The door was not defective. The pursuer has failed to show the door was in poor state of repair. The door was suitable for the specific task of the pursuer closing the door on 17 November 2015.

[22] There was no requirement on the defenders to replace the PDCs on doors by 17 November 2015.

[23] The injury to the pursuer on 17 November 2015 was not reasonably foreseeable. The accident happened as there were unforeseen circumstances beyond the control of the defenders.

[24] The pursuer has failed to establish fault and negligence on the part of the defenders at common law, with regard to Health and Safety Regulations made prior to the Enterprise and Regulatory Reform Act 2013, and in particular, regulations 4 and 5 of the Provision and Use of Work Equipment Regulations 1998. Decree of absolvitor is granted in favour of the defenders.

[25] At the request of parties expenses are reserved. The sheriff clerk will fix a hearing on expenses.

Witnesses

[26] The following is a summary of each of the witnesses who gave evidence:

1. Chris King

[27] Mr King was employed as a therapeutic support worker with the defenders from December 2014 until November 2016. On 17 November 2015 he was working for the defenders at Cobblehaugh Cottage near Lanark ("the Cottage") which was a residential care facility for young persons that accommodated up to 3 young persons. Mr King was providing support to CB who was aged about 15 and resident at the Cottage. During the evening CB was more anxious and agitated than usual because of what had happened to him in his past.

[28] At around 23:00 hours Mr King was in CB's bedroom giving him support and reassurance before telling CB's he was going to bed. As he got up to leave CB had said "just get out". There was no shouting. CB was not aggressive.

[29] As Mr King exited the room and was closing the door with his left hand the door slammed trapping his thumb between the door and doorframe causing injury. Mr King believed CB's had struck the door with force causing the door to slam shut.

[30] Prior to the accident Mr King had reported to his supervisor, Mary Dixon, that the bedroom door was not self-closing.

[31] Mr King said the bedroom door should have been fitted with a self-closer in which case the accident would not have happened.

[32] Mr King was a matter of fact witness. The circumstances of the accident were not in dispute. It was Mr King's view the bedroom door should have had a door closer. There was no suggestion Mr King had any expertise in fire doors or self-closers. Mr King was a witness to fact not opinion.

2. Michael Carrigan

[33] Mr Carrigan had been employed by The Scottish Fire and Rescue Service from 1984 until 2015. He was now retired. In 2015 he was the Watch Manager, a position he held for about three years.

[34] As Watch Manager Mr Carrigan worked in the fire safety department and carried out fire safety audits at commercial premises, care homes and schools. The audits were carried out annually. Production 5/9 was a report of an audit carried out at the Cottage in June 2015.

[35] The fire safety audit would include looking at fire doors within the property as part of fire compartmentation. Mr Carrigan made a recommendation in the report that perko door closers ("PDC") should be replaced by overhead hydraulic door closers capable of closing the door automatically from all angles of opening. The bedroom door where the pursuer had his accident was fitted with a PDC.

[36] Mr Carrigan qualified his report as follows:

> "The above risk control measures should not be regarded as the only option for achieving the benchmark standards. Other fire safety risk assessment methods or fire safety measures which achieve the same end may be considered".

[37] The audits were undertaken in terms of The Fire (Scotland) Act 2005 ("the 2005 Act"), Part 3 and The Fire Safety (Scotland) Regulations 2006.

3. Ross Burgess

[38] Mr Burgess was a deputy support worker with the defenders from November 2013 until January 2016, based at the Cottage from around March 2015 until January 2016 when he left that employment.

[39] Mr Burgess was not working on the day of the pursuer's accident. He heard about the accident the following day.

[40] Mr Burgess was not aware of any changes being made to the door of CB's bedroom while he was working at the Cottage. He said the door was faulty. There was a chain mechanism on the door which was dangerous and did not support the door. The door "just flapped about" and was not in line with the fire officer's recommendations.

[41] Mr Burgess' recollection was that only the office had a door with a hydraulic arm and only CB's bedroom had a chain. All the other doors in the Cottage had no mechanism for self-closing. His understanding of the fire audit was that a hydraulic arm fitted to the door would stop the door slamming. Mr Burgess described hearing doors slamming but no further details.

[42] Mr Burgess worked at 9 of the 10 houses run by the defenders including the Cottage. The working environment could be volatile: one day normal and other days very violent with staff being attacked, property destroyed and young persons running away.

[43] Mr Burgess was doing his best to tell the truth but his evidence was in general terms only. It was unclear which house he was talking about at times in the course of his evidence. His recollection was incorrect at times. I did not accept his evidence that the door to CB's

bedroom was faulty or that the door "just flapped about". I did not find Mr Burgess to be a reliable witness.

4. Daniel Pointon

[44] Mr Pointon was a consultant scientist and engineer who was the senior partner of Burgoynes and based in Glasgow. Mr Pointon had many years' experience investigating claims including injuries involving doors and matters relating to fire safety. Mr Pointon adopted his report dated 18 June 2019, production 6/1, as his evidence subject to any points of clarification.

[45] Mr Pointon was asked various questions about the position of the door handle on the proposition the door handle had been installed too close to the doorframe. Mr Pointon rejected that proposition and did not depart from the conclusion in his report at para 6.1:

> "The configuration of the door handle is consistent with standard and common practices in the UK …"

[46] The door was fitted with a PDC. As stated at para 4.9:

> "… the door would close fully from any distance beyond 11cm. However, below 11cm, the door moved until the latch contacted the keep but did not then close fully".

[47] Mr Pointon explained the door would not close to the extent of 1.5cm if released below 11cm. Mr Pointon tested the PDC. The PDC on the door operated as he expected. There was no fault with the PDC. There was no fault with the design or construction of the door. The door was not a certified fire door.

[48] At para 5.11 Mr Pointon noted that any door will always represent a trapping risk, irrespective of the gaps to door furniture and any user needed to be aware of that risk. The final conclusion of the report was at para 6.2:

> "It appears that Mr King has inadvertently placed part of his hand into a gap which has then closed suddenly. This is a feature of any door, especially if subject to being kicked".

[49] Mr Pointon demonstrated knowledge and experience in giving evidence. His opinion and views were persuasive, in the absence of any contradictor. No expert evidence was led by the pursuer.

Submissions generally

[50] Written submissions for both parties were lodged and expanded upon in oral submissions. These written submissions were of assistance to the court. The written submissions are referred to for their terms.

Submissions for pursuer

[51] The motion for the pursuer was to grant decree in favour of the pursuer in the sum of £25,000 and to fix a hearing on expenses.

[52] The pursuer proposed findings in fact supported by an analysis of the law. The pursuer provided a brief summary for each of the witnesses and inviting the court to find the pursuer, Mr Carrigan, and Mr Burgess as credible and reliable. Mr Pointon strayed into matters beyond his area of expertise, for example evidence about handles, and parts of his report and parts of his evidence were confused. Mr Pointon's opinion should not be accepted.

[53] The pursuer claimed damages at common law, informed by health and safety regulations made prior to the Enterprise and Regulatory Reform Act 2013 ("the 2013 Act") and the Occupiers Liability (Scotland) Act 1960 ("the 1960 Act"). The pursuer referred to the

cases of *Gilchrist* v *Asda Stores Limited* 2015 CSOH 77 and *Dehenes* v *T Bourne and Son* [2019] SC EDIN 48.

[54] The defenders accepted door closers were work equipment for the purpose of the Provision and Use of Work Equipment Regulations 1998 ("the 1998 Regulations").

[55] The pursuer relied on the fire safety audit report, production 5/9. A recommendation was made that the PDCs be replaced by overhead hydraulic door closers capable of closing the door automatically from all angles of opening. That placed a duty of care on the defenders to implement the recommendation. The report was dated 19 June 2015. Mr Carrigan expected that recommendation to be complied with. The defenders were under a duty to replace the PDCs before the date of the pursuer's accident. A period of 12 months, submitted by the defenders if a duty of care existed, was too long. There was a risk of fire and a risk of injury to employees and others if exposed to fire.

[56] The pursuer sought support from the Rosepark Nursing Home FAI where the fire service had recommended replacement of PDCs in January 1993. The fire occurred in January 2004 by which time a number of PDCs had been removed but not replaced with any door closers.

Note: The Rosepark Nursing Home FAI could be distinguished on its facts. That case was not relevant to the facts and circumstances of the present case.

[57] While there was no case of fault under the 2005 Act the pursuer submitted sections 53(2) and 53(2)(b) were of particular importance when looking at the audit report, 5/9 under the heading:

> "Sections 53 & 54
>
> Inadequate provision of reasonable measures taken to reduce the spread of fire".

[58] The audit report had concluded the PDC was not a reasonable measure and thereby inadequate provision of reasonable measures to reduce the spread of fire.

[59] The case of *Robb* v *Salamis* (M&I) Ltd 2006 UKHL, Lord Hope at paras [24], [25], [26] and [29], set out the approach to be taken under regulation 4(2) of the 1998 Regulations and in particular to identify the risks to the health and safety of workers if things go wrong.

[60] The pursuer referred to two other cases:

1. *Hide* v *The Steeplechase Co (Cheltenham) Ltd and Others* [2013] EWCA Civ 545;
2. *Kennedy* v *Chivas Brothers Ltd* 2013 SLT 971.

These cases demonstrated the pursuer's accident was reasonably foreseeable. Even if an accident was a possibility (even if not likely) it was foreseeable in terms of regulation 4(2). It was then for the defenders to show the accident was not foreseeable.

[61] There was a duty of care at common law, as informed by regulation 4(2) and having regard to the context of the accident. The pursuer accepted it was not an open ended duty to take reasonable care.

Submissions for defenders

[62] The defenders adopted the written submissions. The motion for the defenders was to grant decree of absolvitor.

[63] The pursuer's pleadings were skeletal. There had been no evidence to establish a departure from a standard size lock on the door. There was no evidence to contradict the opinion of Mr Pointon. At its very highest all the pursuer could prove was that the measurement between the spindle and the doorframe did not meet the published recommendation by a trade body, whose members manufactured locks with precisely the

same measurement as found on the bedroom door. That could not be a basis for fault on the part of the defenders that the door handle was too close to the frame of the door.

[64] No contributory negligence would arise if the case were to succeed on the construction of the door.

[65] There was no foreseeability in this case. There was no foreseeability of the door being kicked by CB. There had been no prior incident of a door being kicked by CB.

[66] There was no report of any defect in the PDC. Had the PDC not been operating at all that would have been recorded in the Fire Door Checks, production 5/10.

Section 69 of the Enterprise and Regulatory Reform Act 2013

[67] In both *Gilchrist* and *Dehenes* the court took the approach that the regulations remained relevant at common law in relation to workplace injuries and concessions by the defenders. The defenders in the present case had no difficulty with that broad concession but that was nowhere near specific enough to be able to tell how the regulations ought to be construed in any particular case.

[68] There were two important factors to be considered:

1. The nature of the regulation concerned;
2. The particular circumstances.

[69] There were two extremes on the spectrum. On the one hand the regulations were very specific. Examples included the Manual Handling Regulations and the Control of Noise at Work Regulations. In those cases it would be appropriate to adopt the standards in those regulations as the standard of care required at common law.

[70] At the other end of the spectrum there were regulations which were more general in their requirements, such as: "culpable failure by employers".

[71] That envisaged two types of situation:

1. Where the accident is not foreseeable;

2. Where the accident is foreseeable but the accident is caused by circumstances beyond the control of the defenders, see *Hide*.

[72] The overarching point about the construction of s69 of the 2013 Act was that it must have been intended by Parliament to have some outcome. There must be some actual change in the law.

[73] The defenders adopted the approach taken by Deputy High Court Judge Rice in the case of *Cockerill* v *CXK Ltd* [2018] EWHC 1155 (QBD) at paragraphs 15-18, and in particular, at 18:

> "It removed direct action ability by claimants from the enforcement mechanisms to which employers are subject in carrying out those statutory duties. What I have referred to as this 'rebalancing' intended by s.69 was evidently directed to ensuring that any breach of those duties would be actionable by claimants if, but only if, it also amounted to a breach of a duty of care owed to a particular claimant in any given circumstances; or in other words, if the breach was itself negligent. It is no longer enough to demonstrate a breach of the regulations. Not all breaches of the statutory regime will be negligent".

Accordingly, the circumstances of an accident would be an important component of any question of liability. In the present case injury was not caused directly by equipment but by the deliberate act of a third party, CB.

[74] PDCs were work equipment for the purpose of the 1998 Regulations. The 1992 Workplace Regulations did not apply to the present case.

[75] Referring to the case of *Robb*, if the pursuer could not succeed on a case under regulation 4(2), then the pursuer could not succeed on any other case against the defenders. It was not a question of strict liability but what was reasonably foreseeable, see regulation 4(4).

[76] In *Robb* Lord Hope said at para [24]:

> "But the question of foreseeability has to be examined in its context. The aim on both regulations is the same. It is to ensure that work equipment which is made available to workers may be used by them without impairment to their safety or health… The obligation is to anticipate situations which may give rise to accidents. The employer is not permitted to wait for them to happen".

[77] Lord Hope continued at para [25]:

> "It requires an assessment of risk be carried out before the work equipment is used by or provided for persons whose health or safety may be at risk. The aim is to identify the risks to the health and safety of workers if things go wrong."

[78] There was no evidence of any risk assessment of the PDC. It was not clear if a risk assessment would have identified a foreseeable risk of injury to employees.

[79] *Robb* was a case about a ladder and could be distinguished from the circumstances of the present case where there had been a series of events, the last of which was the deliberate harmful act of a third party, CB. The reason for providing a hydraulic door closer was to reduce the risk of harm caused by fire.

[80] The underlying duty on the defenders was not to ensure, rather, to take reasonable care.

[81] An accident of the kind in this case was not reasonably foreseeable. Otherwise all doors would have to be assessed for the risk of a trapping injury.

[82] In the context of this case the court had heard evidence of some doors being slammed and that young persons were sometimes violent. Without more by way of factual or opinion evidence, there was not enough evidence for the court to form a conclusion that an accident of this kind was reasonably foreseeable.

[83] Only if the accident was reasonably foreseeable would it then be necessary to consider whether there was anything unsuitable about the PDC. The defenders submitted there was nothing unsuitable about the PDC.

[84] The defenders relied on the case of *Hide* at para [25], LJ Longmore:

> "… The fact that an injury occurs in an unexpected way will not excuse the defendant unless he can show further that the circumstances were "unforeseeable" or "exceptional"… ".

[85] That was the factual position in the present case. There was a deliberate, harmful act by a third party in circumstances which were beyond the control of the defenders. The circumstances were unexpected and not reasonably foreseeable.

[86] There was a disconnect between the pursuer's submissions based on duties under the 2005 Act and the duty at common law to take reasonable care for the safety of employees in matters other than the risk of harm from fire.

Supplementary submissions for pursuer

[87] The court should prefer the approach taken in the two Scottish cases *Gilchrist* and *Dehenes* rather than the case of *Cockerill*. In *Gilchrist* Lady Stacey traced back the history of the intention of Parliament. The discussion in *Cockerill* extended to one paragraph. The opinion of Lady Stacey in *Gilchrist* should be preferred.

[88] It was not the pursuer's submission to look at the conduct of CB on 17 November 2015. The evidence was that he was volatile; that was his character. CB had good days; he had bad days, sometimes smashing items of property and slamming doors. Mr Pointon had been told by the defenders that CB had a history of aggressive and violent conduct. It was wrong to look at duties of care on the defenders to a particular day. You had to look at the context, as stated by Lord Hope in *Robb*. The context would be important. Every case would be different.

[89] This case concerned a residential environment and residents with behavioural concerns. According to Mr Pointon there was always a risk of injury with the doors. The

defenders were under an obligation to assess risks to employees, whether health and safety regulations or fire regulators. As of June 2015 a risk was identified from the fire audit report. The defenders had to replace the PDC. Where persons were known to have behaved in an aggressive or violent manner there was a reasonably foreseeable risk of injury. For all these reasons the defenders were at fault.

[90] On timescale to replace the PDC, Mr Carrigan did not give a timescale but he expected the recommendation to be complied with by the next annual review.

Note

[91] There is no dispute how the pursuer sustained injury in the accident on 17 November 2015. The claim in damages is at common law for failure to take reasonable care and in terms of section 2 of the Occupiers Liability (Scotland) Act 1960 ("the 1960 Act").

[92] In summary, the pursuer said the door of CB's bedroom was not suitably constructed in that the door was not fitted with a safety device recommended by the Scottish Fire and Rescue Service to allow the door to self-close. The PDC fitted to the door did not always allow the door to self-close. In these circumstances, it was reasonably foreseeable an accident, such as the accident to the pursuer, would have occurred.

[93] The Health and Safety Regulations made prior to the Enterprise and Regulatory Reform Act 2013 ("the 2013 Act") were relevant to a consideration of the scope and standard of the duties at common law. The pursuer relied on regulations 4(2)(b) and 5 of the Provision and Use of Work Equipment Regulations 1998 ("1998 Regulations").

[94] The duty at common law and in terms of the 1960 Act was to take reasonable care having regard to the specific circumstances of the case.

[95] Some time was spent hearing evidence about the position of the door handle. The proposition for the pursuer on record was that the door handle had been installed too close to the doorframe. The only evidence before the court was that the door was fitted with a standard size lock. In the event the pursuer did not insist on that case of fault in submissions.

[96] It was accepted by the defenders that the PDC was work equipment for the purpose of the 1998 Regulations.

[97] The primary question for the court to determine was whether the accident was reasonably foreseeable.

Discussion and decision

[98] When considering the effect of section 69 of the 2013 Act the authorities are consistent that any liability is dependent upon the precise circumstances of the case under consideration. The pursuer accepted the court must have regard to the context of the accident.

[99] *Robb* pre-dates the 2013 Act and can be distinguished on the facts, but the approach to be taken under regulation 4(2) of the 1998 Regulations by Lord Hope provides useful guidance.

[100] The sheriff in *Robb* was persuaded the accident was not reasonably foreseeable as there was no evidence of previous accidents of a similar kind. That was too narrow an approach, see Lord Hope at para [29]:

> "The employer must anticipate that it may not be possible to predict the precise ways in which situations of risk may arise, especially where the risk is created by carelessness. The employer was liable even if he did not foresee the precise accident that happened".

Lord Hope approved what was said by Lord Reid in *Hughes* v *Lord Advocate* 1963 SC (HL) 31 at p40, namely, the fact that an accident was caused by a known source of danger but in a way that could not have been foreseen affords no defence.

Reasonable foreseeability

CB's behaviour

[101] The pursuer had known CB for at least some months prior to the accident. The pursuer had a good relationship with CB, giving him support. The pursuer described CB as having normal teenage behaviour. CB could be quite stroppy at times: he would not engage; he would swear; he would name call; he would verbalise his annoyance; he would storm out of a room.

[102] On the evening of the accident CB had been more anxious than usual due to things that had happened in the past. CB was saying to the pursuer he did not want to be there.

[103] At around 23:00 hours CB was sitting on his bed, with his back to the wall and his feet up on the bed. CB was repeating he did not want to be there. The pursuer reassured CB before saying he was going to bed. As the pursuer left the bedroom CB said "just get out". CB was not shouting. He did not lose his temper. He was not aggressive. He was still sitting on the bed. As the pursuer closed the door, the door slammed on the pursuer's hand. This was the only occasion during his employment with the defenders that the pursuer witnessed a door being slammed. The pursuer did not see CB being physical at any time and he had no reason to anticipate CB would be physical.

[104] There was no other reliable evidence of CB slamming his bedroom door at any time. The kicking of the door was a deliberate unexpected act by CB in circumstances which were beyond the control of the defenders.

No previous incidents

[105] There was no evidence of anyone, staff or otherwise, being injured by the operation of any door including the door to CB's bedroom.

The door/operation of the door

[106] There was only a passing reference to any risk assessment. Mr Pointon gave evidence he tested the PDC and the door operated as he expected. There was no fault with the PDC. There was no fault with the design or construction of the door. The pursuer has not proved the door was in a poor state of repair. The door was not a certified fire door. There was no record of any fault with the door or the operation of the door prior to the accident.

[107] The fire safety audit was concerned with fire safety measures and the spread of fire. The pursuer's submissions based on duties under the 2005 Act did not advance the pursuer's case. The fire safety audit only formed part of the factual background. The action is based on a duty to take reasonable care for the safety of employees in the use of a door, not matters relating to the risk of harm from fire.

Reasonable foreseeability

[108] The pursuer sought to rely on the cases of *Hide* and *Kennedy* to demonstrate reasonable foreseeability. In *Hide* the claimant, a jockey, came into contact with a guard rail post which was work equipment. The accident was not at all likely but was possible. It was for the defendant to show the accident was due to unforeseeable circumstances beyond its control or to exceptional circumstance. In *Kennedy* the pursuer sustained injury when

pushing a loaded trolley. The trolley was not suitable and it was reasonably foreseeable an accident might result.

[109] These cases can be distinguished on the facts. There was no evidence of CB being physical at any time. The door was suitable for the specific task of the pursuer closing the door. The accident was not caused by a known source of danger. The accident was caused by the sudden, unexpected actions of a third party, CB, which were unforeseen circumstances beyond the control of the defenders. The accident was not reasonably foreseeable.

[110] The pursuer has failed to prove fault on the part of the defenders. Decree of absolvitor is granted in favour of the defenders.

[111] Expenses are expressly reserved. The Sheriff Clerk will fix a hearing on expenses.