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

[2019] SC EDIN 91

PN2465-17

JUDGMENT OF SHERIFF ROBERT D M FIFE

in the cause

SHEILA VARNEY

Pursuer

against

FIFE SCOTTISH OMNIBUSES LTD, a company incorporated under the Companies Acts

Defender

Pursuer: Lloyd; Lawford Kidd
Defender: Boyle; Clyde & Co, Aberdeen

Edinburgh, 18 November 2019

[1] A proof in this action proceeded on 1, 2 and 3 October with a hearing on submissions on 25 October 2019. The pursuer claims damages following an accident on 24 March 2016 when she lost her footing at the emergency exit steps while on a coach operated by the defender ("the defenders") intending to travel from Aberdeen to Stonehaven sustaining injury. Damages were agreed. The proof was restricted to liability and contributory negligence.

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

1. *Wyngrove* v *Scottish Omnicoaches Limited* 1966 SC (HL) 47.
2. *Bolton* v *Stone* [1951] AC 850; [1951] 1 All ER 1078.
3. *Kennedy* v *Cordia (Services) LLP* [2016] UKSC 6; 2016 SC (UKSC) 59; 2016 SLT 209.

4. *Matthew Robinson* v *Abellio Greater Anglia Limited* [2018] EWHC 272 (QB).
5. *Bowes* v *Highland Council*, [2018] CSIH 38; 2018 SLT 757.
6. *Jackson* v *Murray*, [2015] UKSC 5; 2015 SC (UKSC) 105; 2015 SLT 151.
7. *McCrory* v *Hutchison's Coaches (Overtown) Ltd* 2007 SLT (Sh Ct) 187.
8. *Pitt or Maxwell* v *Strathclyde Coaches Lt*d, 1990 GWD 25-1404; [1990] Lexis Citation 526.
9. *Fletcher* v *United Counties Omnicoach Co. Ltd*, [1998] PIQR 154
10. *Gubinas (Justinas)* v *HMA* 2017 SLT 1017.
11. The Road Vehicles (Approval) Regulations 2009.
12. *Donnelly & Others* v *Glasgow Corporation* 1953 SC 57.
13. *Perrett* v *Collins* [1999] PNLR 77.
14. *Toner* v *Glasgow Airport Ltd* [2019] SC EDIN 78 (unreported).
15. *R* v *Chargot Ltd and Others* [2009] 1 WLR 1.
16. *Cavanagh* v *Ulster Weaving Co Ltd* [1959] 3 WLR 262; [1960] AC 165
17. Health and Safety at Work etc. Act 1974
18. Provision and Use of Work Equipment Regulations 1998
19. Management of Health and Safety at Work Regulations 1999.

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

Findings in fact

[4] On 24 March 2016, the pursuer, who was accompanied by her husband, boarded a coach operated by the defenders at a bus stop in Holburn Street, Aberdeen. They were on a day trip to Stonehaven.

[5] The coach was a Plaxton Elite i Interdeck coach ("Plaxton Interdeck coach"), operating on the X7 route between Aberdeen and Perth. The coach had vehicle registration YX64 WBZ and Fleet No 54236 ("the coach").

[6] The design of the coach was that the main passenger deck was on an upper level, above the level of the driver. Access to the main passenger deck was via a set of stairs at the front of the coach staircase from the lower level. On the lower level, behind where the driver sat, there were two passenger seats. To the nearside of the driver's seat, there was a space for a wheelchair passenger.

[7] Upon ascending the stairs to the main passenger deck, a passenger could turn to the left, to seats at the front of the coach, or to the right, to seats at the rear.

[8] The coach was stationary at the bus stop at the time of the pursuer's accident.

[9] The pursuer ascended the front stairs to the main passenger deck. The pursuer was carrying a bag in her right hand. At the top of the stairs the pursuer turned right onto the central passenger deck gangway ("the gangway") to walk towards the rear of the coach. As she did so there was no-one in front of her. The pursuer had an unobstructed view as she walked along the gangway.

[10] The pursuer was looking for two seats together, for herself and her husband. As she walked along the gangway, her body was rotated, slightly to her left.

[11] The gangway measured 520mm at its widest point. The available width was narrowed because the passenger seats, which were on elevated platforms, on either side, overhung into the gangway. The available width for passengers to walk along the gangway at seat level was 430mm.

[12] There was an onboard passenger toilet on the nearside of the coach, about halfway along the gangway. The toilet was located on the lower level of the coach, adjacent to an

emergency exit door. Access for passengers to the toilet was via a second set of stairs being the emergency exit steps ("the emergency stairs") leading down from the main passenger deck. The emergency stairs encroached upon the width of the gangway of the main passenger deck, so that at the top of the stairs there was an ingress.

[13] The gangway narrowed from 520mm to 432mm, measured at floor level, being from the edge of the elevated seat platform, to the edge of the top step of the stairs. The edges of the ingress measured approximately 88mm. The ingress was a hazard for passengers.

[14] As the pursuer approached the ingress on the gangway, the ingress was to her right. The pursuer was not looking to her right hand side. The pursuer did not see the emergency stairs or the ingress.

[15] The pursuer stepped with her right foot onto the edge of the nosing of the top step of the emergency stairs. Her right foot went over the edge, falling down onto the step below, and causing the pursuer to stumble forward.

[16] To arrest her fall, the pursuer managed to grab hold of yellow bars which formed a guard for the passenger seats immediately to the rear of the stairwell of the emergency stairs. Attached to the guard was a handrail for the emergency stairs.

[17] The accident was reported by the coach driver Mr McGill. The pursuer sustained injuries including a fractured right ankle as a result of the accident.

[18] The floor of the gangway was coloured red. The nosing at the front edge of the top step at the ingress was a plastic, yellow coloured, strip ("yellow nosing").

[19] The yellow nosing extended over the width of the top step. Its purpose was to mark the leading edge of the step for anyone using the emergency stairs.

[20] The sides of the ingress at the top step were not marked with yellow nosing. There was a metal edge strip on each side. There was no warning sign to passengers of the presence of the ingress.

[21] The Plaxton Interdeck coach was introduced by the defenders to the X7 route in about November 2014, when the defenders had taken delivery of 8 coaches from the manufacturers, Plaxton.

[22] The defenders are one of a number of coach and bus operating companies within the Stagecoach group company ("the group company"). Procurement of coaches and buses was a process whereby the operating companies submitted bids to the group company. The bids were assessed by the group company. The group company decided which type of coach/bus and the numbers of coaches/buses to be delivered in response to any bid.

[23] There was no input from the operating companies in terms of design or specification of coaches/buses beyond a bid for a generic type, such as coach.

[24] When coaches and buses were delivered to operating companies, a risk assessment was carried out of route safety, being an assessment of risk to determine whether the coach or bus type could operate safely on the planned route.

[25] The defenders made a route safety risk assessment in respect of the Plaxton Interdeck coaches on the X7 route. That assessment was made by Kenny McWalter, Operations Manager of their Arbroath depot, who was an experienced driver, by driving the route.

[26] The defenders made no risk assessment, either before or after delivery of the coaches, relating to the onboard safety of passengers.

[27] The defenders relied on the coaches and buses delivered to them being in possession of an EU Certificate of Conformity, and of a type which had been approved for use on UK roads. The defenders relied on the coaches and buses being road legal.

[28] The process for a coach or bus type securing approval involved the UK Regulator, the Vehicle Certification Agency (VCA), which has a coach and bus industry safety role. Approval would be granted if the coach or bus met certain standards. The process of securing regulatory approval was one that was left to the coach/bus manufacturers and the VCA.

[29] Any risk assessment for onboard passengers would have identified the ingress as a hazard, and a reasonably foreseeable risk of injury to passengers. There was a requirement on the defenders to take reasonable control measures to eliminate or minimise that risk of injury to passengers.

Findings in fact and in law

[30] The ingress on the coach was a hazard. There was a foreseeable risk of injury to passengers.

[31] The pursuer suffered loss, injury and damage on 24 March 2016 as a result of the fault of the defenders at common law for failure to take reasonable care.

[32] The defenders have established contributory negligence on the part of the pursuer, assessed at 60%, and the defenders are liable for 40%.

[33] Grants decree against the defenders for payment to the pursuer of damages in the sum of £16,495.60, with interest at 8% per annum from the date of decree until payment

[34] Reserves all questions of expenses. The Sheriff Clerk will fix a hearing on expenses.

Witnesses

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

Sheila Varney

[36] Mrs Varney was aged 66 at the date of proof. She was retired.

[37] On 24 March 2016 Mrs Varney was intending to travel from Aberdeen to Stonehaven with her husband by coach on the X7 route operated by the defenders. At or about 2:26pm Mr and Mrs Varney boarded a coach, registration YX64 WBZ, on Holborn Street, Aberdeen.

[38] After boarding the coach Mr and Mrs Varney went upstairs where the seating was on the coach. Mrs Varney was ahead of her husband. At the top of the stairs it was her intention to find two seats together. Mrs Varney was looking for seats together, walking down the gangway towards the rear when, all of a sudden, her right foot went down a step. Mrs Varney did not know there was a step on her right-hand side of the gangway at that point. The step was the first step of a set of steps for an emergency exit and a toilet. Mrs Varney did not see this at all before she lost her footing. As a result of the fall she sustained a broken ankle and other injuries.

[39] Mr and Mrs Varney did not travel from Aberdeen to Stonehaven regularly. This had been a day out. Mrs Varney had been on this type of coach before on 2 or 3 occasions or so.

[40] After the accident the driver came upstairs to see if she was alright. He asked if she wanted an ambulance. Mrs Varney was embarrassed at what had happened. She said she was fine and would carry on with the journey to Stonehaven. By the time she reached Stonehaven, Mrs Varney could not stand and the driver phoned for an ambulance.

[41] The incident was recorded on CCTV from a number of different cameras. Mrs Varney did not know why she did not see the yellow nosing on top of the top step. She did what she usually did when on a coach. She was looking for seats further up the coach. She was walking up the gangway towards the rear of the coach, walking at an angle and with a crossover shoulder bag to her right-hand side.

Note: The CCTV footage and, in particular, camera 8 showed Mrs Varney walking towards the rear of the coach looking for seats. She had an unobstructed view. There were no passengers ahead of her on the gangway. She was focussing her attention on her left-hand side of the coach looking for seats. She was not looking to the right-hand side of the coach. If she had been looking to the right-hand side of the coach it is likely she would have seen the yellow nosing warning of the stairs to the emergency exit and/or seen there was an emergency exit.

[42] Mrs Varney was asked to look at a photograph 6/19/3 which showed a modification at the emergency exit steps to a Bluebird coach, not owned by the defenders, being a non-lockable barrier across the steps. Had such a barrier been fitted to the coach she was travelling on, Mrs Varney could not definitely say the accident would still not have happened.

[43] If the barrier had been level with the inside edge of the top step on both sides Mrs Varney did not think the accident would have happened.

[44] It was put to Mrs Varney there were a number of distinct features on the coach:

1. the emergency exit steps;
2. either side of the steps there was a gap in the seats which were wider apart at that point;
3. on one side of the coach the seats were quite regularly spread;
4. on the other side of the coach the seats were regularly spread then there was a gap for the emergency exit then the seats regularly spread again;
5. on one side of the coach there was an orange handrail at the emergency steps;
6. at the top of each step there was a yellow strip;

7. there was a yellow strip on the top step where there was an ingress on the gangway.

[45] Mrs Varney said she did not see any of these features. Had she seen any of these features it was probable she would not have had a fall.

Roderick McGill

[46] Mr McGill was aged 58 at the date of proof. He was a coach driver with Stagecoach Strathtay, part of the Stagecoach East group. He had been a coach driver for 22 years and had driven the X7 route since the Plaxton Interdeck coaches were introduced into service in 2014. He currently drove the X7 route about 50 per cent of the time.

[47] Mr McGill recalled the accident to Mrs Varney on 24th March 2016. He had been boarding quite a few passengers at the first stop in Holburn Street. As the last passenger went up the stairs and he was making to move off, a young lady came down the stairs and said someone had fallen down the stairs to the toilet.

[48] Mr McGill made the vehicle safe then went upstairs to try and help. When he arrived Mrs Varney was sitting on a seat directly opposite the emergency exit. Mr McGill offered her any assistance she might feel she wanted. She said she was fine. It was about 40 to 50 minutes later when the coach was in Stonehaven that he was asked to phone for an ambulance.

[49] Mr McGill had had previous experience of someone falling down the emergency stairs. The stairs encroached into the gangway. Various engineering staff had mentioned to Mr McGill previously that that could be a problem.

[50] Mr McGill could only recall one previous occasion when that had happened. A young foreign national lady had boarded the coach at Ninewells Hospital, Dundee. She

went upstairs. The coach was stationary. Someone came down and told him the lady had hurt her foot and banged her head on the emergency exit door. Mr McGill did not see the incident. He went upstairs and spoke to the lady. She said she did not need any assistance. She wanted to carry on with the journey.

[51] Mr McGill completed a traffic report, not an accident report, to highlight something had happened. Mr McGill would have passed the traffic report to the duty supervisor at Arbroath depot.

[52] When Mrs Varney had her accident, Mr McGill completed an accident report which would be logged on a computer system as an accident, with a form being sent to the insurers, PSV. Production 6/1 was a copy of the completed accident report form.

[53] Mr McGill would complete an accident report form where an injury was sustained. Any reports (traffic report or accident report) would be given to the supervisor at the depot. It would then be up to the supervisor what action was taken. Mr McGill was himself a supervisor for about 2-3 years around 2012.

Vivien Wylie

[54] Ms Wylie was aged 47 at the date of proof. She was a coach driver for around 25 years on and off, leaving the defenders on 21st January 2018. Ms Wylie was now a residential care worker in a secure unit for young people.

[55] Ms Wylie was a driver on the X7 route for a period of about 3-4 years from when the X7 route was introduced. Ms Wylie had concerns about the safety of the ingress at the emergency exit. She mentioned this informally with various traffic supervisors and managers. She felt there was a risk of falling.

[56] Ms Wylie had a couple of incidents of passengers falling down the emergency stairs. The first incident was about 3 weeks after the service was introduced. The incident happened in Arbroath. The coach was stationary. Passengers were disembarking. Ms Wylie saw the incident looking on her digital monitor. A boy, who was aged about 4-6, was walking in front of his mother up the gangway in a queue following other passengers, when he fell into the emergency toilet area. He had quite a bad tumble with a bump to his head.

[57] Ms Wylie offered assistance but the boy's mother declined assistance and would not give any details. She just wanted away. Ms Wylie completed a traffic report, not an accident report, so that the incident was recorded. She would have handed the completed form to the supervisor at the depot.

[58] The second incident was some time later. Alcohol was involved. A very large man had gone down to use the toilet. There was a smaller man under the influence of alcohol who fell on top of the man. Ms Wylie completed a traffic report, not an accident report, so that there was a record of the incident.

Councillor James Ingram

[59] Councillor Ingram was aged 79 at the date of proof. He had a long career in local government, including being parking manager for Grampian Region. He had always been interested in transport. He was a councillor for Aberdeenshire.

[60] A special meeting of the Banff and Buchan, Buchan and Formartine Area Bus Forums was held on 18 February 2016, because of the volume of issues raised by the public and passengers about the Buchan Express services operated by Stagecoach Bluebird on the Aberdeen to Peterhead/Fraserburgh routes.

[61] Councillor Ingram contacted the senior transport officer for Aberdeenshire for the meeting to be arranged. Concerns had been raised about the new range of vehicle introduced by Stagecoach Bluebird in November 2014, the Plaxton Interdeck coaches. The meeting was attended by Mr Walker from Stagecoach.

[62] There were about 300 people in attendance. The majority of people were elderly and disabled. The main complaint was the steepness of the stairs leading up to the seating deck and the lack of bell pushes. A smaller number, about 10-12 persons, expressed concern about the ingress to the gangway at the stairwell that accessed the toilet and the emergency exit. Passengers felt unsafe if the coach was moving.

[63] Councillor Ingram's evidence was of limited assistance to the issue of liability in this case.

Gordon Morris

[64] Mr Morris was aged 66 at the date of proof. He was a consultant engineer with G A Morris and Associates Ltd, trading as Morris Engineering Design Services. Mr Morris had prepared 3 reports, productions 5/16, 5/18 and 5/19. In view of the restriction of the pursuer's cases of fault in the course of the proof, the reports 5/18 and 5/19 no longer required consideration.

[65] While Mr Morris had some historic involvement with bus and semi-trailer design in around the mid-1970s and possibly into the early 1980s, Mr Morris had no experience of bus and coach design for over 30 years. Mr Morris was not an expert witness in bus and coach design. No weight has been attached to any evidence from Mr Morris about bus and coach design.

[66] Mr Morris expressed an opinion on measures to warn passengers of the emergency stairs and the presence of an ingress in the gangway. While there was yellow nosing on the stairs that was of little value to passengers in their line of vision. The nosing would be suitable for passengers using the stairs but not for walking along the gangway.

[67] An upright post could have been erected on either side of the emergency stairs in line with the top step of the stairs, at the corner of the ingress. Such a post could have been seen by passengers at eye line as a warning of the emergency stairs. That would have avoided the accident to Mrs Varney.

[68] Mr Morris was primarily instructed to consider the configuration and size of the gangway around the area of the emergency stairs. The report dated 14th September 2018, production 5/16, focused on design, which was a matter not within his area of expertise.

[69] Mr Morris concluded a reasonable risk assessment would have identified the narrow gangway at the emergency stairs and the need to provide a barrier at that location. The yellow nosing was insufficient in itself.

[70] Mr Morris favoured a hinged moveable bar such as was installed on the Bluebird coach shown in photograph 6/19/3, but as the pursuer in the course of the proof departed from the case of fault based on the fitting of a hinged moveable bar, that evidence was of no assistance.

[71] Mr Morris expressed the opinion that upright posts could have been fitted at either side of the ingress, at the corners of the top step, as a suitable guarding or warning. The upright posts would be without any bar across the emergency stairs. Mr Morris had not undertaken any enquiries to see whether upright posts could be fitted by manufacturers or would be approved by the regulator VCA.

Steve Walker

[72] Mr Walker was aged 48 at the date of proof, and the Managing Director of Stagecoach North East.

[73] Mr Walker attended a Bus Forum in February 2016 when he was Managing Director of Stagecoach North Scotland. The meeting was to address a number of complaints about the Plaxton Interdeck coaches which was operated by Bluebird along the Buchan corridor.

[74] The principal concern was that there were only two seats downstairs and one space for a wheelchair. Other concerns were raised. There were concerns about the tinted glass. At night most of the route was in darkness as passengers could not see out. Concerns were also expressed there were not enough bell pushes.

[75] The previous coaches had one additional step. Passengers had to climb steps to pay the fare. What passengers had to do on the Plaxton Interdeck coaches was similar, except there was one further step to reach the seats. That was the main concern for disabled and infirm passengers.

[76] Mr Walker did recall one person expressing concern about the risk of falling at the emergency stairs, when a coach was moving.

[77] At the end of the day it was an extremely heated meeting from the floor. Mr Walker undertook to have a look at all the issues raised. The main complaint was the lack of seats at lower level and the stair depth at the front.

[78] Any changes to the front of the coach would have involved a complete re-design of the coach, which was not practical. Mr Walker was looking for a quick win to make changes within cost parameters. The fitting of a barrier at the emergency exit was a quick win. Another quick win was to tone down the lighting so that passengers could then see out of the coach.

[79] Mr Walker had little knowledge of risk assessment and could only speak about Stagecoach North East.

Kenny McWalter

[80] Mr McWalter was aged 53 at the date of proof and the Operations Manager for the defenders, working out of the Arbroath depot since about 2005/2006. He had worked for coach companies since 1988.

[81] The defender had 9 Plaxton Interdeck coaches, 8 with a 64 plate and 1 with a 66 plate. The first 8 coaches came into service about November 2014. The X7 route had mixed groups of passengers including workers, students, pensioners, and weekend travellers. The lower deck had storage capacity and a cycling rack.

[82] When Mr McWalter was informed the coaches were ready for delivery, drivers were sent to Plaxton to collect the coaches.

[83] When the coaches arrived at Arbroath every driver was given familiarisation training; a ticket machine was fitted; and a risk assessment of the X7 route was carried out by him personally. All the coaches came with a Certificate of Conformity.

[84] Apart from the risk assessment of route X7 no other risk assessment was carried out. In particular, there was no risk assessment for either onboard passengers or employees. As Mr McWalter put it: "There is no need for it to be done. The coach comes fit for purpose".

[85] Where an accident occurred a driver was required to complete an accident report within 24 hours, and pass the report to the controller at the depot. The report was entered into risk, sent away to the insurers PSV, with a copy being retained at local level.

[86] If there was a serious incident where, for example, ambulance or police were called, the local supervisor would complete a Major Incident Form. Mr McWalter was aware of

very few major incident forms. Production 6/2 was a major incident form completed concerning the index accident. That was an internal form to make management aware of the incident.

[87] Traffic reports, more formally called driver report forms, were regularly completed by drivers. Generally, these forms were used for time off but they could be used to report anything. The forms would not be used to report an accident. The forms were passed to the local controller ("controller"). The forms would be used by drivers to communicate with the controller.

[88] If a driver reported an accident on a traffic report, Mr McWalter would expect the controller to tell the driver they must complete an accident report straightaway.

[89] Mr McWalter was not aware of any traffic reports of accidents involving emergency stairs on any of the coaches, apart from the index accident.

[90] Mr McWalter knew the drivers Mr McGill and Ms Wylie. They were both good drivers. Mr McWalter did not see the ingress into the gangway as a risk to passengers, or otherwise, as the ingress was clearly marked, but he did accept there might be circumstances where there might be a risk of an accident, as there was an ingress.

[91] If there had been a history of accidents (there was no evidence of that) Mr McWalter would have highlighted that with the directors, discussing the matter with them. It was impossible to say what his advice would have been in the absence of any history of accidents.

[92] Mr McWalter viewed a number of video stills leading up the accident, production 5/11. Looking at these stills, Mr McWalter agreed there was an obvious risk of injury as Mrs Varney began to stumble and fall.

[93] No-one had special responsibility for health and safety at the Arbroath depot. Mr McWalter said everyone was responsible for health and safety.

[94] Mr McWalter personally saw very few traffic reports. Generally, the supervisor would deal with more than 90% of the forms. Mr McWalter would receive traffic reports, for example, for a holiday change.

[95] Mr McWalter had not seen any traffic reports for the incidents reported by Ms Wylie and Mr McGill of falls down the emergency stairs. It would be the duty supervisor who would receive the traffic report. The supervisor would deal with the traffic report there and then in almost all cases. The traffic report was in paper form. Once dealt with by the supervisor, the traffic report would be destroyed, not retained.

[96] Mr McWalter was a matter of fact witness. While he was a very experienced Operations Manager he demonstrated no understanding of the purpose of risk assessment beyond risk assessment of the coach route for the coach.

[97] On his own evidence no-one had specific responsibility for health and safety at the Arbroath depot. No consideration had been given to carrying out any risk assessments for onboard passengers. The total reliance on a Certificate of Conformity for the coach on matters concerning the health and safety of passengers using the coach was not satisfactory.

Adrian Havlin

[98] Mr Havlin was aged 61 at the date of proof. Mr Havlin was the Stagecoach Group Technical Engineer for 20 years prior to his retirement on 31 July 2019. Mr Havlin's CV was production 6/36. He had extensive experience with trucks and coaches. Since 1999 his role as Group Technical Engineer included procurement and dealing direct with manufacturers. He had experience in coach and bus design.

[99] The UK regulator was VCA (Vehicle Certification Authority). Only the first vehicle of a new model of coach required VCA approval. Each coach of that model was then issued with a Certificate of Conformity by the VCA.

[100] Mr Havlin was involved in the procurement process for purchasing new coaches/buses. The priority for specification was "the look, the feel" to make it a Stagecoach coach. Mr Havlin would focus on the colour scheme, floor covering and type of passenger seats, as opposed to the detail of fittings and fixtures. Stagecoach were not experts in the design of vehicles. Stagecoach relied on the coach manufacturers for design.

[101] 8 Plaxton Interdeck coaches were delivered in November 2014. A Bluebird coach, not owned by the defenders, was shown in photograph 6/18/4. An orange handrail and pole were shown to the left-hand side of the emergency stairs. The handrail extended down the stairs. That was a modification made by the manufacturers Plaxton after delivery of the coaches.

[102] When the coaches were delivered and Mr Havlin saw the coaches, he was concerned about the absence of any pole or handrail at that point for a passenger intending to use the emergency exit or toilet. He felt exposed. In his view, that was not acceptable. Mr Havlin highlighted that with Plaxton, and Plaxton made the modifications.

[103] Photograph 6/19/3 showed a silver barrier across the emergency stairs on a Bluebird coach. That barrier has to be lockable in the upright position to comply with VCA. While VCA did not like barriers at emergency exits that modification complied with VCA. Its purpose was as a warning, to be careful that there was an emergency exit at that point. The modification was offered by Plaxton.

[104] While Mr Havlin approved the modification he did not like it, as he thought the silver barrier was very flimsy, that it had sharp edges, and that it was not suitable as an

armrest. The function was just as a warning, for passengers to pause and stop and get hold of the handrail to descend the stairs.

[105] Mr Havlin said the yellow nosing at the top of the top step into the gangway was a sufficient warning of the emergency exit.

[106] Mr Havlin could see the point of moving the orange barriers out into the gangway on the corners at the top of the ingress, although he was not aware of any coach with that configuration. Mr Havlin did not see that as a bad design. He could not say whether such a design would be approved by VCA.

[107] Mr Havlin was aware of the accident to Mrs Varney. There had been no modifications to the design of the Stagecoach Megabus fleet as a consequence of that accident. It had been an isolated incident. There had been no similar incidents. Nothing of a similar nature had been raised as an issue at any forums or health and safety meetings over the past 20 years.

[108] Mr Havlin looked at a number of stills from the CCTV footage, production 5/11. Mr Havlin accepted the ingress could cause a risk of injury, but the yellow nosing provided a warning.

[109] Mr Havlin accepted the ingress was a hazard, because there had been an incident, but given the size of the fleet and the number of kilometres travelled a year, he would have expected to see a lot more similar occurrences.

[110] Mr Havlin's position was that if the coach had a Certificate of Conformity, that was sufficient.

[111] So far as Mr Havlin was aware no risk assessments were undertaken, either for passenger safety or employees, for coaches/buses. Mr Havlin agreed that, generally, the board of Stagecoach were reactive rather than proactive on health and safety matters.

[112] Plaxton were embarrassed at the lack of a handrail down the left-hand side of the emergency stairs on the Bluebird coach. They rectified that promptly.

[113] The silver bar modification was nothing to do with Mr Havlin. That came about following a passenger forum where a great deal of complaints had been made about the Plaxton Interdeck coaches. The primary complaint was difficulties accessing the front entrance door at steps. The modification of a silver bar was a secondary issue. The purpose of that modification was to demonstrate to the public that they had listened to complaints and taken action.

Submissions

[114] Full written submissions for both parties were lodged and discussed at the hearing on 25 October 2019. The written submissions are referred to for their terms.

Submissions for pursuer

[115] The motion for the pursuer was for decree in the sum of damages agreed in the Joint Minute.

[116] The action was based at common law for failure by the defenders to take reasonable care.

[117] The defenders stated they had taken reasonable care. The coach was a road legal coach. The defenders relied on the issue of an EU Certificate of Conformity by the VCA that the coach was safe. Regulatory compliance was a relevant factor, but was not determinative of negligence. It was necessary to consider all the facts and circumstances of the present case.

[118] The defenders had not undertaken any risk assessment of onboard passenger safety. In particular, the defenders had not carried out any suitable and sufficient risk assessment as regards the ingress. The yellow nosing at the edge of the top step was designed to warn passengers using the emergency stairs, not the narrowing of the gangway. The ingress presented a hazard. There was a reasonably foreseeable risk of injury to passengers such as the pursuer. The risk was real.

[119] A reasonable modification would have been to erect an upright post on either side of the emergency stairs in line with the top step of the stairs, at the corner of the ingress. Such a post would have been seen by passengers at eye line as a visible warning of the ingress, and would have physically prevented the pursuer's foot going down the edge of the top step of the stairs.

[120] The railings on the far side of the emergency stairs were guarding to prevent passengers in seats from falling down the stairwell, see the United Nations: Agreement Concerning the Adoption of Uniform Technical Prescriptions for Wheeled Vehicles etc: Addendum 106: Regulation No107; Revision 5 dated 14 June 2014, production 6/17, at para 7.12.

[121] The primary submission was that there was no contributory negligence as the pursuer's conduct was inadvertent, failing which contributory negligence should be assessed at no more than 25%.

Submissions for defenders

[122] The motion for the defenders was to grant decree of absolvitor as the pursuer had failed to prove fault on the part of the defenders.

[123] The duty on the defenders was to take reasonable care. The obligation was to use a road legal coach sourced from a reputable manufacturer, the coach having an EU Certificate of Conformity issued by the VCA, and conform to Directive 2007/46/EC regime.

[124] Risk assessment took place at Stagecoach UK level and the defenders relied on that. *Esto* the court decided there was no risk assessment, which was denied, had the defenders carried out a risk assessment it would have been reasonable for the defenders to rely on the combination of a reputable manufacturer, the EC Certificate of Conformity from VCA and the over watch role of Mr Havlin, who consulted with various bus industry groups and trade unions on health and safety matters. The defenders were not aware of any previous similar accidents.

[125] In the event liability was established, there was sole fault on the part of the pursuer for failure to take reasonable care for her own safety. The pursuer was not looking with sufficient attention where she was going. She was looking down the length of the coach for 2 seats. She ought to have seen the ingress into the gangway and the structures round about it. She was not aware of the emergency stairs. She did not see the yellow nosing on the edge surround of the top step of the emergency stairs. She did not see the waist height orange handrail immediately to the rear of the emergency stairs. *Esto* there was not sole fault there should be a very substantial finding of contributory negligence on the part of the pursuer.

Note

Introduction

[126] Mr Morris in his evidence and the parties, in submissions, made reference to the applicability and non-applicability of various health and safety statutory and regulatory

provisions, and HSE guidance including the Health & Safety at Work etc. Act 1974, the Provision and Use of Work Equipment Regulations 1998 and the Management of Health and Safety at Work Regulations 1999. None of these provisions and guidance is relevant to the determination of liability in the present case.

[127] The action is based on fault at common law. The pursuer says the accident was reasonably foreseeable, and that the defenders failed to take reasonable care for the pursuer and are liable in damages. The defenders say they complied with the duty to take reasonable care.

Pursuer's cases of fault on record

[128] The cases for the pursuer on record at the start of the proof were that the defenders had chosen the wrong bus for the X7 route; there was no need for any ingress into the gangway; and the defenders should have fitted a non-lockable barrier with uprights positioned at the corner edge of the narrowed area of the gangway where there was yellow nosing.

[129] In the course of the proof the pursuer departed from the cases of fault on record.

[130] The pursuer accepted the defenders were entitled to select which bus was operated on the X7 route.

[131] Mr Morris gave evidence it was physically possible to design the emergency stairs without the requirement for an ingress, to rebut averments by the defenders that an ingress was required, but there was no other evidence from Mr Morris which could be accepted by the court to support a case of fault that there was no need for an ingress. Mr Morris was not an expert in bus and coach design. I rejected any evidence from Mr Morris on bus or coach design. The coach was designed with an ingress and was road legal.

[132] The pursuer no longer insisted on a case of fault on the fitting of a non-lockable barrier.

[133] The remaining case of fault was that the defenders should have warned passengers of the ingress, such as fitting upright posts on either side of the top step of the ingress.

Commentary, Decision and Reasons

[134] The circumstances of the pursuer's accident were straightforward and not in dispute. The accident was captured on CCTV cameras within the coach, from different angles. There were a number of video stills from the CCTV footage ("the footage"), production 5/7/10.

[135] I have reviewed the footage. It is a jury question whether the ingress was a hazard for passengers. The ingress extended into the gangway to the extent of 88mm. To put it another way, the ingress narrowed the gangway by 88mm. The ingress was a hazard for passengers. Mr Havlin conceded the ingress represented a risk. There was a reasonably foreseeable risk of injury.

[136] There were no signs within the coach to warn passengers of the ingress. The yellow nosing on the top step of the emergency exit stairs was at the front edge of the step. There was no yellow nosing at the top sides of that step. This is shown in photographs 3 and 4 from the report from Mr Morris, production 5/16, in the appendix to this judgment.

[137] The yellow nosing was on the top front edge of each of the steps for the stairs. The yellow nosing was designed to warn passengers when using the emergency exit stairs and not specifically to warn passengers of the ingress.

[138] The pursuer said she did not see the ingress. The pursuer said she did not see and was not aware of the emergency stairs.

[139] The footage showed the pursuer walking along the gangway towards the rear of the coach looking for empty seats. She had an unobstructed view ahead of her. From seeing how the pursuer positioned herself, with her body rotated slightly to her left, the pursuer was not looking in the direction of the ingress or the emergency stairs at the time of the accident.

[140] No onboard passenger risk assessment of the coach was undertaken by the defenders. The defenders gave no positive consideration to any onboard passenger safety risk assessment. The defenders said there was no need for a risk assessment. The defenders relied upon the coach being road legal and with an EC Certificate of Conformity.

[141] The position of the defenders on risk assessment was inconsistent with the evidence of Mr Havlin following delivery of a batch of Plaxton coaches. Mr Havlin was concerned about the safety of passengers in the absence of railings at the emergency stairs. The railings were not required for the coaches to be road legal. The railings were subsequently retro fitted by the manufacturers.

[142] The defenders said that, had a risk assessment been carried out, it would have been reasonable to rely on the combination of a reputable manufacturer Plaxton, the EC Certificate of Conformity and the over watch role of Mr Havlin. Nothing further would be required.

[143] Mr Havlin retired from his role as Group Technical Engineer in July 2019. In the 2-3 years prior to his retirement Mr Havlin was office/home based. Mr Havlin had attended Stagecoach Group health and safety meetings; and he had been in consultation with industry wide safety groups and trade union bodies.

[144] Mr Havlin had no designated health and safety role in relation to the Plaxton Elite i Interdeck coaches operated by the defenders and, in particular, the coach involved in the index incident.

[145] There was no evidence of the defenders having any system for risk assessment, beyond a route safety risk assessment. Any other risk assessment was reactive not proactive. The witnesses for the defenders appeared to have little understanding of the purpose of risk assessment, the focus being entirely on the route safety for buses and, in the present case, for coaches on the X7 route.

[146] The defenders had a duty of care to take reasonable care for onboard passengers. That was a positive duty of care on the defenders. That duty of care was independent of any obligations there might be on the manufacturers. The defenders could not simply rely upon the manufacturers or that the coach had been issued with an EC Certificate of Conformity and was road legal.

[147] The defenders said they were unaware of any similar previous accidents. The incidents spoken to by the drivers Mr McGill and Ms Wylie had not been reported to senior management. I had no reason to doubt that the incidents spoken by these witnesses had occurred. There was no record of these incidents which are reported, where there is no injury. The traffic reports are destroyed at the discretion of the supervisor/controller. That appears to be a systems failure.

[148] While no similar incidents may have been mentioned at any industry health and safety meetings attended by Mr Havlin, the defenders had an obligation to take reasonable care. The ingress was an unprotected hazard. Any risk assessment would have identified the ingress as a hazard.

[149] Reasonable control measures could have been taken to reduce or minimise the risk of injury to onboard passengers of a fall at the ingress. As examples, the yellow nosing could have been extended to the sides of the top step; warning signs could have been displayed on the upper deck; an upright post could have been positioned on either side of the top step to prevent passengers from the risk of falling at the ingress. The specification of any such post is not material for the purpose of establishing liability.

[150] In all the circumstances the pursuer has proved on a balance of probability the defenders failed to take reasonable care for the pursuer and are liable in damages at common law.

Contributory negligence

[151] The footage is clear. The pursuer failed to exercise reasonable care for her own safety. This was not a case of mere inadvertence on the part of the pursuer. The pursuer was paying no attention to the opposite side of the gangway. The pursuer said that even if there had been a barrier across the emergency exit stairs, she might still have had an accident. The pursuer had prior experience of travelling on similar coaches.

[152] The authorities on contributory negligence before the court are of interest as examples, but the assessment of any contributory negligence is case specific. This is a matter the court, in the exercise of the court's discretion, and having regard to all the facts and circumstances of the present case.

[153] Plaxton Interdeck coaches are in regular use, and a familiar sight, across the UK and EC countries. Emergency stairs on the upper deck are a feature on these coaches. An ingress at the top of the emergency stairs is not uncommon on these coaches. The pursuer was completely unaware of the emergency stairs, quite apart from the ingress. There was

yellow nosing on the top step of the emergency stairs. On the other side of the stairwell there was an orange handrail for the emergency stairs. The pursuer was completely unaware of that handrail.

[154] Having taken these factors into consideration I assess contributory negligence at 60%, with the defenders liable for 40%.

Decision

- Solatium was agreed at £21,000 with interest on 2/3 to the past at 4% annually from 24 March 2016. Interest to 1 October 2019 was £1,973.
- Past services were agreed at £2,000 with interest at 8% annually from 24 March 2016. Interest to 1 October 2019 was £564.
- Past wheelchair and orthotic costs were agreed at £1,731 with interest at 8% annually from 24 March 2016. Interest to 1 October 2019 was £488.
- Future wheelchair and orthotic costs were agreed at £13,380.

[155] Damages, inclusive of interest to 1 October 2019, have been agreed at £41,136 on a full liability basis. Interest to the date of decree adds a further £103, giving a total of £41,239.

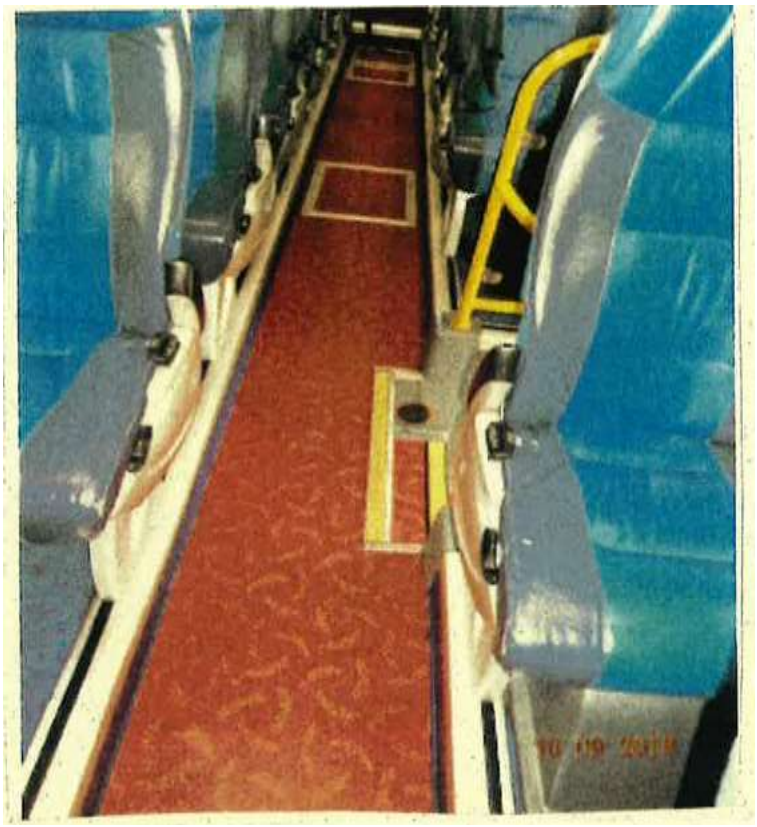
[156] Reducing damages by 60% for contributory negligence, the pursuer is entitled to damages of £16,495.60.

[157] I shall grant decree against the defenders for payment to the pursuer for £16,495.60.

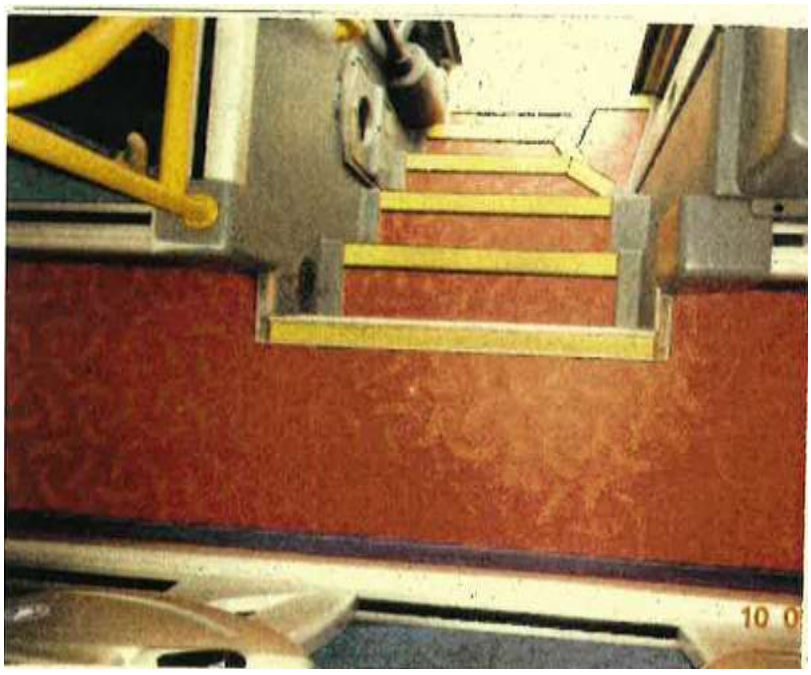
[158] At the request of parties expenses are reserved. The Sheriff Clerk will fix a hearing on expenses.

APPENDIX

PHOTOGRAPHS 3 AND 4 (PRODUCTION 5/16)



Photograph 3 – Gangway looking to rear of omnibus and Emergency Exit



Photograph 4 – Emergency Exit Steps