DOLMANS INSURANCE BULLETIN

Welcome to the October 2022 edition of the Dolmans Insurance Bulletin

in this issue we cover:

REPORT ON

- The impact of an investigation by a Department of Transport specialist investigation body on the Coroner's inquest process - how does an AIB report influence the conduct of inquest in light of recent case law?

RECENT CASE UPDATES

- Assessment of costs - conduct - reasonableness
- Costs - pre-action protocol for low value personal injury claims in road traffic accidents - exiting portal
- Negligence - duty of care - foreseeability of psychiatric harm
- Occupiers liability - duty of care - car parks

If there are any items you would like us to examine, or if you would like to include a comment on these pages, please e-mail the editor,
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REPORT ON

The Impact of an Investigation by a Department of Transport Specialist Investigation Body on the Coroner's Inquest Process - How does an AIB Report Influence the Conduct of Inquest in Light of Recent Case Law?

Background

In a number of situations in the UK where serious accidents and deaths arise, there is an initial investigation conducted by a specialist accident investigation body which is part of the Department of Transport. In context, the names of these bodies very readily explain the ambit of their operations. The Air Accident Investigation Branch (AAIB) deals with incidents relating to aircraft – a recent example being the AAIB investigation of the Shoreham Air Show Disaster (see below); the Rail Accident Investigation Branch (RAIB) deals with incidents on the railways – a recent example being the RAIB investigation into the Sandilands Tram Crash in Croydon; and finally the Marine Accident Investigation Branch (MAIB) deals with incidents on waterways.

Dolmans have been involved in, and continue to be involved in, a number of cases where there are ongoing or previous AIB investigations. The involvement of these specialist investigators gives rise to particular issues in the context of the Coroners' Service jurisdiction and, specifically, in terms of how relevant inquests are conducted in fatal cases. Defendant organisations need to be aware of these issues as the law in this area has developed (and continues to develop) in recent years.

Moreover, on 29 June 2022, the Government announced that it was establishing a new "AIB" – albeit the title of this body is the Road Safety Investigation Branch or RSIB. The function of this body is:

"(to) investigate incidents on the country's roads and provide insight into what needs to change to help save lives."

Some of the explicit terms of reference of the new body will be self-driving vehicles and electric vehicles.

In this article, I will consider recent case law as to the basis for the conduct of inquests in circumstances where there has been an AIB investigation (either AAIB, RAIB or MAIB) and the explicit impact that the involvement of these specialist investigators has upon the approach to the investigation of the death which is permitted to be taken by HM Coroner and, therefore, the issues which arise for Interested Persons to such an inquest. The role of the RSIB in the context of inquests is yet to be clarified but, given the intended function of this body and its terms of reference, it is at least arguable that the case law referred to below will have relevance to cases in which it is involved and there is a subsequent inquest.

REPORT ON

Caselaw Developments

We begin the history of the development of the law in this area with the case *of R (on the Application of the Secretary State for Transport) v HM Senior Coroner for Norfolk* [2016] EWHC 2279 (Admin) 28 September 2016.

This was a claim (by way of judicial review) by the Secretary of State for Transport in relation to certain rulings made by the Senior Coroner for Norfolk relating to disclosure (initially to her) of a recording of a cockpit voice and flight data recorder and/or a full transcript of that voice recording. An intervener in the JR proceedings was the British Airline Pilots Association (BALPA).

The Secretary of State submitted that HM Coroner had no power to make such an order and sought judicial review of her decision in that regard.

The claim grew out of a helicopter crash on 13 March 2014, near Gillingham Hall, in Norfolk. The crash of this Augusta Westland AW139 G-LBAL resulted in the deaths of 4 persons. On 8 October 2015, a report into the incident was prepared by the AAIB (Air Accidents Investigation Branch). Inquests into the deaths mentioned above were heard before HM Coroner and a jury between 12 and 15 January 2016. In the period leading up to the inquests, HM Coroner ordered the AAIB and it's Chief Inspector to disclose to her the audio of the said cockpit flight recorder and/or a full transcript of the voice recording.

The AAIB asserted that the Coroner had no power to make this order for disclosure on the basis of certain elements of the so called Chicago Convention (the Convention on International Civil Aviation, dated 7 December 1944) which underpinned such investigations by the AAIB and prohibited disclosure "to the State" of certain materials available to the AIB in the course of its investigations. Moreover, UK Regulations dated 1996 – the Civil Aviation (Investigation of Air Accidents and Incidents) Regulations 1996 – *specifically Regulation 18 – protected "relevant records" from disclosure which are defined by reference to the aforesaid Chicago Convention*.

The Court in the Norfolk case stated:

"It is a fundamental feature of the Chicago Convention, the EU Regime and the 1996 Regulations that investigations have a single object: the prevention of accidents and incidents. Their purpose is not to apportion blame or liability …"

The non-disclosure provisions discussed above were designed, it is said, to promote full and frank disclosure of all matters which may be of relevance in that context. The point being that a relevant investigation can be conducted fully and properly only where individuals (including, possibly, deceased individuals on board the aircraft in question) are suitably protected from further disclosure of information in other environments, notably Courts and Coroner's inquests.

REPORT ON

There are exceptions to this non-disclosure provision, notably, by means of Regulation 18 of the 1996 Regulations, the High Court is permitted to intervene (so to speak). This was accepted and reinforced by the Judge in the *Norfolk* decision. This, in itself, the Court so found, meant that the Senior Coroner for Norfolk did not have power to make the order(s) for disclosure against the AAIB which she sought to do. The further issue in the *Norfolk* case was whether the Coroner's Act 2009 permitted the Coroner to make such an order (as the Norfolk Coroner asserted it did). The Judge (Singh J) refused to accept that the generalised language of the Act (specifically Schedule 5 thereof – which dealt with the Coroner's powers as to disclosure) permitted a Coroner to order disclosure of such material.

He stated:

"I accept (Counsel for the Secretary of State)'s submission that the general words of Schedule 5 cannot override the specific legislation which governs the present context. This is particularly so when that specific legislation is itself the product of a carefully crafted code which has been enacted so as to give effect in domestic law to obligations imposed on the United Kingdom by international treaty and by EU law."

Singh J also stated (importantly in the present context):

"… it is important to emphasise that there is no public interest in having unnecessary duplication of investigations or inquiries. The AAIB fulfils an important function in that it is an independent body investigating matters which are within its expertise. I can see no good reason why Parliament should have intended to enact a legislative scheme [under the Coroner's Act 2009] which would have the effect of requiring or permitting the Coroner to go over the same ground again when she is not an expert in the field. The Coroner's functions are of obvious public importance in this country and have a long pedigree … However, none of that, in my view, points to, still less requires an interpretation of Schedule 5 to the 2009 Act which would have the effect for which [the Norfolk Coroner] contends. On the Secretary of State's interpretation, there will still remain the possibility of disclosure being ordered, but that disclosure can only be ordered by the High Court, which must weigh these different public interests in the balance, as required by Regulation 18 of the 1996 Regulations."

The Lord Chief Justice – Lord Thomas of Cwmgiedd, who was sitting with Singh J in the *Norfolk* case – added the following, which is even more important in the present context and discussion:

"I consider it important to underline the significance of paragraph 49 of the Judgment of Singh J [the paragraph quoted above] in light of the submission made to us on behalf of the Coroner that she had a duty to conduct a full inquiry into the accident as a death had occurred during the accident. The submission reflected the tendency in recent years for different independent bodies, which have overlapping jurisdictions to investigate accidents or other matters, to investigate, either successively or at the same time, the same matter. On occasions each body considers that it should itself investigate the entirety of the matter rather than rely on the conclusion of the body with the greatest expertise in a particular area within the matter being investigated. The result can be that very significant sums of money and other precious resources are expended unnecessarily."

> *"The circumstances of the present case provide an illustration of what in many cases will be the better approach. There can be no doubt but that the AAIB, as an independent state entity, has the greatest expertise in determining the cause of an aircraft crash.*
>
> ***In the absence of credible evidence that the investigation into an accident is incomplete, flawed or deficient, a Coroner conducting an inquest into a death which occurred in an aircraft accident should not consider it necessary to investigate again the matters covered or to be covered by the independent investigation of the AAIB.*** *The inquest can either be adjourned pending the publication of the AAIB report or proceed on the assumption that the reasons for the crash will be determined by that report and the issue treated as outside the scope of the inquest."*
>
> ***(emphasis added)***

It should not, in such circumstances, be necessary for a Coroner to investigate the matter de novo. ***The Coroner would comply sufficiently with the duties of the Coroner by treating the findings and conclusions of the report of the independent body as the evidence as to the cause of the accident. There may be occasions where the AAIB inspector will be asked to give some short supplementary evidence … However, where there is no credible evidence that the investigation is incomplete, flawed or deficient, the findings and conclusions should not be reopened*** *…"*

(emphasis added)

Lord Thomas then suggested that the Coroner's Rules 2013 would benefit from being revisited in this context and suggested that the Chief Coroner should consider the same as necessary.

Summary

The effect of *Norfolk* appears to have been as follows:

- Investigatory bodies – such as the AAIB, the RAIB and the MAIB – are the acknowledged experts in their respective fields and they are charged with the responsibility of investigating the incident in order to draw conclusions, but without attribution of blame.
- In that context, they are provided with limitations as to the material they can be asked to disclose – to ensure that they can rely upon the information they are provided with during the course of their investigations.
- It would be wrong, therefore, and despite the concurrent quasi-judicial function of the Coroner to arrive upon certain statutory conclusions as to causes of death, to require the Coroner to reinvestigate or "trample the same ground" as the AIBs.
- There is an exception to that latter prohibition, however, in circumstances where *"there is credible evidence"* that the AIB investigation is *"incomplete, flawed or deficient."*

I pause here to make an observation: it is clearly difficult to conclude whether an investigation has been conducted on an incomplete, flawed or deficient basis when all one has to go on is the report arising from that investigation and none of the materials provided to the investigator. This is usually the position faced by Interested Persons in AIB cases, as AIBs will normally only provide their report to HM Coroner.

REPORT ON

We move on to consider next the case of *HM Senior Coroner for West Sussex v Chief Constable of Sussex Police (1) Secretary of State for Transport (2) and Mr Andrew Hill (3)* [2022] EWHC 215 (QB) 4 February 2022.

This case represents the next time the issues seen in *Norfolk* were revisited and was heard in December 2021 following, again, a dispute as to disclosure of materials arising from an Air Accident Investigation Branch investigation – on this occasion, in regard to the Shoreham Air Crash which, readers will recall, took place on 22 August 2015 when a Hawker Hunter jet aircraft (piloted by Mr Andrew Hill, the Third Defendant) crashed into the A27 Shoreham Bypass whilst performing at the Shoreham Air Show, leading to the deaths of 11 persons.

Mr Hill was partially ejected from the aircraft on impact, sustaining multiple serious injuries. He had no memory of the incident, but was charged with – but ultimately acquitted (in March 2019) – of 11 counts of manslaughter in connection with the deaths.

The Coroner sought an order pursuant to the successor provision of that considered by the Court in *Norfolk* – Regulation 25 of the Civil Aviation (Investigation of Air Accidents and Incidents) Regulations 2018 – that specified records be made available for the purpose of her inquest(s).

In a somewhat déjà vu moment, the main record sought by the Coroner was the cockpit video recording from the Hawker Hunter aircraft, which, as discussed already, attracts a presumption of non-disclosure for purposes other than safety investigations.

The AAIB (in another déjà vu moment) resisted the application for disclosure of this material. It asserted that there was no public interest in the re-examination of a matter which it had already considered. Further, the AAIB argued that disclosure would have a negative impact on future investigations and the British Air Line Pilots Association supported this submission.

Not unexpectedly, there was a detailed discussion of the legal framework protecting the materials in question from disclosure. This legal framework, as implied above, had evolved somewhat since the *Norfolk* case, but in form rather than substance: the underlying position remained the same – this was material which should, generally, be protected from disclosure.

Dame Victoria Sharp (who gave the Judgment in *West Sussex*) also cited the passages of the Judgements of Singh J and Lord Thomas referred to earlier in this article.

There was then a very detailed consideration of the investigatory process undertaken by the AAIB, together with additional material which the Coroner had had placed before her – namely a report from a Dr Mitchell – which suggested it was possible that Mr Hill was suffering from some kind of cognitive impairment at the time of the incident, leading to a misjudgement and, thus, the fatal manoeuvres. This provided a different explanation for the incident compared to the AAIB report.

Ultimately, the Court accepted the position argued by the AAIB and refused to grant disclosure of the material in question.

The exception to the presumption of non-disclosure set out by Lord Thomas in *Norfolk* is re-stated, but is explicitly described by Dame Victoria Sharp in the following terms:

"It is clear why such a strict requirement is imposed: anything less would open the door to wasteful and duplicative reinvestigation by Coroners. 'Credible evidence' is the condition precedent or gateway – it is an important control mechanism."

"The situation postulated by the Norfolk test is intended to cover the rare case where there might be an obvious deficiency in an AAIB's (sic) investigation. We agree with the AAIB that it was not intended that, on a topic of complexity and technical difficulty, where different experts hold different views … that a Coroner (who is not an expert in the field) would need to seek a range of independent expert opinion, based on material that she would obtain, in order to test whether the AAIB's conclusions were correct or incomplete. Rather, the Coroner should 'rely on the conclusion of the body with the greatest expertise in a particular area' (adopting the language used by Lord Thomas CJ)."

Later, Dame Victoria stated:

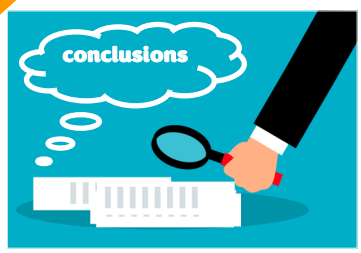
"We accept that the extent of legitimate consideration of matters considered by the AAIB that a Coroner can undertake at early stages in an investigation is a matter of fact and degree. If it is suggested (for example by an Interested Person) that an AAIB investigation is incomplete or flawed, then a Coroner is entitled to consider this and make a decision. This is intended to be a decision taken primarily on the basis of information available to the Coroner, and with due regard to the specialist expertise of the AAIB and a corresponding threshold applied to that decision-making. ***A Coroner should be very slow to find credible evidence that an expert investigation was incomplete, flawed or deficient****."*

(emphasis added)

REPORT ON

The Impact of *Norfolk* and *West Sussex* on Inquest Proceedings

So, what is the collective impact of *Norfolk* and *West Sussex* in cases where AIBs are involved and inquest proceedings are anticipated or already in train?



We have experience of situations where, in the context of the *Norfolk* and, more recently, *West Sussex* decisions, Coroners are being urged to dispense with what one could describe as a conventional inquest and rather to place the report of the AIB before the Coroner's jury as the relevant established factual matrix, from which they are to derive their conclusions.

This is an obvious departure from the coronial process as it normally transpires. Moreover, this is in the context of the explicit duties upon Coroners as to the prevention of future deaths and the issuing in Regulation 28 Prevention of Future Deaths Reports. Equally, narrative verdicts by juries at inquest are frequently important in terms of decisions by enforcing authorities as to possible prosecution.

However, the above approach is said to be consistent with the approach found to be appropriate in *Norfolk* and *West Sussex*. In that context, it is said to fulfil the need to avoid duplicative enquiries. Despite the independent investigatory role of the Coroner, the approach being taken by AIBs and their legal teams is that their investigation is (or should be) the complete basis for the factual enquiry at inquest.

This can give rise to explicit problems when representing a party who is subject to adverse findings in such a report.

Additionally, from a position where the *Norfolk* case appeared to provide a (limited) basis for seeking to explore the explicit investigation and findings within an AIB report – that the investigation was flawed or deficient – *Norfolk*, now viewed through the prism of *West Sussex*, appears to suggest that the cases where this will be permitted will be few and far between. Indeed, our recent experience is that in the face of an argument that an AIB report does demonstrate evidence of flaws or deficiencies, an argument will be deployed that the report is merely a summary of a wider investigation and, therefore, in reality, what appears to be a gap in that investigation will not bear scrutiny and, therefore, a different approach (to simply putting the AIB report before the jury) should not be permitted. Clearly, that is a difficult argument to deal with in the absence of disclosure of the material lying behind the report, which, in some senses, is the whole issue.

In summary, in the context of the independent coronial jurisdiction as to the investigation of unnatural deaths – where an AIB becomes involved via their role to investigate certain incidents – the case law can now be interpreted to suggest that the involvement of the AIB can, in some senses, overtake or replace the role of the Coroner and give rise to the inquest to taking place on a very different basis from the norm, or what one might reasonably anticipate would be the norm.

This is, again, a concern in the context of the Coroners' prevention of future deaths jurisdiction in particular.

Consider in that context, and by way of contrast, if you will, the situation pertaining to industrial accidents and the HSE. In that situation, the HSE will investigate the incident, sometimes via multiple specialist inspectors. These persons are undoubtedly experts in their field, and yet there is no suggestion that the status of their view is such that it can be safely put to a jury without being tested. We have explicit experience of that very approach being urged upon Coroners.

Conclusions

Incidents where a specialist investigation branch established by the Secretary of State has an involvement in an inquest context give rise to particular issues. This is ably demonstrated by the discussion above.

The law in relation to these situations continues to develop and parties who are the subject of findings or criticism in an AIB report, particularly if they are Interested Parties at inquest (and/or parties with a concurrent interest as possibly being the recipients of a prosecution or civil proceedings arising from the death), may well regard aspects of an AIB report as requiring further exploration or scrutiny. However, the extent to which that exploration or scrutiny can take place, given the current state of the law, is controversial.

Clearly, the shape of an inquest involving an AIB is not 'as normal' and, therefore, navigation of the same will require specialist input and knowledge, and care is required to ensure appropriate interaction with that investigative body in the context of the potential difficulty there will be to challenge their conclusions at inquest (see above).

Into this arena now steps (see above) the proposed RSIB. The remit of this organisation is anticipated to be identical to that of the AAIB, RAIB and MAIB; specifically to investigate incidents and reach conclusions "without attribution of liability". One might argue that the position of the RSIB will be similar – at inquest (and as to the shape of inquest) – to that adopted by the other AIBs and, on one level, the case law discussed above could be used to support that view.

This area of the law continues to develop and, as above, Dolmans are involved in a number of cases where issues are being considered and pursued both within and without an inquest environment. We will continue to keep our readers advised in that regard.

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RECENT CASE UPDATES

Assessment of Costs - Conduct - Reasonableness

UK Sovereign Investments Limited v Hussain
[2022] EWHC 2390 (SCCO)

The Claimant had recovered the sum of £103,819 from the Defendant, plus costs to be assessed, in a claim for the return of a deposit and damages.

The Claimant served a bill seeking costs of £83,425. The claim for costs was eventually settled at £59,000, inclusive of interest.

A dispute arose as to the basis upon which the costs of the assessment should be paid.

CPR r.47.15 provided for provisional assessment costs for bills up to £75,000. The maximum amount that the Court would award any party was £1,500 plus VAT and any Court fees paid.

CPR r.47.14 provided for detailed assessment costs, under which there was no costs cap and the receiving party could recover whatever sum was reasonable, necessary and proportionate.

The Defendant argued that provisional assessment costs should be awarded under CPR r.47.15 and contended that the Claimant's bill had only exceeded £75,000 because it had been grossly exaggerated, together with unreasonable conduct, which took the assessment out of the r.47.15 regime.

The Court held that the fact that the bill claimed was over £83,000, but the matter was settled for £59,000, did not lead to an "irrefutable inference" that the costs claimed had to be exaggerated. It was reasonable to surmise that the Claimant was willing to discount the bill for a number of reasons. The Court was not persuaded that the Claimant's costs should be limited to £1,500. CPR r.47.15 did not say that if a bill was brought in for assessment at over £75,00, but was allowed at less than that figure, it meant that it was obviously exaggerated, so provisional costs had to apply.

The Claimant was awarded costs of £9,000 plus VAT and Court fees. A total of £12,456 was awarded.

RECENT CASE UPDATES

Costs - Pre-Action Protocol for Low Value Personal Injury Claims in Road Traffic Accidents - Exiting Portal

Lally v Butler
27 September 2022

The Claimant, 'C', suffered minor personal injury in a road traffic accident in November 2020. C submitted a Claims Notification Form through the RTA portal in accordance with the Pre-Action Protocol for Low Value PI Claims in RTAs. Liability was admitted. C obtained a medical report which anticipated a full recovery from soft tissue injuries after 6 to 7 months. 10 sessions of physiotherapy were recommended. No reference was made to the need for a further medical report. The report was served on the Defendant, 'D', on 23 February 2021 with a request for a stay pursuant to paragraph 7.12 of the Protocol because C was uncertain as to whether she would recover in line with the prognosis in the medical report. C requested an interim payment of £1,615. D did not reply and did not make an interim payment. On 18 March 2021, C notified D that her claim would now exit the portal pursuant to paragraph 7.28 (failure to make an interim payment).

C issued Part 7 proceedings and the claim was settled. D refused to pay C's Part 7 costs. At first instance, D was ordered to pay C's costs on the ground that C was entitled to exit the portal because D had failed to respond to the request for a stay or had failed to pay any interim payment.

D appealed, submitting that C had no valid reason to leave the portal. No right to request an interim payment had arisen. A further medical report was not needed. Further, as no stay had been agreed, the request for an interim payment was premature. In any event, it was unreasonable for C to exit the portal.

Paragraph 7.12 provides *"Where a Claimant needs to obtain a subsequent expert medical report … the parties should agree to stay the process in this Protocol for a suitable period. The Claimant may then request an interim payment …"*.

The Judge held that *Greyson v Fuller [2022]* was clear authority that a Claimant can be said to 'need' a subsequent medical report (as required by para 7.12) only where that report is 'justified'. Accordingly, an interim payment can only be requested under para 7.12 where a second medical report is justified. C's medical report had provided a clear prognosis. No right to request an interim payment arose in this case because there was no need for a subsequent medical report. In the circumstances, there was no obligation for D to make an interim payment and no right to exit the portal under para 7.28.

Accordingly, D's appeal was allowed was on the first ground of appeal and the Judge did not go on to consider the further grounds of appeal.

RECENT CASE UPDATES

Negligence - Duty of Care - Foreseeability of Psychiatric Harm

Wokingham Borough Council v Arshad
[2022] EWHC 2419 (KB)

The Claimant, 'C', was a taxi driver who had held a hackney carriage vehicle licence ('HCVL') with the Defendant Council since 2006. The Council's licencing policy required that for a licence to be issued a vehicle had to accommodate a fully grown adult passenger whilst seated in their wheelchair. In 2016, C needed to purchase a new vehicle and contacted the Council, told them the make and model of the new car he intended to purchase and asked if it would be approved. A Council Technical Officer confirmed that it would. C bought the vehicle and was issued with a new HCVL on 16 February 2017. However, on an inspection of the vehicle on 27 February 2017 by the Council, it transpired that there was inadequate headroom for a wheelchair user and C's licence was suspended. His appeal against the suspension was unsuccessful.

Nine other licensed vehicles were also identified as non-compliant and suspensions issued. The Council decided to draft a revised licensing policy clarifying the size of wheelchair to be accommodated and the necessary dimensions of the interior of vehicles. Six of these other drivers appealed and were permitted to continue operating pending a change in legislation or policy.

C complained to the Local Government Ombudsman, which found the Council at fault for giving wrong advice and recommended a fresh appeal hearing and payment of £500 compensation. The Council accepted this recommendation. A fresh appeal resulted in the issue of a new licence to C on 28 August 2018.

However, in the meantime, C had suffered a depressive disorder and, ultimately, gave up work as a taxi driver. C brought a claim for damages against the Council alleging discrimination, breach of statutory duty and negligence. C represented himself.

At first instance, C's personal injury negligence claim was successful and he was awarded general damages of £42,500 for personal injury consisting of psychiatric illness. Claims for consequential financial loss failed because they could not be proved and a claim for aggravated and exemplary damages also failed. The Council was ordered to pay C's costs of £6,270.60. No order for costs was made in respect of the claims upon which C had failed.

The Council appealed.

The Appeal Judge agreed with the First Instance Judge that it was fair, just and reasonable in these circumstances to impose a duty of care to avoid economic loss which plainly would be a reasonably foreseeable consequence of the negligent advice. However, the issue was whether there was a duty to avoid causing psychiatric harm and, in particular, whether such harm was reasonably foreseeable. On the facts of this case, the Appeal Judge held that psychiatric injury was not so reasonably foreseeable as to make it appropriate for a Local Authority, giving discretionary pre-application advice on a licencing matter, to owe a duty of care not to cause psychiatric harm.

Accordingly, the Council's appeal was successful, C's claim was dismissed and the award of damages was set aside.

The Council was entitled to an order for its reasonable costs of the appeal, but such costs could not be enforced unless an exception to QOCS applied. The proceedings had included claims other than personal injury claims and the exception in CPR 44.16(2)(b) for 'mixed claims' thus applied. The Judge considered this was a genuinely mixed claim. However, it was noted that C was a victim of negligence, although suffered loss of a kind that was not reasonably foreseeable. The personal injury element was a substantial part of the claim. The claim failed not because it lacked factual merit, but because of the legal issues around claims for psychiatric harm which the Judge commented "*are challenging for lawyers, let alone for litigants in person*". The Judge concluded that, bearing in mind what he had heard about the impact on C's personal and financial situation, it was not 'just' to permit any enforcement of the costs order against C.

Occupiers' Liability - Duty of Care - Car Parks

Juj v John Lewis Partnership plc
[2022] EWHC 2418 (HC)

The Claimant sought damages for personal injuries sustained in an accident in a car park adjacent to a Waitrose store in May 2015. It was alleged that the Defendant had breached their duty of care under the Occupiers' Liability Act 1957 by causing the Claimant to trip on a kerb next to a disabled parking bay in which his wife (who was disabled) had parked their car. The Claimant was 83 years old at the time of the fall. The trial was of liability only.

At first instance, the Claimant's claim was dismissed. The Judge found that:

- The accident had been caused by the Claimant catching his foot on the face of the kerb.
- Although the Defendant had sufficient control to be an occupier of the car park, that control was limited to dealing with immediate hazards within it and reporting matters to the Local Authority (who owned the car park).
- The design of the parking bay, including the presence of the kerb, was an unreasonable danger for the class of visitors using that bay; in breach of section 2(2) of the Act.
- The Claimant's injuries arose from what was, simply, a true accident and nothing the Defendant had done, or failed to do, had caused it.

RECENT CASE UPDATES

The Claimant appealed, advancing four grounds of appeal:

(1) The Judge had erred in limiting the Defendant's duty under Section 2(2) to dealing with "immediate hazards" and reporting matters to the Local Authority.

(2) Having made a finding of fact that the Defendant ought to have known that the disabled parking bay represented an unreasonable danger to its intended users, the Judge had erred in concluding that the Defendant had not been expected to take any steps other than reporting it to the Local Authority.

(3) Having concluded that the Defendant was in breach of duty to report the presence of the unreasonable danger, the Judge had erred in finding that proper compliance with that duty would have made no difference to whether the parking bay would have remained in that unreasonably dangerous state.

(4) The Judge had erred in concluding that the Claimant's accident had been 'an accident in the true sense of the word', thereby disregarding any contribution to its occurrence made by the Defendant's breach of duty.

On appeal it was held:

(1) The Defendant was the joint occupier of the car park; *Wheat v E Lacon & Co Ltd [1966] A.C.552, [1966] 2 WLUK 48* followed. The Judge was wrong to have excluded from the Defendant's control the ability to put up warning signage, where necessary, and to reiterating, with reasonable frequency, any concerns regarding issues which had not been attended to by the Local Authority.

(2) The Defendant was not under any duty to warn visitors of the danger of the kerb as identified by the Judge. The size of the bay and the presence of the kerb would be obvious to a user entering it. The kerb itself was not of abnormal height, defective or in a state of disrepair. In all the circumstances, the kerb did not constitute a trap. No warning was required. The degree of risk was not sufficient to trigger Section 1(1) of the OLA.

(3) The Claimant had been aware of the kerb and had fallen when he had caught his foot on it. Neither the danger as identified by the Judge nor the breach of any duty had caused the accident.

(4) The Judge had been right to conclude that it had been a "true accident" to which no breach of duty on the part of the Defendant had contributed.

The Claimant's appeal was, therefore, dismissed.

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- Flooding and drainage – duties and powers of Highway Authorities for drainage and flooding under the Highways Act 1980. Consideration of case law relating to the civil liabilities of the Highway Authority in respect of highway waters
- Highways training
- Housing disrepair claims
- Industrial disease for Defendants
- The Jackson Reforms (to include : costs budgeting; disclosure of funding arrangements; disclosure of medical records; non party costs orders; part 36/Calderbank offers; qualified one way costs shifting (QWOCS); strikeout/fundamental dishonesty/fraud; 10% increase in General Damages)
- Liability of Local Education Authority for accidents involving children
- Ministry of Justice reforms
- Pre-action protocol in relation to occupational disease claims – overview and tactics
- Public liability claims update

If you would like any further information in relation to any of our training seminars, or wish to have an informal chat regarding any of the above, please contact our Training Partner, **Melanie Standley** at **melanies@dolmans.co.uk**