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Case No: KB-2021-CDF-000014

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION
CARDIFF DISTRICT REGISTRY

Cardiff Civil Justice Centre
2 Park Street
Cardiff CF10 1ET

Date: 14/10/2024

Before :

MRS JUSTICE JEFFORD DBE

- -

Between :

RYAN JONES — **Claimant**

- and -

(1) PERSIMMON HOMES LIMITED
(2) MACOB SCAFFOLDING LIMITED — **Defendants**

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- -

Nicholas David Jones (instructed by New Law Solicitors) for the **Claimant**
Matthew Snarr (instructed by Clyde and Co LLP) for the **First Defendant**
John Brown (instructed by Kennedys Law LLP) for the **Second Defendant**

Hearing dates: 9 to 12 October 2023

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Approved Judgment

This judgment was handed down remotely at 11.00am on Monday 14th October 2024 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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MRS JUSTICE JEFFORD DBE

Mrs Justice Jefford:

The parties

1. The claimant, Ryan Jones, claims damages in respect of an injury sustained in an accident at work on 8 August 2018. He was 33 years old at the time. He was an experienced carpenter and used to working at height.

2. At the time of the accident, Mr Jones was working on a construction site, being a housing development at Old St Mellons, Cardiff. The development was undertaken by the first defendant, Persimmon Homes Limited ("Persimmon"), which was the principal contractor for the purposes of the CDM regulations. The second defendant, Macob Scaffolding Limited ("Macob"), was engaged by Persimmon as scaffolding contractor. Mr Jones was engaged as a self-employed labour only carpenter through Greenheart Carpentry, and, at the time of the accident, had been fitting fascias and soffits to a house, in the course of construction on plot 431.

Summary of the claimant's case

3. To carry out his work, Mr Jones was using the access scaffold. A ladder was fixed to the scaffold to ascend and descend. The ladder was fixed with clamps or clips securing the stiles or rails of the ladder to the scaffold. For the avoidance of doubt, in this judgment I will use clamp and clip interchangeably and nothing turns on the different terms. Mr Jones' case is that in order to descend the ladder from the second lift of the scaffold he placed his left hand on the left stile of the ladder but his hand was fouled by the clamp which was facing outwards. Mr Jones instinctively let go of the stile with his left hand and, in so doing, instinctively transferred his weight to his right hand side. That caused the ladder to move and his right hand was pinched between the right hand stile and the clamp on that side. He instinctively let go and, as a result, fell backwards on to the ground. The fall was one of nearly 5 m and he fractured his left ankle. The trial and this judgment are concerned with liability only in respect of this accident.

4. The claimant's case in respect of the accident is as follows:

   (i) The clamp or clip on the left hand side of the ladder was positioned with the unused portion facing outwards rather than inwards which created an obstruction and led to the sequence of events which caused the fall. It is a necessary part of that case that the fixing of the clamp in this manner was negligent.
   (ii) The feet of the ladder were not placed on a baseboard. The feet ought to have been placed on a baseboard to provide stability to the ladder and the failure to place the feet on a baseboard was negligent. The absence of a baseboard causatively contributed to the movement of the ladder.
   (iii) The ladder was set at too steep a pitch. It was set at a pitch of between 1 in 4.6 and 1 in 5.3 but ought not to have been at a pitch greater than 1 in 4. The pitch increased the likelihood of someone falling backwards (if they lost their grip) and of being unable to regain their grip.

5. As against Persimmon, the claimant contended that, when Persimmon took possession of the scaffold from Macob on 27 July 2018, it ought to have ensured (i) that there were no obstructions on the stiles to the user – in other words that the clamps were fixed facing inwards; (ii) that the ladder was footed on a baseboard; and (iii) the ladder was at an appropriate pitch. Further or alternatively, if something changed

between that date and the date of the accident, Persimmon ought to have observed and remedied the issue. By the conclusion of the trial, the claimant accepted that Macob had fitted a baseboard, and handed over the scaffold with the ladder footed on a baseboard, and that the pitch of the ladder had changed because of the removal of the baseboard. It was, therefore, the alternative case that was material against Persimmon.

6. As against Persimmon, the claimant placed some reliance on:

(i) the duties engaged by the Work at Height Regulations 2005 as follows:
"12 Inspection of work equipment
...
(2) Every employer shall ensure that, where the safety of work equipment depends on how it is installed or assembled, it is not used after installation or assembly in any position unless it has been inspected in that position.
...
(4) Without prejudice to paragraph (2), every employer shall ensure that a working platform -
(a) used for construction work; and
(b) from which a person could fall 2 metres or more,
is not used in any position unless it has been inspected in that position ... within the previous 7 days.
..."
For the avoidance of doubt, there was no dispute that these regulations applied to the scaffolding and that the ladder formed part of the scaffold structure.

(ii) Schedule 6 to the said regulations headed Requirements for Ladders:
"...
2. Any surface upon which a ladder rests shall be stable, firm, of sufficient strength and of suitable composition safely to support the ladder so that its rungs or steps remain horizontal, and any loading to be placed on it.
3. A ladder shall be so positioned as to ensure its stability during use.
..."

(iii) Regulation 13(1) of the Construction (Design and Management) Regulations 2015:
"The principal contractor must plan, manage and monitor the construction phase and coordinate matters relating to health and safety during the construction phase to ensure that, so far as is reasonably practicable, construction work is carried out without risks to health and safety."

7. Persimmon accepted that these duties were engaged but pleaded that the regulations do not in themselves give rise to civil liability (see section 69 Enterprise and Regulatory Reform Act 2013). That is right but they may nonetheless be relevant to the exercise of reasonable care and skill and both the claimant and Persimmon placed reliance on the terms of the Work at Height Regulations.

8. I note that, in opening submissions, counsel for the claimant, additionally relied on the fact that the height of the 2nd lift was 4.84m which was in excess of HSE guidance and Persimmon's own guidance. Although not relied on as a distinct breach of duty, it

was submitted that where the height of the ladder was at the margins of what was safe, it was all the more important that all other steps were taken to ensure that the ladder was safe.

9. As against Macob, the claimant's case was that, when erecting the scaffold, Macob ought to have ensured (i) that the clips were facing inwards so as not to create an obstruction; (ii) that there was a baseboard at the foot of the ladder; and (iii) that the ladder was set at an appropriate pitch.

Summary of Persimmon's case

10. In its Defence, Persimmon contended, firstly, that it had exercised reasonable care and skill in engaging a specialist scaffolding contractor, Macob. When the scaffold was handed over on 25 July 2018, Macob confirmed that the scaffolding including the ladder conformed with British Standards and the Work at Height Regulations 2005 and Persimmon was entitled to rely on Macob in that respect.

11. Macob used standard ladder clamps. These clamps can be fixed with the unused portion facing outwards or inwards. There is no "right" way. The slot not being used extends beyond the edge of the vertical stile (whether inwards or outwards) – it can clearly be seen and is entirely safe. There could be no breach of duty in Persimmon permitting the clamps to be fixed facing outwards and permitting use of the ladder in that condition.

12. Persimmon pleaded that after handover its Site Manager (who was qualified to inspect the scaffolding) had frequently inspected the scaffolding "even more than the mandatory weekly scaffold checks". That appeared to be based on the fact that the statutory weekly checks were not undertaken at weekly intervals but on 27 and 30 July and on 6 and 8 August (the last being the day of the accident). Persimmon said that the Site Manager had ascended and descended the ladder on at least a daily basis including on the day of the accident. The Defence contained a statement of truth signed by a Managing Director of the first defendant.

13. Persimmon further said that the claimant was inducted on to site on 27 March 2018 (which is not in dispute); he was aware of the need to maintain 3 points of contact when using the ladder; and on the days before the accident, he had used the ladder without any difficulty or complaint.

14. Taking these points together, the thrust of Persimmon's case was that the ladder was safe for use and, if the fall took place in the way that the claimant said, that was because he was not paying proper attention to where he placed his hand or had used the ladder inappropriately by sliding his hand down the ladder whilst maintaining a tight grip.

15. Persimmon put the claimant to proof of the circumstances of the accident including the sequence of events that the claimant said led to the fall. In particular, Persimmon required the claimant to prove the "fouling" of his left hand and, as I have said, averred that if the claimant's left hand had been fouled in this way that was because he was using the ladder in an inappropriate way.

16. Persimmon neither admitted nor denied that there was no baseboard but denied that the baseboard or its absence had anything to do with the accident. Persimmon said that it installed a scaffold "margin" around the plot foundation – which is an industry norm – with hard core laid to the margin and then compacted. Thus the ladder was placed on firm ground, it did not require a baseboard, a baseboard was not mandatory, and the absence of a baseboard (if that were the case) did not cause movement of the ladder.

17. Persimmon denied that the pitch of the ladder was too steep and, in any event, that it was causative of the accident.

18. As to any statutory duties, Persimmon said that it had complied with its duties under the CDM Regs 2015 and its inspection duties under the Work at Height Regulations.

19. Persimmon further contended that the accident was wholly caused by or significantly contributed to by the claimant's own negligence. In summary the nature of that case, as I have indicated at paragraphs 14 and 15 above, was that the manner in which the claimant had slid his hand down the ladder had caused it to come into contact with the clips and that he had not paid proper attention or taken sufficient care to avoid that contact. It was also expressly alleged that the claimant had failed to report any concern relating to the ladder whether in respect of the presence of the clip, the absence of the baseboard or the steepness of the ladder.

Summary of Macob's case

20. Macob similarly put the claimant to proof of the manner in which the accident had occurred, including whether the ladder had moved and the contribution (if any) of the absence of a baseboard and the pitch of the ladder.

21. As to the clips, Macob said that they were standard, had been installed properly and did not create an obstruction. In particular, it was denied that they ought to have been installed facing inwards.

22. As to the baseboard, Macob pleaded that, as erected, there was a baseboard under the foot of the ladder. Macob admitted that, when its contract manager attended, shortly after the accident, the baseboard was not under the feet of the ladder but said that that was not Macob's responsibility.

23. As to the pitch, Macob pleaded that the ladder had been installed at a pitch of about 1 in 4 but admitted that when its contract manager attended the pitch was greater than that.

24. On Macob's case, those changes to the baseboard and pitch must have been made after the ladder was installed and after they had handed over the scaffold to Persimmon. The handing over certificates dated 15 July and 27 July stated that no unauthorised modifications were to be made or used.

25. Macob also pleaded a case on contributory negligence in similar terms to Persimmon and which I will summarise as being that the claimant failed to take sufficient care

when using the ladder and/or failed to report that the ladder was unsafe and continued to use it when it was unsafe to do so.

The evidence

26. Witness statements were served from, and evidence given at trial by, the following:
    (i) Ryan Jones, the claimant
    (ii) Gavin Skym, a skilled worker used to working at height who was part of the team working with the claimant at the time of the accident. He is also a cousin of the claimant.
    (iii) Jade Simmons, Persimmon's site manager with qualifications as a site manager and scaffold inspector.
    (iv) Caroline North who, at the time of the accident, was a Group Health and Safety Advisor for Persimmon.
    (v) Glenn Walton who, at the time of the accident, was a Senior Group Health and Safety Advisor for Persimmon Homes Ltd. (South West Region).
    (vi) Clive Stevens, a scaffolder for Macob with 40 years experience and qualifications as an advanced scaffolder and scaffold supervisor. He was involved in the erection of the scaffold on site.
    (vii) Eugene Costello, also an advanced scaffolder and scaffold supervisor employed by Macob. He was not involved in the erection of the scaffold on site.

27. Expert evidence was adduced from the following engineers:
    (i) for the claimant, Mr David Jackson, a civil engineer with experience in health and safety matters;
    (ii) for Persimmon, Dr Patrick Barbour, a mechanical engineer at Hawkins and Associates;
    (iii) for Macob, Mrs Angela Rutherford-Hacon, a civil engineer with experience in health and safety matters and formerly an HSE inspector.

    The experts produced a joint statement dated 28 July 2023.

The cause of the fall and sequence of events

28. The principal factual evidence as to the cause of the fall came, of course, from the claimant himself. Mr Jones' evidence was that he had not worked on Plot 431 for about 2 weeks prior to 8 August 2018. He referred to his invoice dated 30 July 2018 which he said in oral evidence was for work done the previous week.

29. On 8 August, he was instructed by Jade Simmons to fit the fascias and soffits. He was asked in cross-examination whether he had checked the ladder first and said that he did not recall. He agreed, however, that he did not feel any movement in the ladder when he went up it and that, if he had any concern, he would have given the ladder a good shake.

30. He and his colleagues, Gavin Skym and Kean Gooch, went up onto the scaffold at about 9.15am and did not come down until about 2 pm. Mr Jones denied that any one of them had gone down and up the ladder in the meantime and he maintained that position in cross-examination. He was not asked about any other workmen using the scaffold or the ladder during this period.

31. On descending, Mr Jones was the first onto the ladder. In his witness statement he said this:

"… I opened the [safety] gate and put my left hand on top of the ladder stile, followed by my right hand. I stepped with both feet and the spring-loaded gate closed behind me. I took one step down to the next ladder rung. I moved my left hand down the ladder in a shimmy motion. I caught my left hand on the protruding ladder clip, which was attached to the ladder incorrectly protruding outwards. This caused me some pain and caused me to let go of the ladder with my left hand which then transferred my weight to my right hand. This moved the ladder slightly which then in turn pinched my right hand between the ladder clip and stile, on the right side. ….. This then forced me to instinctively remove my right hand from the ladder as it was, which in turn led me to have no attachment to the ladder other than my feet."
That led to the fall and Mr Jones was unable to regain his hold on the ladder.

32. Shortly after the accident, Mr Jones gave an account of what had happened which was consistent with this evidence. This account was sent, apparently by e-mail dated 15 August 2018 to Greenheart Carpentry and was forwarded to Persimmon on 17 August 2018. In this account, Mr Jones described stepping onto the ladder and moving his hand in a shimmying motion. He then said:

"I caught my left hand on the ladder clip which was attached to the ladder incorrectly protruding outwards, this caused me some pain causing me to let go with my left hand & then this transferred my weight to my right hand this moved the ladder slightly which then in turn pinched my right hand between the ladder and the clip on the right side…. This then forced me to instinctively remove my hand from the ladder as it was pinched between the ladder and the clip ….."

33. In cross-examination, Mr Jones did not agree that he would have seen the clips before he stepped on to the ladder. When it was put to him that he would have seen them when going up the ladder, his response was that his hands would not have been positioned above the clips. His evidence was that when he came down the ladder, he placed his hands in what he said was the natural position above the clips. His feet, he said, were on the 7th rung from the top and his hand above the clips. He ultimately agreed that the clips were clear and obvious when you stepped on to the ladder.

34. In cross-examination, Mr Jones described the movement of his hand, consistently with his statement, as more of a shimmy than a slide. He agreed that if the clips were facing outwards, you would have to move your hand out of the way. When it was put to him again that the clips were clear and obvious, he first said that they were <u>now</u> and he appeared to agree that he may not have been paying attention. It was also put to Mr Jones that if he had been moving slowly and cautiously he would not have caught his hand. There was some measure of agreement to this proposition but, in my view, Mr Jones did not fully appreciate what was being put to him in terms of different propositions and his answers were unclear. In short, there was a modicum of acceptance that he <u>might</u> not have paid sufficient attention but no concession to that effect.

35. He was challenged about his account of "shimmying" his hand down and the clip "fouling" his hand. It was put to him that his "shimmying" was, in fact, sliding his hand down quickly which Mr Jones denied was what he did. He was asked whether

the word "fouled" was his or that of his lawyers and he said that he would have used the word "caught" or, in this context, fouled.

36. His account of how his hand was "fouled" was also challenged on the basis of what another had recorded he had said. On 8 August 2018, Jade Simmons completed a Persimmon form headed "Incident Investigation Injured Party/ Witness/ Non-Visual Witness Account of Event". In that she recorded that when Mr Jones was lying on the ground at the foot of the ladder he stated that he had fallen "because he had gotten on to the ladder and his hand had slipped on the ladder securing clip."

37. The use of the term "fouled" may have been intended to create a certain impression or to be pejorative but it does not seem to me to matter whether one says that Mr Jones caught his hand or that his hand was fouled. The short point is that I accept that his hand came into contact with the outward facing part of the clip causing him to let go. The report of him saying that his hand had slipped is no more than that and seems to me merely to reflect the reporter's choice of phrase.

38. Mr Jones' movement to the right was then a sudden action. He agreed he was at that point unstable but he maintained that he still had three points of contact. He said there was a slight movement in the ladder. At this point, he said, his right hand was pretty much on top of the ladder clip and he accepted that his right hand might have moved down slightly. What he was clear about was that his hand was pinched and he thought that had occurred because the gap between the centre point of the clip and the ladder closed because the ladder moved.

39. It was put to Mr Jones that, given that his hand was almost on top of the space and that he moved it down or placed pressure on it, it could have been caught without the movement of the ladder. Mr Jones understood what was being put to him and agreed that that could have happened but he was adamant that it was not what had happened and that the ladder had moved.

40. This account of how his hand was pinched was also challenged on the basis of what others had recounted:

    (i) The A&E report recorded that Mr Jones caught his hand and fell.
    (ii) The solicitors' Letter of Claim to Persimmon dated 22 October 2019 said that the ladder had moved causing Mr Jones to fall. It did not mention his right hand being pinched.
    (iii) A psychiatric report on Mr Jones, dated 20 April 2020, was prepared by Professor Jonathan Bisson. Under the heading Description of Incident, Professor Bisson similarly recorded Mr Jones telling him that the ladder moved and that he fell – there was no mention of his right hand being pinched.
    (iv) The medical report of Mr Rhys Thomas dated 8 June 2021 described the circumstances of the accident as being that Mr Jones caught his hand on the clip and as a result the ladder moved and Mr Jones fell.

41. There are obviously differences in these accounts and an absence of reference to the pinch. Having said that, as I noted above, Mr Jones' first written account on 15 August 2018 included the pinch to his right hand. That was repeated in Persimmon's letter to the HSE dated 2 October 2018. The attached Safety Advisers Discussion

Paper on the Incident, under the heading "Background", omitted any reference to the fouling of Mr Jones' left hand and simply stated that he alleged that his hand became trapped in the clip used to secure the ladder to the scaffold which would appear to be consistent with the hand being pinched. The minutes of the Incident Review Meeting (also attached) recorded:

"Initial conversation with the IP and the SGHSA whilst still in hospital identified the reason he believes he fell is due to the fact that this hand became trapped in between the ladder and the ladder clip, causing him to pull his hand out suddenly and subsequently lose his balance."

These accounts serve to demonstrate not only how accounts and records of an account can differ but also that the pinch featured in some of these from a very early stage.

42. In my judgment, on the balance of probabilities, the mechanism of the fall was broadly as recounted by Mr Jones – that is that his hand caught on the left hand clip causing him to let go and transfer his weight to his right hand side; his hand was pinched; the pain caused him to let go on the right hand side, thus losing 3 points of contact and causing the fall. A constant element in Mr Jones' statements and in all the reports of what Mr Jones had said to others was that the ladder moved. The only exception is the A&E record which is indicative of how perfunctory that record was. Movement of the ladder – which could only ever have been slight – would not itself have caused Mr Jones to let go on the right hand side. If anything, it might be thought that it would cause his grip to tighten. It, therefore, seems to me most probable that his hand was in some way pinched and his involuntary reaction to the pain was to let go. That was what Mr Jones said had happened a week after the accident and what he said had happened when he gave a detailed statement. It was also consistent with the pinch mark on Mr Jones' right hand shown in photographs taken on 11 August 2018.

43. The absence of the pinch detail from other accounts may cast some doubt on the evidence but, as counsel for Mr Jones submitted, the precise mechanics of the fall were not of central importance to most of those recording what Mr Jones had told them and not material at all to the medical reports. In all the circumstances, I accept Mr Jones' evidence that his right hand was pinched and that that caused him to let go.

44. For completeness, I would add that Mr Skym was not able to say whether the claimant's hand was pinched but I do not consider this to be relevant as he was not realistically in a position to see whether or not Mr Jones hand was pinched.

45. Having accepted Mr Jones' account of the pinch, the issue that remains is whether the pinch was caused by the ladder moving, albeit slightly, or by the flesh of the hand entering the gap because of transfer of weight or pressure on the hand as was put to him.

46. There is no issue that there was a small gap between the ladder stile and the clip. In the joint statement (at paragraph 2.2), the experts recorded the following agreement:

"We note the photograph appearing to show a pinch injury to Mr Jones' right hand and agree that if his hand was pinched between the ladder restraining clip and the ladder then there must have been relative movement between these items at a time when Mr Jones' right hand was in close contact with both the clip and the ladder."

In short, at the time of the joint statement, not one of the expert engineers suggested that the pinch might have been caused without such movement. By the time of the trial, that position had shifted from this apparently simple agreement or, at the least, had been elaborated upon. The issue as to whether the ladder had, in fact, moved was closely related to the evidence as to whether it could have moved and/or whether it was probable that it had moved.

47. Firstly, there was some evidence, particularly from Mr Stevens, as to how the clips would have been fixed. This is done using an electronic "gun" which spins when a pre-set torque is reached. Mr Stevens checked the fittings after the accident and was satisfied with them. The inference that was sought to be drawn from this evidence was that the ladder could not have moved relative to the clips. Mr Jackson accepted that that was evidence that the clips must have been fairly tightly fixed and said that it was difficult to tell if there was a slight looseness before the gun spins. None of the experts seemed to think that relative movement could not have occurred – although they differed as to the type of movement – and the evidence as to the method of fixing was not sufficient for me to discount this possibility and the expert evidence.

48. As to whether movement did occur, it is convenient to start by referring to the photograph of the ladder taken after the accident (at B14 and 15 in the trial bundle). In these photographs, the baseboard can be seen alongside the ladder and not at its base. This in in contrast to the scaffold poles which are all founded on baseboards. Mr Skym's evidence was that the baseboard was in the same position as it had been when they went up the ladder. Without the baseboard, the ladder is supported on the ground. In the photograph the right hand ladder stile (as it would have been to Mr Jones) is founded on the edge of the unmade ground and hardcore. The left hand stile had sunk into the ground. The rungs are horizontal.

49. Mr Jackson agreed that if the ladder was resting on soil when the men approached it to go up the ladder it would be twisted but, as they ascended the ladder, it would sink and the rungs would become horizontal. He later agreed that if the ladder found a firm footing it would not then have moved. There was, however, no specific consideration of what might have happened with the sudden change of pressure or weight caused by Mr Jones' uneven movement. As I have said, the photographs of the ladder, after the accident, showed the rungs to be horizontal but that was after both Mr Skym and Mr Gooch had descended. Mr Jackson's position, in line with the experts' agreement, was that the ladder must have moved and he said that was an opinion based on experience and common sense.

50. I note, in this context, that Mr Skym's evidence, in his witness statement, was that when he and Mr Gooch then came down the ladder it was sliding along the top bar and seemed to have slipped from its original position. It seemed quite flimsy and was bouncing and bowing at the centre. I do not place any particular reliance on this evidence of movement in the ladder. It seems to me exaggerated and influenced by Mr Skym knowing that Mr Jones had fallen from the ladder.

51. Dr Barbour agreed that the claimant's description of the cause of the accident was a plausible scenario. In the context of the relevance of the presence of the baseboard, he agreed that, if the ground was too soft to support the ladder, a baseboard was

necessary but he did not agree that the presence of a baseboard would have prevented the accident for the reason that movement would occur in any case because of the flex of the ladder. In other words, he did not dispute that movement occurred, or at the least could have occurred, but he attributed it to a cause other than movement at the base of the ladder.

52. It was put to Dr Barbour that in the joint statement he had expressed his opinion as follows:

"PB is not aware of any evidence to indicate that the absence of a baseboard affected the stability of the subject ladder at the time of the incident or cause (sic) Mr Jones to lose 3 points of contact with the ladder. The top of the ladder was secured to the scaffold by the clips, which would have minimised any flexing of the ladder at the position Mr Jones was when he fell."

53. In other words, Dr Barbour's opinion appeared to be that he would expect any flexing at the top of the ladder to be minimal. He ultimately agreed that you would expect the ladder to flex more at the bottom than at the top and that, if the baseboard had been properly fitted, the movement would have been minimal and, with no baseboard, greater.

54. It seems to me that the thrust of Dr Barbour's evidence was that, in the circumstances of this case, there would be some movement in the ladder stiles as a result of flexure and irrespective of any issue with the footing of the ladder but that, in the absence of a firm footing, there was a greater risk of movement because there was another possible cause of movement. On a firm footing, the extent of flex at the top of the ladder would be, if not non-existent, minimal.

55. The evidence of Mrs Rutherford-Hacon was that, if Mr Jones' hand was pinched, that could have been the result of movement of the ladder or the hand pressing into the slight void. However, like Dr Barbour, her opinion was that there would be movement in the ladder even without movement at the feet. She agreed that the ladder could move within the clamp and could have moved when Mr Jones' weight shifted.

56. Taking this evidence as a whole, it seems to me far more likely that the pinch was caused by movement in the ladder when Mr Jones' weight shifted and not by Mr Jones' hand being otherwise pressed into the gap in the clip. In reaching this view, I take account of the experts' agreement in the joint statement, their common view that there could have been movement in the ladder, and the fact that the pinch to Mr Jones' hand was sufficiently painful to cause him to let go. I address the issue of the cause of the movement further below.

Was it negligent to install the clips facing outward?

57. In their joint statement, the experts recorded the following agreement:

"2.3 We agree that the double-sided ladder clips used to secure the ladder to the scaffold were of a type that is commonly used and were suitable for this purpose.
2.4 We agree that there is no guidance upon whether such double-sided clips should be installed on the outside of the ladder stiles (with the unused portion facing

outwards, as at the time of the accident) or on the inside of the ladder stiles (unused portion facing inwards, as was done after the accident). Whether the smaller or the larger side of the clip would be used to secure the ladder would depend on the dimensions of the stile."

58. The experts did not agree as to whether, despite the absence of such guidance, the clips should be installed with the unused portion facing inwards or outwards. Mr Jackson's view was the former but in Dr Barbour and Mrs Hacon-Rutherford's opinion it could be either. They also disagreed as to the safety risk posed.

59. In the joint statement Mr Jackson maintained outward facing was not "optimal" and gave rise to "an avoidable and unnecessary obstruction" in that the clip projected further from the ladder stiles and presented a greater obstruction than if facing inwards.

60. In his report dated 8 June 2023, which preceded the joint statement, Mr Jackson's opinion was that, as a matter of good practice, double-sided metal clamps of the nature used in this case should be installed inside the ladder stiles rather than outside. He was not aware of any guidance or instructions to this effect. The matters he was able to point to in support of this good practice were images on suppliers' websites that showed clamps installed facing inwards and the statements and actions of Persimmon after the accident, including Persimmon's Safety Adviser's discussion paper.

61. As I have said, all the experts agreed that the clamps could be installed facing inwards or outwards and, in my view, what is shown on a supplier's website without any advice or guidance is unlikely to be anything other than illustrative of how the clamps can be installed.

62. The Persimmon paper referred to would appear to be the record of the Incident Review Meeting included with Persimmon's letter to the HSE dated 2 October 2018. Under the heading Review Notes and Comments, it was noted, at paragraph 3, that the ladder clip had been fitted to the exterior of the stiles and that good practice would be to fit the clips on the inside. Paragraph 4 continued:

"It is recommended that ladder clips are not used to secure ladders as there is no way of ensuring that ladders are fixed tight by the bracket. Moving forward, ladders should be secured using cordage."

That was reflected in the letter which also said that the clips were being changed and replaced with cordage to eliminate the risk. There is photographic evidence that, before the clips were replaced, they were re-fixed facing inwards.

63. Following the accident, Caroline North had deployed a colleague to site and much of her evidence was, therefore, commentary. She was, however, in attendance at the Incident Review Meeting and in her witness statement she said that, as a knee jerk reaction to the accident, Persimmon asked Macob to review the scaffolding and they replaced the clips with cordage. In cross-examination she similarly described getting rid of the clips as an immediate reaction.

64. I have no hesitation in accepting the evidence that Persimmon's position – both in terms of re-orientating the clips and then replacing them entirely - was a reaction to the incident and not indicative that the orientation of the clips was negligent. That view is supported by the fact of the decision to replace the clips entirely with cordage as that would imply that the use of clips was itself negligent and/or not good practice and that clearly is not right. I, therefore, find no support in this for Mr Jackson's opinion as to good practice.

65. Dr Barbour's view was expressed in his report as follows:

"… the ladder clips (and any other type of restraining device) will obstruct the sliding of a hand along the stile of a ladder regardless of whether the unused side is on the inside or the outside of the stile. As such, the user would be required to release their grip of the stile and move their hand over the clip, regardless of how the clip was orientated, which if done hand-by-hand would not prevent the user maintaining 3 points of contact with the ladder at all times."

66. In cross-examination, Dr Barbour agreed that there was nothing wrong with the user moving their hands over the stile "shadowing" the stile and that an inward facing clip would then present only a small obstruction. That was by no means a concession that the clip ought to have been inward facing. He also considered that there was very little difference in terms of the obstruction posed by an inward or outward facing clip and he made the point that, if the user is holding the rungs rather than the stile, the inward facing clip would pose an obstruction.

67. Mrs Rutherford-Hacon's view was expressed in her report as follows:

"… the ladder clip forms an inherent part of the scaffold access design to secure the ladder regardless of whether the unused side of the clip is located inside or outside the ladder. Any person ascending/ descending a ladder must lift their hand (one at a time) over each of the securing points (clips) maintaining three points of contact at all times."

68. In her oral evidence, she similarly said that the clip forms part of the scaffold design and is an inherent obstruction which is equal whether facing inwards or outwards. As she put it simply, you have to move your hand over it whichever way it is fixed.

69. There was further a body of evidence from witnesses of fact as to common practice. Glenn Walton's experience was that the fixing of the clips inward or outward facing varied; Persimmon might tell the scaffolding contractor what it would like; but the scaffolding contractor would follow its own rules and could insist on a particular configuration. Clive Stevens said in his witness statement, and repeated in oral evidence, that the clips could be fitted facing inwards or outwards and that there was no "correct" way of fitting them. Whilst he agreed that the clips could present an obstruction, his point was that the user should not be touching the clips in any case. Eugene Costello gave evidence about general practice and said that the clamps were a common type and there was no right or wrong way to fix them. He further said that whichever way the clips were fixed, you could not negate some obstruction and that he personally had never had a problem whichever way they were fitted. This evidence was entirely credible and I attach weight to this evidence as evidence that there is no established "good practice" of placing the clips facing inwards.

70. As I have indicated, the common sense point was also made that whether the clip is fixed with the unused portion facing inwards or outwards, that unused part forms an obstruction to a person's hands and the extent to which it forms an obstruction depends on the way in which an individual holds the ladder. Some people with hold the stiles while others will hold the rungs. If the clip is fixed inward it is more likely to "foul" a person's hands if they are holding the rungs.

71. Taking all these matters together, I reject the contention that there is a good practice of fixing the clips facing inwards or that it was negligent to fix the clips facing outwards. It follows that, although the sequence of events that led to the accident started with Mr Jones catching or fouling his hand on the clip, no liability attaches to Persimmon or Macob in this respect.

The baseboard

72. At the point when the claimant caught his left hand on the clip, he still had three points of contact with the ladder. He fell, as I have found on the balance of probabilities, because the ladder moved and that caused the pinch to his right hand. The next issue, therefore, is what caused the ladder to move and/or what, if anything, could or should have prevented the ladder from moving.

73. The claimant's case is that the ladder was not stable because the baseboard was absent and that, if there had been a baseboard, the ladder would not have moved. It is no longer in issue that Macob installed the baseboard when erecting and handing over the scaffold so no liability could attach to Macob in any event in this respect. Persimmon's case is that, if the baseboard was not present when the claimant went up the ladder on the day of the accident, that is not sufficient to establish any lack of care and skill on Persimmon's part – Persimmon had a reasonable system of inspection in place; the scaffold had been inspected on 6 August 2018 and it can be inferred that the baseboard was then present; the exercise of reasonable care and skill did not require Persimmon to inspect further on 8 August 2018; in any event, even if the baseboard was absent on 6 or 8 August, that was not something that required actioning as the evidence demonstrates that the ladder was stable even without the baseboard. Alternatively, Persimmon contends that the presence of the baseboard would have made no difference to the movement of the ladder and the cause of the fall.

The evidence of fact as to the presence or absence of the baseboard

74. Clive Stevens' evidence in his witness statement was that Macob would not have left the ladder without a baseboard. In his oral evidence he said variously that the baseboard had been put in place because it was part of "Persimmon's specification", because it was what Macob did as a matter of course, and because the ground was soft. His own view, given as an experienced scaffolder, was that without the baseboard the ladder could move.

75. Jade Simmons gave evidence as to the inspections she had carried out. In her witness statement dated 12 April 2023, her evidence was that she checked the scaffolding and ladders at least once a week, checking that the scaffolding and ladders were secure; that the ladder was at the correct pitch; and that "if present the baseboard is underneath". She said: *"I am aware that Macob say they placed the baseboard under*

the ladder when they erected the scaffolding. I cannot say whether this is true or not as I cannot remember."

76. Ms Simmons' evidence was that she had checked the ladder in question on 6 August and she said that, if the baseboard had been moved at that time, she would have recognised this on that inspection. The inspection is recorded in her Inspection Checklist which, in respect of this inspection, simply records "loading bay gate needed together with HB sign". Ms Simmons also stated that there was no requirement for a baseboard where the ladder is pitched on firm ground. In re-examination, she clarified that her inspection would have included a visual inspection and checking that the ladder was secure before climbing it and that she would have climbed up to the third lift.

77. In cross-examination, she was unable to confirm that she had gone up and down the ladders/ scaffolding on a daily basis as Persimmon had pleaded – indeed she had not said so in her statement. She did not seem to have seen the Defence and said she was unsure about what she had done because it was a long time ago. When pressed she volunteered that if no-one was working on the scaffolding she had no reason to go up.

78. Ms Simmons was taken to the minutes of the Incident Review Meeting which said that in "the Site Manager's statement" she had confirmed that no faults were identified on her walk round on Plot 431 on the morning of the accident. She was not able to identify the statement being referred to and instead said that she generally walked the site and did not inspect every scaffold because it would be unrealistic to inspect the whole of the site. Her evidence was that she did not go up and down the ladder on 8 August – she just walked the street and this plot was at the back of the site. When Ms North was cross-examined about "the Site Manager's Statement" she was also unable to identify the source of the information that Ms Simmons had found no faults and speculated that this had come from a verbal statement.

79. Despite this evidence, Ms Simmons maintained that when she inspected (on 6 August 2018) there was a baseboard in place and the ladder was at the correct pitch. She insisted that a missing baseboard and an incorrect pitch were not things she would have missed. She was not sure about the pitch and baseboard after the accident. If the baseboard was missing she thought that it could have been kicked out of place – there would be no reason for that to be done deliberately but it could have been done accidentally when someone used the ladder.

80. I have already referred to the evidence of Mr Skym that the baseboard was absent when the men went up the ladder on 8 August and the photographs showing it alongside the ladder after the fall.

81. Ms Simmons seemed to me a patently honest witness and not one who coloured her evidence to suit the first defendant's case. In light of her evidence much of what Persimmon had pleaded as to the extent of its inspections was not sustainable as a matter of fact but I accept that it does not inexorably follow from that that there was any breach of duty.

82. I accept that Ms Simmons carried out weekly inspections of scaffolding as she was required to do and regularly walked the site. Her evidence in relation to the baseboard

was, however, not at all clear. On the one hand, she did not recall whether Macob had fitted a baseboard and expressed her view that a baseboard would not be necessary if the ladder was on firm ground. She also climbed the ladder after the accident as recorded in the inspection report when there was clearly no baseboard in place, implying that she was not concerned about its presence or absence. It was not replaced until Mr Stevens did so. But at the same time, and to my mind inconsistently, Ms Simmons insisted that, on her inspections, she would have noticed if the baseboard were missing.

83. I return to this evidence below but, taking the evidence as a whole, there seems to me to be little doubt that the baseboard was missing on the morning of 8 August.

The relevance of the presence or absence of the baseboard to movement

84. I have already referred to some aspects of the expert evidence in relation to the cause of movement and the possibility that the ladder moved within the clamp or was the subject of flexing.

85. One aspect of the expert evidence, which itself related to the need for, and causative relevance of, the baseboard was the evidence as to whether the ladder was founded on firm ground. As I have said, the nature of the argument is that, if the ladder was founded on firm ground, it would not have moved anyway – implying both that the movement was normal flexing and that the absence of the baseboard was not causative.

86. The factual evidence was that the ladder rungs were horizontal in the morning, consistent with the ladder being stable on firm ground. The ladder rungs were also horizontal when photographed after the accident but after both Mr Skym and Mr Gooch had descended the ladder so that if the ladder had moved it was likely to have settled further. The photographs also show that one stile of the ladder was on the interface between hardcore and ground and the other had penetrated into the ground. Mr Stevens' evidence was also clearly that the baseboard was installed because the ground was soft.

87. I take into account the expert evidence to which I have referred above, the evidence that the ladder was unlikely to have flexed much at the top, the extent of movement that would have pinched Mr Jones' hand sufficiently to make him let go, and the evidence of the ground conditions and the stile penetrating the ground. I conclude that it is more likely than not that the ladder moved, rather than simply flexed, and did so because the ladder was not firmly footed. Had the baseboard been in place that movement would not have occurred.

88. I should add, for completeness, that Mr Snarr referred to the decision in *Clough v First Choice Holidays & Flights Limited*, an unreported decision in 2005 of David Foskett QC, then sitting as a Deputy High Court Judge. The case concerned a serious injury caused to the claimant when he, on his case fell, and, on the defendant's case dived, into a shallow pool. The judge referred to the submission of the claimant's counsel that, if there was a fall, the lack of non-slip paint made a "material contribution" to the fall. At [74] he then said this:

"On the issue of causation, in my view, the Claimant has to prove, on the balance of probabilities, that but for the absence of proper non-slip paint he would not have slipped as I have found that he did. The other way of putting it, as Mr Ritchie submitted, is that he must prove, on the balance of probabilities, that the absence of proper non-slip paint caused or materially contributed to his slip and his subsequent fall. However, in my judgment, if the slip is as likely to have occurred irrespective of the absence of a proprietary brand of non-slip paint as it would have had such paint been provided, or the evidence does not permit of a conclusion on the balance of probabilities, then the necessary evidential hurdle has not been surmounted and the "but for" test has not been passed."

89. Mr Snarr submitted that that was a proper statement of the law and that the present case was analogous in that the evidence did not permit a finding that the fall would not have occurred if the baseboard had been present or, put the other way, that the fall would not have occurred but for the absence of the baseboard. The evidence in this case, he argued, did not permit a finding that went beyond one to the effect that the absence of the baseboard was a contributory factor, if that.

90. It will be apparent from what I have said above that I do not accept that argument and that, in my judgment, there is sufficient evidence for me to find on the balance of probabilities that, but for the absence of the baseboard, movement sufficient to cause Mr Jones to let go of the ladder would not have occurred, he would have maintained three points of contact, and the fall would not then have occurred.

Persimmon's inspections

91. The next issue then is whether any liability attaches to Persimmon in respect of the missing baseboard:

    (i) Persimmon places reliance on Regulation 12(4) of the Work At Height Regulations as to frequency of inspection.
    (ii) Persimmon further submits that the quality of inspection is to be judged by reference to a reasonable body of site management opinion: *Adams v Rhymney Valley DC* [2001] PNLR 4 at [38]; *Bowen v The National* Trust [2011] EWHC 1992 (QB) at [7]; Parker *v The National Trust* [2021] EWHC 1589 (QB) at [12]. Although each of those cases involved a very different factual scenario, the general submission as to the manner in which the court should judge the exercise of reasonable care and skill is well made.

92. Accordingly, Persimmon submits that even if the ladder was not in the same condition as when it was first installed as part of the scaffolding, that does not in itself evidence any negligence and Persimmon relies on the weekly inspections (in accordance with the regulations) and the quality of the inspections to refute any allegation of negligence.

93. There are a number of possible factual scenarios concerning the potential liability of Persimmon. One scenario is that, when Ms Simmons inspected on 6 August 2018, the baseboard had already been displaced and she did not observe this and/or take an action. A second scenario is that the baseboard was in place on 6 August but was displaced before the men went up the ladder on 8 August. The third scenario is one in

which the baseboard was displaced after they had gone up the ladder but, on the facts, that is a scenario I have already rejected.

94. As I have said, on 6 August 2018, Ms Simmons recorded in her inspection report "Loading bay gate needed along with HB sign". There was no reference to the baseboard being missing despite Ms Simmons recording a matter that needed to be rectified or addressed. Persimmon relies on that as strong evidence that the baseboard was in place and as evidence that supports Ms Simmons' assertion that, if the baseboard was absent, that was not something she would have missed. I do not accept that submission as Ms Simmons' evidence, to my mind, makes it clear both that she either did not know that there had been or should have been a baseboard in place and that it was not something she was concerned with.

95. It seems to me entirely likely that the missing baseboard is something that Ms Simmons would have missed or not actioned. Further, by the time the men went up the ladder on 8 August, the stiles had already settled into the ground. There was no direct evidence of use between 6 August and 8 August which might have caused the baseboard to be displaced and allowed for the stiles to settle into the ground. Therefore, it also seems to me far more likely, and more likely than not, that the baseboard had already been displaced by 6 August when the scaffold had been in use prior to that inspection.

96. On that basis, I am satisfied that the failure to observe that the baseboard was missing was a failure to exercise reasonable care and skill. I do not accept the submission that the purpose of the inspections was solely to ensure that the ladder was sufficiently sturdy for use or reasonably safe for use as Mr Snarr put it. The purpose of the inspections was also to ensure that the scaffold was as erected and certified by Macob. Whether or not Ms Simmons appreciated why the baseboard was in place, it was part of the scaffold as designed and handed over and its absence ought to have been observed and remedied.

97. In opening, Mr Snarr submitted that it would be a far reaching finding for the court to conclude that a ladder ought always to have a baseboard as a matter of safety and, I infer, irrespective of the ground conditions but that is not the effect of my decision. On the evidence, the baseboard was there for good reason and, in any event, was part of the scaffold as handed over. Whether the ladder moved as a result of its absence is a discrete matter of causation on which I have made separate findings.

98. I am also conscious that Ms Simmons recorded on 8 August after the accident that the loading bay gates had been completed. If I am wrong about the absence of the baseboard on 6 August, then the most likely occasion when the scaffold was used and the baseboard displaced is when the loading bay gates were installed. There was no specific evidence as to when that was done or what was done but it is the only matter that might be evidence of use of the scaffold between 6 and 8 August. As I noted above, it was not suggested to Mr Jones that anyone else was using the ladder on 8 August. The obvious inference that I draw is that the loading bay gates had been installed before that. That involved a change to the scaffold which Ms Simmons ought to have inspected, as she did later on 8 August. But by that time, she had given instructions to Mr Jones to work on the scaffold and she ought to have inspected it before she did so and ought to have observed and acted on the missing baseboard. It

follows that, on either of these factual bases, I would find that there was a failure to exercise reasonable care and skill on the part of the first defendant.

Pitch

99. As I said in summarising the claimant's pleaded case, prior to the trial, the pitch of the ladder also appeared to be a significant element of the claimant's case as to negligence. By the conclusion of the trial, it was accepted that the ladder was "out" by a small margin; that the ladder had been installed at the correct pitch; and that any apparent increase in pitch was the consequence of the removal of the baseboard.

100. Counsel for the claimant submitted that the pitch contributed to the fall and reduced the chance of breaking the fall. Counsel for Persimmon submitted that it was not causative of the fall. On this issue, I accept Persimmon's submission. The cause of the fall was as considered above. The pitch of the ladder had nothing to do with this.

Contributory negligence

101. It was submitted for the claimant that, if the clips should have been facing inwards, there was no contributory negligence. Further, it was submitted that, if the court were to find that the clips were positioned correctly but (i) the baseboard should have been in place and (ii) the absence of the baseboard was causative, then the claimant's contributory negligence should be found to be 25%. I do not accept either of those submissions.

102. Even if I had found that the positioning of the clips facing outwards was negligent, I would have found a substantial element of contributory negligence, and one far greater than 25%, on the claimant's part. As Mr Jones stepped on to the ladder to descend he placed his hands on both sides above the clips. At that point, the clips and their position must have been clear and obvious, and to a large extent that was fairly accepted by Mr Jones. In that case, it was incumbent on him to move his hands past the obstruction and to do so with reasonable care. He could easily have moved one hand at a time ensuring that he maintained three points of contact. Whether what he did was properly described as sliding his hands or shimmying his hands, he did not, in my view, take care to avoid the clips as he should have done. My view in this respect accords with the evidence of Dr Barbour and Mrs Rutherford-Hacon and also with common sense.

103. In the event, I have found that it was not negligent to fit the clamps facing outwards and no liability attaches to the defendants in this respect. The liability of Persimmon is only in respect of the baseboard. The first step in the sequence of events that led to the fall was Mr Jones' inattention to the clamps. In addition, in my judgment, there is a measure of contributory negligence in relation to the baseboard.

104. Mr Jones was aware that the ladder should be on a firm level base and that if it was not it should have been reported. As I have said above, it seems to me on the balance of probabilities that the baseboard was not in place when Mr Jones and his colleagues went up the ladder and, given where it clearly was after the fall, that it was already alongside the ladder. Rather than replace the board or report it for someone else to remedy, Mr Jones and his colleagues simply went up the ladder. In doing so, Mr Jones was at fault and in a manner that contributed to his fall and injury, although less so than his failure to avoid the clip. Taking these two matters into account, I find that Mr Jones was 50% contributorily negligent.

Conclusion

105. I, therefore, find that no liability attaches to Macob. Persimmon is liable to Mr Jones in respect of the fall but Mr Jones was 50% contributorily negligent.