Neutral Citation No.: [2009] NIQB 35

Ref:	**McCL7467**
Delivered:	**30/03/09**

Judgment: approved by the Court for handing down
*(subject to editorial corrections)**

07/64817

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

QUEEN'S BENCH DIVISION

BETWEEN:

PETER DICKSON WOODS

PLAINTIFF

-and-

POLICE SERVICE FOR NORTHERN IRELAND

DEFENDANT

HEADNOTE

Employer/employee – course of employment – claim for damages for personal injuries – negligence – unsafe system of work – toleration by employer – Regulation 3, Management of Health and Safety at Work Regulations (NI) 2000 – risk assessment, delegation by employer to Plaintiff – whether sufficient discharge of statutory duty – breach of Regulation 3 – material factors – contributory negligence – Section 1(1) Law of Reform (Contributory Negligence) Act 1945 – apportionment of responsibility – 50% contributory negligence.

McCLOSKEY J

I INTRODUCTION

[1] Peter Dickson Woods, the Plaintiff in this action, was born on 1st September 1958 and is now, therefore, aged fifty years. He brings this claim for damages against his employer, the Police Service of Northern Ireland ("*the Defendant*"). The Plaintiff is employed by the Defendant as a senior armourer

at Seapark, Holywood. This is the main PSNI armour workshop in Northern Ireland. The Plaintiff claims damages for personal injuries and other losses alleged to have been sustained by him arising out of an accident which, according to the Statement of Claim, occurred at approximately 11.15am on 12th February 2007.

[2] In simple terms, the Plaintiff shot himself in the hand. This occurred when, following an exercise in test firing, he was beginning to dismantle a weapon, which had been presented as defective by a police officer. The weapon in question was a Glock 19 mm pistol. The accident occurred at the Seapark firing range. The Plaintiff's primary cause of action against the Defendant lies in negligence. Secondly, he contends that the Defendant was guilty of breaches of Regulations 4 and 5 of the Provision and Use of Work Equipment (Northern Ireland) Regulations 1998 ("*the 1998 Regulations*"). The Plaintiff also alleges a breach of Regulation 3 of the Management of Health and Safety at Work Regulations (Northern Ireland) 2000 "*the 2000 Regulations*". His various allegations of breach of statutory duty were made somewhat belatedly, reflected by the presentation of two successive amended Statements of Claim during the course of the trial. The final approved version of his Statement of Claim is that dated 26th March 2009.

II THE EVIDENCE – A SUMMARY

[3] Certain aspects of the evidence adduced before the court were of a highly technical and intricate nature. These related to the design, make up and functioning of the weapon (which was mainly uncontroversial), together with the detailed mechanics of the Plaintiff's accident. I shall summarise the salient parts of the evidence below.

The Plaintiff

[4] The Plaintiff gave evidence of an impressive, and significant, employment history. He was a Reserve police officer between 1991 and 2003. From the mid-1970s until 1990, he worked in the family business in Ballymena, in the sale of fishing tackle and guns. He trained in "gunsmithing" abroad. His training encompassed courses in the manufacture of guns and, in particular, their maintenance. He began working as an armourer in the Royal Ulster Constabulary in 1990.

[5] From 1992, Seapark in Holywood became the main RUC armoury workshop. There are six other police armouries scattered around Northern Ireland. In 2000, the Plaintiff was appointed Senior Armourer. In such capacity, he was line manager as regards the armourers employed at the seven bases in Northern Ireland. The Plaintiff's own line manager was one Colin Ashe, whom he described as the "head" of Seapark. From around 2003, the Plaintiff's line manager was Sergeant Ferguson, who was in charge of

"Weapons Control". This hierarchical structure also included Inspector McCrudden, described as the "Chief Firearms Instructor" and Mr. Campbell Brown. From 2000, the Plaintiff's duties concerned mainly the maintenance of weapons. This entailed inspections, repairs and the replacement of defective parts. The Plaintiff was also responsible for (in his own words) "*setting up proper procedures*". He explained that he had been trained in health and safety and that he had certain duties in this sphere. These duties included the preparation of risk assessments. He underwent some training in England. He asserted that he had received no training in the dismantling of weapons.

[6] The exercise described as "function testing" was carried out on the test firing range at the Seapark premises. The Plaintiff described a counter, a workshop and a firing range. On 12th February 2007, a police officer (Detective Constable McClure) presented himself at the counter and recounted that his Glock 19 mm pistol ("*the weapon*") had been locking to the rear, during weapons training, in circumstances where the magazine was not empty. According to Mr. McClure's statement, he "***... proved** to Mr. Woods that the pistol was unloaded*" [emphasis added]. The word "*proof*", in this context, connotes that Mr. McClure had, in an adjoining facility, duly carried out the established procedure for ensuring that the weapon was unloaded. The Plaintiff took the weapon to the firing range, in order to carry out function testing. At the range, he loaded the weapon with a magazine. Next, he "washed" (i.e. pulled back) the slide, to allow the automatic loading of rounds into the breach. The Plaintiff then fired three rounds, sequentially. After the third shot, the slide recoiled viz. it withdrew to a retracted position. However, the weapon did not reload. As a result, a fourth shot could not be fired. This retracted position signalled, in theory, that the magazine was empty. However, the Plaintiff was aware that there were some nine or ten rounds still in the magazine.

[7] This prompted the Plaintiff to look into the "port" of the gun, located on top. He could see several brass live rounds still in the magazine. He thereupon pushed the magazine release button, removed the magazine and (he believed) placed it in his pocket. Next, he checked to see whether there was any live round left in the breach. He claimed that he carried out this check by "racking" the slide, three times. This exercise of "racking" the slide entailed unlocking the slide stop, a small notch, or ratchet, located on the side of the weapon. He "racked" the slide, by pulling it back and then releasing it. In this way, he learned that the spring in the slide stop was in the wrong position.

[8] According to the Plaintiff, at this stage, he proceeded to reload the magazine. He then repeated the earlier process viz. he "racked" the slide a second time and fired three further rounds, sequentially. Having fired the third round, the same problem recurred i.e. the slide "jammed" in the open position. Upon inspection, the Plaintiff observed that the magazine still

contained live rounds. At this juncture, he removed the magazine and released the slide forward. He then "racked" the slide some three times, again. Having done so, he walked from the firing point to a bench in order to remove the slide from the gun. This is a purely manual operation. The Plaintiff's injuries were sustained during this operation.

[9] The Plaintiff testified that he placed the magazine on a bench (evidently a work surface of some kind). He then moved the slide back a certain distance, using his right hand, following which his left hand was deployed in holding the slide open. His right hand gripped the handle of the weapon, with his right index finger on the trigger. His left thumb and forefinger were positioned to manipulate the two "slide locks", which are situated on each side of the weapon. The Plaintiff undertook these actions in such a way that the heel of his left hand was positioned over the muzzle of the weapon. This (on his account) was the only unguarded, inadvertent aspect of the whole operation. Everything else was both conscious and deliberate. The act of squeezing the trigger was an essential part of the operation of removing the slide. The Plaintiff then depressed the trigger with his right index finger. Simultaneously, the left index finger and thumb were operating the slide locks, pushing them down. The Plaintiff testified that these two actions must coincide. He demonstrated how his left hand could have been deployed to equal effect in two alternative positions, in a manner which would have removed it from the bullet's line of travel. Upon depressing the trigger, a round was discharged from the weapon, entering and exiting his left hand, inflicting the injuries for which he claims damages.

[10] The Plaintiff agreed in cross-examination that he was very familiar with the "Glock Manual". He acknowledged that he had undergone specific training courses in respect of this weapon. The courses included the dismantling of the weapon and the correct procedure for ensuring that it was not loaded. He further acknowledged that there are two fundamental principles governing the handling of weapons, which are:

(a) To remove the magazine from the weapon.

(b) To verify that there are no rounds left in the chamber, by pulling back the slide and locking it in the open position.

The next step is to "dry fire" the weapon.

[11] The Plaintiff further acknowledged the four steps specified in the Glock Manual, which are in sequence:

(a) Visually verifying that the weapon's chamber is empty.

(b) Pointing the weapon in a safe direction.

(c) Pulling the trigger.

(d) Physically removing the slide.

The Plaintiff admitted that, on the occasion of his accident, he had not executed the second of these steps. As regards the first step, he asserted that he visually checked the inside of the chamber, by pulling back the slide. He agreed that there must have been a round in the chamber. He suggested that his visual check was executed quickly. He denied that he had failed to carry out this check. He further agreed that any remaining round inside the chamber would have been clearly visible, by virtue of its colour. He denied that he had failed to remove the magazine. He accepted that he had not locked the slide in the open/retracted position. He was adamant that he had carried out two rounds of test firing.

[12] The Plaintiff agreed that if he had followed the procedure specified in the Manual, his accident would not have occurred. His theory was that a bullet case must have been jammed in the breach. This was the only explanation that he could suggest for his accident. In carrying out function testing, he had worked unaccompanied throughout the entirety of his career. He agreed that he could have sought the assistance of a fellow armourer. He denied that he had carried out the test in a hurry, in order to attend a union meeting. He further denied that he had placed the slide in its forward position, thereby releasing a round of ammunition into the chamber. He accepted that he had not palpated inside the chamber with one of his fingers.

[13] The topic of risk assessments was probed in some depth. The Plaintiff readily accepted that, by virtue of his tenure of the senior armourer post, he was responsible for the preparation of risk assessments. It would appear that there had been a slowly progressing programme of compiling risk assessments. At the time of transfer to the new Seapark workshop in 2003/2004, the Plaintiff received from John Adamson all risk assessments previously compiled by him. Following this transfer, no further risk assessments had been completed by the Plaintiff. In other words, he had achieved nothing on this front during a period of some three to four years prior to his accident. He accepted that, with reference to this discrete duty, he was not answerable to anyone. He testified that he "*hadn't got round to doing them*". The extant risk assessments were available to employees through display on a notice board in the Weapon Control General Office.

[14] The Plaintiff returned to work in May 2007. During his period of absence, of some three months' duration, Mr. Diamond, one of the armourers employed at Seapark, had "acted up" and, in this capacity, had prepared a risk assessment in relation to weapon function testing viz. the activity upon which

the Plaintiff was engaged when his accident occurred. This risk assessment has two noteworthy features. Firstly, it stipulates that an armourer must be accompanied by a fellow armourer at all times on the firing range, with a view to verifying that the weapon has been cleared. Secondly, "dry firing" is required: this entails pointing the gun in a safe direction and pulling the trigger, i.e. firing the weapon, before beginning the process of dismantling. When questioned about any previous dry firing practice, the Plaintiff claimed that he had observed this precaution on some occasions. He further claimed that he had *consciously* decided not to "dry fire" on the accident date. He suggested that, as a precaution, this was rarely undertaken. He further testified, vaguely, that this might be done in exceptional circumstances, without elaboration.

Dr. Alexander B.Sc.

[15] This witness, a forensic scientist by profession, specialising solely in firearms during the past two decades, gave exhaustive evidence of the minutiae of the *modus operandi*, design and components of the weapon. It is unnecessary to rehearse these aspects of his evidence *in extenso*, as they were uncontroversial. In its material respects, this evidence was corroborative of the Plaintiff's evidence, making due allowance for certain differences of vocabulary.

[16] Dr. Alexander's evidence clarified that the slide is located on top of the weapon. It goes forwards and backwards during the firing action. Cartridges are loaded by a spring device in the slide stop. When the last cartridge has been discharged, the slide and slide stop should come together, producing a "locking" effect, with the slide in its fully retracted position. This signals to the user that the magazine is empty. At this stage, the magazine should be removed. If firing is to be continued, the following three steps should be taken:

(a) The weapon should be pointed "down range", away from the operator.

(b) The magazine release catch should be depressed with the operator's right thumb, thereby releasing the magazine, which will fall freely on to the floor.

(c) A new magazine should now be inserted.

[17] Dr. Alexander described what he termed a "generic safe procedure", to be observed before any dismantling of a weapon in the kind of circumstances prevailing when the Plaintiff's accident occurred. This entails the following steps:

(a) The physical removal of the magazine from the weapon.

(b) A visual check inside the chamber.

(c) A check of the position of the slide: if all rounds have been fired, this should be in its fully retracted (or "locked") position.

Dr. Alexander further testified that if all cartridges had not been fired, the slide should be in the forward position. If in this position, it should be manually retracted, to be followed by a visual inspection of the chamber. Precisely the same inspection should be conducted if the slide is in its retracted position.

[18] Continuing, Dr. Alexander testified that neither the forward position of the slide nor its retracted position is an absolute indicator of whether the magazine is empty. If the slide is in the forward position, this is a strong, but not failsafe, indication that the magazine is not empty. Similarly, if the slide is in the retracted position, this is persuasive, but not conclusive, evidence that the magazine is empty. Dr. Alexander suggested that since neither position provides an absolute guarantee, it is necessary to have a second "inspector" in order to eliminate human error. This, he claimed, is normal procedure in all firing ranges where he has worked, since 1979 at the latest. The witness supported this claim by reference to a series of documentary materials concerned with the subject of safety on the shooting range. Each of these details a safety plan (or risk assessment), one feature whereof is the designation and presence of a suitably qualified individual to perform the duties of "range officer". Dr. Alexander described this as "*absolutely standard practice*", a universal safety rule.

[19] Dr. Alexander further testified that before "dry firing", the slide should be "racked" several times. This entails repeatedly retracting and releasing it. Throughout this process, the weapon should be pointed safely down range. Upon completion of this process, the trigger can be pulled. Then the whole exercise should be repeated. These steps should be taken before the operator begins to dismantle the weapon. The operator should carry out dismantling in the following way:

(a) Place the slide in its forward (i.e. closed) position.

(b) Point the weapon down range.

(c) Pull the trigger.

(d) Retract the slide very slightly – approximately half an inch.

(e) Push down on the "disassembly" catches.

(f) Detach the slide from the frame of the gun.

These are the procedures detailed in the Glock Manual (pp. 12 and 13). The Plaintiff's account of what he was doing at the material time indicated that he was combining steps (c), (d) and (e): however, step (c) should have been separated from the next two steps.

[20] Dr. Alexander acknowledged that the Glock Manual specifies two particular, linked precautions. The first is a visual inspection of the chamber. The second is a manual palpation of the inside of the chamber by the operator. With specific reference to the Plaintiff's accident, he suggested that the following possibilities exist, in the abstract:

(a) The Plaintiff failed to visually check the inside of the chamber.

(b) Alternatively, the Plaintiff conducted an inadequate visual check of the inside of the chamber.

(c) The shooting was due to a defective cartridge – a very rare occurrence, according to the witness.

(d) The slide was in the forward position at all material times viz. the Plaintiff had not "racked" it at all.

(e) Alternatively, if "racking" of the slide had been executed prior to removal of the magazine, this would inevitably have released a cartridge into the chamber.

If the Plaintiff did remove the magazine, as he claimed, the slide must have been in the retracted position. When in the forward position, a visual check of the chamber is impossible.

[21] It appeared to the court that the centrepiece of Dr. Alexander's critique of the Defendant's system of work was the absence of a fellow armourer, to act as second "inspector", or "range officer" (or "range safety officer"). As a subsidiary criticism, he found it "*very surprising*" that the manufacturer's manual was not available to armourers on the range. He testified that the Plaintiff must have failed to observe a cartridge inside the chamber, describing this as the "*primary failure*" causing or contributing to the accident. A further contributory factor was the Plaintiff's failure to close the slide and then "dry fire" the weapon. He considered it "*highly improbable*" that a defective cartridge had been a cause of the weapon discharge.

The Defendant's Case

[22] The Defendant's evidence, which consisted of a combination of sworn testimony and certain documentary materials, included the written statement and oral evidence of Mark Holmes, a fellow armourer. In the immediate aftermath of the Plaintiff's accident, Mr. Holmes observed the weapon positioned on the counter (or bench), with the slide in the locked, retracted position. The magazine was positioned beside the weapon. There were live rounds in the magazine. Mr. Holmes' statement continues:

> "*I picked up the Glock 19 and walked halfway down the range and attempted to do a make safe on the gun by racking the slide to the rear. However, the slide kept locking back and in my view the mechanism, i.e. the slide lock had been fitted incorrectly*".

In evidence, Mr. Holmes stated that, having removed the slide, his inspection of the weapon confirmed that the spring was in the wrong position. He suggested that this defect had nothing to do with the Plaintiff's accident. Magilligan, where he works, is a PSNI training establishment, equipped with a training range (as opposed to the test firing range at Seapark). On the Magilligan range, there is a designated range safety officer at all times. This person is a qualified firearms instructor, who supervises all aspects of weapon use and handling.

[23] The Defendant's evidence also included a report prepared by Mr. Crawford, a PSNI Scientific Officer, based on his examination of the relevant weapon the day following the accident. Mr. Crawford's oral testimony confirmed the contents of his report, which recites, in material part:

> "*On initial examination a fault in the slide stop lever was found. This defect had the effect of holding the slide to the rear without manual engagement. A normally functioning slide stop applies automatically only when the slide is pulled rearwards on an empty magazine …*
>
> ***This defect in my opinion could cause the user to mistakenly think the magazine in the weapon was empty when in fact it was not.***"

[My emphasis].

Live firing tests demonstrated that the slide occupied the retracted position after each shot. The fault diagnosed by Mr. Crawford was that the slide stop had been assembled incorrectly and he rectified this accordingly. Shots could be discharged from the weapon in the usual way only viz. by depressing the

trigger: in other words, this was not a case of a rogue, inadvertent discharge of a cartridge.

[24] Evidence was also adduced from Mr. Greer, a Senior Scientific Officer employed by Forensic Science Northern Ireland. His main report explains that the function of the slide stop lever is to lock the slide open after the last cartridge has been discharged from the magazine. This conveys to the operator that the magazine is empty and facilitates a swift reload. At the time when this witness examined the offending weapon, the defect had been rectified and the slide was functioning correctly. Mr. Greer expressed the opinion that when the Plaintiff released the slide, the magazine was *in situ* and was *then* removed from the weapon. This was followed by the firing. He further questioned whether the Plaintiff had visually inspected the inside of the chamber, suggesting that the presence of an ammunition round would have been "*obvious*". He considered the faulty cartridge hypothesis to be highly improbable, for the reasons detailed particularly in his supplementary report. He found the Plaintiff's claims about "racking" the slide hard to believe. He testified that the *primary function* of a range officer is to check the weapon prior to dismantling.

[25] On behalf of the Defendant, there was also evidence from Mr. Diamond, an armourer employed at Seapark at the material time. He described the Plaintiff as his "*boss*". Immediately after the Plaintiff's accident, Mr. Diamond was instructed by Mr. Brown, whom he described as the "*head of department*", to prepare risk assessments for the test firing range. Mr. Diamond duly did so. Within three weeks, he prepared a document entitled "Health and Safety Range Orders and Procedures – Armourer's Test Range" (dated March 2007) and a related compilation entitled "Risk Assessment – Base Armourer's Ten Metre Range" (with the same date). The first of these documents contains the following salient passages:

> "*(a) When the firearm is handled* ***irrespective of the source i.e. another member of staff, storage or PSNI officer*** *it must always be checked to ensure that it is unloaded and therefore safe to handle …*
>
> *(c) Before any test firing begins the Range Conducting Officer must ensure … (etc.)*
>
> *Firing can only take place if two people are present on the firing point and qualified to be on the range …*
>
> *At the end of the test firing the Range Conducting Officer will complete Range Certificate …*
>
> *(e) All loading and unloading of firearms and detachable magazines, where fitted, must take place on the range. The*

> *muzzle of a loaded firearm must at all times be pointed down the range with safety catch applied when not firing. On completion of firing, the weapon must be unloaded and then checked by the Range Conducting Officer to ensure that the weapon has been unloaded and is in a safe condition to handle*".

[The emphasis is the author's].

Within the risk assessment, there is an instruction that all staff must comply with Range Orders, viz. the first-mentioned document.

[26] Elaborating, Mr. Diamond explained that the safety procedures and instructions devised by him post-accident were based on a combination of established practice at military firing ranges, his own experiences and contributions from Inspector McCrudden (Chief Firearms Instructor at Garnerville) and Mr. Brown (the "*head of department*"). Seapark was the only weapon firing range in Northern Ireland where there was no practice of employing a designated range officer. In Mr. Diamond's words, he exposed a major safety flaw in the weapons testing system in vogue at Seapark. He testified that, from the perspective of safety, there is no distinction to be made between weapons training ranges and weapons testing ranges. He described the precautions detailed in the "Health and Safety Range Orders and Procedures" quoted above as "*standard*". He suggested that, at the time of the Plaintiff's accident, a risk assessment, incorporating these precautions, should have been in existence.

III THE PARTIES' COMPETING CONTENTIONS

[27] It seems to me that, properly analysed, the Plaintiff's primary case resolves to the proposition that the Defendant permitted an unsafe system of work to evolve and tolerated this. The case made was that the system of work was unsafe, on two counts. Firstly, the system should have required "dry firing" of the weapon, on the shooting range, prior to dismantling. Secondly, the system should have entailed the checking of the weapon by a second "inspector" (or "range officer") viz. a fellow armourer, before the onset of dismantling. The Plaintiff made the case that each of these precautions is an essential, and widely recognised, element of a safe system of work in the sphere of weapon testing and dismantling.

[28] The Plaintiff also asserts a breach of Regulation 3 of the Management of Health and Safety at Work Regulations (Northern Ireland) 2000, which provides:

> "*Every employer shall make a suitable and sufficient assessment of –*

> *(a) the risk to the health and safety of his employees to which they are exposed whilst they are at work; and*
>
> *(b) the risks to the health and safety of persons not in his employment arising out of or in connection with the conduct by him of his undertaking,*
>
> *for the purpose of identifying the measures he needs to take to comply with the requirements and prohibitions imposed upon him by or under the relevant statutory provisions*".

In argument, Mr. O'Donoghue QC also drew to the attention of the court certain provisions of Council Directive 89/391/EEC, in support of a submission that an employer cannot discharge his obligation under Regulation 3 by instructing one of his employees to compile a risk assessment. Articles 5-7 and 9 of the Directive were prayed in aid accordingly. By virtue of the amendment introduced by SR 2003 No. 454, in operation since 24th November 2003, the breach of any duty imposed on an employer by the 2000 Regulations confers a right of action on an injured employee. The Plaintiff's alternative case rested on a breach of Regulations 4 and 5 of the 1998 Regulations. I characterise this an "alternative" case, as it is predicated on the hypothesis of a faulty cartridge, which forms no part of the Plaintiff's primary case.

[29] It was submitted by Mr. Aldworth on behalf of the Defendant that the Plaintiff was guilty of a series of fundamental errors any of which, individually, was sufficient to cause the accident giving rise to his injuries. The two fundamental failures, he argued, were the omissions to conduct a visual and manual check of the chamber (both of which were admitted by the Plaintiff). He further drew attention to the omission of the "*failsafe check*" of dry firing the weapon and the dangerous position of the Plaintiff's left hand. It was submitted that the Plaintiff could not have "racked" the weapon, as claimed by him. The Plaintiff's extensive experience and his tenure of the post of senior armourer were highlighted. It was submitted that the Defendant could not be held accountable for the Plaintiff's failure to compile a risk assessment. Finally, it was argued that the Plaintiff must have known that the designation of a suitably qualified person to act as range officer is a standard precaution in this field.

IV <u>FINDINGS AND CONCLUSIONS</u>

[30] My first finding is that the events surrounding the Plaintiff's accident occurred essentially in the manner described by him. I accept the central core of the Plaintiff's evidence. I assess him to be an honest and credible witness. I find that none of his evidence was fabricated or exaggerated. Any imperfections or uncertainties in his testimony were of the kind to be expected, having regard to (a) the highly technical nature of the subject

matter, (b) the elapse of time since the accident and (c) the consideration, sometimes easily overlooked, that the victims of accidents in the workplace do not perform their duties in the knowledge and expectation that their actions will be exposed to microscopic scrutiny in the courtroom at a distant future date.

[31] I refer to the first of the asserted shortcomings noted in paragraph [27] above, said by the Plaintiff to give rise to an unsafe system of work. I reject the Plaintiff's case on this count, having regard to his unequivocal evidence about his familiarity with the Glock Manual: see in particular paragraphs [10] – [12] above. I find that "dry firing" is an integral component of a safe system of working in the specific context of weapon function testing and dismantling. In this respect, I consider that the Defendant acquitted its duty to take reasonable care for the Plaintiff's safety through the medium of the various training courses which the Plaintiff underwent. The Plaintiff's affirmation that he was particularly familiar with the Glock Manual is a reflection of the efficacy of these courses. The Glock Manual is unambiguous: "dry firing" is a separate, freestanding precautionary step, which should precede slide removal viz. the initiation of dismantling the weapon. The Plaintiff was attempting a combination of both steps at the material time. I hold that his failure to correctly carry out dry firing of the weapon cannot be attributed to any want of reasonable care on the part of the Defendant.

[32] The second aspect of the unsafe system of work asserted by the Plaintiff is the absence of a second "inspector" or "range officer". According to Dr. Alexander, this is a widely recognised safety requirement of longstanding. Notably, there was no challenge to Dr. Alexander's evidence about this matter. Moreover, Mr. Greer readily volunteered that the "*primary function*" (his words) of a range officer, in this context, would be to check the weapon before dismantling begins. Dr. Alexander testified, in forceful terms, that this would almost inevitably have identified the presence of a round of ammunition in the chamber. Again, there was no substantial challenge to Dr. Alexander's evidence in this respect. I refer also to Mr. Diamond's evidence on behalf of the Defendant, summarised above. I accept Dr. Alexander's evidence about this matter. This gives rise to the following findings:

(a) This shortcoming rendered the Plaintiff's system of work unsafe.

(b) This shortcoming was causative in the legal sense, as it was a factor contributing to the event which inflicted the Plaintiff's injury viz. the discharge of the live round.

[33] Thus I hold that the Defendant was guilty of negligence causing or contributing to the Plaintiff's injuries. I also find that there was a breach of Regulation 3 of the 2000 Regulations. At the time of the Plaintiff's accident, there was no risk assessment at all in respect of the weapons test firing range.

This omission was not rectified until after the Plaintiff's accident, which was clearly the impetus for the rectification. I accept that the Plaintiff was responsible for the omission, in the sense that the preparation of a risk assessment formed part of his duties and he had failed, inexplicably and inexcusably in my view, to compile one. However, I hold that the Defendant was legally responsible for this omission. I thus hold on account of two factors, in combination. The first is the hierarchical management structure pertaining to the weapons testing range, as disclosed in the evidence before the court. The second is the striking laxity on the part of senior management as regards this matter. The Plaintiff's failure to compile a risk assessment endured throughout a protracted period and, on the evidence, did not attract any reminder, fresh instruction, warning or any action of any kind. It may be that, in the abstract, an instruction on the part of senior management to a suitably designated employee to compile a risk assessment will, in certain circumstances, preclude a finding by the court of a breach of Regulation 3. However, this is not such a case, for the two reasons explained above. While I entertain significant reservations about Mr. O'Donoghue's submission to the contrary, which was that such an instruction can *never* discharge the employer's obligation under Regulation 3, the correctness of this argument does not fall to be determined, having regard to my conclusions and findings.

[34] The Plaintiff's alternative case is predicated on the suggestion that the offending cartridge was in some way faulty. There is no direct evidence to this effect. This discrete claim can be established only by inference. Both parties' experts testified, without reservation, that this hypothesis is extremely unlikely. In my opinion, there is no evidence to warrant the finding, by inference, that the cartridge was defective. Accordingly, I reject the Plaintiff's case to the extent that it is based on an alleged contravention of the 1998 Regulations.

Contributory Negligence

[35] Section 1(1) of the Law Reform (Contributory Negligence) Act 1945, abolishing the former common law rule whereby contributory negligence was a complete defence, provides:

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

This gives rise to two questions in the present case:

(a) Were the Plaintiff's injuries sustained as the result partly of his own fault?

(b) If "yes", what was his "*share in the responsibility for*" his injuries?

Question (b) encompasses the possibility of a finding by the court of contributory negligence to the extent of 100%. Question (b) arises only if the court supplies an affirmative answer to question (a). If it does so, the court is then enjoined to reduce the Plaintiff's damages "*to such extent as* [it] *thinks just and equitable*".

[36] The essence of contributory negligence has been described in the following terms:

> "*A person is guilty of contributory negligence if he ought reasonably to have foreseen that, if he did not act as a reasonable, prudent man he might hurt himself; and in his reckonings he must take into account the possibility of others being careless*".

[See ***Jones –v- Livox Quarries*** (1952) 2 QB 608, per Denning LJ at p. 615].

In ***Caswell –v- Powell Duffryn Associated Collieries*** [1940] AC 152, Lord Wright drew attention to the need "*… to give due regard to the actual conditions under which men work in a factory or mine, to the long hours and fatigue, to the slackening of attention which naturally comes from constant repetition of the same operation, to the noise and confusion … to his preoccupation in what he is actually doing at the cost perhaps of some inattention to his own safety*": see pp. 178-179. Thus, in certain cases, some momentary inadvertence or lapse of attention on the part of the Plaintiff may not suffice to constitute contributory negligence. Most recently, in ***St. George –v- The Home Office*** [2008] EWCA. Civ 1068, the English Court of Appeal has highlighted that in applying the test enshrined in Section 1(1) of the 1945 Act, it is necessary to have regard both to blameworthiness and so-called "causal potency". Furthermore, it is incumbent on the court to adopt a broad commonsense approach. See paragraphs [50] and [52] in particular. As regards the issue of causation, Lord Atkin stated in ***Caswell***, at p. 165:

> "*I find it impossible to divorce any theory of contributory negligence from the concept of causation … and whether you ask whose negligence was responsible for the injury, or from whose negligence did the injury result, or adopt any other phrase you please, you must in the ultimate analysis be asking who 'caused' the injury*".

More recently, in ***Corr –v- IBC Vehicles*** [2008] 2 WLR 499, Lord Walker , referring to the test enshrined in Section 1(1) of the Law Reform

(Contributory Negligence Act 1945, invoked the same vocabulary when highlighting that "*… in applying this test the court has to have regard both to blameworthiness and to what is sometimes called causal potency …*".

[37] In my opinion, the Plaintiff was guilty of contributory negligence, in four respects:

(a) He ought to have "dry fired" the weapon prior to beginning dismantling, in accordance with the Glock Manual.

(b) He failed to point the weapon in a safe direction, again contrary to the Manual.

(c) He was combining the separate, sequential exercises of depressing the trigger and activating the slide locks, also in contravention of the Manual.

(d) He had failed to discharge the duty, personal and exclusive to him, of preparing a risk assessment for the activity of weapon function testing and dismantling. I find that this failure was inexcusable. I further find that, having regard to the evidence of Dr. Alexander, such a risk assessment would have incorporated the requirement of a second "inspector" (or "range officer").

In the circumstances of this case, having regard to the lethal nature of the equipment with which the Plaintiff was working and his training, expertise and experience, each of these departures plainly constituted a failure to take reasonable care for his safety. I find that these failures contributed to the infliction of the Plaintiff's injuries. The nexus is clear and undeniable.

[38] The next question to be considered is that of apportionment. In ***Stapley –v- Gypsum Mines*** [1953] AC 663, Lord Reid stated, at p. 682:

> "*A court must deal broadly with the problem of apportionment and in considering what is just and equitable must have regard to the blameworthiness of each party, but the Plaintiff's share in the responsibility for the damage cannot, I think, be assessed without considering the relative importance of his acts in causing the damage apart from his blameworthiness*".

The court is enjoined to take into account all the circumstances. Furthermore, the court is not required to engage in a scientific exercise. Rather, a robust, common sense approach is what is required. This is illustrated in ***St. George*** (*supra*). I refer also to the observations of Lord Hoffmann in ***Reeves –v- Commissioner of Metropolitan Police*** [2000] 1 AC 360, at p. 371 to the effect

that the 1945 Act requires the court to apportion the relative responsibility of the two parties, rather than degrees of carelessness, taking into account the policy of the legal rule by which the relevant liability is imposed.

[39] The failures which I have found on the part of the Defendant giving rise to findings of an unsafe system of work and a breach of Regulation 3 of the 2000 Regulations are, in my view, of considerable potency. They operated as real and substantial causes of the Plaintiff's accident and ensuing injuries. On the other hand, the Plaintiff's failures, while individually of somewhat less moment, were, collectively, of undeniable significance. They were not, however, of such magnitude to warrant a finding of one hundred percent contributory negligence. Applying the principles set out above, I find that the Plaintiff was guilty of contributory negligence to the extent of fifty percent.

V QUANTUM OF DAMAGES

[40] The medical evidence describes a gunshot wound to the Plaintiff's left hand, giving rise to extensive soft tissue damage and a compound fracture at the base of the fifth metacarpal. The fracture required internal fixation by a screw. The Plaintiff was admitted to hospital for four days. The history recorded by Mr. Sinclair, FRCS, consultant plastic and reconstructive surgeon, some three months after the accident suggests that the Plaintiff had, at that stage, resumed his hobby of fishing without impairment and was able to play the guitar, albeit with some restriction. This report describes a slight limitation of extension of the left little finger, coupled with reduced sensation. Some fourteen months post-accident, when examined by Mr. Brennen, FRCS, consultant plastic surgeon, the Plaintiff asserted an inability to play the guitar, together with certain other complaints. Examination revealed a fifty percent extension contracture of the PIP joint of the left little finger. Mr. Brennen considered the fracture well united, in good position. He noted the absence of any tendon injury. He was disposed to accept the presence of altered sensation in the injured finger, albeit as an irritant rather than a functional impairment. He acknowledged some damage to the small muscles of the hand. Mr. Brennen anticipated no long term complications.

[41] The Plaintiff's injuries also have a scarring dimension. This is considered by Mr. Brennen to constitute some degree of cosmetic disfigurement. Mr. Sinclair opined that the scar on the ulnar border of the injured hand is the site of tenderness, on traumatic contact, by virtue of its adherence to the underlying bone. Further, it is depressed, giving rise to a slight contour deformity. When examining the Plaintiff for a second time, some fourteen months post-accident, Mr. Sinclair noted a significant improvement in the scarring. At the trial, some enduring cosmetic deficit was visible, albeit, in my view, of relatively modest dimensions.

[42] There are three factors of some significance, which may be highlighted. The first is that the injury was to the Plaintiff's non-dominant hand. The second is that he was able to return to work five weeks after the accident. The third is that the Plaintiff appears to have worked without impairment or interruption subsequently and there is no threat to his continuing or future employment. In all the circumstances, I assess general damages for pain and suffering and loss of amenity, past and future, at £27,500. I also award the Plaintiff the agreed sum of £2,023, representing his loss of overtime earnings during the period of nine weeks absence from his employment immediately following the accident.

[43] Making allowance for the finding of 50% contributory negligence, the Plaintiff will have judgment against the Defendant for £14,761.50, plus interest. There are differing interest calculations, to reflect the date of the Writ of Summons, 14th June 2007 (as regards general damages) and the date of the accident, 12th February 2007 (as regards special damage). The agreed calculations are as follows:

(a) *General damages of £13,750: interest at 2% from the date of the Writ of Summons (14th June 2007) to the date of judgment (30th March 2009), 655 days: £493.49.*

(b) *Special damage: interest at 8% from the accident date (12th February 2007) to the date of judgment (30th March 2009), 777 days: £172.26.*

The sum of these two figures is £665. Accordingly, the Plaintiff will have judgment against the Defendant in the amount of £15,427.25. Finally, I award costs to the Plaintiff.