CLAIM No 2YM 60226

IN THE LEEDS COUNTY COURT
BETWEEN:

MARK GOUGH

Claimant

And

(1) STAR WALLS LIMITED
(2) PHILIP LEE

First Defendants

Approved judgment handed down without attendance at Bradford county court on 23 October 2013

1. The Claimant, Mark Gough ("Mark") fell from a climbing wall operated by the First Defendant, Star Walls Limited trading as Leeds Wall ("Leeds Wall") on 27 September 2010. The Second Defendant, Philip Lee ("Philip") was at the time operating as an "Belayer" for Mark. I will explain below what function Philip performed or was meant to perform by acting as Belayer for Mark but in simple terms Phillip's function, in acting as Belayer, was to prevent Mark from falling, more than a few feet if he slipped from the wall. In fact Mark fell approximately 36 feet suffering fractures to his ankle and an injury to his back.

2. Mark claimed against Leeds Wall on the basis that it failed in its duty to ensure that Philip was competent to belay for Mark either in its training or lack of it or in its supervision of Philip. Leeds Wall issued a Contribution Notice against Philip on the basis that Mark's injury was caused wholly or in part by Philip's negligence. Mark subsequently joined Philip as Second Defendant on the basis that he failed to undertake the belay with reasonable skill and care.

3. Philip and Leeds Wall both claim that Mark contributed to his own injury by his negligence.

4. The hearing was concerned only with the question of liability as between the parties.

5. Each party was represented by counsel. Mark was represented by Mr Copnall, Leeds Wall was represented by Mr Gargan, and Philip was represented by Mr Paul. I am grateful to each of them for their assistance and for the clarity of their submissions.

BACKGROUND

6. Mark became a member of Leeds Wall in September 2008 and Leeds Wall's records show that he attended Leeds Wall on 80 occasions between September 2008 and 27 September 2010.

7. Philip became a member of Leeds Wall on 28 December 2008, Leeds Wall's records show that he attended Leeds Wall on 48 occasions between 28 December 2008 and 27 September 2010.

8. Leeds Wall runs an indoor climbing centre containing artificial climbing walls. There are, for present purposes, two basic forms of climbing that may be undertaken at Leeds Wall:

8.1 top rope climbing; and

8.2 lead climbing.

9. Top rope climbing means that the rope to which the climber is attached (via a harness) is passed through a fixed point at the top of the climb and then down to the belayer. In this case referred to as the "top rope belayer". The top rope belayer passes the rope through a belay device which, if used correctly, arrests a climbers fall should he slip from the wall. The belay device relies on friction to enable the belayer, without significant effort, to arrest the climber's fall. In top rope climbing the belayer pulls in or withdraws the rope as the climber ascends.

10. Indoor "lead climbing", involves the climber passing the rope through clips as he ascends the wall. In this case the lead climb belayer lets out or "pays out" the rope as the climber ascends, allowing the climber to ascend and from time to time to pass the rope through the fixed clips on the wall as he climbs up to them.

11. One important difference between "top rope" climbing and "lead climbing" is that, if the climber falls, he is likely to fall a very short distance if he is top rope climbing because he only falls the distance of any slackness in the rope. In the case of lead climbing however, if the climber falls, he will fall the distance of any slackness in the rope (which is likely to be more than in top rope climbing if the lead climb belayer has paid out additional slack to the climber to enable him to pass the rope through a fixed clip) plus the distance to the last clip that the rope has been passed through.

12. In order to register as a member of Leeds Wall, Mark and Philip had to first take a four-week course at the end of which they were assessed as to their climbing and belaying skills. The four-week course is termed a basic course and only teaches and assesses top rope climbing and top rope belaying skills.

13. Leeds Wall does run a course for lead climbing including lead climb belaying but members are not prevented from lead climbing or lead climb belaying if they have not attended the course nor are they required to demonstrate any competence in lead climbing or lead climb belaying before being allowed to undertake those activities at Leeds Wall.

14. Leeds Wall employs "floor walkers". As the name implies "floor walkers" walk around the floor at Leeds Wall to observe members climbing and belaying on the various walls. One of the principal functions of the "floor walkers" is to spot and correct any incorrect climbing or belaying techniques being used at Leeds Wall by its members and to warn members about those incorrect techniques.

15. Leeds Wall runs sessions known as "partners in climb" sessions which, allow members who attend at Leeds Wall without a climbing partner to meet with another member so that they can climb together (one acting as climber and the other as belayer).

16. On 27 September 2010 Philip and Mark attended Leeds Wall and were partnered together through the "partners in climb" facility operated by Leeds Wall (see below). It is common ground that they did not know each other and had not climbed together before.

17. Philip says that he acted as climber first and Mark as belayer and Philip chose to ascend as a lead climb, a section of wall rated 6(B) which, it is common ground is of above average difficulty but not exceptionally difficult (the most difficult climb at Leeds Wall is rated 9). Philip says that, when he had finished the climb he suggested to Mark that he try the same climb as it was a "good route".

18. Although Mark had been a member of Leeds Wall for longer than Philip and had attended on more occasions, he says that he had only just started to lead climb and had only climbed the 6(B) wall before by way of a top rope climb. Philip on the other hand says that, of his 48 visits to Leeds Wall as a member, on approximately half of these occasions he had engaged in lead climbing.

19. Mark remembers little of what happened on 27 September 2010. Philip was the only witness to what happened and he says that:

19.1 about half way up the climb Mark moved over to an easier climb;

19.2 as Mark reached the top of the climb approaching the last clip, Philip looked down with a view to stepping forward in order to start the process of slackening the rope to allow Mark to lift the rope into the last clip. As Philip looked down the rope was yanked through his hands and through the belay device and Mark fell approximately 36 feet to the floor.

Factual Witnesses

20. There were three witnesses of fact:

20.1 Mark;

20.2 Philip; and

20.3 Emma Curry ("Emma"). Emma is and was at the time of Mark's fall the Assistant Manager at Leeds Wall.

21. I should say at this point that I found all three witnesses of fact to be honest witnesses concerned to provide the Court with their honest recollection both in their witness statements and in response to questions asked of them at the trial.

FACTUAL ISSUES

22. The factual issues that I need to resolve are as follows:

22.1 what were the circumstances of Mark's fall on 27 September 2010?

22.2 why was Philip unable to arrest or slow down Mark's fall?

22.3 if the cause of Philip's failure to slow down Mark's fall was due to a failure by Philip to belay correctly, to what extent is that failure attributable to:

22.3.1 poor or defective training of Philip by Leeds Wall; or

22.3.2 poor supervision of Philip's belaying activities by Leeds Wall particularly on 27 September 2010.

22.4 What additional risks were introduced by Leeds Wall offering "partners in climb" sessions to its members?

22.5 How were Philip and Mark introduced to each other on 27 September 2010?

22.6 Was it appropriate for Noddy to suggest on 27 September 2010 (if I find he did) that Philip and Mark should be climbing partners?

22.7 What, if anything, did Mark do to contribute to his own fall or the failure to arrest it?

The circumstances of Mark's fall

23. I find as facts that Mark's fall and Philip's failure to arrest that fall happened in the following circumstances:

23.1 Philip purchased a new rope on 27 September 2010 which had a diameter of 28 mm, some 2 mm narrower than the rope which Philip was used to using. This was the rope used by Philip to belay for Mark;

23.2 approximately half way up the climb, Mark moved from the "6(B)" route referred to in evidence as the "black route" to a "red route" which was easier to climb;

23.3 as Mark was approaching the top of the climb and Philip judged him to be about to reach up to the final clip to insert the rope through it, Philip looked down to

the floor to see if it was clear for him to walk forward in preparation for and as part of the process of creating slack in the rope to enable Mark to lift the rope into the final clip at the top of the climb;

23.4 as Philip was looking down, Mark fell from the wall and the rope ran quickly through the belay device and Phillips hands so that Philip was unable to arrest/slowdown Mark's fall.

24. The evidence of the above facts comes from Philip. Mark fairly accepted that he only has a very vague recollection of what happened on the evening in question. Mark accepted that he could not recall whether he moved from the black route to the red route or why he did so or falling from the wall or why he fell. Mark does not dispute Philip's evidence, there is nothing to contradict it. Philip's evidence is also supported by his complaint of rope burns to his wrist and hand, which rope burns were noticed by Emma when she met with Philip 2-3 days after Mark's fall (see below).

Why was Philip unable to arrest/slowdown Mark's fall?

25. I will consider now the reasons why Philip was not able to arrest or slow down Mark's fall after Mark, for whatever reason, lost his grip on the climbing wall. The position of Mark in his amended Particulars of Claim is that Philip failed to operate the belay device correctly. In its defence to Mark's claim, Leeds Wall's position was that it did not admit that Philip failed to operate the belay correctly. Philip's position in respect of the operation by him of the belay device at the time of Mark's fall has changed over time as follows:

25.1 in his defence to both Mark's claim and Leeds Wall's contribution notice Philip asserts that he did operate the belay correctly at the time of Mark's fall;

25.2 in the Skeleton Argument prepared on behalf of Philip by Mr Paul, it was conceded that Philip was using the wrong belay technique at the time of Mark's fall and in particular that at that time Philip did not have any grip or any sufficient grip on the control rope (that part of the rope below the belay device) with his right hand and thus was unable to lock the belay device adequately;

25.3 in his Witness Statements and at trial, Philip asserted (at least initially) that he had used the proper belay technique at the time of Mark's fall.

26. The only direct evidence of why Philip failed to arrest Mark's fall is that of Philip himself. There is, however indirect evidence in two forms (a) from Emma and (b) from the three experts that were instructed on behalf of Mark, Philip and Leeds Wall.

27. Emma says that following a telephone call she had with Philip, the day after the fall, Philip came to see her at her invitation to discuss the incident. Emma says

that when Philip spoke to her initially on the telephone, he could not understand why he had been unable to arrest Mark's fall. When Philip came to see Emma 2-3 days after Mark's fall, Emma says that she asked Philip to demonstrate for her the belay technique he used for lead climbing. Emma says that although she did not spot it straight away, when Philip demonstrated his technique for paying out rope a second time she noticed that he was allowing the control rope below the belay device to slip through his right hand while paying out rope (I will refer to this as technique A) rather than keeping a firm grip of the control rope and moving his right hand towards the belay device to pay out rope whilst still gripping the rope (I will refer to this as technique B).

28. Emma demonstrated technique A and technique B to the Court. Technique A, Emma says created a danger that the control rope would slip through Philip's right hand if Mark fell whilst Philip was paying out rope because Mark was not, by this technique, maintaining friction between the rope and the belay device.

29. In his cross-examination Philip:

29.1 demonstrated the technique for paying out rope during a lead climb belay that he says he had learnt from Noddy Crouch, an instructor employed by Leeds Wall ("Noddy"). This technique was technique B which had already been demonstrated by Emma;

29.2 said that to the best of his recollection technique B was the technique which he had used when Mark fell and when he was demonstrating his lead climb belaying technique to Emma (2-3 days after Mark's fall);

29.3 maintained that he believed he locked the belay device correctly at the time of Mark's fall. I will explain below what is meant by "locking the belay" and why it is important; and

29.4 suggested that his failure to arrest Mark's fall may have been caused or contributed to by the use of a new and thinner rope that he had not used before and possibly by there being an excess amount of slack rope.

30. At the end of Philip's cross examination, however, he conceded very fairly that he probably had not been correctly locking the belay at the time of Mark's fall and that this is likely to have been the reason why he did not arrest Mark's fall.

31. Each party instructed an expert and each expert prepared a report. There was also a joint expert report setting out those matters which were agreed as between the three experts. The three experts were:

31.1 Colin Watt ("Mr Watt") who was instructed by Mark. Although Mr Watt attended the hearing in the event, Mr Copnall chose not call him for cross-examination;

31.2 Ian Dunn ("Mr Dunn"), the expert instructed by Leeds Wall who was cross-examined; and

31.3 Iain Peters ("Mr Peters") who was instructed by Philip and who was cross-examined.

32. All three experts agreed that none of the equipment in use at the time of Mark's fall was defective.

33. Much of the expert evidence on belaying technique was concerned with the question of whether or not the use of technique A was an appropriate technique for paying out rope during lead climb belaying. Mr Peters maintained that either technique A or technique B could be appropriate according to circumstances whereas Mr Watt and Mr Dunn were more firmly of the view of that technique A was an inappropriate belaying technique in all circumstances. Mr Peters ultimately conceded however that technique B was likely to be a more appropriate means of Philip maintaining control of the rope in the circumstances in which he was lead climb belaying for Mark on 27 September 2010.

34. What became apparent from the evidence of Mr Peters, Mr Dunn and Philip was that the belaying technique which is relevant to the question of why Philip failed to arrest Mark's fall is not the technique used by Philip to pay out rope at all but instead the technique used by Philip to lock the belay before and whilst he looked away from Mark to look at the floor in front of him. Mr Peters objected to the phrase "locking the belay" and to the idea that a belay device could be definitively locked (Mr Peters considered that it was possible that the belay device would not hold a climber even if "locked"). Mr Peters nevertheless accepted that if the rope and belay device had been held by Philip in the locked position it is likely that it would have arrested Mark's fall even though the rope was new and of a narrower diameter than the rope that Mark was used to using (and as a result could be expected to slip through the belay device more easily and quickly than an older/wider diameter rope).

35. It was common ground that in order to lock the belay, the Belayer should hold the rope firmly in one hand (in Philip's case his right hand) below the belay device, holding the rope taut at an angle of approximately 90 degrees to the belay device so that friction is exerted between the belay device and the rope.

36. I find as a fact that Philip failed to hold the control rope below the belay device firmly in his right hand taut, at an angle of approximately 90 degrees to the belay device and thereby failed to lock the rope against the belay device effectively. The expert evidence (that Philip is likely to have been able to arrest Mark's fall had he been holding the rope against the belay device in the locked position) supports that conclusion and Philip himself ultimately accepted at the end of his cross-examination that although he believed that he had held the

belay device in the "locked position" at the time of Mark's fall, having considered the expert evidence he accepted that he probably had not done so. In addition Philip's counsel, Mr Paul, in his closing submissions accepted that the weight of evidence pointed to Philip having failed to arrest Mark's fall because he had used an incorrect belaying technique.

Is Philip's failure to arrest Mark's fall attributable to poor or defective training by Leeds Wall?

37. I will deal, at this point, with two factual questions namely:

37.1 what training did Philip receive from Leeds Wall; and

37.2 was any of the training defective in a relevant respect and if so in what respect?

<u>What relevant training was provided by Leeds Wall?</u>

38. It is accepted by all parties that in order to be registered as a member of Leeds Wall, a climber has to attend a basic course and will be assessed upon their climbing and belaying skills at the end of that course.

39. The basic course lasts for four weeks and at the end of that period the prospective member is assessed upon the knowledge that they have obtained during the course. The basic course teaches fixed rope climbing but not lead climbing.

40. Mark accepts that he attended a basic course before becoming a member in September 2008 and that he signed a registration form confirming that he had learnt certain skills including how to use a belay device and arrest the fall of a climber. Philip accepts that he attended a basic course before becoming a member of Leeds Wall on 28 December 2008 and he signed the same standard registration form as Mark on that date containing the same confirmations.

41. The fact that Mark and Philip both attended the basic course and signed the registration forms was not in dispute, more controversially Philip asserted that Noddy, then an instructor employed by Leeds Wall, informally provided Philip with training on the techniques to be used for lead climbing (including lead climb belaying). Philip says he did this during four or five sessions of 20-30 minutes each after "partners in climb" sessions (to which I refer below).

42. Noddy did not provide a witness statement, I understand that he is no longer employed by Leeds Wall. There is nothing to contradict the evidence of Philip as to the training provided to him informally by Noddy, he was not seriously challenged on this point in cross-examination. I accept Philip's evidence that he received training from Noddy on lead climbing, including lead climb belaying, in

the manner described by him on four or five occasions with each occasion consisting of 20-30 minutes training.

Was the training provided to Philip defective in a relevant respect?

43. The suggestion that incorrect or inadequate training was provided to Philip by Leeds Wall was first raised in Philip's defence to the contribution notice issued by London Wall in which Philip asserts that he was trained on the beginner course by Nathan Eastwood, an employee of Leeds Wall and that that training was defective or inadequate. This argument was however abandoned at trial.

44. In a supplemental statement dated 24 February 2010 Philip referred to the informal training he received from Noddy in respect of lead climbing and lead climb belaying to which I have referred above. It is not however suggested in that supplemental statement and was not suggested at trial by Philip that the training provided to him by Noddy was in any way inadequate or wrong.

45. In his skeleton argument, Mr Paul on behalf of Philip pointed to the statement of Emma in which she said that Philip had used technique A in her presence 2-3 days after Mark's fall and the skeleton asserted that the use of technique A by Philip was a result of the defective or inadequate training provided to Philip by Noddy.

46. As I have already indicated the key question is not whether Philip was using technique A or technique B to pay out rope on 27 September 2010 (because I have accepted Philip's evidence that he was not paying out rope at the time of Mark's fall). Rather the key question is whether or not Philip had correctly locked the belay device when he looked away from Mark (immediately prior to Mark's fall) to look at the floor to ensure that it was clear before stepping forward.

47. I am satisfied that Philip knew how to lock the belay device because he demonstrated how to do this in court, he also said that he thought he had locked the belay device properly at the time of Mark's fall. It was accepted by all parties and by the experts that the technique for locking the belay device is the same for top rope climbing as it is for lead rope climbing and I find that Philip was correctly taught how to lock the belay device during the basic course. In making this finding I rely in particular upon the registration form signed by Philip on 28 December 2008 in which he confirmed that he knew how to belay and arrest the fall of a climber correctly and upon Philip's own demonstration of how to lock the belay device. There is simply no evidence that suggest that Philip had not received correct training as to how to lock the belay device, all the evidence points in the opposite conclusion.

48. As to the question of whether Philip knew that he should lock the belay device if he looked away from a climber and in particular at a time when the climber was

reaching the top of the climb/about to place the rope in a clip, I find that Philip knew this because of the training that he had received from Leeds Wall and/or from his climbing experience and/or from what he had learned from his climbing peers. I have come to this conclusion for the following reasons:

48.1 Philip was, by 27 September 2010 a reasonably experienced climber, he registered as a member of Leeds Wall on 28 December 2008 having completed the four-week basic course and thereafter he climbed at Leeds Wall on 48 occasions, according to the evidence of Philip, on around half of those occasions he was involved lead climbing. Philip also confirmed that he had experience of climbing outdoors. It is simply inconceivable in my judgement, that Philip would not know that there is a greater risk of a climber falling when he was reaching to place the rope into a clip (because to do so he would need to remove one hand from the wall in order to place the rope in the clip). It is also in my judgment, inconceivable that he did not understand that looking away from the climber for even a short period created an added risk that he would not see the climber getting into difficulty or start to fall and was therefore an additional reason why the belay should be held in the locked position at any point when he looked away from the climber;

48.2 Philip never suggested that he did not understand that he should have been holding the rope against the belay device in the locked position at the time of Mark's fall, on the contrary, it was Philip's evidence that he believed that he had locked the belay device at the time of Mark's fall. For this very reason Philip was at a loss to explain why he had not arrested Mark's fall.

49. It follows that I find that there was no relevant defect in the training provided by Leeds Wall to Philip.

Poor Supervision of Philip's belaying activities by Leeds Wall

50. Mr Copnall suggested in cross-examination of Emma that there may be an issue as to whether or not the floorwalkers employed by Leeds Wall had adequate training to enable them to spot errors in climbers techniques. Emma accepted that not all floorwalkers were qualified instructors. The uncontroverted evidence of Emma however was that the two floorwalkers on duty on the evening of 27 September 2010 were Noddy and Joshua Farrell ("Joshua"). Noddy was an instructor and Joshua, whilst not being an instructor, was, I understand at the time (and may still be) a member of the British mountaineering team.

51. Mr Dunn gave evidence that not all indoor climbing centres use floorwalkers and that the level of training provided by Leeds Wall to its floorwalkers was above the industry average. In particular Leeds Wall has a training manual for floorwalkers and it was Mr Dunn's opinion that this was not common in the

industry. Mr Dunn has experience in the design, construction and management of artificial indoor climbing walls and I accept his evidence that the use and training of floor walkers by Leeds Wall is carried out to a standard above the industry average. Mr Copnall did not pursue, in his closing arguments, any suggestion that either Noddy or Joshua were inadequately trained to spot errors in Philip's technique. For these reasons I find as a fact that, in so far as it was possible to spot errors in Philip's belaying technique, Noddy and Joshua were adequately trained and experienced to do so and to take action to intervene and prevent such errors from continuing.

52. I find as a fact that Leeds Wall through its employees, Noddy and Joshua, did not fail to supervise Philip's belaying activities with reasonable skill and care. My reasons are as follows:

52.1 I find that Philip's error was a momentary failure to apply the correct technique to lock the belay and not a bad technique which Philip would have exhibited regularly prior to Mark's fall. Philip demonstrated that he knew how to properly lock the rope against the belay device and he gave evidence that he had successfully arrested falls on a number of occasions previously. There is simply no evidence that Philip was regularly using the wrong technique to lock the belay device and such a conclusion would be contrary to Philip's own evidence;

52.2 I find that it would be practically impossible for floorwalkers to spot any failure on the part of Philip to lock the belay correctly because, Philip would be facing the wall with his back to the floorwalkers when locking off the belay device and it would only be possible for floorwalkers to see the angle at which Philip was holding the rope to the belay device and whether he was holding it taut against the belay device, if they walked around to the front or side of Philip and stood in very close proximity to him;

52.3 As I have found that Philip's failure to lock the belay device correctly at the time of Mark's fall was not an error that Philip would make regularly. There would be very little opportunity for floorwalkers to see Philip making any mistake in relation to the locking of the belay device even if they had stood within a few feet of him, either directly in front or to the side;

52.4 the use by Philip of technique A rather than technique B to pay out rope may be slightly easier to spot. Had it been spotted, this may have led the floorwalkers to look more closely at Philip's technique for locking the belay however I have found that any error on the part of Philip in using technique A rather than technique B to pay out rope was also intermittent and I find that it is highly unlikely that the floorwalkers would have had an opportunity to spot the use of technique A rather than technique B;

52.5 as Mr Gargan points out, there is no evidence of Philip using an incorrect technique to lock off the belay on any day other than 27 September 2010 and the only evidence of Philip using an incorrect technique on that occasion is that the experts conclude he did so because he was unable to arrest Mark's fall.

What additional risks did "partners in climb" introduce?

53. Mr Copnall contends that by offering a facility whereby climbers could meet and pair up with other climbers, Leeds Wall introduced additional risk into the climbing activities of its members who chose to use that facility.

54. All three experts agreed that the "partners in climb" sessions were an informal social arrangement offered by Leeds Wall to help climbers to meet other climbers, they would then make their own climbing arrangements. Mr Watt was of the opinion that although the sessions were meant to be informal the "partners in climb" sessions should still have involved some input from Leeds Wall.

55. Mr Dunn made the point that even without "partners in climb" sessions being offered by Leeds Wall it was common for climbers at indoor climbing clubs such as Leeds Wall to regularly meet with and climb with new climbing partners and this was one of the benefits (and risks) that becoming a member of an indoor climbing club brought with it.

56. I accept that the activity of climbing involves additional risk if the two partners who participate in it do not know each other and are therefore unfamiliar with each other's experience, skills, training, technique and abilities. I also however accept Mr Dunn's point that the "partners in climb" sessions did not introduce a new risk into the climbing activities carried on by members of Leeds Wall because such members would in any event make their own arrangements to climb with new partners (who were also members of Leeds Wall) that they had not climbed with before.

57. I find that the function and effect of the "partners in climb" sessions was to make it easier for members to find other members to climb with who may or may not be members that they had climbed with before. If they were new climbing partners then the two climbers would be unfamiliar with each others abilities, training, techniques, skills and experience. The unfamiliarity of new climbing partners with each other increased the risk of injury resulting from the climbing activities that they were carrying on. The limit of the involvement of the employees, servants or agents of Leeds Wall in the partners in climb sessions I find was to designate a place within the Leeds Wall premises where members could meet (I understand known as the "A Frame") and, where members did not decide themselves who (amongst those who were attending the partners in climb session) to climb with, an employee of Leeds Wall may

make a suggestion as to suitable climbing partners amongst those members present. The findings in this paragraph concerning "partners in climb" sessions were common ground between Emma, Mark and Philip.

How were Philip and Mark introduced to each other on 27 September 2010?

58. Emma says in her statement that Mark and Philip were not introduced to each other by Noddy on the evening of 27 September, during the "partners in climb" session, but instead they were introduced to each other through a mutual friend.

59. Philip said that he was introduced to Mark by Noddy, who suggested that Mark and Philip may be suitable climbing partners. Mark has no recollection of how he and Philip came to be introduced to each other on the evening of 27 September.

60. I accept the uncontroverted evidence of Philip that Noddy suggested that Mark and he would be suitable climbing partners and that he and Mark accepted that suggestion and decided to climb together and this is how they were introduced to each other on the evening of 27 September.

Was is appropriate for Noddy to suggest that Philip and Mark were suitable climbing partners?

61. I asked Mr Dunn whether, in his view, it would appropriate for Noddy to suggest that Philip and Mark would be suitable climbing partners. Mr Dunn's answer was that in his view they were suitable climbing partners based upon their relative climbing experience. Noddy may well have had additional information from his own experience of training Philip in lead climbing techniques and his familiarity with both climbers which may have suggested one way or another whether Philip and Mark were appropriate climbing partners. None of that information is available to me. The only information I have is the comments of Mr Dunn which are based upon the date when Mark and Philip became members of Leeds Wall and the number of visits that each of them made to Leeds Wall. Based upon this information there is nothing to suggest that Noddy in anyway made an error in suggesting that Philip and Mark were suitable climbing partners and I find that Noddy cannot be criticised for suggesting that they climb together.

What if anything did Mark do to contribute to his own fall or failure to arrest his fall?

62. There are five ways in which it is said either by Philip or Leeds Wall or both that Mark contributed to his injuries by his own negligence on 27 September 2010 namely:

62.1 he attempted an above average difficulty climb (6(B) referred to as a black route) as a lead climb when he had only just started lead climbing;

62.2 having met Philip for the first time on the evening of 27 September he attempted the black route before establishing any sort of relationship with Philip or finding out what Philip's knowledge, skill, experience or techniques for climbing and belaying was;

62.3 Mark should have warmed up with Philip first on easier climbs before attempting the black route;

62.4 when Mark moved from the black route to the red route he should have told Philip that he was tired or finding the black route difficult so that Philip was alerted to take more care in belaying; and

62.5 Mark failed to give any warning to Philip that he was about to fall or that he was falling.

63. My findings of fact relevant to the above points and my brief reasons for them are as follows:

63.1 Mark had only just started lead climbing and had not attempted the black route as a lead climb, having only previously completed that climb as a fixed rope climb. This was the uncontroverted evidence of Mark himself, which I accept;

63.2 Philip climbed the black route first with Mark acting as belayer, then Mark attempted the same climb with Philip acting as belayer. Philip encouraged Mark to tackle the black route by describing it as a "good route" or words to that effect. This is the uncontroverted evidence of Philip, which I accept;

63.3 Philip and Mark had not climbed together or met before 27 September 2010. Very little if anything was discussed between Philip and Mark about their previous experience of either climbing or belaying or the techniques that either of them used. This is the evidence of Philip and to a lesser extent Mark (who has a very limited recollection of the events on 27 September) and I accept that evidence;

63.4 the black route is of above average difficulty but not exceptionally difficult. This was the uncontroverted evidence of the experts, Philip, Mark and Emma;

63.5 Mark climbed sideways from the black route to the red route. This is the uncontroverted evidence of Philip. There is no direct evidence as to why Mark moved from the black route to the red route. Mark is unable to recall moving from the black route to the red route let alone having any recollection of why he may have done this and Philip cannot give any evidence on this point. On the balance of probabilities I find that Mark moved from the black route to the red

route because he was finding the black route hard and/or his limbs were tired (Mr Dunn explained that climbers often suffer a build-up of lactic acid in their arms which may result in the climber losing his grip) or both. I come to these conclusions because they are the most obvious explanation for Mark moving from the black to the red route. They also coincide with the views of the experts;

63.6 Mark did not alert Philip to the fact that he was changing from the black route to the red route or why he was making the change. This is the uncontroverted evidence of Philip which I accept; and

63.7 Mark gave no warning to Philip that he was about to fall or that he was falling. Again this is the uncontroverted evidence of Philip which I accept.

DUTY OF CARE

I will now consider what, if any duties of care were owed by Philip and Leeds Wall to Mark.

Duty of care owed by Philip

64. Mr Paul did not seek to contend that Philip did not owe Mark a duty of care in acting as belayer whilst Mark was climbing. There is, in my judgment, no doubt that Philip did owe Mark a duty of care to carry out his belaying with reasonable skill and care because it was clearly foreseeable that Mark could suffer injury in the event that Philip failed to do so.

Duties of care owed by Leeds Wall

65. Mr Copnall contended that Leeds Wall owed the following duties of care to Mark:

65.1 to provide such training as it did provide with reasonable skill and care;

65.2 to supervise the activities of climbers at Leeds Wall so as to prevent climbers from engaging in dangerous techniques/practices;

65.3 to take steps to eliminate the risk of injury to members of Leeds Wall involved in their participating in the "partners in climb" sessions organised by Leeds Wall.

66. I will consider each of these suggested duties of care in turn determining whether I consider that the duty contended for by Mr Copnall was owed by Leeds Wall and if not whether any other relevant duty was owed.

Duty to provide training with reasonable skill and care

67. Mr Gargan did not contend that Leeds Wall did not owe a duty of care in respect of any training that it actually gave to Mark and Philip and I find that it did owe

such a duty of care. Again it was clearly foreseeable that a failure to provide adequate training to Philip, in particular in respect of belaying techniques, may result in injury to the climber for whom Philip was acting as belayer.

<u>A duty of care to adequately supervise the activities of climbers at Leeds Wall to prevent them from engaging in dangerous techniques/activities</u>

68. Mr Gargan disputed Mr Copnall's assertion that Leeds Wall owed a duty of care to adequately supervise the activities of climbers at Leeds Wall to prevent them from engaging in dangerous techniques/activities. He relied for this objection upon the case of *Trustees of Portsmouth Youth Activities Committee v Poppleton (2008 EWCA Civ 646)* ("Poppleton"). In that case Mr Poppleton attended the Portsmouth indoor climbing facility to take part in an activity known as "bouldering" which is low level simulated rock climbing without the use of a rope. The walls were a maximum of 16 feet high and to protect climbers from injury the floor was covered in shock absorbing matting. Mr Poppleton was offered no instruction, the risk of climbing "boulders" were not explained to him and there was no supervision of the activities of climbers. It was left to those using the "boulders" to use them sensibly. Having observed another climber leap from the wall, grab a hold of a girder and then drop to the floor, Mr Poppleton tried the same manoeuvre but lost his grip on the girder as a result of which he somersaulted through the air and fell on his head suffering severe injuries as a result. At first instance the indoor climbing operator was found liable for 25% of Mr Poppleton's damages and Mr Poppleton 75% responsible for his own injuries.

69. The Judge at first instance accepted that the Defendants had no duty of care to ensure that Mr Poppleton was competent to climb or that he had appropriate training or supervision because the Defendants had not undertaken any of those responsibilities.

70. The Defendants appealed against the Judge's order and Mr Poppleton cross-appealed contending that the Judge was wrong in finding that there was no duty on the part of the Defendant to (a) assess participant's competence, (b) offer training, and (c) supervise and monitor the climbing room. The cross-appeal failed with the Court of Appeal finding that Mr Poppleton had voluntarily undertaken the inherent and obvious risks involved in the activity of bouldering. The Defendant found the Court of Appeal, was not required to prevent Mr Poppleton from undertaking that risk or to train or supervise him when he did so.

71. The distinguishing feature in this case is that, unlike in Poppleton, London Wall did provide floor walkers to provide a certain level of supervision. The principle function of floor walkers (as is apparent from Leeds Wall floor walkers manual) was to spot and warn members about dangerous activities and techniques.

Unlike in Poppleton it is arguable that by employing floor walkers and allocating those floor walkers to spot and warn members about dangerous activities and techniques, London Wall was taking on a degree of responsibility for the supervision of climbers which the Defendant in Poppleton did not take on. It is necessary for me to decide whether this is a sufficient assumption of responsibility by Leeds Wall to make it reasonable that I should impose upon it a duty of care in respect of the supervision of activities carried on by the floor walkers and if so the nature and extent of that duty.

72. I do not consider that it would be reasonable to impose upon Leeds Wall a general duty to ensure that it supervised, with reasonable skill and care, the climbing activities carried on by members at Leeds Walls' premises. My reasons are:

72.1 the climbing activities carried on at Leeds Wall are inherently and obviously dangerous in the same way as "bouldering" was in Poppleton, but for the assumption of some responsibility by Leeds Wall, I do not consider that it had an obligation to supervise or monitor those activities;

72.2 Leeds Walls' conditions of use which members accept when registering as members specifically point out that (a) climbing is a potentially dangerous sport, (b) use of the wall is unsupervised and (c) by registering to climb members confirmed that their equipment was in good working order and that they knew how to use it. These conditions of use which were accepted both by Mark and Philip when they registered as members help to make it clear, in my view, that Leeds Wall is not accepting responsibility for supervising climbing activities at Leeds Wall and it is the members themselves who are responsible for ensuring that they climb in an appropriate manner; and

72.3 I do not consider that Leeds Wall can fairly be said to have voluntarily assumed a general obligation to supervise climbing activities at the centre merely by providing floor walkers.

73. It is common ground that Leeds Wall, employed floor walkers for the principal purpose of spotting dangerous activities and techniques and warning members about them and I find that it would be reasonable to impose on Leeds Wall a duty of care to ensure that its floor walkers were adequately trained for that purpose (ie to spot dangerous techniques and practices and to intervene as appropriate to seek to prevent such activities from continuing).

<u>A duty of care to eliminate risks associated with "partners in climb" sessions run by Leeds Wall</u>

74. Again, in deciding the extent to which, if any, Leeds Wall owed a duty of care in relation to the partners in climb sessions run by it, I have to decide to what extent (if any) it is reasonable to impose such a duty upon Leeds Wall.

75. Mr Copnall asserts that I should find that Leeds Wall, by running the partners in climb sessions took on a very wide duty to eliminate the risks that members took on in climbing with a member that they had not climbed with before (namely unfamiliarity with a new partner's technique, skills, experience and training). Mr Copnall says that if Leeds Wall could not eliminate those additional risks that they introduced through the "partners in climb" sessions they should not have run those sessions. It is not, Mr Copnall said, for him to prescribe how Leeds Wall can eliminate those risks but they could, for example:

75.1 carry out a specific risk assessment for the risks associated with partners in climb sessions;

75.2 ensure that members had specific training in lead climbing and lead climb belaying and assess members on those skills to ensure that they were competent in those skills before allowing them to lead climb.

76. Mr Gargan says, relying on Poppleton that the risks of climbing with a new partner were inherent and obvious risks and were not risks about which Leeds Wall had any duty to specifically warn members or in respect of which it was under a duty, as Mr Copnall suggests, to eliminate such risks.

77. In Poppleton at first instance the Judge found that the Defendant owed a duty of care to warn Mr Poppleton that the floor matting would not make climbing the wall safe. The Judge found, there was a danger that climbers would consider that because of the matting climbing the boulders was safe.

78. The ground for the appeal was that the matting did not constitute a hidden danger, it was obvious that a climber who fell awkwardly could still be injured in spite of matting and to impose a duty to advise of or supervise these obvious risk was inconsistent with established authority. The court of appeal overturned the Judge's ruling that the Defendant had a duty to warn Mr Poppleton about dangers that were present in spite of the matting, it considered that the danger of injury if a climber fell awkwardly was inherent and obvious and there was no duty therefore to warn him of it.

79. I accept Mr Copnall's point that it may be reasonable to impose a duty of care upon Leeds Wall insofar it introduced new risks to members who utilised the partners in climb sessions, because Leeds Wall could be regarded as having assumed responsibility for those risks that it introduced. Mr Copnall's task of course was to try to persuade me that I should find that running the partners in climb sessions involved Leeds Wall undertaking a very wide duty of care to eliminate all risk associated with that activity. Mr Copnall seeks to do this because, in order for Leeds Wall to be liable to Mark for breach of this duty he has to show that a breach of that duty of care by Leeds Wall in some way caused or contributed towards Philip's failure to arrest Mark's fall.

80. I do not consider that it would be reasonable to impose upon Leeds Wall the type of wide ranging duty that Mr Copnall proposes should be imposed on it. It would in effect impose a duty upon Leeds Wall to take responsibility for inherent and obvious risks which the case of Poppleton suggests should not normally be imposed upon it and would not link the imposition of the duty of care to the additional risks introduced by Leeds Wall by running the partners in climb sessions. I find that the duty of care that it would be reasonable to impose upon Leeds Wall as a result of it running the partners in climb sessions is a duty of care to ensure that, if an employee, servant or agent of Leeds Wall introduced one member to another during a partners in climb session with a view to them climbing together or suggests the climbing partnership, then Leeds Wall undertook a duty to ensure that those members were suitable climbing partners based upon their knowledge, experience, skill and training as known to the relevant employee, servant or agent of Leeds Wall that effected the introduction or made the suggestion.

81. The reasons why I consider that it is reasonable to limit of the responsibility taken on by Leeds Wall as a result of running the partners in climb sessions to the suitability of the climbing partners introduced or suggested by its employees, servants or agents are as follows:

81.1 running the partners in climb sessions, Leeds Wall were not introducing to its members a new risk of injury resulting from their lack of knowledge of the skills, experience, training and techniques of the other climber where they chose to climb with a new partner through the "partners in climb" sessions. These risks were inherent whenever a member climbed with another member who he had not climbed with before;

81.2 I found as a fact that members met and climbed with new climbing partners regularly both at Leeds Wall and other indoor climbing clubs outside of partners in climb sessions;

81.3 all that the partners in climb sessions did was to make it easier for members to meet with new climbing partners. Once they met with new climbing partners at the "A frame" they went off and made their own arrangements with each other as far they concerned familiarising each other with their technique, skill, training and experience and they decided what to climb and how to climb it;

81.4 the involvement of Leeds Walls' employees, servants or agents in the partners in climb session was limited to introducing one member to another as potential climbing partners or making suggestions as to appropriate partnerships where members did not choose their own partners; and

81.5 as I have already noted that Leeds Wall's conditions of use which were accepted both by Philip and Mark emphasised the dangerous nature of climbing, that the

climbing is unsupervised and that members are responsible for ensuring that their own equipment is functioning and that they know how to use it. In my judgment the conditions of use make it clear that members of Leeds Wall are responsible for their own safety on the climbing walls and by necessary implication that of their climbing partners. I do not consider that I should find Leeds Wall to owe a duty of care to its members that makes it responsible or partly responsible for their safety whilst they use the climbing walls merely because those members chose to participate in "partners in climb" sessions (which enabled them to meet other members with whom they could then participate in climbing activities).

BREACH OF DUTY OF CARE/CAUSATION

82. In order to find Philip/Leeds Wall liable to Mark for the injuries caused to him on 27 September 2010 it is necessary not only for me to find that Philip/Leeds Wall owed a duty of care to Mark but also (a) that they breached that duty if care and (b) that breach of duty of care caused or at least was a substantial cause of Philip's failure to arrest Mark's fall with the consequences that Mark suffered injury.

83. I propose to deal with the issues of breach of duty of care and, where relevant, causation together.

Did Philip breach his duty of care to provide a belay for Mark with reasonable skill and care?

84. I have found that Philip failed to lock the belay device correctly (in the manner described by me in paragraph 35 above) at the time of Mark's fall. I have also found that Philip had been correctly trained as to how to lock the belay device, knew how to lock the belay device and that he should have held the belay device in the lock position at the time of Mark's fall but did not do so.

85. Philip's failure to hold the belay device in the locked position at a time when (a) Philip knew that Mark was reaching the top of the climb and was about to reach up and place the rope in the final clip and therefore the risk of Mark falling was heightened and (b) Philip was temporarily looking away from Mark, was, in my judgment, a failure by Philip to use reasonable skill and care in belaying for Mark.

Was Philip's breach of his duty of care a substantial cause of Mark's injury?

86. I have found that Philip's failure to arrest Mark's fall was due to Philip's failure to hold the belay device in the locked position at the time when Mark fell. Mark's

injuries resulted from his fall, it follows that Philip's breach of his duty of care caused the injuries to Mark that he suffered as a result of the fall.

Did Leeds Wall fail to provide training to Philip with reasonable skill and care?

87. I have found as facts that:

87.1 Philip received two types of training from Leeds Wall namely:

87.1.1 he attended the basic climbing course immediately prior to registering as a member on 28 December 2008; and

87.1.2 he received informal training from Noddy on lead climbing techniques, in 4 or 5 separate 20-30 minute sessions.

87.2 there was no defect in the training provided by Leeds Wall to Philip.

88. It follows that Leeds Wall did not breach the duty of care it owed to provide training to Philip with reasonable skill and care.

Breach of duty of care to ensure floor walkers were adequately trained to spot dangerous activities and practices and intervene as appropriate to stop them

89. I have found that:

89.1 the floor walkers on duty at Leeds Wall on the evening of 27 September 2010 were Noddy and Joshua who were adequately trained and experienced to spot dangerous techniques and practices, and to intervene as appropriate to prevent them continuing;

89.2 Noddy and Joshua did not fail to supervise the climbing activities of Philip and Mark with reasonable skill and care.

90. I find that Leeds Wall is not in breach of its duty to ensure that floor walkers were adequately trained to spot dangerous techniques/practices and intervene as appropriate.

Duty to ensure that Philip and Mark were suitable climbing partners

91. I have accepted Mr Dunn's expert evidence that, by virtue of their relatively similar levels of experience, Mark and Philip were suitable climbing partners. There is no basis for saying that Leeds Wall's employee, Noddy, failed to exercise reasonable skill and care in suggesting that Philip and Mark climb together on the evening of 27 September 2010. I find that Leeds Wall did not therefore breach the relatively limited duty of care that I have determined it had as a result of running partners climb sessions and in particular, the sessions which it ran on the evening of 27 September 2010.

Did Mark contribute by his own negligence towards his injury?

92. As I have already noted in paragraph 62 above, there are five bases on which it is said that Mark contributed to his injury by his own negligence. I will consider each of these in turn.

Attempting a "black route" as a lead climb when Mark had only just started lead climbing

93. I do not consider that Mark can be criticised for undertaking a climb that he knew would be difficult to complete. To make such a finding would mean that any climber who sought to improve their climbing by climbing to the limit of their abilities, would be acting negligently in doing so, because of the increased risk of their falling as a result of their operating at the limits of their capabilities. In my judgment Mark was entitled to assume that if he slipped from the wall, as climbers frequently do, Philip would operate the belay device correctly and arrest his fall. This was the whole purpose of Philip acting as belayer.

Failure to establish a relationship with Philip and to discuss knowledge, skill and technique/climbing easier routes first

94. The experts agreed in their joint expert report that Philip and Mark should have taken time to build a rapport and establish each other's competence, and it would be normal or common for them to have climbed an easier route first before attempting the more difficult black route.

95. I have no doubt that what the experts suggest can be regarded as best climbing practice, and I have found as a fact that none of this activity actually occurred. I do not, however, think that I could properly hold Mark to have acted negligently in not taking those steps and in particular in following Philip in climbing the black route (as I have found, Mark did, at Philip's suggestion, and with Philip's encouragement). The process of discussion and familiarisation would be a joint process undertaken by both Philip and Mark, and I do not think that I should find Mark to be negligent in not insisting in engaging in a process that both Mark and Philip jointly appear not to have embarked upon, or for Mark's choice of first climb (which Philip appears literally to have led the way on).

96. In any event I think that there is a fundamental difficulty in holding Mark in some way to have contributed towards a failure by Philip to arrest Mark's fall even if I had found Mark was negligent in not engaging in discussion with Philip, and in tackling easier climbs first. I am not satisfied that any amount of discussion or, within reason, any amount of easier climbs tackled first, would have revealed to Mark that there was any defect in Philip's technique for locking the belay device, or that Philip did not understand when he should do so. In simple terms this is because I have found that Philip knew how and when to lock

the belay device. It is highly unlikely that he would, in discussions with Mark during easier climbs, or in any other way, have revealed a defect in his belaying technique, or that he did not know how or when to lock a belay device correctly. I cannot therefore see how it could be said that Mark in any way "contributed" to his own injuries, even if I had found (which I have not) that Mark in some way acted negligently in not engaging in discussions or familiarisation with Philip, or in undertaking easier climbs before tackling the black route.

Mark should have alerted Philip when he was moving from the red to the black route

97. I have found that Mark moved from the black route to the red route either because he was tired, or because he was finding the black route too difficult or both, and that he did not inform Philip that he was changing routes or why.

98. On Philip's evidence, that I have accepted, Mark moved from the black route to the red route when he was approximately half way up the climb. On this basis, Philip would have seen Mark move across from the black route to the red route and climb up the red route for approximately 18ft (half the estimated 36ft height of the wall. As Mr Copnall pointed out, it would serve no additional purpose for Mark to tell Philip that he was moving from the black to the red route because Philip clearly watched him do so.

99. Even if I considered that Mark had acted negligently in not telling Philip why he was moving from the black route to the red route (which I do not), it is clear to me that this did not contribute towards Philip's failure to arrest Mark's fall because, as I have already found, there was every reason for Philip to be alert to the risk of Mark falling at the time when he did fall because:

99.1.1 Mark had, as Philip knew, moved from the black route to the red route;

99.1.2 Mark was nearing the top of the climb and, most importantly;

99.1.3 Mark was about to reach up with one hand to place the rope into the last clip.

100. At this moment in time, the risk of Mark's falling was therefore higher than, in all probability, at any other point during his climb. Philip understanding that Mark had moved from the black route to the red route because he was:

100.1.1 tired;

100.1.2 finding the black route difficult; or

100.1.3 both, would not in my judgment have added to Philip's need for caution at the time when Mark fell, or in any way have added any real emphasis to Philip's need to ensure that the belay device was in the locked position when he looked away from Mark.

Mark should have warned Philip that he was about to fall or when he fell

101. I have accepted as a fact that Mark did not shout out or otherwise warn Philip that he was about to fall, or that he was falling. I have made no finding as to why he did not give a warning, and there is no evidence from which I can sensibly make such a finding. The burden falls on Philip, as the party I have found to be responsible for failing to arrest Mark's fall, to show that Mark's failure to call out (if his failure to call out was in any way negligent) in some way contributed to Philip's failure to arrest his fall. I am not satisfied on the balance of probabilities that it did do so, because I am not satisfied that Mark would have known that he was about to fall a sufficient period of time before he actually fell, to enable him to shout a warning to Philip in sufficient time to cause Philip to act differently from the way in which he acted. More importantly, I have found that Philip thought he was doing exactly what he should have done at the time of Mark's fall (i.e. holding the belay device in a locked position). In light of this, I cannot see why he would have acted any differently if Mark had shouted a warning to him. Such a warning would only have been of use if Philip did not believe that he was already holding the belay device in the locked position and the warning caused him to lock it.

Conclusion

102. In summary, I find that Philip owed Mark a duty of care to ensure that the belay device was in the locked position when he looked away from Mark momentarily at the time of Mark's fall. Philip breached that duty of care by failing to ensure that the belay device was in the locked position, and this was the cause of Philip's failure to arrest Mark's fall. Philip's failure to hold the belay device in the locked position at the time of Mark's fall was not attributable to any defect in his training by Leeds Wall, nor a failure on the part of any employee, servant or agent for Leeds Wall to spot any defect in Philip's belay technique. Running the partners in climb session did not impose on Leeds Wall a duty of care to eliminate the risks associated with members using those sessions to climb with new members or any wider duty than ensuring that climbing partners were suitable when introducing or suggesting new climbing partnerships. I am satisfied that Leeds Wall, by its employee, Noddy complied with that duty. Mark did not, by his own negligence, contribute towards Philip's failure to arrest his fall.

103. Philip is therefore liable for the loss and damage suffered by Mark as a result of his falling to the ground on 27 September 2010.

An Additional Point

104. I received further written submissions from Mr Copnall and Mr Gargan for which I am grateful, and it is appropriate that I should comment at least briefly upon those written submissions, and the reasons why I invited Counsel to make them (although in the event, they have not proved to be of relevance to my decision).

105. As I have said, during Mr Copnall's closing argument, Mr Copnall asserted that Leeds Wall owed a duty of care as a result of it providing the "partners in climb" facility to its members, to eliminate the risks associated with the "partners in climb" facility.

106. One of the ways in which Mr Copnall said Leeds Wall might do this would be to require that members take a course in lead climbing and, pass an assessment in lead climbing before being allowed to lead climb. In this context, I asked Mr Copnall whether there would in fact be a causation problem with this suggestion, because it appeared that notwithstanding the training that Philip had received and his experience, and that he knew (a) how to lock the belay device, and (b) that he should have held the belay device in the locked position at the time of Mark's fall, he had nonetheless failed to do so. How therefore could it be said that additional training or assessment would have led to Philip locking the belay device correctly.

107. Mr Copnall's response to this question was to refer to the Court of Appeal decision in *Wright v Cambridge Medical Centre 2011 EWCA EIV 669*. Mr Copnall suggested that this case created a presumption that the training and assessment (that he suggested Leeds Wall might carry out to comply with the duty to eliminate the risk, for which he contended) would have resulted in Philip handling the belay device correctly at the time of Mark's fall.

108. In Wright a medical general practitioner ("GP") failed to refer an 18 month old girl to hospital for tests. It was accepted that the GP was negligent in not doing so. When the girl was subsequently referred to the hospital it initially made an error in her diagnosis. It was submitted on behalf of the Defendant that due to a general lack of competence shown by the hospital, even if the Defendant had referred the girl to the hospital at the right time the hospital would still have acted negligently in its diagnosis and the loss would still have been caused.

109. Neuberger MR (as he then was) considered (page 332 G – H) that that finding was not justified on the facts but stated (as Mr Copnall accepts obiter) that once the Claimant established that (a) she could and should have been referred to the hospital earlier, (b) she would not have suffered the damage, had she been referred earlier and treated competently then she had the benefit of a presumption that she would have been properly treated. The justification for this presumption was that, in the absence of evidence to the contrary, the Court

would presume that professional people would act competently. There was some debate between the members of the Court of Appeal as to whether the presumption is a legal presumption shifting the burden of proof (as advocated by Lord Neuberger) or a shifting of the evidential burden (as advocated in the dissenting judgment of Elias J (the third member of the Court of Appeal, Dame Janet Smith was undecided on the point).

110. In my judgment there are two reasons why there would be no presumption here that Philip would have locked the belay device correctly if he had received relevant training/ assessment by Leeds Wall:

110.1 Lord Neuberger made it clear that in order for the issue of the presumption to arise at all it was necessary to find first that the relevant act of negligence was a substantial cause or causative (page 324F) of the loss (in this case Philip's failure to arrest Mark's fall). I do not consider that I would have been satisfied (given as I have found that Philip knew at the time of Mark's fall how to lock the belay device and that he should have held it in the locked position) that any failure to carry out additional training and assessment by Leeds Wall that I might have found that they were obliged to carry out in order to comply with a duty of care would, if carried out, have resulted in Philip arresting Mark's fall. This is because in my judgment the purpose of training would be to inform Philip of the correct techniques and when to apply them (which in each case he already knew) and to assess his knowledge of those matters. Philip demonstrated to the Court that he knew how to lock the belay device and confirmed that he knew that he should have been locking it at the time of Mark's fall therefore I have no reason to suppose that he would have failed any assessment and the most therefore that any training and assessment would achieve would be to act as a reminder of something that Philip already knew. I do not think that that reminder would make it any more likely that Philip would avoid Philip's momentary lapse on 27 September 2010; and

110.2 as I see it the rationale in Wright was that it should be presumed (in the circumstances applying in that case) that if the hospital had been given an opportunity at another time to get things right then it would have got it right. I cannot see that providing Philip with additional training and assessment would have given Philip another opportunity on another occasion to lock the belay device at the time of Mark's fall which would mean (consistent with Wright), that I should presume that he would have locked the belay device on that occasion correctly. I would still have to proceed upon the basis that Mark would have fallen when he fell on 27 September 2010 the question in my mind would have been whether, as a result of any additional training or assessment that Philip might hypothetically have received I should presume that he would have arrested Mark's fall by properly locking the belay device. I do not consider that a presumption should apply in these circumstances which are to my mind very

different from those in which Lord Neuberger applied the presumption (whether of law or evidence) in Wright.

111. If I am wrong and there is a presumption either of law or fact that, if properly trained and assessed, Philip would have locked the belay device correctly at the time of Mark's fall, then I would have found that Leeds Wall had rebutted the evidential presumption or discharged its legal burden of proof as the case may be given that Philip (a) knew how to lock the belay device, (b) knew that he should have held the belay device in the locked position at the time of Mark's fall, and (c) he thought he was holding the belay device in the locked position at that time. I have found that Philip's failure to lock the belay device at the time of Mark's fall was due to a momentary failure to apply the right technique and I am satisfied in the hypothetical situation where Philip had received additional training and assessment prior to Mark's fall that this would be no reason to suppose that he would still not have failed to lock the belay device given that he already knew what he should be doing and how to do it.