EMPLOYMENT TRIBUNALS

Appellant: Dacorum Sports Trust Ltd (a company limited by guarantee)

Respondent: Rebecca Connolly (EHO, Dacorum Borough Council)

Heard at: Watford Employment Tribunal (in public; by video)

On: **6 to 8 July 2021 and (in chambers) 9 July 2021**

Before: Employment Judge Quill; Mr P English; Mr S Woodward

Appearances
For the appellant: Mr I Wright, counsel
For the respondent: Mr G Menzies, counsel

RESERVED JUDGMENT

(1) The unanimous Decision of the Tribunal is that Prohibition Notice U000822 dated 6 January 2020 is affirmed subject to the Modifications set out at Schedule A of this Decision.

(2) The unanimous Decision of the Tribunal is that Improvement Notice U000834 (incorrectly dated 8 January 2019 rather than 8 January 2020) and Schedule of Works is affirmed subject to the Modifications set out at Schedule B of this Decision.

REASONS

Introduction

1. The Appellant runs the 'XC' extreme sports facility based at Jarman Park, Hemel Hempstead. It includes a climbing wall facility. The Respondent has been appointed by Dacorum Borough Council as an inspector under section 19 of the Health and Safety at Work etc. Act 1974 ("the Act"). This appeal concerns two notices (a prohibition notice and an improvement notice respectively) issued in January 2020.

The Notices

2. As amended, the main body of the prohibition notice (PRO U000822) reads:

> I, Rebecca Connolly, Environmental Health Lead Officer (Food Health and Safety), of Dacorum Borough Council, The Forum, Marlowes, Hemel Hempstead, HP1 1DN ….., being an inspector appointed by an instrument in writing made pursuant to Section 19 of the said Act and entitled to issue the notice hereby give you notice that I am of the opinion that the following activity, namely:
>
> Free climbing (not using any belay mechanism or any other device to prevent a fall or arrest a fall) on the climbing walls
>
> Which is carried on by you or under your control at:
>
> XC, Jarman Way, Hemel Hempstead Hertfordshire HP2 4JS
>
> involves a risk of serious personal injury
>
> because:
>
> On the 9th July 2017 a customer Mr Cook was free climbing on the climbing wall and fell 8m suffering skin burns and a fractured to a lower limb.
>
> On the 5th October 2018 a customer Mr Melvin was free climbing on the climbing wall and fell 13m and suffered the following injuries broken pelvis, broken leg, broken lumbar vertebrae, broken ribs and broken sterum. (sic)
>
> and I hereby direct that the said activity shall not be carried on by you or under your control immediately unless the said contraventions have been remedied.

3. That notice was dated 6 January 2020 originally. The version above is text agreed between the parties and noted in the judgment following the 11 December 2020 preliminary hearing discussed below.

4. The improvement notice (U000834) replaced an earlier version and the main body reads:

> I, Rebecca Connolly, Environmental Health Lead Officer (Food Health and Safety) of Dacorum Borough Council The Forum Marlowes, Hemel Hempstead, Herts, … hereby give you notice that I am of the opinion that at the you, as a person wholly or partly in control of the premises, have contravened, in circumstances that make it likely that the contraventions will be continued or be repeated, the:
>
> XC JARMAN PARK HEMEL HEMPSTEAD HERTS HP2 4J8
>
> The Management of Health & Safety at Work Regulations 1999 as amended, Regulation 3(1)(b)
>
> The reason for my said opinion is that:
>
> The current risk assessments titled "Auto-belays (and routes)" dated 17/01/2012 review date: October 2019 and "XC Auto Belay Competent Climber"
>
> Are not suitable or sufficient in that:
>
> 1. The risk assessments do not Identify nor evaluate the risks arising from the identified hazards. For example in the "Auto-belays (and routes)" risk assessment the "Climbers not clipping in" is listed under the heading "Risk"

which is under the heading "List significant hazards". The risk from not clipping in has not been identified nor evaluated. Given the recent incidents involving Mr Cook (9th July 2017 and Mr Melvin (5th October 2018) the risk is well known.

2. The existing control measures in the risk assessments have not been effective in reducing the likelihood of harm occurring or reducing the potential severity of that harm. For example in the "XC Auto Belay Competent Climber" on page 3 In the column "List significant hazards", lists "Attaching to the auto belay correctly". In the last column "List the existing control measure or note where the information may be "found". The risk assessment fails to explain to how:

   a. "Signage indicating to check your harness",

   b, "Staff vigilance and training" and

   c. "Area checked every two hours on the daily log sheet"

   Will reduce the likelihood of a similar incident to those involving Mr Cook and Mr Melvin, or reduce the potential severity of the harm suffered by Mr Cook and Mr Melvin.

3. The risk assessments also fail to identify how climbers would be brought to: safety if they are found "free climbing" * on the walls. Particularly given the. dangers associated with "free climbing" and that the hand and foot holds become loose.

   * free climbing is not using any belay mechanism or any other device to prevent a fall or to stop a fall.

   and I hereby require you to. remedy the said contraventions or, as the case may be the matters occasioning them by 10th February 2020

   In a manner stated in the attached schedule which forms part of this notice.

5. That notice bore the date 8 January 2019, but should have been dated 8 January 2020. The "attached schedule" mentioned in the last sentence cited read:

Schedule of Works

HEALTH AND SAFETY AT WORK ETC ACT 1974 — SCHEDULE
IMPROVEMENT NOTICE Reference Number U/000734

Or undertake works which will have the equivalent effect

1. Review the risk assessments where the undertaking of the Dacorum Sports Trust at XC JARMAN PARK HEMEL HEMPSTEAD HERTS HP2 4J8 places those not under their employment at risk of injury.

2. Identify the hazards arising from the undertaking particularly the use of the climbing walls and auto belay.

3. Evaluate the risk from the hazards in item 2 above. Therefore evaluate the potential harm from the hazard being realised. The British Mountaineering

> Council recognises that climbing and mountaineering are activities with a danger of personal injury or death. Insignificant risks can be ignored, as can risk arising from routine activities associated with life in general.
>
> 4. Identify controls measures either existing or new that.
> a. prevent the harm from hazard occurring, or
> b. reduce the likelihood of the harm occurring, or
> c. reduce the potential severity of that harm ie any resultant injury
>
> This is a relevant Notice for the purpose of the Environment and Safety Information Act 1988.

6. So the schedule has the reference number U/000734, but it should have been U/000834 to match the notice.

7. By letter dated 6 January 2020, the Respondent sent Prohibition Notice Reference: U000822 to the Appellant (along with an improvement notice reference U000823, which was not in the bundle).

8. By letter dated 8 January 2020, the Respondent withdrew improvement notice reference U000823 and sent new improvement notice reference U000834. The 8 January 2020 letter cross-referenced to the 6 January 2020 letter for the reasons that the improvement notice was being served. As far as we are aware, the new notice (U000834) replicated the previous one (U000823) save for correcting/amending dates for compliance.

The Issues

9. The parties have agreed the following list of four issues (we have retained their numbering, and so there is no 3 or 5):

> [1] The Tribunal will decide whether to cancel or affirm each notice and, if it affirms it, will decide whether to do so either in its original form or with such modifications as the Tribunal may in the circumstances think fit. Following submissions made at the Preliminary Hearing which took place on 11th December 2020 it is agreed the Prohibition Notice PRO U000822 can be modified by removing the reference to a breach of s3(1) of the Health and Safety at Work etc. Act 1974 as it is not necessary to show a breach of the law to issue such a notice. Therefore, in reaching its decision the Tribunal will consider:
>
> *Prohibition Notice (PRO U000822)*
>
> [2] If the Appellant was carrying on or in control of the activity described as 'free climbing (not using any belay mechanism or any other device to prevent a fall or arrest a fall) on the climbing walls' at the XC on 6.1.20;
>
> [4] If the Appellant was carrying on or in control of the activity described then whether the activity involved a risk of serious personal injury on 6.1.20;
>
> *Improvement Notice (U/000834)*
>
> [6] If the Appellant was in breach of Regulation 3(1)(b) of the Management of Health & Safety at Work Regulations 1999 as contended in the opinion of the Respondent, or at all, on 8.1.19 (sic)- 8.1.20;

The litigation up to this hearing

10. The appeals were presented in two claim forms on 22 January 2020 and 21 February 2020 respectively. A response was presented.

11. A preliminary hearing took place before EJ Lewis on 9 April 2020. At that stage, prosecution was being considered, but no decision made. The Respondent applied for strike out of paragraph 13 of the details of claim. EJ Lewis listed both a 4 day final hearing for 5 to 8 July 2021, and a public preliminary hearing for 11 December 2020.

12. The preliminary hearing took place before EJ Bedeau on 11 December 2020, as a result of which there was a judgment with reasons and also some orders, including in relation to expert evidence (each side having permission to appoint their own).

13. By the time of the hearing before EJ Bedeau, a decision to prosecute had been made. For the reasons which he gave, EJ Bedeau refused the Appellant's application to stay the employment tribunal proceedings. In paragraph 18 of his reasons, he explained why the Respondent's strike out application in relation to paragraph 13 of the details of claim had now fallen away. In paragraphs 17 and 60 of those reasons, he recorded that there had been an agreement to the parties as to an amended form of wording for the prohibition notice (without prejudice to either side's primary arguments as to why the notice should be affirmed or cancelled). As noted in the reasons and the orders, the parties had not supplied EJ Bedeau with either the original notices under appeal, or the agreed amended wording for the prohibition notice. Paragraph 11 of his orders recorded that the amended wording was to be supplied. It was not in the bundle, and we asked for it on Day 1 of the hearing. We received it during submissions on Day 3.

14. We were told that the criminal trial is due to take place in March 2022. Our findings and decisions below are for the purposes of considering the appeals before us only, and we have not addressed our mind to the matters which are outside our jurisdiction and are to be properly decided in a different forum in due course.

The Hearing and the Evidence

15. The hearing had to be reduced from 4 days to 3 days, due to a lack of judicial resources on what would otherwise have been the first day. In any event, the parties told us on Day 1 that they wanted written reasons, and so we agreed to reserve our judgment.

16. The hearing took place fully remotely by video, and there were no significant technical problems. (Mr Wright's video freezing briefly, and Ms Hemmant's audio issues each being solved fairly promptly). On the afternoon of Day 1, we heard Mr Petherick's evidence, and on Day 2, we heard the remaining witnesses, with submissions being dealt with on the morning of Day 3.

17. We had a pdf bundle of 544 pages, to which there were an additional 4 pages. We had a legal material bundle of 176 pages, to which there was an additional 46 pages (being the HSE Enforcement Management Model (EMM) Operational

version 3.2). As already mentioned, we also had an agreed the list of issues and, shortly before the end of submissions, the agreed amended version of the prohibition notice.

18. We heard oral expert evidence from Mr Petherick for the Appellant and Dr Cooper for the Respondent. Their respective written reports were in the main bundle and we also received their joint statement dated 5 July 2021. We were satisfied that each of them had appropriate expertise as described in their respective reports, and that each of them complied with their duty to the tribunal. Neither was unduly partisan to the party which had instructed them.

19. We also heard oral evidence from Ms Connolly (the Respondent) and, on behalf of the Appellant, Ms Rebecca Hemmant (Managing Director) and Mr Chris Kirkpatrick Operations and Climbing Wall Manager at the XC Sports Facility. Each of them had produced a written statement, and answered questions from the other side and the panel. We are satisfied that each of them did their genuine best to state their honest recollections (and opinions).

The Law

20. The Health and Safety at Work Act 1974 ("the Act") includes the following extracts.

1.— Preliminary.

(1) The provisions of this Part shall have effect with a view to—

(a) securing the health, safety and welfare of persons at work;

(b) protecting persons other than persons at work against risks to health or safety arising out of or in connection with the activities of persons at work;

(c) controlling the keeping and use of explosive or highly flammable or otherwise dangerous substances, and generally preventing the unlawful acquisition, possession and use of such substances

(2) The provisions of this Part relating to the making of health and safety regulations and the preparation and approval of codes of practice shall in particular have effect with a view to enabling the enactments specified in the third column of Schedule 1 and the regulations, orders and other instruments in force under those enactments to be progressively replaced by a system of regulations and approved codes of practice operating in combination with the other provisions of this Part and designed to maintain or improve the standards of health, safety and welfare established by or under those enactments.

(3) For the purposes of this Part risks arising out of or in connection with the activities of persons at work shall be treated as including risks attributable to the manner of conducting an undertaking, the plant or substances used for the purposes of an undertaking and the condition of premises so used or any part of them.

(4) References in this Part to the general purposes of this Part are references to the purposes mentioned in subsection (1) above.

3.— General duties of employers and self-employed to persons other than their employees.

(1) It shall be the duty of every employer to conduct his undertaking in such a way as to

ensure, so far as is reasonably practicable, that persons not in his employment who may be affected thereby are not thereby exposed to risks to their health or safety.

(2) It shall be the duty of every self-employed person [who conducts an undertaking of a prescribed description][1] to conduct the undertaking in such a way as to ensure, so far as is reasonably practicable, that he and other persons (not being his employees) who may be affected thereby are not thereby exposed to risks to their health or safety.

(2A) A description of undertaking included in regulations under subsection (2) may be framed by reference to—

(a) the type of activities carried out by the undertaking, where those activities are carried out or any other feature of the undertaking;

(b) whether persons who may be affected by the conduct of the undertaking, other than the self-employed person (or his employees), may thereby be exposed to risks to their health or safety.

(3) In such cases as may be prescribed, it shall be the duty of every employer and every self-employed person, in the prescribed circumstances and in the prescribed manner, to give to persons (not being his employees) who may be affected by the way in which he conducts his undertaking the prescribed information about such aspects of the way in which he conducts his undertaking as might affect their health or safety.

4.— General duties of persons concerned with premises to persons other than their employees.

(1) This section has effect for imposing on persons duties in relation to those who—

(a) are not their employees; but

(b) use non-domestic premises made available to them as a place of work or as a place where they may use plant or substances provided for their use there,

and applies to premises so made available and other non-domestic premises used in connection with them.

(2) It shall be the duty of each person who has, to any extent, control of premises to which this section applies or of the means of access thereto or egress therefrom or of any plant or substance in such premises to take such measures as it is reasonable for a person in his position to take to ensure, so far as is reasonably practicable, that the premises, all means of access thereto or egress therefrom available for use by persons using the premises, and any plant or substance in the premises or, as the case may be, provided for use there, is or are safe and without risks to health.

(3) Where a person has, by virtue of any contract or tenancy, an obligation of any extent in relation to—

(a) the maintenance or repair of any premises to which this section applies or any means of access thereto or egress therefrom; or

(b) the safety of or the absence of risks to health arising from plant or substances in any such premises;

that person shall be treated, for the purposes of subsection (2) above, as being a person who has control of the matters to which his obligation extends.

21. Improvement notices.

If an inspector is of the opinion that a person—

(a) is contravening one or more of the relevant statutory provisions; or

(b) has contravened one or more of those provisions in circumstances that make it likely that the contravention will continue or be repeated,

he may serve on him a notice (in this Part referred to as "an improvement notice") stating that he is of that opinion, specifying the provision or provisions as to which he is of that opinion, giving particulars of the reasons why he is of that opinion, and requiring that person to remedy the contravention or, as the case may be, the matters occasioning it within such period (ending not earlier than the period within which an appeal against the notice can be brought under section 24) as may be specified in the notice.

22.— Prohibition notices.

(1) This section applies to any activities which are being or are likely to be carried on by or under the control of any person, being activities to or in relation to which any of the relevant statutory provisions apply or will, if the activities are so carried on, apply.

(2) If as regards any activities to which this section applies an inspector is of the opinion that, as carried on or likely to be carried on by or under the control of the person in question, the activities involve or, as the case may be, will involve a risk of serious personal injury, the inspector may serve on that person a notice (in this Part referred to as "a prohibition notice").

(3) A prohibition notice shall—

(a) state that the inspector is of the said opinion;

(b) specify the matters which in his opinion give or, as the case may be, will give rise to the said risk;

(c) where in his opinion any of those matters involves or, as the case may be, will involve a contravention of any of the relevant statutory provisions, state that he is of that opinion, specify the provision or provisions as to which he is of that opinion, and give particulars of the reasons why he is of that opinion; and

(d) direct that the activities to which the notice relates shall not be carried on by or under the control of the person on whom the notice is served unless the matters specified in the notice in pursuance of paragraph (b) above and any associated contraventions of provisions so specified in pursuance of paragraph (c) above have been remedied.

(4) A direction contained in a prohibition notice in pursuance of subsection (3)(d) above shall take effect—

(a) at the end of the period specified in the notice; or

(b) if the notice so declares, immediately.

23.— Provisions supplementary to ss. 21 and 22.

(1) In this section *"a notice"* means an improvement notice or a prohibition notice.

(2) A notice may (but need not) include directions as to the measures to be taken to remedy any contravention or matter to which the notice relates; and any such directions—

(a) may be framed to any extent by reference to any approved code of practice; and

(b) may be framed so as to afford the person on whom the notice is served a choice between different ways of remedying the contravention or matter.

24.— Appeal against improvement or prohibition notice.

(1) In this section *"a notice"* means an improvement notice or a prohibition notice.

(2) A person on whom a notice is served may within such period from the date of its service as may be prescribed appeal to an employment tribunal; and on such an appeal the tribunal may either cancel or affirm the notice and, if it affirms it, may do so either in its original form or with such modifications as the tribunal may in the circumstances think fit.

(3) Where an appeal under this section is brought against a notice within the period allowed under the preceding subsection, then—

(a) in the case of an improvement notice, the bringing of the appeal shall have the effect of suspending the operation of the notice until the appeal is finally disposed of or, if the appeal is withdrawn, until the withdrawal of the appeal;

(b) in the case of a prohibition notice, the bringing of the appeal shall have the like effect if, but only if, on the application of the appellant the tribunal so directs (and then only from the giving of the direction).

(4) One or more assessors may be appointed for the purposes of any proceedings brought before an employment tribunal under this section.

53.— General interpretation of Part I.

(1) In this Part, unless the context otherwise requires—

"the existing statutory provisions" means the following provisions while and to the extent that they remain in force, namely the provisions of the Acts mentioned in Schedule 1 which are specified in the third column of that Schedule and of the regulations, orders or other instruments of a legislative character made or having effect under any provision so specified;

"the general purposes of this Part" has the meaning assigned by section 1;

"health and safety regulations" has the meaning assigned by section 15(1);

"inspector" means an inspector appointed under section 19;

"prescribed" means prescribed by regulations made by the Secretary of State;

"prohibition notice" means a notice under section 22;

"the relevant statutory provisions" means—

(a) the provisions of this Part and of any health and safety regulations; and

(b) the existing statutory provisions;

21. The Management of Health and Safety at Work Regulations 1999 ("the Regulations") are a statutory instrument made under the Act (including under the powers referred to in section 15(1) of the Act) and include:

3.— Risk assessment

(1) Every employer shall make a suitable and sufficient assessment of—

(a) the risks 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.

(3) Any assessment such as is referred to in paragraph (1) … shall be reviewed by the employer …. who made it if—

(a) there is reason to suspect that it is no longer valid; or

(b) there has been a significant change in the matters to which it relates;

and where as a result of any such review changes to an assessment are required, the employer … concerned shall make them.

22. In Railtrack v Smallwood [2001] EWHC Admin 78, the court made the following comments

14.. The notice states:

"… I am of the opinion that the following activities namely:

THE PROVISION OF RAILWAY INFRASTRUCTURE INCLUDING SIGNALLED ROUTES SN81C, SN83B, SN85 AND SN 87A, ALONG LINE 3 AS FAR AS SIGNAL SN 109

which are being carried on by you …

ON THE RAILWAY BETWEEN LONDON PADDINGTON AND ACTON MAIN LINE

involve, or will involve, a risk of serious personal injury, and that the matters which give rise…

the said risks are:

THE RISK OF TRAIN COLLISIONS

and that the said matters involve …contravention of the following statutory provisions:

17.. Later the same day Railtrack appealed against the notice. The Notice of Appeal stated that:

"The grounds of the appeal are that the appellant is not contravening either or both of the relevant statutory provisions. The reasons advanced in the Prohibition Notice as to why the Inspector is of the stated opinion are unsound in fact and law."

27.. Pausing there, it might be wondered why Railtrack thought it necessary to appeal against the notice, since it prohibited only that which Railtrack itself asserted would have been "unthinkable". There is no question of Railtrack wishing to bring SN 109 or the routes leading thereto back into use in an unmodified form. On 22nd October 1999 Railtrack's

solicitor asked the Respondent to consider whether it was "necessary to pursue … the enforcement processes now in hand given the absolute assurance of Railtrack that it will comply with the requirements of the notice."

30.. … [Railtrack's counsel] submitted that there was an important principle at stake where an employer, such as Railtrack, had deliberately shut down operations in the interests of safety and had made it plain that there was no likelihood of those operations being resumed pending the outcome of all necessary inquiries and the approval of relevant bodies such as HMR1, it should not be liable to service of a prohibition notice under section 22. It would be oppressive for that statutory power to be used in such circumstances.

59.. [Railtrack's counsel] acknowledged that the Tribunal's power to modify was not so limited. "Modifications" are widely defined by section 82(1)(c) to include, "additions, omissions and amendments" and the power to modify is expressed in very general terms:

"Such modifications as the tribunal may, in the circumstances think fit."

60.. In my judgement he was right to do so. Subject only to considerations of fairness, giving the parties an opportunity to deal with proposed modifications, the power is a broad one, and deliberately so. It is desirable in the interests of public safety, that there should be a broad power to modify notices under sections 21 and 22 in response to the evidence as it emerges before the Tribunal.

61.. [Railtrack] submits that "activities" in section 24 above means what it says, an active, not a passive state of affairs. In the aftermath of the crash there were no activities of the kind described in the notice being carried on as at 8th October 1999.

62.. For the reasons described above, no trains were running or were likely to run on the four lines approaching SN 109. … The infrastructure had been withdrawn from use, so that "activities" were not being carried on, much less activities involving any risk of train collisions.

63.. Much of the argument before the Tribunal centred on the fact that the notice was expressed in the present, rather than the future tense. It alleged that the "activities" described in the notice "are being carried on", the words "likely to be carried on" having been deleted; the risk of train collisions "give rise" to a risk of serious personal injury, "will give rise" having been deleted, and that these matters "involve" a contravention of statutory provisions, "will involve" having been deleted.

64.. It was established in cross-examination that these deletions were deliberate. In the HSE's view, use of the present tense was appropriate. The future tense was used in a notice if a new activity, for example, the use of a new tunnel boring machine was likely to be commenced. It was not used where activities had been (to use a neutral word) "interrupted" by an accident.

65.. [Railtrack] submitted that where …there were no activities, because the relevant infrastructure had been withdrawn from use, the Inspector had power to prohibit a resumption of activities, but only if he was satisfied that that resumption was "likely".

84.. Notwithstanding my views as to the breadth of the power to affirm a notice with modifications under section 24 above, if [the] submission that no activities were being carried on at the date of the notice is correct, I do not consider that the notice could have been modified so as to refer to "activities which are … likely to be carried on."

85.. I do not doubt that such a modification would be within the scope of the powers conferred by section 24 in an appropriate case where the Tribunal had heard evidence of likelihood. …. The Tribunal … did not address the question of likelihood. Had it done so, the only reasonable

conclusion on the evidence would have been that resumption was unlikely. ...

89.. The appeal turns, therefore, on whether [the] submission that no relevant activities were taking place on 8th October is correct.

90.. There is no dispute that the underlying purpose of the Act is preventive, to protect not merely employees (section 2), but also members of the public (section 3) (see the Science Museum case). The starting point must be the ordinary meaning of the words in section 22(1), but that does not mean that they should be interpreted literally, or in a vacuum without regard to the factual context in which the section is likely to be engaged. A purposive approach to interpretation, one which renders section 22 effective in its role of protecting public safety should be adopted.

91.. Section 22 is … one of the most powerful weapons in an Inspector's armory. Subject to any direction from the Tribunal, a prohibition notice under section 22 takes immediate effect, and is not suspended by an appeal to the Tribunal. This may be contrasted with an improvement notice under section 21, which is suspended pending the outcome of an appeal (see section 24(3)). It is a criminal offence punishable with a substantial fine and/or imprisonment to contravene any requirement of a prohibition notice (see section 33(1)(g)).

92.. Thus, it is to be expected that the power to issue a prohibition notice would be available to an inspector in the aftermath of a very serious accident. Whilst the facts of each accident will be unique, all other things being equal, it is to be expected that the more serious the accident, the greater the likelihood that operations, to use a neutral expression, will be suspended, to enable the injured to be treated, the bodies of the dead to be recovered, fires to be extinguished, the police to investigate and damage to be repaired.

94.. In my judgment, it would be very surprising, and a significant lacuna in the Act if an Inspector, in the aftermath of such a serious accident, when operations have been suspended precisely because of the gravity of the accident, was unable to issue a prohibition notice upon the basis of a present risk of serious personal injury.

95.. In this case, it is not in dispute that the Respondent would have been entitled to issue a prohibition notice in respect of signal SN 109 prior to the accident, based upon all the information now known to have been available, because there is no dispute that "activities" (the running of trains along the four routes up to and past the signal) were being carried on.

96.. Following the accident, and as a direct consequence of it, trains ceased to run on those routes, but the need for a prohibition upon the use of SN 109 had been confirmed in the most dreadful way imaginable. It would be extraordinary if, in those circumstances, an Inspector who arrived too late to serve a notice which would have prevented the accident was then prevented from serving a notice because "activities" had ceased as a result of the very accident that he had been called to investigate, unless he could be satisfied that a resumption of activities was not merely possible but was likely.

97.. In such circumstances, exposure to the possibility of danger would only be prevented (the underlying purpose of the act, see above) if the Inspector had power to serve a prohibition notice based upon the fact that activities were still being carried on. The possibility of danger, tragically demonstrated by the accident in question, could not be prevented if the Inspector first had to decide, perhaps upon conflicting information in the confusion whilst frantic rescue attempts were being made following a serious accident, whether resumption of activities was likely. In such circumstances any risk of operations being resumed following the accident would be unacceptable in terms of public safety, to say nothing of public confidence.

98.. Looking at the words of section 22(1) in this context, and bearing in mind in particular the fact that section 22 must have been intended to confer powers upon Inspectors, not merely prior to, but also in the aftermath of, the most serious accidents, I am satisfied that "activities" are (still) being carried on for the purposes of section 22 if they have been temporarily interrupted or suspended as a result of a major accident. I do not consider that such an interpretation does any violence to the ordinary meaning of the words in section 22, provided they are considered in a realistic context.

99.. The word "activities" cannot sensibly be given a literal meaning in any event. In a literal sense, "activities" may cease, and a state of inactivity prevail, for any one of a number of reasons: during the lunch break, over the weekend, during holiday periods. It may be a question of fact and degree in each case, but I do not consider that merely because activities have been temporarily suspended, that means that they have ceased, for the purposes of section 22.

100.. All the surrounding circumstances, including the reason for the temporary inactivity will have to be considered. There may well be a distinction to be drawn on the facts between a factory that is inactive because the employer has gone bankrupt and dismissed all of his employees, and a factory that is inactive because it has closed for the summer holidays. If, however, the factory has just closed, and the workers had been sent home, because of a tragic accident, I do not consider that activities will have ceased for the purposes of section 22. The position may be different if, not as a result of an accident, but pursuant to a pre-planned closure programme, for example, to replace outdated and unsafe machinery, the factory is at a standstill for some weeks or months.

104.. Thus, the Respondent was entitled to frame the notice in the present tense and to conclude that so long as there was a risk, however remote, that the infrastructure referred to in the notice might be brought back into full use, a prohibition notice could be issued.

23. We have included this lengthy extract because one of the Appellant's points is similar to (though not identical to) Railtrack's. In this case, the Appellant is arguing that the activity in question was not one to which any of the "relevant statutory provisions" (as defined in the Act, and as mentioned in section 22(1) of the Act) applied. In particular, it disputes that the activity was part of the conduct of the Appellant's undertaking because its rules forbid the activity.

24. In R -v- Associated Octel Company Limited (1996) ICR 972, the House of Lords decided that repair works during an annual shut done were activities which could be described as part of the employer's undertaking. Lord Hoffmann's speech included the following:

Section 3 of the Act of 1974 is not concerned with vicarious liability. It imposes a duty upon the employer himself. That duty is defined by reference to a certain kind of activity, namely, the conduct by the employer of his undertaking.

And

What, then, amounts to the conduct by the employer of his undertaking? Mr. Walker said that it meant carrying on activities over which the employer had control. In Austin Rover Group Ltd. v. Her Majesty's Inspector of Factories [1990] 1 A.C. 619 , 634, Lord Jauncey of Tullichettle said:

"Sections 2 and 3 impose duties in relation to safety on a single person, whether an individual or a corporation, who is in a position to exercise complete

> control over the matters to which the duties extend. An employer can control the conditions of work of his employees and the manner in which he conducts his undertaking."

Mr. Walker says that the absence of a right to control the way in which the work is done is traditionally the badge of an employer's relationship with an independent contractor. So, as R.G.P. were independent contractors, it must follow that Octel was not in a position to exercise that complete control which is the basis of liability under section 3.

This again seems to me a confusion of thought. Lord Jauncey was stating what is, if I may respectfully say so, the self-evident proposition that a person conducting his own undertaking is free to decide how he will do so. Section 3 requires the employer to do so in a way which, subject to reasonable practicability, does not create risks to people's health and safety. If, therefore, the employer engages an independent contractor to do work which forms part of the conduct of the employer's undertaking, he must stipulate for whatever conditions are needed to avoid those risks and are reasonably practicable. He cannot, having omitted to do so, say that he was not in a position to exercise any control. This is precisely why Octel insisted that its contractors adhere to the "permit to work" system.

The concept of control as one of the tests for vicarious liability serves an altogether different purpose. An employer is free to engage either employees or independent contractors. If he engages employees, he will be vicariously liable for torts committed in the course of their employment. If he engages independent contractors, he will not. The law takes the contractual relationship as given and in some cases the control test helps to decide the category to which it belongs. But for the purposes of section 3, the category is not decisive.

The question, as it seems to me, is simply whether the activity in question can be described as part of the employer's undertaking. In most cases, the answer will be obvious.

And

It seems to me wrong to try to find some formula … to take the place of the simple words of the statute. Whether the activity which has caused the risk amounts to part of the conduct by the employer of his undertaking must in each case be a question of fact. The place where the activity takes place will in the normal case be very important; possibly decisive. But one cannot lay down rigid rules.

And

The employer is under a duty under section 3(1) to exercise control over an activity if it forms part of the conduct of his undertaking. The existence of such a duty cannot therefore be the test for deciding whether the activity is part of the undertaking or not.

And

I think that there was evidence upon which the justices were entitled to find in the particular circumstances of the case that having the asbestos sheets removed was part of the employers' undertaking. The facts were a matter for them and their decision should not have been disturbed.

25. In HM Inspector of Health and Safety v Chevron North Sea Limited (Scotland), the Supreme Court commented:

14. It is common ground between the parties that a section 24 appeal is not limited to a review of the genuineness and/or reasonableness of the inspector's opinion, but requires the tribunal to form its own view of the facts, paying due regard to the inspector's expertise. It is also common ground that the tribunal should be focussing on the risk existing at the time when the notice was served. These agreed propositions still leave room, however, for the debate about what material the tribunal is entitled to take into account when forming its view of the facts as they were at the material time.

18. When the inspector serves the notice, section 22 makes clear that what matters is that he is of the opinion that the activities in question involve a risk of serious personal injury. If he is of that opinion, the notice comes into existence. However, as it seems to me, when it comes to an appeal, the focus shifts. The appeal is not against the inspector's opinion but against the notice itself, as the heading of section 24 indicates. Everyone agrees that it involves the tribunal looking at the facts on which the notice was based. Here, as the inspector spelled out in the notice, the risk that he perceived arose by virtue of corrosion of stairways and gratings giving access to the helideck, and the focus was therefore on the state of that metalwork at the time when the notice was served. The tribunal had to decide whether, at that time, it was so weakened by corrosion as to give rise to a risk of serious personal injury. The inspector's opinion about the risk, and the reasons why he formed it and served the notice, could be relevant as part of the evidence shedding light on whether the risk existed, but I can see no good reason for confining the tribunal's consideration to the material that was, or should have been, available to the inspector. It must, in my view, be entitled to have regard to other evidence which assists in ascertaining what the risk in fact was. If, as in this case, the evidence shows that there was no risk at the material time, then, notwithstanding that the inspector was fully justified in serving the notice, it will be modified or cancelled as the situation requires.

20. The effectiveness of a prohibition notice is in no way reduced by an appeal process which enables the realities of the situation to be examined by a tribunal with the benefit of additional information. Once served, the notice provides immediate protection, reinforced by the existence of criminal sanctions. It is common ground between the parties that, even if ultimately cancelled by a tribunal, any contravention of the notice prior to cancellation would still be a criminal offence.

21. Furthermore, there does not seem to me to be any reason to suppose that the wider interpretation of section 24 would undermine the role that prohibition and improvement notices play in encouraging employers to have robust systems in place with a view to demonstrating easily, when an inspection takes place, that no risk exists. A prohibition notice remains in force during the appeal process, unless suspended by the tribunal, and such is the disruption and financial loss that this may cause that employers have plenty of encouragement to do what they can to avoid getting into such a situation in the first place.

23. Turning to the situation of an employer in receipt of a prohibition notice, it is clear that there are potent considerations in favour of the wider interpretation of section 24 . As the inspector cannot withdraw an immediate prohibition notice, even if he is completely convinced by material produced subsequently by the employer, the only means by which the notice can be cancelled under the statutory scheme is an appeal. Yet if the appellant's interpretation is right, in such a case the appeal process would not dislodge the notice, which would remain in force, with all the attendant disadvantages for the business, even though the perceived risk never in fact existed. Indeed, it is even possible that in some cases, in order to be able to restart the activity named in the notice, an employer might have to carry out works which have been demonstrated to be unnecessary. The appellant argues that, in practice, confining the tribunal's role

narrowly would not cause any problems because, provided with convincing evidence that there was in fact no risk, the inspector would recognise that and not seek to enforce the notice, although the notice would still be registered on the public database because, the appellant argues, that is appropriate to reflect the fact that it was correctly served on the basis of the information then available to the inspector. This suggested solution does not, in my view, address the problem. The notice would still have the capacity to damage the reputation of the employer and his ability to do business. Furthermore, it cannot be right, in circumstances such as these, that the employer continues, after his appeal is concluded, to be exposed to the possibility of criminal proceedings, however improbable it is that proceedings would actually be taken. In addition, the appellant's proposal proceeds upon the basis that the inspector is able to accept the evidence put forward subsequently by the employer, but he may not be able to do so. In those circumstances, a forum is required in which to determine the continuing dispute between the inspector and the employer or, putting it more constructively and in the spirit of the health and safety legislation, to determine whether the circumstances that concerned the inspector did in fact give rise to a relevant risk. The appeal process provides that necessary forum.

24. I would therefore interpret section 24 of the 1974 Act as the Inner House did. In my view, on an appeal under section 24 , the tribunal is not limited to considering the matter on the basis of the material which was or should have been available to the inspector. It is entitled to take into account all the available evidence relevant to the state of affairs at the time of the service of the prohibition notice, including information coming to light after it was served. I would accordingly dismiss the appeal.

26. Modification "is a very wide term" (Chrysler (UK) Limited v McCarthy [1978] commenting on section 82 and 24(2) of the Act), but that does not confer an unlimited power on a tribunal. A Tribunal may rephrase a notice and/or extend time limits for remedying the breach if appropriate.

27. "Risk" means the possibility of danger and there is no need to show there had been actual danger (R v The Board of Trustees of the Science Museum [1993]).

28. The Legal Material also included the Supreme Court decision in Kennedy v Cordia (Services) LLP (Scotland). As acknowledged in the decision (paragraphs 90 to 92), not all risks are completely avoidable and the fact that there is an unavoidable risk does not mean that an activity must not take place. By the same token, the fact that there is an unavoidable risk does not mean that the risk assessment is sufficient simply by mentioning the risk, or by identifying a control measure which is to warn people to take care. On the facts of that case, there was a breach of Regulation 3 of the Regulations (specifically Regulation 3(1) on those facts, as it concerned employees) where:

It was also accepted that the injuries which might be sustained included fractures and head injuries, and were therefore potentially serious. No consideration, however, was given to the possibility of individual protective measures, before relying on the measure of last resort, namely giving appropriate instructions to employees.

The Facts

29. The Appellant is a registered charity and company limited by guarantee (04868497) incorporated on 15 August 2003. It operates sports facilities (including a climbing wall) and a sports development service from the 'XC' at Jarman Park Hemel Hempstead. It employs around 100 people (or did so at the relevant times)

in a ratio of around 40:60 permanent to casual. Around 75% of the permanent staff are full-time.

30. Ms Hemmant has been Managing Director since 1 April 2018. As per the Appellant's Health and Safety policy (signed by Ms Hemmant in April 2019; page 399 of bundle), the Managing Director has overall accountability for health and safety and the Group Operations Manager has overall responsibility for the delivery of health and safety. Ms Hemmant does not regard it as part of her role to know the details of the procedures or the risk assessments for any of the individual facilities. She relies on the expertise of those more closely running each of them. She believes that she should, and does, have an overall strategic view of the procedures at the climbing wall, but that the details should be left to staff running it, as with a gym, golf course or swimming pool.

31. As Operations and Climbing Wall Manager at the XC Sports Facility, Mr Kirkpatrick's duties include implementing and managing Health and Safety and Operational Procedures; monitoring and reviewing all processes, ensuring an effective performance; overseeing site Operational Managers and assist with staffing reviews, management of staff, and training systems; amongst other things. He has significant climbing wall qualifications and experience, as set out in paragraph 3 of his statement. He has been employed by the Appellant for about 10 years, and, as well as his other duties, he spends a lot of time teaching climbing to customers. In other words, he spends a lot of time close to the climbing wall and in a position to see some of the users of the wall, albeit while focusing mainly on anyone to whom he was giving instruction.

<u>The Climbing Walls</u>

32. There are various payment methods to use the climbing wall, including pay on the day, or a membership package. On the day on which a person wishes to use the wall, they report to reception and are granted access. As of February 2019, the climbing team consisted of about 7 permanent employees (including Mr Kirkpatrick) and around 3 casual, as well as around 6 "freelance".

33. There are designated "bouldering walls". "Bouldering" activities take place close to the ground and no rope or harness is used to prevent a fall. The notices which are the subject of this appeal relate to the "climbing walls" not the designated "bouldering walls".

34. There are 3 climbing walls, the tallest of which has a maximum height of 14m. At the risk of stating the obvious, the activities carried out on this wall include "climbing". That is, the participants, rather than keeping their feet on the floor, use the footholds and handholds on the wall (and other equipment) to ascend. When they wish to descend, they might either use the footholds and handholds until they reach the floor, or they might deliberately let go (and push away from the wall) and allow their own weight to cause them to descend, but with the speed and acceleration of the descent controlled by a rope or wire or webbing which is connected to another person, or to a device. This latter type of descent was not expressly forbidden by the Appellant's rules.

35. Specific types of climbing that are permitted by the Appellant on the climbing walls include:

    35.1 Top rope climbing, where a climber uses a rope anchored from above, and belayed from the ground by a second climber.

    35.2 Lead climbing, which is climbing with a rope and clipping in to fixed protection - known as "quickdraws" - along the route to protect from a fall. Lead climbing can be done outdoors or indoors. For indoor climbing, the quickdraws are already pre-hung at various intervals along an ascending climbing route. This form also requires a second person to act as "belayer" (Petherick, paragraph 2.5.1).

    35.3 Climbing using an auto-belay, which requires a climber to attach themselves to the auto- belay before commencing their climb. The auto-belay operates by lowering climbers using a magnetic braking system. The climber attaches the auto-belay karabiner to their harness. As the climber ascends the webbing retracts automatically into the auto-belay. When a climber lets go of the wall the machine automatically lowers the climber to the floor at a controlled speed.

36. At 2.5.4 of his report, Mr Petherick notes:

    A further form of climbing, not generally promoted in climbing centres, is 'free climbing'. This form of climbing solo normally involves use of handholds and footholds but differs from 'bouldering' because the climber will normally ascend to greater heights and can (and should) make use of forms of protection at anchor points to prevent falls, but not to assist progress up the wall. Free climbing is also commonly referred to as 'traditional climbing' or 'sport climbing'. The term 'free' refers to lack of use of aids, including ropes, to assist progress up a wall.

    We accept the Appellant's evidence (and it is not disputed by the Respondent) that this form of climbing (which, as stated, is distinct from "bouldering") was not something that was permitted on its climbing walls by the rules of the Appellant.

37. Of the climbing methods that are permitted by the Appellant, the use of an auto-belay (unlike other methods) can potentially be done without a second person. Precisely because auto-belays do not require a second person, they are a potentially useful and attractive feature for users of the Appellant's climbing wall. The Appellant and its staff are aware of this, and aware that – potentially at least – some of the users of the auto-belays will have attended the site by themselves and without a friend or climbing partner acting a second pair of eyes, looking at their equipment or decision-making or doing any safety checks.

38. Auto-belays are only found on artificially created climbing walls (whether indoors or outdoors) and are not used when climbing natural features such as crags and mountains, etc. The Appellant and its staff are aware of this, and aware that – potentially at least – some of the users of the auto-belays might be individuals who have a great deal of climbing experience, but – because that experience has been on natural climbs, do not have a great deal of auto-belay experience.

39. The Appellant has around 8 auto-belays. In principle, they can be removed from the wall (eg for annual service) and relocated, but in practice usually remain in the

same place. Each of the auto-belays is at the top of a "climb", a "climb" being a route which the Appellant has created by means of footholds/handholds on the "climbing wall". Footholds/handholds can be relocated by the Appellant with comparative ease when it wishes to create a new "climb" to provide a slightly different experience for its regulars. Not all "climbs" have autobelays at the top.

40. The climbing walls are not a single vertical plane surface. There are corners and protuberances. There is not a single particular location at which a staff member can stand and have line of sight to the entire wall. The Appellant's witnesses estimated that from reception perhaps 80% is visible. We treat that as the witnesses' very rough approximation, rather than the product of specific measurement. In any event, some parts the walls are not visible from reception. The number of staff that are working in the vicinity of the wall varies. Typically, there might be several instructors (or other staff) on duty at some part of the wall, working with a supervised group. Potentially, at least, those staff might notice if an unsupervised climber did something unsafe or in breach of the rules. Staff are trained to look around when possible, but checking on other climbers is not their specific task at the times that they are working with a particular supervised group.

<u>The customers and their documentation</u>

41. The Appellant caters for both climbers which it assesses as novices and those which it assesses as experienced. The former are required to climb under constant supervision; the latter are permitted to climb unsupervised.

42. In order to be classed as sufficiently experienced to climb unsupervised, there are two requirements:

    42.1 Signing a waiver

    42.2 Having a rope competency test.

43. The document signed by Mr Melvin in April 2018 is at pp 316-319 of the bundle. It shows, amongst other things:

    43.1 That the supervision of "supervised" climbing for the "novices" does not have to be by the Appellant's staff. ("*An adult who has registered as unsupervised climber at the centre may supervise up to two novice climbers as long as they are prepared to take full responsibility for the safety of those people. Groups of three or more novices must only be supervised by an instructor holding the relevant Mountain Leader Training Board Qualification*")

    43.2 It has a "BMC Participation Statement" being: "*The BMC recognises that climbing and mountaineering are activities with a danger of personal injury or death. Participants in these activities should be aware of and accept these risks and be responsible for their own actions and involvement*."

    43.3 Under "Risk Statement and Advice", it states: "*It is the intention of the directors. management and consultants of XC to offer the following details regarding risks of participation in climbing related activities at XC. Climbing and other adventurous activities whether at height or not. are physically and mentally demanding. They have inherent hazards and risks associated with*

them and the only way to truly remove these risks and hazards is not to take part: you have this choice throughout the course/activity. Whilst XC staff and contractors take all necessary precautions to try and ensure the safety of all participants, unfortunately accidents may occur as a consequence of taking part. Each participant should familiarise themselves with the hazards and try and minimise these as much as possible by complying with XC and its contractors risk management guidelines and advice. Bumps, bruises, cuts, grazes, sprains and strains are very common and more serious injuries cannot be ruled out. This is a reality. You are also agreeing that you will act in the best interest of safety towards other participants. This means always conduct a pre-commitment check on your partner and confirm with your XC instructor before leaving the ground or any secure point. There are no exceptions to this rule. all are involved with checking no matter your age or position on the course/activity. The management accepts no responsibility for any loss or injury resulting from any person's involvement in the adventurous activity. Understand you are here for adventure and this carries risks that cannot be removed. Furthermore. it is understood and agreed that individuals participate at their own risk. If you are on a supervised session with the XC, you will be further briefed before your session."

43.4 Under General Rules, it states: "*New users and beginners to the XC are advised to familiarise themselves with the layout of the facilities. This includes making note of all safety signage around the XC*." And "*Due to the hazardous nature of the activities performed in the XC participants are advised that this is an extremely dangerous environment and entry is done so at your own risk. Liability for personal injury or death cannot be taken by Dacorurn Sports Trust, its directors, staff and volunteers, unless negligence is proven*."

43.5 Under XC Climbing Standard Rules, it states: "*Staff are here for your safety and have a duty of care to make comment on unsafe practices. Anyone who does not follow the safe practices even after comment will be asked to attend a refresher course or in severe cases, have their registration revoked*." And "*No soloing of any roped, lead or auto belay routes under any circumstances*".

43.6 In the section "BMC Conditions of Use", the paragraph "OUR DUTY OF CARE" states: "*The rules of the climbing centre are not intended to limit your enjoyment of the facilities. They are part of the duty of care that we as operators, owe to you, the customer by law. As such they are not negotiable and if you are not prepared to abide by them then the staff must politely ask you to leave*."

43.7 In the section "Association of British Climbing Walls Standards and Rules (General Safety)", and under the heading "Auto belays", it states:

- Only use the attachments/carabiners provided on the apparatus.
- Always check below you before descending as to avoid colliding with another climber.
- Always check that you are correctly attached before climbing and before lowering.

44. The Appellant's witnesses were not able to recall specific incidents of users having been asked to leave because of rule breaches. It was Mr Kirkpatrick's oral evidence that a record would be kept against an individual climber's name if they had done something unsafe, or against the rules, which came to the attention of the Appellant's staff. This was not something mentioned in his written statement to the tribunal (though we do note that on 18 June 2019, he told the Respondent and her team leader that if persistent bad climbing behaviour was noted, climbers would get a warning and DST could revoke membership if rules not adhered too), or the contemporaneous documents to which we were taken in the bundle and therefore we are not satisfied that the Appellant has a clear and consistent policy, understood by all relevant staff, as to what they should do if they spot something unsafe, or against the rules. We were also not taken to any particular notification (GDPR compliant or otherwise) to the users that the Appellant had such a practice. Thus the deterrence value (if any) of the record keeping to which Mr Kirkpatrick alluded is potentially limited, as it is not obvious that users were aware that a permanent record of (for example) instances of "free climbing" would be retained.

45. An earlier document (signed by Mr Melvin on 22 September 2016) is at page 332/333. The reverse (333) contains a smaller print version of General Rules, XC Climbing Standard Rules, BMC Conditions of Use, Association of British Climbing Walls Standards and Rules (General Safety) just mentioned. The front contains several boxes requiring a yes or no answer. These include confirmation of understanding and agreeing to abide by the rules, and that he understands that failure to exercise due care could result in his injury or death. He confirms that he is able to perform 3 particular techniques and does not need training in those techniques. The form has been counter-signed by a member of staff that the individual passed Rope Competency Check. The form does not ask any questions about auto-belay.

46. The rope competency assessment is described in paragraphs 4.16 and 4.15 of Mr Kirkpatrick's statement. His oral evidence was that he would first follow the process in paragraph 4.16 (which broadly corresponds to the 3 techniques mentioned in the form on 333, and does not include auto-belays). After that, he would then follow what is alluded to in paragraph 4.15. In his written statement, he states that: "*Only when the Instructor is satisfied that the customer is competent in climbing techniques, including how to safely use the auto-belays, will the customer be signed off as rope competent. Evidence of this competency is retained by the XC on its customer database to ensure future compliance with the supervised/ unsupervised climbing policy*." His oral evidence was that knowledge of the techniques in 4.16 of his statement would not necessarily mean that the climber was familiar with autobelays (since they are only used at climbing walls, and an individual could be an experienced and competent climber, but whose previous experience was not on climbing walls). Therefore, his opinion was that a briefing would always be given about the use of autobelay and that this was part and parcel of the "rope competency assessment" (ie it was not a separate piece of training or assessment). His opinion was that a specific record that the briefing on the auto-belay had been delivered would be recorded by the Respondent. We were shown no such specific document or record for any user. (We have described already, what is shown on page 333 for Mr Melvin.)

<u>Auto-Belays</u>

47. At paragraph 2.4 of Dr Cooper's statement, he says this about auto-belays: Auto belays are automatic devices that takes up the slack as a climber ascends the climbing wall. If the climber reaches the top, or falls, the auto belay immediately arrests the fall and lets the climber descend to the ground safely and automatically.

48. At paragraph 2.6 of his report, Mr Petherick states

> Over the last two decades where climbers are sufficiently experienced and are attending a climbing facility on their own, or are being introduced to climbing under direct supervision, auto-belay devices have become commonplace. As stated at Para 8.2 of the BMC's 'Climbing Wall Manual' (page 56 of Appendix Six):
>
> > "These consist of a block mounted at the top of a route, into which winds a retractable cable or sling. As the climber ascends, tension in the cable is maintained as it is reeled in automatically. Once the weight of the climber comes onto the cable, the cable unwinds with the speed of descent controlled by a braking system.
> >
> > These devices are very useful for climbers who wish to climb routes but do not have a partner to belay them. Accidents have occurred where users have failed to clip in to the cable, and it is important that they are only used for essentially vertical and straight up routes."

49. Each of the experts provide photographs, both of the Appellant's actual auto-belays, and those in other locations. Each report was prepared while the Appellant's climbing wall was not in use, because of Covid restrictions.

50. We can summarise as follows:

    50.1 When a "climb" with an autobelay is not being used, the autobelay webbing is attached to a "gate" or barrier at the bottom of the climb. This connection is under tension, because the autobelay device is seeking to recoil the rope/webbing upwards (ie towards the autobelay device at the top of the "climb"). The "gate" meanwhile is attached to the floor. It is a piece of triangular fabric (one corner of the triangle being attached to the autobelay webbing and the other two corners being on the ground). The tension is what holds up the triangular fabric gate or barrier.

    50.2 To use the autobelay, the climber must disconnect the autobelay webbing from the gate and attach it to themselves. (This was referred to as "clipping on" or "clipping in" during the hearing and in some of the documents.)

    50.3 If the climber disconnects the autobelay webbing from the gate and fails to attach it to themselves then, when they let go of the webbing, the mechanism of the auto-belay will pull the entire webbing up to the device itself (ie at the top of the wall). It ought to be obvious to a climber if they have (a) detached the autobelay webbing from the gate and (b) failed to attach it to themselves, because they should see the webbing rise. [Mr Pethertick mentioned the possibility of a climber incorrectly/unsecurely attaching the webbing to themselves, such that the connection was strong enough to prevent the webbing becoming loose – at least temporarily – while the climber was ascending the wall, but – in the event of a fall/dismount – not being strong enough to support the climber's weight. That is one way that a person could hypothetically believe that they were using the autobelay correctly when, in

actual fact, they were not. However, we were provided with no evidence of that having actually happened at the Appellant's premises.]

50.4 If the climber does not disconnect the autobelay webbing from the gate, and seeks to start the climb while the autobelay webbing is still attached to the gate, then the signs that either the climber themselves might be able to notice, or else a well-informed observer (one of the Appellant's staff, or another customer) might notice, are that

- the gate would still be in place, when it should not be;
- getting around the gate, while not impossible, would require a conscious and deliberate effort; [Our finding, based on the photos, is that it would not be unduly difficult to start the "climb" while the gate was in place. We acknowledge that Mr Petherick and the Appellant do not necessarily agree. However, if a climber chose to deliberately ignore the barrier, then it seems obvious to us that the positioning of the triangle and the footholds and handhold make it fairly straightforward to get onto the wall and to ascend above the barrier. We accept, of course, that the gate reduces the likelihood of the climber being able to do this "accidentally", that is without being aware that they had failed to "clip on".]
- while climbing the wall, the climber would be able to see (and indeed would potentially be slightly impeded by) the auto-belay webbing going in a straight vertical line from the top of the climb to the bottom and being between them and the wall. [For the avoidance of doubt, if the climber positioned themselves so that the auto-belay webbing was behind them, rather than between them and the wall, then that would make it even more obvious to both the climber themselves, and any alert and well-informed observer, that they had not "clipped in" (whether deliberately or otherwise).]

50.5 Only one climber at a time is allowed to be on any particular "climb". Thus the only possible positions for the autobelay webbing are: (1) attached to a climber who is actively using it; (2) connected at the bottom of the vacant climb, ready for the next user; (3) out of action, due to being released, so that it is wound into the device at the top.

<u>The "Cook Incident"</u>

51. On 10 July 2017, the Appellant made a RIDDOR report. It related to a Mr Cook and stated that he had had a fall from height, the height being 8m. It stated he had a lower limb fracture. The description was:

> … Cook is a competent Climber. He is a regular and has been for around 5 years. He was climbing on the auto belays as he does on a regular basis but he just simply forgot to clip himself in on the climbing mechanism and fell once he got to the top of the wall as he had no form of safety line to keep him safe. He fell from around 8 metres but he did have the presence of mind to grab hold of the lanyard mechanism whilst failing which broke his fall. By doing this he had minor skin burns to his hands.

52. The minutes of the 12 July 2017 XC Team Meeting (page 485), include this mention (as one of 6 bullet points for H&S): "Climbing area incident, guy fell off overhang autobelay. Open fracture to leg"

53. The only other near contemporaneous document is the minutes of the 19 July 2017 Board meeting (page 413). Under the heading "Health and Safety report" is about half a page of text, dealing with several different issues. In relation to Mr Cook's incident, the minutes state this (and only this):

> *Rebecca informed the Board of a reportable incident that happened at XC a week ago. The customer had forgotten to clip himself onto the auto belay and fell from 8 metres. The customer broke his leg and injured his hand, however he has been extremely apologetic to everyone since! Rebecca explained that the XC staff were fantastic at dealing with the situation. A climbing specialist has since stated that the most common cause of accidents when climbing is people forgetting to clip themselves on!*
>
> *Rebecca said that risk assessments are being reviewed and they are also looking at ways to raise awareness to customers.*

It is unclear what the source of Ms Hemmant's information was (she was the only "Rebecca" in attendance).

54. The minutes of the Health & Safety Committed meeting of 13 July 2017 (also attended by Ms Hemmant) do not refer to the incident, and nor do those of 19 October 2017 (though it is possible that the version in the bundle has one or more pages missing) or 25 January 2018. This is despite paragraph 4.3 of Ms Hemmant's statement asserting:

> The Trust has an established Health and Safety Committee who meet regularly to address all health and safety issues relating to the Trust's activities. The Health and Safety Committee is responsible for reviewing the Trust's policy statement (see page 399 of the Appeal Bundle), training and development, risk assessments, legislation and industry updates. An example of the health and safety meeting minutes can be found at page 400 of the bundle.

55. As per its statement to the local authority in February 2019, following Mr Cook's fall, "*No remedial action was deemed necessary following this incident*." We have seen no accident investigation documents for this incident (and nor has Mr Petherick), and the Appellant does not claim to have documented an investigation. The voluntary statement says: "… *he failed to clip in to the auto belay and then let go from the wall after erroneously believing he was connected*." The source of the information that Mr Cook deliberately let go of the wall is unclear. Furthermore, and in any event, we find it surprising that there appears to have been no formal investigation into the suggestion that he thought he was clipped in. For the reasons mentioned above, it is not obvious how someone could (a) be on a climb which has an autobelay and (b) not be clipped into that autobelay and (c) erroneously think that they were clipped in. A more detailed investigation might have either found specific reasons for the accidental error (eg Was the autobelay fully wound in at the top, meaning the "gate" was down? Was the webbing loosely attached to his harness, but not attached well enough to bear his weight? etc). Alternatively, if there had been a deliberate breach of the rules, an investigation might have uncovered that. There is simply an absence of information from the Appellant.

According to the February 2019 statement, Mr Cook had returned to climbing at XC by then, and so an inability to contact him is not the reason for the absence of more detailed information.

56. In its October 2019 statement to the local authority, the Appellant added: "Notwithstanding [the fact that no remedial action was deemed necessary after the Cook incident], the Trust installed additional signage following the [Cook] Incident despite the fact it was of the view that sufficient signage was already in place."

The "Melvin Incident"

57. On 5 October 2018, the Appellant made a RIDDOR report. It related to a Mr Melvin and stated that he had had a fall from height, the height being 13m. It stated he had a lower limb fracture. The description was:

> 17.14pm A competent Climber that has been climbing many years did not take appropriate safety measures to ensure he was safe. He forget to clip himself onto the wall or did not realise he was not clipped in and safe to climb.

58. The following day, the Appellant commenced an investigation with the assistance of Arrampica Ltd. In attendance was Arrampica's Mr Paolo Fubini, one of the UK's leading technical advisers for climbing walls. Arrampica's 6 October 2018 preliminary draft report is in the bundle at page 306, and it notes:

    58.1 Mr Melvin's activities at the time of the incident were believed to have been: "Lead climbing without a belayer"; "Climbing without a climbing partner". It recorded: "(potential auto-belay unused, refer to this investigation for relevance)".

    58.2 Under the heading "anything unusual" it was noted: "Climbing on line 2 with his mock lead rope next to the autobelay wail (witness?)" & "Climber was not clipped to autobelay." & "Had no belayer for his lead rope".

    58.3 Under the heading "if there was an injury, how did it occur and what caused it?": "Failing to clip in to autobelay and not having any lead or top rope belayer" & "Impact with floor from approx. 13 meters (witness?), end of event pics of scene (evidence? - pictures)"

    58.4 Under the heading "Was the risk known? if so, why was It not controlled? If not, Why Not?": "The risk of not clipping into an autobelay ls known. It is controlled by signage and warning triangle when climbing on the correct line…". Our finding is that reference to "correct line" is significant. Under the heading "Was the safety equipment sufficient?" the report notes, "An Autobelay is in place (on line 1) which Is next to the incident (line 2). The climber was using his own personal dynamic rope and harness, on Inspection, this dynamic rope seems to be of a EN single rope which is appropriate for lead climbing." In other words, Mr Melvin was believed to have ascended the wall using a route called "climb 2" or "line 2". There was no autobelay at the top of this climb. There was an autobelay on an adjacent route, called "climb 1" or "line 1", but (a) Mr Melvin had not used that climb and (b) not attached himself to that autobelay and (c) climb 1 was not in use and the autobelay for climb 1 was attached to the triangular gate at the bottom of climb 1. The report

includes a diagram (not to scale) showing the route that Arrampica believed Mr Melvin to have taken.

58.5 It was not possible to include a detailed account of Mr Melvin's version of events in this 6 October report (albeit he had been spoken to). The people "present" were listed as Paolo Fubini, Rebecca Hemmant, Henry Thomas, Janine Dealey, Chris Kirkpatrick, Craig Baker, Tom Reynolds. The report stated under the heading "root cause": "Immediate failure to clip in to autobelay, assumption from the team is a lack of concentration and diligent pre-climblng self-checks, of which the root cause we cannot establish amongst those present". There was description of Mr Melvin's activity (based on CCTV), which, in summary, was that he seemed to have been adopting the "lead climbing" method of climbing, but without a "belayer" (ie a second person on the ground holding onto the rope) and that, earlier in the visit, he had done this while attached to an autobelay, but, at the time of the fall, he was not "clipped in". The report stated: "The team discussed the practice of using Autobelays for practicing lead climbing clipping (trailing an un-belayed lead climbing rope) whist primary safety of fall control and lowering is provided by an auto-belay. The team felt that this practice was not the cause of the accident, the root cause being **failure to check attachments and belayers, which has occurred when using auto-belays without trailing an un-belayed lead rope**." (Our emphasis).

58.6 Under the heading, "Did the organisation and arrangement of the activity/work influence the event?": "The centre was quiet, no high ropes activities running, no group sessions. John had recently finished a taster session with another group, therefore no groups. (staff witnesses?)"

58.7 Under the heading, "Do similar risk elsewhere, if so what and where?": "Yes, Failure to clip in and failure to tie in correctly have both occurred and remain a risk across all forms of climbing, potentially **a general lack of PPE precommitment checks is the root control method that is lacking**." (Our emphasis). There is reference to an accident "earlier this year" (which the parties agree was a reference to the Cook incident, which was 2017, rather than 2018).

58.8 The report stated: "There is a real frustration that despite best efforts, an event like this still seems to occur, and this is not Just at XC, but across the climbing world. The hypothesis that signage works seems worryingly naive baring in mind this incident". The desirability of (to paraphrase) a second pair of eyes to check clipping in is discussed (with that second pair of eyes potentially being another customer or a member of staff).

58.9 A long term control measure was stated to be that XC would work with other climbing centres to gather "near miss" data. This was expected to be a 3 to 5 year project. We infer that Arrampica was not using "near miss" to describe somebody almost forgetting to "clip in", but realising the error before starting the ascent. In context, "near miss" is being used to refer to incidents where a person has been at height without being clipped in, but without suffering injury.

59. The minutes of the 15 October 2018 Health and Safety Committee make reference to the Melvin incident, the Arrampica investigation, the Exeter incident, and say that Mr Fubini of Arrampica should asked to provide some statistics for "climbing accidents".

60. On 2 November 2018, Mr Melvin sent back a completed questionnaire which the Respondent had sent to him. As well as describing his injuries (in a manner which matches the information in the Prohibition Notice), he describes what he was doing at the time as "climbing", and refers to that as something he has done multiple times, and that he has attended climbing walls for 20 years. He says that the accident was due to his human error, a momentary lapse of concentration, but without giving details of what he did (or failed to do), or why. He says nothing about autobelays, or about climb 1 or climb 2, or about "clipping in".

61. The Appellant's own report of the Melvin incident was dated 9 November 2018. It did not refer to which climb Mr Melvin had been on, or the location of the autobelay in relation to where he had been climing. It stated amongst other things:

    61.1 "[Mr Melvin] was practicing his lead climbing with back up from an auto belay, as he was climbing alone. All evening he was using the equipment correctly and was always backed up on the wall by the auto belays. On this occasion, [Mr Melvin] had managed to climb the wall, but failed to clip himself into the autobelay. Because of this, he had fallen from the climbing wall. He fell 13 metres to the floor. [Mr Melvin] was taken to hospital by air ambulance, as they were unsure of his injuries, but had to get him there quickly."

    61.2 "Action taken to prevent recurrence: Nothing of immediate effect as this was user error. We have received recommendations to help stop reoccurrence. These have been passed on to senior managers to discuss."

62. That mention of "recommendations" is a reference to the contents of the Arrampica draft preliminary report. Additionally, the report also made recommendations that reshuffling the signage and colour coding of the matting could be implemented.

63. At page 339 to 349 is the finalised version of Arrampica's report. In terms of what Mr Melvin was believed to have been doing on 5 October, there are no significant changes to the draft. In particular, it does not include any analysis of why Mr Melvin was using a climb without an autobelay at the top of it. (There is a discussion about changing floor markings, but the report does not say that the conclusion is that Mr Melvin believed he was actually on climb 1, rather than climb 2, at the time of the accidents. It repeats that the CCTV showed him on climb 1, using the autobelay correctly on that climb, earlier in his visit.) Mr Kirkpatrick's oral evidence was that if Mr Melvin had clipped into the autobelay for climb 1, while using climb 2, then that would be a breach of the Appellant's rules (or expectations, at least) as a fall, or deliberate release, from climb 2 would then have caused Mr Melvin to swing like a pendulum, which is not the appropriate use of the autobelay (albeit, the mechanism should still have been robust enough to provide a slowed descent).

64. The "Step 3 Identifying Suitable Risk Control Measures" section in the final report states that the team had come up with several ideas, including more regular changes of signage, permanent floorwalking, having a second person check

"clipping in" on autobelays. It states that XC is going to gather further evidence and expresses the opinion that, "*The subject of checking before departure on every climb is a cultural issue across the climbing fraternity*." Under "similar" events, the Cook incident is correctly dated. The section concluded with the following passage (our emphasis):

> The whole team were present as we discussed the **events over time in the industry (relevant in some way to this accident), these included (list not exhaustive): Exeter, Gloucester and Sunderland fatalities**, a list of example accidents and near misses involving failure to clip in to Autobelays. History or auto-belay attempt to reduce risk of failing to clip in including the introduction of clip warning barriers and triangles. The instigators to the BMC mini warning signs and cases that focused the industry on production of such warnings etc.
>
> Near misses such as belayer and climbing teams failing to check each other, to include teams having both parties on belay leading to climber falling were also discussed.

65. Section 4, Implementation Plan and Recommendations included: "The hypothesis that signage works seems worryingly naive baring In mind this incident, however, the team discussed how best we can help fellow climbers reduce risk of injury and more importantly how to have each climber at XC and farther afield remember key safety checks before leaving the ground. The team discussing this shows the commitment by XC and Sportspace to focus on real and mature new methods of reminding all climbers to perform meaningful check on themselves and each other of all aspects of the climbing safety chain before leaving the ground" and:

> **Which risk control measures should be implemented in the short and long term?**
>
> Short Term: XC Team and Elise to work on warning signage that can be rotated monthly in terms of colour ad style, this to become a Papertrail Task.
> Short Term: XC Team attending the two-day evidence trail workshops in December will have the style of the event focus on checking each other before climbing.
> Long Term: XC continue to work alongside Westway and other Arrampica partners in gathering near miss data with a view to presenting to the wider industry, this is underway already, but is a good 3-5 years work before useful data and test results of control measures show good evidence-based results.
>
> **The risk control action plan**
>
> XC Team and Elise will produce the warning signage; warning triangles to be replaced with larger versions.
>
> **Which risk assessments and safe working procedures need to be reviewed and updated**?
>
> XC Autobelay new controls as details above should be put in place.

66. In its February 2019 statement to the local authority, the Appellant states that: "*Arrampica were asked to attend the XC to undertake a full and thorough investigation in to how the accident involving [Mr} Melvin occurred. The root cause of the incident was identified as Mr Melvin's failure to check that he was attached to the auto belay. No remedial action was taken save that the Trust decided to change the colour of the warning signage which was already in place prior to the accident*." And: "*The root cause of the accident on 5 October 2018 has been identified as Mr Melvin's failure to check and ensure that he was attached to the*

auto belay, despite his training, and the ample control measures in place." And: "*The risk of climbers failing to clip in to the auto belay is known, and the risk assessments in place were suitable and sufficient. There were no additional reasonably practicable measures that the Trust could have implemented to prevent the accident from occurring*."

The Risk Assessments and the Appellant's other documents

67. The Appellant has a 5 page risk assessment for "XC Auto Belay Competent Climber". It is on the pro forma of one of its Health & Safety advisers, Right Directions. It has 3 columns: List significant hazards; List groups of people who are at risk from the significant hazards identified; List existing control-measures or note where the Information may be found List risks which are not adequately controlled on the list reduction plan.

    67.1 One of the rows has "Attaching to the Auto Belay correctly" in the first column, "climbers" in the second, and in the third it has:

- Ropes competency test or Auto Belay induction required for climbers
- Signage indicating to check your harness
- Staff vigilance and training
- Area checked every two hours on the daily log sheet

    67.2 Another has "Other climbers" in the first column, "Staff/public/climber" in the second, and in the third it has:

- Ropes competency tests
- Auto Belay induction
- Signage indicating rules of climbing
- Staff monitoring area and staff training
- All climbers must fill out a disclaimer before entering the climbing area

    67.3 Another has "incorrectly fitted harness" in the first column, "staff/public" in second and in the third:

- Staff training
- Staff vigilance and regular floor walking
- Auto Belay Induction or Ropes Demonstration Check required to climb on Auto Belays
- Area checked every two hours on the daily log sheet

67.4 Another refers to “injured climber” and in column 3, amongst other things, is listed “Constant floor walking procedures to ensure vigilance/reduced time from injury to first aid”.

68. We have two versions of the document in the bundle: pages 215 to 219 (the “former” document) and pages 220 to 224 (the “latter” document), with corresponding internal numbering 1 to 5. They both show the document was created 7 December 2015, and reviewed 1 February 2016, 1 February 2017 and 14 May 2019. The latter also mentions reviews in October 2018 and December 2018. We did not hear from Mr Thomas or Ms Dealey, and so were unable to ask either of them why the reviews for October 2018 and December 2018 were listed in the document after the review said to have been conducted on 14 May 2019. For completeness, we note the following differences.

68.1 Page 1 of the latter has blue ink on the top two rows

68.2 The former says “Issue 1” on each of the 5 pages; the latter says “Issue 2” on page 1, and “Issue 1” on the other 4 pages.

68.3 The former has the “Right Directions” logo in the centre of the footer of each page. The latter has a similar footer to the former, except the “Right Directions” logo is not there.

68.4 On page 1, for “review date”, the former says “14/05/2019” and the latter says “December 2019”.

68.5 On page 1, in the section “Risk: EQUIPMENT”, at row 1, columns 2 and 3 are the same, but whereas the former just says “spinners” in column 1, the latter has some text inserted both before (the phrase “personal injury caused by:”) and after the word “spinners”.

68.6 On page 1, at row 2, columns 2 and 3 are the same, but whereas the former just says “wall fixing failure” in column 1, the latter has some text inserted before that phrase (the phrase “personal injury caused by:”).

68.7 On page 2, there are some differences in the top row. Each column 1 includes: “PPE failure (Helmets, Harness’ (chest and sit) Auto Belay”, but that is the full text in the former document. The latter has “Injury caused by:” preceding that and then two bullets, the first being “PPE failure (Helmets, Harness’(chest and sit) Auto Belay” and the second is “Not wearing helmets on autobelay routes”. Column 2 in each says “climbers”. Column 3 is identical save for an extra bullet at the bottom of the latter document being “No helmets on auto belays – eliminate strangulation risk”.

68.8 On page 3, in the row “hitting head on wall”, the latter document has a new bullet point inserted in column 3, “Helmets not to be worn when using autobelays”. (Both documents have the bullet point “Advising all climbers to wear helmets unless on the auto belay”).

68.9 On page 5, the first three rows of “review conducted by” are identical, and in chronological order, with the third one being dated “14/5/19”. But on the former document the next two rows are blank, and in the latter document they

are each completed to state that Janine Dealey, Duty Manager, conducted reviews in "October 2018" and "December 2018" respectively. Unlike the first three "Review Conducted by:" rows, no specific date of review is mentioned, just a month.

69. So, to sum up, the former document does not appear to have anything missing that is in the latter document. Whereas the latter document includes certain pieces of text that are not present in the former. If it were true that the latter document was produced in December 2018, and the former on 14 May 2019, then it would follow that on or around 14 May 2019 Henry Thomas, Operations Manager, chose to make certain deletions to the latter document to produce the former (including, on this hypothesis, the deletion of the last two rows on page 5). However, if it were true that the latter document was produced in December 2018, then that would not explain why it includes reference on page 5 to Henry Thomas having done a review on 14 May 2019. The more likely explanation is that the former document was actually the result of a review by Mr Thomas on or around 14 May 20**18**, and he dated page 5 incorrectly, and the "review date" on page 1 was to indicate that the risk assessment should be reviewed again in 12 months' time (this is consistent with how "review date" on page 1 is used in the other assessments). Therefore, that is our finding of fact, and we find that the former document is what was "current" as of the Melvin Incident and that the latter document shows later additions to the former document inserted in October (after the Melvin Incident) and/or December 2018, and was "current" as of January 2020 when the notices were issued.

70. There is another risk assessment using the same pro forma with the title "Auto—Belays (and routes)". (Page 225 to 229 of bundle). One of the rows has "Climbers not clipping in" in the first column, "climber" in the second, and in the third it has:

- Signage reminding to check attachment
- Signage indicating practice of falling from 1 metre before starting climb
- Use of 'belay master 2009' karabiner or equivalent.
- Climbers must be signed of as rope competent, be supervised by an instructor or rope competent climber to use the auto belays.

71. This was created on 17 January 2012, and reviewed 17 January 2013, 20 November 2013, 20 November 2014, 20 November 2015, 1 November 2016, 10 October 2017, and October 2018

72. The risk assessments just described are the ones referred to in the Improvement Notice.

73. The bundle also included a risk assessment with the title "climbing wall". That had:

73.1 A row in which "bad belaying technique" was in the first column, and "staff/public" in the second. The third column lists: "Staff training; Staff vigilance and regular floor walking; Ropes test required to enter climbing area; Area checked every two hours on the daily log sheet".

73.2 A row in which "tieing in correctly" was column 1, "climber" column 2, and column 3 was: "Ropes Competency test required for climbers; Signage indicating use of re—threaded fig of 8 as recommended knot; Staff vigilance and training Area checked every two hours on Papertrail"

73.3 A row in which "other climbers" was column 1, "staff/public/climber" was column 2 and "Ropes competency tests; Signage indicating rules of climbing; Staff monitoring area and staff training" was column 3.

74. The bundle also included a risk assessment with the title "top roping", and we note, in particular, the rows "bad belaying technique", "tieing in correctly", "belayer being lifted", "leader not setting belay position up correctly". For the row, "fall while setting up stance", column 3 states: "Staff vigilance and training; Never untieing or calling safe while setting up".

75. A further assessment for "trad lead climbing" was also in the bundle and included rows for "Traditional protection failing (human error)" and "Tieing in correctly" and "Bad Belaying Technique."

<u>The Respondent's investigation and decision to issue the notices</u>

76. The Melvin incident was investigated by the local authority, specifically by the Respondent and her team leader. It is not disputed that Ms Connolly has been appropriately appointed under section 19 of the Act. She does not purport to be a specialist in climbing or extreme sport. Her duties require her to visit a wide range of businesses, including shops, restaurants, childcare providers, etc, as well as leisure facilities.

77. In response to the Melvin Incident, an initial visit to the XC premises was undertaken by the Respondent on 10 October 2018 with her Team Leader. During this visit information was gathered and the accident site was inspected. A copy of the preliminary Arrampica report was provided to her during the visit. She became aware that for a person climbing by themselves, no checks were done by staff to ensure that person was clipped into an autobelay (though 2 hourly floor walking did take place).

78. She sent a letter to Mr Melvin on 19 October, and received the response we have referred to above. Further information was requested and received from the Appellant and the final Arrampica report and relevant risks assessments were received in December 2018. A case review was undertaken around 16 January 2019, and the information received to that date was reviewed. The Respondent formed the opinion (and we agree) that the Arrampica (preliminary and final) reports identify that the risk of failing to clip into the auto belay was known by the Appellant and within the industry.

79. She noted the control measures which had been discussed as possibilities within Step 3 of the Arrampica final report, and that only reshuffling signage had been adopted.

80. In February 2019, the Appellant was invited to an interview under caution. It elected instead to submit the voluntary statement to which we have referred, and supplied the Respondent with the document which appears at pages 220 to 224

of bundle. The Respondent formed the opinion (and we agree) that this version of the risk assessment had not adopted (and did not mention) the further control measures suggested in the Arrampica reports.

81. In April 2019, the Respondent's team leader emailed Dan Middleton, Technical Officer for British Mountaineering Council ("BMC"). Mr Middleton's response included the following extracts (our emphasis):

    81.1 Operators "should ensure that users of any autobelays understand their correct use and how to climb safely using one, and this should be confirmed prior to use as part of the registration process. If the facility is a roped climbing facility, it is generally deemed sufficient to provide best practice advice next to the autobelays, as roped climbers will already know how to put on a harness and safely operate a locking carabiner."

    81.2 "Climbers using autobelays climb **alone and therefore cannot use buddy checks as roped climbers can do**, which are proven to be a very effective method of preventing accidents caused by human factors. Therefore it is considered **good practice to either take steps to warn users in case they have made an error and failed to connect themselves to the autobelay, and/or to prevent them from accessing the climb until they have**."

    81.3 Having referred to control measures including signage, line of sight from reception, and auto-belay barriers, he noted: "**Floorwalking. This is considered a main line of defence within the industry** to help mitigate risk and can act as an additional source of training for users, if the floorwalking staff are knowledgeable and suitably trained".

82. In May 2019, having requested them, the Respondent received the spreadsheets including notes of floorwalking and maintenance checks (only brief extracts from which have been included by the parties in the bundle).

83. In June 2019, the Respondent attended the premises with her team leader, and spoke to Mr Kirkpatrick about floorwalking, her notes of which appear in the bundle.

84. A further invitation to an interview under caution was made, and the Appellant responded with its October 2019 statement. Some more information about the autobelays was requested and received, and, in December 2019, a decision was made to issue the notices which – in due course – were issued in January 2020.

85. The time taken between October 2018 and January 2020 to move from first site visit to issuing of notice was not because the Respondent had formed the opinion at any stage that the conditions for serving a notice were not met.

86. Furthermore, our finding is that there was no failure on the Respondent's part to alert the Appellant to the fact that she was concerned that the measures which they had in place might not be – in her opinion – adequate.

87. Her covering letter, as well as discussing the legalisation, the contents of the Appellant's statements, and other documents, stated: "*Given the reluctance of the business to modify their practices despite the two aforementioned incidents, the risk of significant person injury still exists. This is the reason for the health & safety*

notice prohibiting free climbing on the walls at the XC Jarman Way and an improvement notice is being served on the business to review and Improve the risk assessments."

Experts

88. We will largely confine our comments on what the experts told us to the analysis section of our decision. We note that of the two, Mr Petherick had more knowledge of climbing and the climbing wall industry. His extracts from the ABC and BMC documentation were very helpful. He was also able to give additional background information on incidents that had resulted in serious injuries or death in the last few years, including those mentioned in the Arrampica reports (which Ms Hemmant confirmed had come to her attention each time via trade updates).

89. We accept that, as described in 2.7 of Mr Petherick's report (and mentioned in the Appellant's statements to the local authority) the Appellant has (since around 2015) used the services of Arrampica Ltd as technical adviser to review procedures and provide training in accordance with industry standards. We note that the risk assessments used by the Appellant are on the stationery of another (more generalist) adviser, and they do not include the matrix shown at figure 1 of paragraph 2.4.6 of his report, which is a matrix "recommended by Arrampica".

90. We note that Mr Petherick's report, at para 4.5, mentioned the following:

> I am aware that subsequent to both the above accidents, but especially as a result of the incident involving Mr Melvin, a review of procedures took place and various changes implemented, including:
>
> - Re-emphasising the need for no free climbing activities (other than within the bouldering areas) and the need to ensure 'competent' classified climbers are reminded of the need to clip in to the cable when using auto-belays;
>
> - Increasing the frequency of floor walking activities throughout the climbing hall to ensure that all areas are visited at least hourly (rather than two-hourly as previously);
>
> - Daily pre-opening checks to include pull tests and karabiner function check of all auto-belay devices; and
>
> - An increased number of 'Are you clipped in?' signs on walls, with changes in colour of signage (see Figure Five D, page 25 above, for examples) with every re-setting of climbing routes.

91. Within paragraph 4.11, there is the following comment:

> If detailed explanations of how control measures will be implemented were to be recorded in risk assessments the document would become overly prescriptive. In fact, since the 'December 2015' risk assessment was last reviewed in December 2018 it is my understanding that one of the control measures has changed, with regularly trained floorwalkers checking each climbing area at least hourly.

92. So, to paraphrase, what the Appellant has told Mr Petherick is that (a) a review of procedures took place and (b) it was as a result of "both" accidents but "especially"

the October 2018 incident and (c) one outcome of that review was to increase floor-walking from 2 hourly to 1 hourly and (d) the most recent risk assessment review was December 2018 and (e) that the increase in floor-walking is not mentioned in that review.

Floor-walking

93. In fact, Ms Hemmant's evidence to the tribunal was that the increase in floor-walking from 2 hourly to 1 hourly did not happen until after the service of the notices, which was in January 2020. She was unable to specify the date of the increase, and we did not see any version of a floor walking policy (either 2 hourly or 1 hourly).

94. We had 2 pages extracted from a spreadsheet of the Appellant's records of the floor walking spot checks. We had the sheet for checks recorded between around 3pm on 13 September 2017 and around 3pm on 28 September 2017 (page 533) and around 3pm on 2 October 2017 and around 8pm on 27 October 2017 (page 532). These sheets do not show an entry for every 2 hour interval within those period.

    94.1 An entry for 14 October shows someone having been "caught" without being clipped in by 3rd clip, and being able to climb down safely.

    94.2 An entry for 14 September shows someone was stopped when they were about to climb, with their autobelay harness being worn incorrectly.

    94.3 On 17 September, a belayer was found not to have buckled up correctly.

95. We accept that each instance of floor-walking would take a variable amount of time depending on numerous factors, and especially the number of people using the facility at the time. We accept that the purpose of the floor-walking included making a check to see if anything needed action (which could include telling a climber that they were doing something unsafe or in breach of the rules) and that, self-evidently, the length of time between the start of the floor walk and the end of it would partially depend on how many issues were found that needed to be fixed on the spot (or recorded for later fixing). The Respondent's estimate was that potentially a floor walk might be around 10 to 15 minutes. We accept that as a reasonable estimate (subject to the caveats mentioned earlier in this paragraph) based on the totality of the evidence. It follows, therefore, that a 15 minute floor walk done 2 hourly, would mean that around 12.5% of the time, a floor walk was in progress, and around 87.5% of the time there was not. The 15 minutes is not spent exclusively looking at the unsupervised climbers.

96. The Appellant has failed to prove what the floor walkers were specifically told to do in terms of (a) checking that someone on an autobelay climb was clipped into the autobelay for that climb; (b) checking that someone on a climb that was not an autobelay climb was or was not clipped into an autobelay; (c) checking whether an unsupervised climber who appeared to be by themselves would climb only using the autobelay; (d) otherwise checking what each unsupervised climber was intending to use as a method to arrest a fall (ie whether they were going to be autobelaying or using a partner).

97. If the sample in the bundle (pp 532-533) is typical, then most floor walks resulted in either a blank entry in the spreadsheet or no entry at all in the spread sheet. We have no reason to doubt that the reason for that was that most floor walks did not result in anything that needed to be put in writing. However, the Appellant has failed to prove what instructions were given to staff about what the precise check they needed to do on each floor walk, and what did need to be logged (whether in the general floor walk spreadsheet, or the file of an individual customer, or at all).

Analysis and conclusions

98. We make the following preliminary observation. For someone who is not using any belay mechanism or any other device to prevent a fall or arrest a fall, then the potential reasons for their leaving their position at height on the wall, and freefalling to the ground include:

    98.1 They made a deliberate decision to climb the wall using autobelay, thought that they had done so (when they had not) and deliberately let go of the wall incorrectly expecting their descent to be controlled by the autobelay.

    98.2 They made a deliberate decision to climb the wall using a partner as a belayer, thought that they had done so (when they had not) and deliberately let go of the wall expecting their descent to be controlled by their partner.

    98.3 They made a deliberate decision to climb the wall using autobelay, thought that they had done so (when they had not) and unintentionally came away from the wall because of their own mistake, or for another reason.

    98.4 They made a deliberate decision to climb the wall using a partner as a belayer, thought that they had done so (when they had not) and unintentionally came away from the wall because of their own mistake, or for another reason.

    98.5 Having made a deliberate decision to climb the wall without using any belay mechanism or any other device to prevent a fall or arrest a fall, through force of habit they deliberately let go of the wall expecting their descent to be controlled, having forgotten that, in this occasion, they were not attached to anything which would control the descent.

    98.6 Having made a deliberate decision to climb the wall without using any belay mechanism or any other device to prevent a fall or arrest a fall, they unintentionally came away from the wall because of their own mistake, or for another reason.

99. This list is not intended to be exhaustive. The Appellant's position is that both the Cook Incident and the Melvin Incident were examples of the first of these 6. As a matter of logic, that means that they do not believe it to have been any of the other 5, or any other possibility not listed by us in the preceding paragraph.

    99.1 For Cook, no written record of how the Appellant came to their conclusion is included in the bundle. We have been provided with no evidence that they took a written statement from him. It appears that believe they have information about where he fell from [12 July 2017 XC Team Meeting minutes say "Climbing area incident, guy fell off overhang autobelay. Open fracture to

leg"], but the source of that belief and the specific reasons for asserting that he deliberately let go because he thought he was "clipped in" are not noted.

99.2 For Melvin, we have noted what is said in the Arrampica report, including under the headings (341) "What Activities were being carried out at the time?"; (343) "Analysis, what happened and why?" and (344) "Skill based errors (a slip or lapse of memory)?" and "Mistakes, errors of judgement, rule based, or knowledge based?" We also note what Melvin wrote to the Respondent. We have not seen where it states that he deliberately let go, or where he says that he believed himself to be clipped in to the autobelay (for climb 1, or otherwise) or where he was questioned about what caused him to be on climb 2 (a route without an autobelay) if his intention and belief was to use an autobelay for the ascent in question. We have not seen the CCTV, and so do not know why the inference from the CCTV was that he was "waiting" to use climb 1. Paragraph 8.5 of the voluntary statement says that the period in which it is claimed he was "waiting" to use climb 1 included his talking to other people and using the bouldering wall. So we do not know why the fact that he was not climbing in that interval is judged to be "waiting" as opposed to choosing to other things. It is not clear if Melvin was actually asked if he was "waiting" to use climb 1.

100. We note that the Respondent accepted, in cross-examination, that she was not seeking to challenge the Appellant's assertion that Cook and Melvin had each intended to clip in, and had simply accidentally overlooked the fact that they had not done so before starting their climb (and before deliberately letting go).

101. We are content to make our decisions below on the basis of assumed facts that the Cook and Melvin Incidents each occurred as per the Appellant's position in the voluntary statement of February 2019 (summarised at paragraph 10.1 for Cook and 8.6 for Melvin {8.4 is not necessarily consistent with the Arrampica report, and we rely on the Arrampica report}). We certainly do not think it would be appropriate for us to decide that either Cook or Melvin deliberately intended to flout the rules, or was ignorant of the rules, when (a) neither party argued that and (b) we have not heard from them as witnesses. However, the fact that we are making our decisions on those assumed facts should not be taken as an indication that we think that the Appellant or anybody else carried out a sufficient investigation such that a court or tribunal could be satisfied, based on the evidence in this bundle, that Cook or Melvin deliberately let go thinking that they were clipped into anything, still less that they thought they were using the autobelay on their climb. We know that for Melvin there was a vacant autobelay on an adjacent climb, and we know that he was able to start his climb without bypassing the autobelay barrier (because there was none on his climb) or noting that the autobelay webbing was at tension and was between him and the wall (because it was not; it was on the adjacent climb). We have no similar information for Cook. We do not know if he was using a climb with an autobelay (and, if so, whether the webbing was fully retracted to the device, or connected to the gate, and, if the latter, how/why he climbed past the gate without being alerted to the need to detach the gate and connect the autobelay to himself) or if, like Melvin, he was also on a climb that did not have an autobelay (and, if so, why it is believed that he thought he was using the autobelay).

102. We are satisfied that we can make our decisions in this case on an assumption that both Cook and Melvin (a) knew the rules and (b) intended to follow them. Furthermore, we will base our decision on the assumption that they intended to use the autobelay and therefore the particular rules which they intended to follow included the rules for use of the autobelay.

103. It is convenient for us to address Item 2 from the list of issues first.

<u>If the Appellant was carrying on or in control of the activity described as 'free climbing (not using any belay mechanism or any other device to prevent a fall or arrest a fall) on the climbing walls' at the XC on 6.1.20</u>

104. The Appellant's undertaking includes the operation and control of climbing walls at XC (as well as the bouldering walls). Access to the climbing walls is controlled by the Appellant and is only available to its customers (whether those who pay on the day, or who pay via a membership scheme, or who have some other payment arrangement with the Appellant). Customers must first report to reception on each visit before being allowed to go to the wall, and it is the Appellant which decides whether the customer can be "unsupervised" or must be "supervised".

105. There is no dispute that both climbing while attached to another human being as belayer (lead climbing and top climbing) and climbing while attached to the auto-belay are permitted by the Appellant as part of its business arrangement with customers. None of the Appellant's customers are obliged to do any of these activities – and they sign a waiver to acknowledge that it is their own free choice to do them – but the whole point of visiting the climbing walls is to climb, and the methods just mentioned are expressly authorised methods. It is also clear from the evidence that customers are permitted to descend from height by pushing off from the walls and having a controlled descent. The documents signed by the users encourage them to descend by climbing down instead, but it is not argued by the Appellant that relying on the belay or autobelay for a deliberate descent is forbidden by the rules or that it only occurs when its staff are not watching. In answering the panel's questions, Mr Kirkpatrick accepted that it is a common method of descent.

106. It is not in dispute that there have been a minimum of 2 occasions on which a climber was "not using any belay mechanism or any other device to prevent a fall or arrest a fall". That is the Cook Incident and the Melvin Incident, for which the Appellant's own findings were that the climber was (a) climbing and (b) not using any belay mechanism or any other device to prevent a fall or arrest a fall.

107. In addition to those occasions, we have also mentioned incidents from the logs on pages 532 and 533, which cover only a comparatively small time period. Our decision is that one of those was an incident where the climber was (a) climbing and (b) not using any belay mechanism or any other device to prevent a fall or arrest a fall. The other two were examples of attempting to use a device to prevent a fall, but doing so incorrectly.

108. We were not shown any evidence that any of the incidents had been logged as a rule breach, which (either of itself, or if repeated) might lead to exclusion from the facility. The Appellant's own account was that Cook had resumed use of the wall.

(By the phrase "rule breach", in this paragraph we are not limiting it to either accidental breaches only or to deliberate breaches only).

109. We note that in the Board Meeting in July 2017, Ms Hemmant referred to advice stating that "*the most common cause of accidents when climbing is people forgetting to clip themselves on*". We also note the descriptions of the Cook and Melvin incidents in the RIDDOR reports, the Arrampica reports, the Appellant's own report for the Melvin Incident, and Mr Melvin's answer to the Respondent's questions. Melvin and Cook are described as having been "climbing". It is not suggested anywhere that they became trespassers at some point as a result of what they did.

110. We are satisfied that the Appellant grants access to its walls so that people can climb. It is aware that some of the time, some people will climb in a way which is contrary to best practice and/or contrary to the Appellant's rules and/or dangerous. Customers should not do any of those things, but they do do them. One particular example of something which is contrary to the Appellant's rules (as well as being bad practice and, as we will discuss below, dangerous) is climbing while not using any belay mechanism or any other device to prevent a fall or arrest a fall and this is something which the Appellant knew would happen from time to time as a result of its allowing customers access to its walls (especially the "unsupervised" access granted to those who passed the rope competency test and signed the waiver.)

111. The Appellant had the ability to control this activity as of 6 January 2020. There is an unlimited range of methods of control it could exercise. One method which it did in fact adopt was informing customers that they were not allowed to climb while not using any belay mechanism or any other device to prevent a fall or arrest a fall. Another method which it did in fact adopt was the 2 hourly floor walking checks. Various other methods such as CCTV, improving line of sight from reception, increasing the staff members monitoring the wall, were all in things which the Appellant had the power to adopt to control the activity. "Controlling" the activity would include methods to prevent customers leaving the ground in the first place if not using any belay mechanism (or any other device to prevent a fall or arrest a fall), as well as method to bring the person back down to the ground in a controlled and safe manner if the lack of belay mechanism is not discovered until the customer is already at height.

112. We therefore go on to consider item 4 from the list of issues.

<u>If the Appellant was carrying on or in control of the activity described then whether the activity involved a risk of serious personal injury on 6.1.20;</u>

113. Falling from height can cause serious injury or death. Each of Cook (fall from 8m) and Melvin (fall from 13m) suffered serious injury.

114. Climbing while not using any belay mechanism (or any other device to prevent a fall or arrest a fall) means that a fall to the ground can happen if (for example): the climber makes an error and loses their grip; suffers a sudden onset of illness and loses their grip; is struck by another climber or object which dislodges them; or if the foothold or handhold fails. Alternatively, according to the Appellant (and not disputed by the Respondent), a person not clipped in could also deliberately push

off from the wall incorrectly believing themselves to be attached to an autobelay or a belayer, and expecting to have a slow descent, but instead having a freefall.

115. As well as the injuries that can be suffered from impacting the ground (on the rubber mats) with force, injuries could occur from attempts to grab onto the wall and/or from body parts striking the wall on the way down.

116. It is not necessarily the case that every time a climber uses the wall while not using any belay mechanism (or any other device to prevent a fall or arrest a fall), they will suffer serious personal injury. They might fall from a very low height. Alternatively, they might not fall off at all. However, each time someone begins an ascent without using any belay mechanism (or any other device to prevent a fall or arrest a fall) there is a danger of serious personal injury which is significantly greater than if they began the same ascent while "clipped in" to the auto-belay, or with the appropriate assistance of a human belayer.

117. It is next convenient to consider item 6 from the list of issues.

<u>If the Appellant was in breach of Regulation 3(1)(b) of the Management of Health & Safety at Work Regulations 1999 as contended in the opinion of the Respondent, or at all, on 8.1.19 (sic) - 8.1.20;</u>

118. One thing that the risk assessments do not do is include any matrix or any other numerical evaluation of the risk. Although there was a lot of cross-examination of the experts on the topic (which we do not need to repeat in full), it was ultimately common ground (and we agree) that it is not a legal requirement that a risk assessment must include a matrix (or any other assignment of a purported numerical value to different risks).

118.1 Each of the experts acknowledged that one way (not the only way) that a risk assessment might demonstrate that the "duty-holder" (a term found in the Enforcement Management Manual) had evaluated the risk was to use a method which identified possible hazards, and then, for each hazard assign a particular integer (commonly in the range 1 to 5, but it could just as easily be 1 to 3, or something else) to each of (a) the likelihood of it happening and (b) the severity of the consequences if it did happen. The more likely the chances of occurrence, the higher the integer; the more severe the consequences, the higher the integer. Multiplying together gives a product which can be treated as a tool to at least rank the risks associated with each identified hazard.

118.2 Dr Cooper said (and we agree) that if this method is to be used, it is absolutely essential that the definitions that are used are in writing and clear and easily applicable so that different individuals do not develop their own systems for deciding to allocate a "2" or a "4" etc. He also noted that a risk factor of (say) 5 could be the product of likelihood = 1 and consequences = 5 or of likelihood = 5 and consequences = 1, and he cautioned that that might be too blunt an analysis. More is required.

118.3 The experts agreed that if matrices were used, their purpose was to assist the "duty-holder" to recognise which of the hazards might need further control

measures put in place to reduce the risk (whether by reducing the likelihood, or the severity, or both). The matrix itself does not reduce the risk.

119. In 2.5, of the joint statement, the experts say:

> We DISAGREE as to whether any review of the RAs took place following the accidents in July 2017 and October 2018. AJP believes that reviews took place, including with the appoint Technical Adviser. MJC DISAGREES in the absence of documentary evidence.

120. After the 2017 incident, there was no review of the "XC Auto Belay Competent Climber" until May 2018 (in our findings of fact, we have said why we think the third review was 14.05.18 rather than, as typed, 14.05.19). Ms Hemmant's oral evidence was that someone had reviewed it prior to then, but she could not say who, or when, or why the review was not mentioned on page 5. We do not accept the Appellant's claim that there was a review. There was a review of "Auto-Belays (and routes)" assessment on 10 October 2017. However, our analysis based on the timing of the other reviews mentioned on pages 4 and 5 of that document, is that the October 2017 review was done because it was 12 months since the previous review, not because of the Cook Incident some months earlier. There is no record of what changes (if any) were made in October 2017 (or any other date) and the Appellant accepts that Mr Thomas could not have been looking at a written report of the Cook Incident when he did his review (because there was no such written report). In summary, neither of risk assessments that are the subject of the improvement notice was reviewed to take account of any lessons learned from the Cook Incident.

121. We have found that there was a review "XC Auto Belay Competent Climber" in December 2018 and the resultant document is at pages 220-224. The changes compared to the 14 May 2018 version (215 to 219) are noted in our findings of fact. (We accepted there was also a review in October 2018, but there is no way to telling which, if any, changes were made in October and which, if any, were made in December.) There was a review of "Auto-Belays (and routes)" assessment in October 2018, but that was the date it was due for its annual review in any event. There is no direct evidence about whether any changes were made, although we do note that it was Ms Dealey who did this review as well, and the document in the bundle (225-229) does not include similar additions to column 1 (eg adding reference to "injury") as appear in the amended version of the "XC Auto Belay Competent Climber". The similarity of the wording when pages 225-229 are compared to 215 to 219 leads us to infer that there were no changes made to the "Auto-Belays (and routes)" document in October 2018.

122. We do not infer that Arrampica was directly involved in the review of the risk assessments. Their stationery is not used, their methodology is not used, and the suggestions in Step 3 and recommendations in Step 4 of their report are not addressed.

123. We have noted paragraph 2.13 of the joint statement, and the cross-referenced parts of Dr Cooper's report. It is our decision that the Appellant's approach to seeking to avoid/reduce instances of falls from height by persons not using any belay mechanism (including the auto-belays provided), or any other device to

prevent a fall or arrest a fall, relies pretty much exclusively on the climber themselves doing this.

123.1 There are signs in place to remind them, but our view, like that of Dr Cooper (and, we infer, Arrampica), is that regular customers are not going to read the signs on every visit; their attention is no longer piqued as a result of their familiarity.

123.2 The risk assessments mention "Auto Belay Induction" which is not something expressly dealt with in Mr Kirkpatrick's written statement. As mentioned in our findings of fact, he refers to both 4.15 and 4.16 as being part of "rope competency assessment, and we have not been shown any documents that specifically record that "auto belay induction" (or the things that Mr Kirkpatrick said orally were part of the checks mentioned in paragraph 4.15 of his statement) has been done for a given climber. However, and in any event, even on the Appellant's own account, after the initial check which allows someone to be given permission climb unsupervised, there are no further scheduled checks or reminders.

123.3 The floor-walking is nothing like constant supervision or monitoring. Reception does not have line of sight to the entire wall and, as Mr Kirkpatrick pointed out, the receptionist's job is to serve customers in reception, not to keep an eye on the wall. Experienced and qualified instructors may well be in the climbing wall area at a given time, but only if they are there to supervise a group; while they are encouraged to keep an eye on the wall, that is not at the expense of closely watching the group they are with.

123.4 The difference of opinion between the experts as to whether the existing triangular barrier was sufficient (Petherick) or a wider rectangular barrier was needed (Cooper) is something of a red herring given that there are climbs (such as climb 2, from which Melvin fell) which have no barriers at all. At least part of the reason for their difference of opinion, it seems to us, both on the barrier issue and the foothold issue, relates to whether the unsupervised wall user should be considered as someone who (i) knows how to clip in and (ii) knows all the risks of not clipping in, and therefore the importance of clipping in and (iii) is deemed to be someone who wants to avoid those risks and wants to clip in, and needs only reminders so that they do not accidentally forget, OR whether significant impediments should be put in the wall users way to make it difficult for them to ascend it not clipped in, whether as the result of forgetfulness or choice. Neither the wider rectangular barrier nor the removal of footholds on the autobelay climbs would necessarily prevent a determined person from using an autobelay climb without being clipped into the autobelay, but would potentially make it more obvious to others in the vicinity that that is what they were attempting to do. We do not know if Cook accidentally climbed on an autobelay route while the triangular sign/barrier was in place (because the Appellant did not document any investigation of what happened); we do know that Melvin accidentally climbed while the triangular sign/barrier was in place; he was able to do so because he ascended an adjacent climb to the autobelay climb, one which had no barrier. Therefore, even on the assumption that wall users should be deemed to be people who will always

clip in if they remember to do so, the barrier does not prompt them to remember to clip in on every route.

124. We note what paragraph 2.12 of the joint statement says and we will consider that alongside paragraph 2.4, which reads:

> We AGREE that the RA was basic, met industry standards, but might have benefitted from a risk rating score. We DISAGREE that in this case industry standards were insufficient. MJC believes that the industry standard fell below the legal requirement.

125. We note that "industry standard" refers to the ABC and BMC position, and we have considered the appendices to Mr Petherick's report as well as the email from Mr Middleton.

125.1 A difference between climbing with a partner and solo climbing using an autobelay is that the former means that there will be two pairs of eyes from the climbers themselves (without the need for a staff member, in other words), but the latter would only have one pair of eyes, unless a particular arrangement is made, eg that the climbing wall operator insists on attachments being checked either by a staff member or another user. Mr Kirkpatrick's comment that "The XC offers unsupervised climbing experience to rope competent climbers who wish to **recreate an authentic climbing experience indoors**," (our emphasis) does not take account of the fact that autobelays are not part of the "authentic" experience elsewhere. The autobelay is not only allowing the activity to take place indoors, it is removing the need for a partner, and therefore removing the second pair of eyes. It is a different "experience".

125.2 Mr Petherick, at paragraph 4.4 states: "This is not a case where Mr Cook and Mr Melvin were being allowed to climb free of any belay devices or the activity was permitted or condoned. **This is an important consideration** which should be borne in mind when considering the management and operating procedures together with the relevant risk assessments." (Our emphasis). In the context of the paragraph, the reference to the BMC manual appears to be used to suggest that accidents "where users have failed to clip in to the cable", are an inevitable outcome of the use of autobelays.

125.3 We note the statistics in the BMC manual which are said to show in Chart 1 a breakdown by "activity being undertaken at the time of the accident". The document does not make clear if a failure to clip into an autobelay is part of the activity of using an autobelay. (We have rejected the Appellant's argument in this case that it would be a different activity, but it is unclear whether BMC adopted our approach, or that of the Appellant). The BMC manual whose extracts are appended to Mr Petherick's report is a 2008 document (written before climbing walls became as widely available as they were in January 2020, and before the injuries and fatalities referred to in the Arrampica report and Mr Petherick's and Ms Hemmant's oral evidence, and before the Cook and Melvin Incidents). Therefore the comment in 5.1 of the manual that "very few major accidents occur at climbing walls" has to be treated with some caution. In context, this remark is part of the justification for the comment in the previous paragraph that "Experienced climbers can be left to conduct their own affairs without direct supervision". (A sentiment echoed by Mr

Kirkpatrick's analogy to drivers with a licence being able to drive unsupervised).

125.4 The comment in the manual that "As long as facilities have not contributed to an accident, sports facility managers are not responsible for injuries that arise from the normal pursuit of sport" is juxtapositioned to the recommendation to use the BMC participation statement, which includes the sentence "Participants in these activities should be aware of and accept these risks and be responsible for their own actions and involvement". These sentences are not specifically addressed to autobelays (only) as the manual refers to various activities on climbing walls, including those where experienced climbers act as a team, looking out for each other.

125.5 We also note the ABC manual, including paragraph 2.1.1 (page 157 of bundle). We also note that it states: "For experienced roped climbers, it is sufficient to provide best practice guidelines next to the autobelays. This is because the key risk with autobelays lies with users not clipping In to the autobelay and roped climbers will already know how to put on a harness and operate a locking carabiner safely. We also note the contents of "2.10 Monitoring".

125.6 Under risk assessments, the ABC manual includes comments that the assessment should consider the likelihood of a hazardous occurrence and the severity of it and that control measures put in place to lower the level of risk wherever possible. It should be reviewed at least annually and whenever there are changes to procedure. The Health and Safety Policy and Operational Procedures should be based on the risk assessments and reviewed (annually, when there are changes and) "in the event of a major incident". It refers to the HSE website for further information.

126. Our decision is that the risk assessments which were current in January 2020 titled "Auto-belays (and routes)" (pages 225 to 229) and "XC Auto Belay Competent Climber" (220 to 224) are not suitable and sufficient. They do not evaluate the risks at all (either before the Cook Incident, or between the Cook Incident and the Melvin Incident, or) after the Melvin Incident.

126.1 "Barriers" as a means to prevent accidental use of an auto belay route without clipping in is not mentioned as a control measure (or at all).

126.2 The possibility of someone using an auto belay route without seeing the barrier because the webbing was fully retracted to the device is not mentioned.

126.3 The possibility of someone ascending without being clipped in, and not seeing the barrier because they were not on an auto-belay route, but on some other climb, is not mentioned.

126.4 Measures to address the possibility of someone deliberately choosing to ignore the rules and/or deliberately circumvent the barrier are not discussed.

126.5 The possibility of someone deliberately letting go because they thought they were clipped in is not mentioned, even though, according to the Appellant,

that was the actual reason for Cook and Melvin falling from height and suffering their injuries (and therefore was a possibility known since 2017).

126.6 More generally, the various possible causes of a "fall" while not being clipped in are not addressed. Injury due to "spinners", or wall fixing failure, or PPE failure are discussed, but not linked to whether, at the time, the user was or was not "clipped in". The risks to other people caused by a climber freefalling from a significant height are not addressed expressly (and certainly not evaluated).

126.7 While "attaching to the auto belay correctly" is mentioned in column 1 (meaning it is seen as a significant hazard), there is no mention in that row that the outcome might be serious injury or death. There is no assessment of the likelihood. We agree with Dr Cooper that 2 separate incidents in 2 consecutive years would, in itself, be something which ought to have alerted the Appellant to consider the likelihood. The Appellant had not assessed the likelihood previously, and so there was no estimate to increase, but even if there had ever been a justification for regarding the likelihood as "low" (and that is not our opinion), the Cook Incident removed that justification, and the Melvin Incident was further reinforcement.

126.8 Similarly, we also think that the incidents elsewhere in the country, including fatalities, were a reason that the Appellant should have reviewed its risk assessments, and assessed the likelihood of a climber falling when they were not attached to something to arrest their fall. Different likelihoods might apply depending on whether the user was in the process of top rope climbing, lead climbing or intending to climb with auto-belay. One reason that there might be different likelihoods is that the risk might be greater for the types of climbing that do not necessitate a partner. The risk assessment documents show no evidence of the Appellant addressing its mind to the likelihoods. (In passing, we comment that we do not agree with Mr Wright's suggestion that – based on the number of users who do not fall without being clipped in, the likelihood should be treated as 1 in a few thousand, etc. That methodology would only make sense if a different risk assessment was to be done for each user for each visit to the centre. However, in a risk assessment intended to be reviewed annually, and to inform procedures and policy, our view is that the Appellant should actually be assessing the likelihood that, over a period of time, at least one climber might fall from height while not attached to – as the case may be – the autobelay device, or whatever other measure they were should have been using at the time to arrest their fall. However, the Appellant did not address the issue at all, regardless of methodology).

126.9 While referring to "staff vigilance and training" as a control measure, that is extremely vague and does not address how that measure will assist to reduce the risk. The same applies to "Area checked every two hours on the daily log sheet". The Appellant's view is that if it notices that a climber is not clipped in, it will speak to the climber about that, but the two measures just mentioned do not suggest that the Appellant will proactively check an "unsupervised" climber is secured. On the contrary, the Appellant's position is that its users do not want it to do that, and that it does not want to do that.

127. The fact that "Free climbing (not using any belay mechanism or any other device to prevent a fall or arrest a fall) on the climbing walls", is not something which the Appellant's customers are allowed to do by the Appellant's terms and conditions is not a reason to fail to include it in risk assessments, or to implement control measures. On the contrary, one of the reasons that the Appellant's terms and conditions inform customers not to do this is that it is known to be very dangerous. The likelihood/consequences of persons breaching the terms and conditions (i) deliberately and (ii) accidentally should be evaluated, and appropriate control measures considered.

128. In other words, the assessments in question do not satisfy the obligation in regulation 3 of the regulations, even taking account of what ABC say, what BMC say, and what we have found to be the Appellant's procedures, and its opinions of what its customers want it to do.

129. We turn now to item 1 of the list of issues.

The Tribunal will decide whether to cancel or affirm each notice and, if it affirms it, will decide whether to do so either in its original form or with such modifications as the Tribunal may in the circumstances think fit. Following submissions made at the Preliminary Hearing which took place on 11th December 2020 it is agreed the Prohibition Notice PRO U000822 can be modified by removing the reference to a breach of s3(1) of the Health and Safety at Work etc. Act 1974 as it is not necessary to show a breach of the law to issue such a notice.

130. We do affirm each notice, though with modifications. We are assessing the situation as of January 2020, and therefore not taking into the account the restrictions imposed because of Covid on various leisure activities, including those offered by the Appellant.

131. As of 6 January 2020, climbing on the Appellant's climbing walls without the use of using any belay mechanism or any other device to prevent a fall or arrest a fall was something which the Appellant's customers had done in the past and were likely to do in the future. It was an activity under the Appellant's control, albeit an activity which the Appellant told its customers not to perform when they registered, and which customers were reminded not to do by signage (and occasionally by floorwalkers or other staff, if noticed). There had been a gap of around 15 months from the Cook Incident to the Melvin Incident. So the fact that there had been a gap of 15 months from the Melvin Incident to the date of service of the notice did not imply that the risk of serious personal injury had gone away. The Respondent was entitled to conclude that the risk of serious personal injury still existed as of 6 January 2020 and we agree that it did. Service of the prohibition notice was appropriate. The amended wording offered by the parties still included the phrase "unless the said contraventions have been remedied", which no longer made good sense, as the amendments were to remove details of the contraventions.

132. We have modified it to replace that wording with "until you have complied with Improvement Notice U000834 (as modified) and implemented the control measures which have been identified in compliance with paragraph 4 of the Schedule of Works forming part of that Notice", which we are satisfied retains the spirit of the original. At the risk of stating the obvious, (i) the amended notice does

not imply that, once it has complied with the condition, the Appellant will be free to authorise users to climb without being clipped in and (ii) we are not seeking to prevent the Respondent from serving a further prohibition notice in the future if that becomes necessary. Our modified notice is at Schedule A.

133. We have also made additions to the Improvement Notice as shown at Schedule B, and we consider these to be self-explanatory. As stated previously, we are happy to assume that each of Cook and Melvin accidentally failed to comply with the rules. However, the Appellant's existing approach seems to rely entirely on the users wanting to comply with the rules, provided they do remember. As well as extra measures to help people remember, and to monitor/rectify forgetfulness, the Appellant should open its eyes to the possibility that some people ignore rules if they do not think the rules are being enforced. We note:

    133.1 that locking autobelays so that the customer needs a member of staff to unlock would not necessarily have prevented the Melvin Incident. And

    133.2 that a rule which required a climber to have a member of staff check their attachments before the ascent (at least, for those ascents which do not involve another climber as partner) would require there to be at least one member of staff (and more than one at busier times) to be at the in the vicinity of the wall ready to be called over by the customer to do the check (and to monitor compliance with such a rule if introduced). However, we do not agree with the Appellant that such a rule would require there to be one such member of staff dedicated to each autobelay route.

    We make these latter two observations purely out of respect for the arguments that were addressed to us. It will be for the Appellant, when complying with the Improvement notice, to consider what control measures to adopt to address the risks once those risks have been sufficiently evaluated.

134. The notice should have been dated 8 January 2020, and we modify it to that extent also, as well as including a date for compliance.

_____

Employment Judge Quill

Date: 14 July 2021

RESERVED JUDGMENT & REASONS SENT TO THE PARTIES ON

.....20/8/2021.....

.....
FOR EMPLOYMENT TRIBUNALS

Schedule A

(showing modifications to Prohibition Notice)

Deletions are shown as struck through
Additions are shown as underlined

I, Rebecca Connolly, Environmental Health Lead Officer (Food Health and Safety), of Dacorum Borough Council, The Forum, Marlowes, Hemel Hempstead, HP1 1DN ….., being an inspector appointed by an instrument in writing made pursuant to Section 19 of the said Act and entitled to issue the notice hereby give you notice that I am of the opinion that the following activity, namely:

"Free climbing (not using any belay mechanism or any other device to prevent a fall or arrest a fall) on the climbing walls",

which is carried on by you or under your control at:

XC, Jarman Way, Hemel Hempstead Hertfordshire HP2 4JS

involves a risk of serious personal injury

because:

On the 9th July 2017 a customer Mr Cook was free climbing on the climbing wall and fell 8m suffering skin burns and a fractured to a lower limb.

On the 5th October 2018 a customer Mr Melvin was free climbing on the climbing wall and fell 13m and suffered the following you injuries broken pelvis, broken leg, broken lumbar vertebrae, broken ribs and broken ~~sterum~~. sternum

and I hereby direct that the said activity shall not be carried on by you or under your control immediately ~~unless the said contraventions have been remedied.~~ until you have complied with Improvement Notice U000834 (as modified) and implemented the control measures which have been identified in compliance with paragraph 4 of the Schedule of Works forming part of that Notice

Schedule B

(showing modifications to Improvement Notice and Schedule)

Deletions are shown as struck through
Additions are shown as underlined

I, Rebecca Connolly, Environmental Health Lead Officer (Food Health and Safety) of Dacorum Borough Council The Forum Marlowes, Hemel Hempstead, Herts, … hereby give you notice that I am of the opinion that at XC JARMAN PARK HEMEL HEMPSTEAD HERTS HP2 4J8

~~the~~ you, as a person wholly or partly in control of the premises, have contravened, The Management of Health & Safety at Work Regulations 1999 as amended, Regulation 3(1)(b)

in circumstances that make it likely that the contraventions will be continued or be repeated. ~~,~~ ~~the~~:

~~XC JARMAN PARK HEMEL HEMPSTEAD HERTS HP2 4J8~~

~~The Management of Health & Safety at Work Regulations 1999 as amended, Regulation 3(1)(b)~~

The reason for my said opinion is that:

The current risk assessments titled "Auto-belays (and routes)" dated 17/01/2012 review date: October 2019 and "XC Auto Belay Competent Climber"

Are not suitable or sufficient in that:

1. The risk assessments do not Identify nor evaluate the risks arising from the identified hazards. For example in the "Auto-belays (and routes)" risk assessment the “Climbers not clipping in” is listed under the heading "Risk" which is under the heading "List significant hazards". The risk from not clipping in has not been identified nor evaluated. Given the recent incidents involving Mr Cook (9th July 2017 and Mr Melvin (5th October 2018) the risk is well known.

2. The existing control measures in the risk assessments have not been effective in reducing the likelihood of harm occurring or reducing the potential severity of that harm. For example in the "XC Auto Belay Competent Climber" on page 3 In the column “List significant hazards”, lists ”Attaching to the auto belay correctly". In the last column "List the existing control measure or note where the information may be "found". The risk assessment fails to explain to how:

   a. "Signage indicating to check your harness",
   b, “Staff vigilance and training” and
   c. "Area checked every two hours on the daily log sheet"

   Will reduce the likelihood of a similar incident to those involving Mr Cook and Mr Melvin, or reduce the potential severity of the harm suffered by Mr Cook and Mr Melvin.

3. The risk assessments also fail to identify how climbers would be brought to: safety if they are found “free climbing” * on the walls. Particularly given the. dangers associated with ”free climbing" and that the hand and foot holds become loose.

4. The risk assessments also fail to identify the risks associated with deliberate rule breaking and the control measures to deal with accidental or deliberate breaches of the rules.

   * free climbing is not using any belay mechanism or any other device to prevent a fall or to stop a fall.

   and I hereby require you to. remedy the said contraventions or, as the case may be the matters occasioning them by ~~10th February 2020~~ [28 days from the date the tribunal decision is sent to the parties]

   In a manner stated in the attached schedule which forms part of this notice.

Schedule of Works

HEALTH AND SAFETY AT WORK ETC ACT 1974 — SCHEDULE
IMPROVEMENT NOTICE Reference Number ~~U/000734~~ U/000834

Or undertake works which will have the equivalent effect

1. Review the risk assessments where the undertaking of the Dacorum Sports Trust at XC JARMAN PARK HEMEL HEMPSTEAD HERTS HP2 4J8 places those not under their employment at risk of injury.

2. Identify the hazards arising from the undertaking particularly the use of the climbing walls and auto belay.

3. Evaluate the risk from the hazards in item 2 above. Therefore evaluate the potential harm from the hazard being realised. The British Mountaineering Council recognises that climbing and mountaineering are activities with a danger of personal injury or death. Insignificant risks can be ignored, as can risk arising from routine activities associated with life in general.

4. Identify controls measures either existing or new that.
   a. prevent the harm from hazard occurring, or
   b. reduce the likelihood of the harm occurring, or
   c. reduce the potential severity of that harm ie any resultant injury
   d. increase the likelihood of instances of free climbing coming to the attention of staff
   e. ensure that any instances of free climbing which do come to the attention of staff are appropriately investigated and recorded, and classified as either deliberate or accidental, as the case may be, and dealt with accordingly with a view to preventing repetition

This is a relevant Notice for the purpose of the Environment and Safety Information Act 1988.