SHERIFFDOM OF LOTHIAN AND BORDERS AT EDINBURGH

IN THE ALL-SCOTLAND SHERIFF PERSONAL INJURY COURT

[2019] SC EDIN 78

PN2041/17

JUDGMENT OF SHERIFF ROBERT D M FIFE

in the cause

MRS SUZANNE TONER

Pursuer

against

GLASGOW AIRPORT LIMITED, a company incorporated under The Companies Acts

Defenders

Pursuer: Haddow, Advocate; Thompsons, Edinburgh
Defenders: Stuart, Advocate; Plexus Law Limited, Edinburgh

Edinburgh, 30 September 2019

[1] A proof in this action proceeded on 20, 21, 22 and 23 August 2019. Damages were agreed at £5,085.37. The proof was restricted to liability.

[2] The following authorities were referred to by parties:

1. *Laird Line* v *United States Shipping Board* 1924 SC(HL) 37;
2. *Steel* v *Glasgow Iron and Steel Company Limited* 1944 SC 237;
3. *Phee* v *Gordon* 2013 SC 379;
4. *Farstad Supply* v *Enviroco* 2012 SLT 348;
5. Gloag & Henderson, The Law of Scotland, 14th edition, paragraph 25.29
6. Stair Vol 15 paragraph 401.

[3] The sheriff, having resumed consideration of the cause, finds the following facts to be admitted or proved:

Findings in fact

[4] The defenders are Glasgow Airport Limited, a company incorporated under the Companies Acts and having a place of business at St Andrew's Drive, Glasgow Airport, Paisley. At all material times the defenders were occupiers of the baggage hall and customs channels within the premises forming the terminal building of Glasgow Airport.

[5] On 12 November 2014 the pursuer was working in the course of her employment as a Border Force officer on one of the customs teams at Glasgow Airport. She was deployed to work in the customs channels.

[6] There were three sets of security doors within the customs channels, as shown on a diagram in the report prepared by John Watkins, production 5/7 at page 8. The diagram is shown in the appendix to the judgment.

[7] Passengers arriving at Glasgow Airport walking from the baggage hall (airside) to the international arrivals hall (landside) pass through the customs channels, selecting either the green channel or the blue channel. There are three sets of security doors within the customs channels: door D3i ("D3") is for the blue channel, door D4i ("D4") is for the green channel and door D2i ("D2") is to exit the customs channel in the direction of the arrivals hall where there is a fourth set of security doors, door D1i ("D1").

[8] These sets of doors were designed to deter the passage of unauthorised people in the opposite direction and to close automatically in the event of a security alert, known as RAID mode. A security alert might involve a terrorist threat but was usually an attempt by a passenger to return to the baggage hall after exiting D2 or D1.

[9] The doors were linked to a control system and sensors. D3 and D4 were normally open. D1 and D2 were normally closed but would open if a person was detected approaching the door in the intended direction of traffic flow from airside to landside. If the

sensors detected that a person was attempting to move through D1 from landside to airside, and if D2 was open, the control system would command D2 to close. If the sensors detected that a person was attempting to move through D2 from landside to airside, D3 and D4 would close. If the doors closed in response to the sensors detecting a person moving against the intended direction of travel, they could only be re-opened from a remotely located control room. Border Force officers working in the customs channels were not provided with local remote controls to re-open the doors.

[10] On 12 November 2014 at about 15:40 hours a 78 year old female passenger Mrs Monica Cooper was walking from the baggage hall towards the blue channel. As Mrs Cooper was about to pass through D3, suddenly and without warning D3 closed. Mrs Cooper was struck with force by the door, causing her to fall to the ground and sustain injuries including a head injury which was bleeding heavily.

[11] D3 was in RAID mode at the time. The door was designed to continue to attempt to close. D3 struck Mrs Cooper then opened and closed again striking Mrs Cooper as she lay injured on the ground.

[12] The pursuer was standing in an area after baggage claim and before D3 and D4. The incident was brought to her attention by one of her colleagues Jim Boyle. The pursuer then observed Mrs Cooper lying injured on the ground with D3 continuing to open and close striking her. The pursuer's immediate reaction was to go and assist Mrs Cooper and prevent Mrs Cooper from further injury. The pursuer acted as a rescuer. The pursuer placed herself between D3 and Mrs Cooper and gave Mrs Cooper medical assistance. After a period of time D3 was deactivated. Mrs Cooper sustained serious injury and was taken to hospital by ambulance. The pursuer sustained injury while assisting Mrs Cooper when she was struck on the upper back and left flank on several occasions by D3.

[13] The security doors were installed by the defenders in mid-2014 and the system went live in September 2014. The designers of the security doors were responsible for the installation of the doors. The designers focused on matters of security. The designers took no responsibility for any health and safety measures including any risk assessment. The defenders focused on the security aspects of the system and not on the safe operation of the doors. The defenders did not consult their own health and safety assurance manager about any health and safety matters or risk assessment before the system went live. No risk assessment was produced by the defenders.

[14] In September 2014 Ms Donna McGrady, a Border Force officer at Glasgow Airport, was passing through D4 in the course of her employment when suddenly and without warning D4 started to close. The door struck her on the arm. Ms McGrady managed to pass through the door before the door closed. Ms McGrady sustained minor injury. The defenders were aware of the incident involving Ms McGrady but took no action to review the assessment of risk of injury to persons passing through doors in the customs channels.

[15] On 27 September 2014 a passenger Ms McNeish backtracked into the international arrivals hall. As she was passing through D3 the door closed on her, pushing her over and causing her injury. Ms McNeish accepted she saw the warning signs and heard the audio alerts but expected the door to open on the pressure of impact. The defenders were aware of the incident involving Ms McGrady but took no action to review the assessment of risk of injury to persons passing through doors in the customs channels.

[16] After the incident involving Mrs Cooper, Mr Welsh the Security Compliance Manager for Glasgow Airport purported to carry out a review of risk assessment in November 2014 but no review of any risk assessment was carried out then.

[17] From September to 12 November 2014 the security doors in the customs channels closed without warning on various occasions when there was no security alert. In the two weeks prior to 31 October 2014 the security doors activated 74 times. The defenders were aware of this from a letter dated 31 October 2014 from Gordon Summers, Assistant Director Border Force to Ronald Leitch ("Mr Leitch"), Head of Security and Terminal Operations for the defenders.

[18] The operation of the doors and in particular D3 in RAID mode was not safe for passengers or staff of the defenders on 12 November 2014.

[19] The defenders took no active steps to review risks to health and safety by the operation of the security doors until after a letter of claim was received on behalf of the pursuer about January 2015.

[20] The incident on 12 November 2014 when Mrs Cooper was injured and subsequently the pursuer while assisting Mrs Cooper was reasonably foreseeable.

Findings in fact and in law

[21] That the pursuer suffered loss, injury and damage on 12 November 2014 as a result of the fault of the defenders at common law for failure to take reasonable care and in breach of section 2 of the Occupiers' Liability (Scotland) Act 1960.

[22] That the pursuer was acting as a rescuer.

[23] That the defenders have failed to establish any contributory negligence.

[24] Finds the defenders liable to the pursuer in the agreed damages of £5,085.37 inclusive of all interest to 16 October 2018; thereafter with interest on said sum at the rate of 4% a year from 16 October 2018 until payment.

[25] Reserves all questions of expenses. The sheriff clerk will fix a hearing on expenses.

Witnesses

[26] The following is a summary of each of the witnesses who gave evidence.

1. Gordon Summers

[27] Mr Summers was Assistant Director Border Force for West of Scotland based at Glasgow Airport and with responsibility for a team of about 100 officers. He had held that post since August 2014. He had worked for Border Force since 1992. Mr Summers had known Ms Toner since 2007 as one of the officers working for him.

[28] The locus of the accident on 12 November 2014 was shown on a diagram in the report prepared by John Watkins, production 5/7 at page 8.

[29] Back-tracking happened when a passenger left airside to go to landside and then attempted to return to airside. The passenger might have forgotten something. There might also be an intruder trying to gain access to airside.

[30] Sliding doors, shown as D3 and D4 on the diagram, were installed in 2014. Before then a security guard sat outside door 2 which was landside.

[31] After the anti-backtrack doors were installed but before the accident on 12 November 2014, there had been concerns about the doors, see letter of 20 November 2014 production 5/6 from Mr Summers to Ms Toner which was sent following the incident on 12 November 2012:

> "I know that the operation of the anti-backtrack doors is a source of concern for all officers – I can assure you that we are working hard to resolve this issue with the airport".

[32] The primary concern was officers being isolated between D3 and D4, and D2, when the doors were activated, creating a seal.

[33] It had also been reported to Mr Summers that, when activated, the doors closed quickly and with some force that could potentially injure a passenger or a member of staff.

[34] Mr Summers had asked officers to keep a log. In the 2 weeks up to 31 October 2014 the doors had been activated 74 times, with the time to clear ranging from 1-20 minutes with an average time of 7 minutes, see letter of 31 October 2014 production 5/18. In that letter Mr Summers referred to the doors malfunctioning, that the doors were being activated when no one was back-tracking and that operating procedures might have to be revised to address that. No action was taken by the defenders prior to the incident on 12 November 2014.

[35] As far as Mr Summers was concerned, the action taken by Ms Toner was an appropriate response to the situation.

2. Stephen Gordon

[36] Mr Gordon was a higher officer with Border Force at Glasgow Airport. He was in charge of a team of about seven officers working mainly in the customs area.

[37] Mr Gordon said the doors just appeared, replacing the security guard who was at the exit to the final set of doors and landside. The main concern about the doors was officers being trapped with no access to open the doors. The customs team kept a diary of the number of times the doors closed. It was not once a day. It was several times a day, at random times, without explanation. The audio would say the doors were closing. It would just happen. Mr Gordon did not think the doors gave passengers much time to get through once they started to close. There were a lot of middle aged passengers coming through customs who might need more time.

[38] There was also a concern about the time taken for the doors to be activated to open again. That did cause delay and frustration to passengers.

[39] Mr Gordon described the closing of the doors as quite forceful because of their size.

3. Donna McGrady

[40] Ms McGrady was a Border Force officer at Glasgow Airport. In 2014 she was working in the immigration office, which was airside.

[41] Ms McGrady said there was an incident with D4 in September 2014. She was coming from the customs office in the direction of the baggage area to investigate a matter. As she was coming through D4, the door started closing. She put her arm up to protect her face. The door struck her on the arm. She managed to get through the door before the door closed. The movement of the door was quite forceful. The door just kept moving. She sustained minor injury to her arm. Her arm was not that sore.

[42] Ms McGrady got a fright as she was not expecting the door to close. She reported the incident to her line manager. The line manager contacted security to let them know what had happened. The CCTV footage was eventually recovered. Ms McGrady was told she should not have put her arm up and she would not have been hit by the door. Ms McGrady said that if she had not put her arm up she would have been hit on the face or the head by the door. As far as she was aware nothing was done following the incident. She thought security should have looked into the matter as there were so many incidents.

[43] She spoke to the duty manager on the day of the incident. She was sure it was Kenny Welsh. She told him there was going to be an accident. Ms McGrady did not know the cause of the doors closing but the doors would close without warning. Ms McGrady's main concern was that the doors would close without warning.

4. Jackie Thoms

[44] Ms Thoms was an acting higher officer and Health and Safety Manager for Border Force working between immigration (passport desks) and customs. She spent about 50% of her time with the team deployed in customs.

[45] After the doors were installed but before the incident on 12 November 2014 there were concerns the doors could close and leave officers trapped and isolated with passengers who might be aggressive. These concerns were raised in her role as Health and Safety Manager. There was another concern about the speed of the doors when closing. Ms Thoms described the movement as sharp, exceptionally rapid, and difficult for passengers to get out of the way.

[46] Ms Thoms was on duty when Ms Toner was injured. She was radioed by one of the other officers that there had been an incident at the baggage hall and could she come down immediately. At the time she was at the passport desks. It probably took her about a minute to reach the baggage hall. The lady, Mrs Cooper, was on the ground. Ms Toner was supporting Mrs Cooper from behind. The airport first aid responder was assisting Mrs Cooper. Mrs Cooper was bleeding. Ms Thoms called an ambulance. Ms Toner had blood all over her shirt from supporting Mrs Cooper.

[47] Ms Thoms completed an accident report form, production 5/4. At some point after the accident the speed of the doors was adjusted but Ms Thoms did not know when that happened.

[48] In the incident Mrs Cooper was struck on the head. Ms Toner had tried to prevent further head injuries and tried to block the door. Border Force officers had a duty of care to members of the public. It was not morally right to stand back and let an elderly lady be repeatedly struck by a door.

5. Suzanne Toner (now Mrs Beckett)

[49] Ms Toner was a Border Force higher officer in charge of the customs team at Glasgow Airport. She had worked for Border Force at Glasgow Airport since 2003. In 2014 she was an officer on one of the customs teams. She had also worked at immigration. In 2014 she was deployed every shift to work in the customs channels.

[50] The main concern about the doors was the frequency of the doors closing. The officers kept a log of the closures. D3 and D4 would close quite quickly, with not enough time to get away when there was a large volume of passengers coming from the baggage hall.

[51] The officers could not understand why the doors were closing. This was brought to the attention of their line manager.

Accident 12 November 2014

[52] Ms Toner was standing in an area after the baggage hall and before D3 and D4. There were two portals before the doors. Ms Toner was standing there looking at passengers coming through from the baggage hall.

[53] Ms Toner was first aware of an incident when her colleague Jerry Hunt said: "Oh my God, someone's fallen". He alerted Ms Toner and another colleague Jim Boyle. Mr Boyle was on the other side of Ms Toner at the head of the green channel. All three of them had been standing in a line. The incident was at the blue channel, D3. Mr Hunt had a view of the blue channel. Ms Toner could not see the blue channel from where she was standing. It was Mr Hunt who heard a noise and reacted first. Ms Toner was not aware of any alarm going off.

[54] Ms Toner ran into the blue channel. A female passenger, Mrs Cooper, had fallen and was lying across the area of D3 with her head in the channel at the edge of the wall. The passenger had been hurt and the door was moving as if trying to close. Ms Toner was about 3 metres away when she was first made aware of the incident. She ran and positioned herself between the passenger and the door. She knelt down beside the passenger.

[55] The passenger had hit her head. There was a lot of blood. She spoke to the passenger and told her not to move. The passenger was conscious. Ms Toner was not a trained fist aider. She had basic first aid awareness. Her main objective was to make sure the passenger was alright. Mr Hunt was beside Ms Toner. Mr Hunt phoned for an ambulance and to get someone to open the door. Ms Toner was taking the force of the door instead of the passenger. Ms Toner wanted the door switched off as soon as possible.

[56] It was seconds before Ms Toner was struck by the door for the first time. She could remember the door striking her down her back on more than one occasion. It could have been a couple of times or a few times. It was perhaps three or four seconds between each time she was struck by the door.

[57] Ms Toner said she was getting angry being struck by the door so she shouted to Mr Hunt to get the door stopped. The door seemed to come out to close, strike her, retract and then come forward and strike her again. After a while the door stopped moving.

[58] The passenger kept trying to move. The duty manager said it was alright for the passenger to sit up. Ms Toner was applying pressure to the head wound.

[59] Ms Toner said she had a duty of care to the passenger who was lying injured in the doorway. She just reacted to assist. She did not think about which part of the body she might use to place herself between the moving door and the passenger. If there had been a failsafe she would have used that to stop the door but there was no failsafe available.

[60] It was not until after the duty manager arrived and everything calmed down before she realised she had hurt herself. Ms Toner escorted the passenger out to an ambulance where she said goodbye. She then returned and sat in the office for a while with the rest of the team and other colleagues. Ms Toner said to Mr Boyle she thought she had done something to her back. She then went home as she was sore and covered in blood. Ms Toner had no back pain before the incident. She was in no doubt the incident caused the back injury.

[61] Ms Toner was a straightforward witness, who robustly defended her actions in cross-examination. She reacted to assist a passenger, the passenger who was injured, and to prevent further injury. Her account of the accident was not challenged. Ms Toner was a credible and reliable witness.

6. Jim Boyle

[62] Mr Boyle was a Border Force officer at Glasgow Airport, where he had worked since about 1996. In November 2014 he was regularly at customs. He was working on 12 November 2014.

[63] At the time of the incident he was with Ms Toner probably looking into the baggage hall. He was first aware of an incident when a colleague, who was closer to the incident, raised the alarm. Mr Boyle and Ms Toner made their way to the incident which was about 2-3 metres away. Ms Toner was just in front of him. He saw an elderly lady lying prone on the floor with a pool of blood coming from her head.

[64] Ms Toner immediately knelt down beside the lady to ascertain the condition of the lady. There was limited space. Mr Boyle stood behind Ms Toner.

[65] The door had already retracted when Ms Toner knelt down beside the lady. The door began to close again and the door hit Ms Toner. The door was moving relatively fast. Mr Boyle recalled the door not going all the way back before closing again.

[66] Mr Boyle did not recall how many times the door struck Ms Toner, but it was definitely more than once. Ms Toner shouted to get the door stopped. Mr Boyle stood up. He went to the other side to see what he could do. It crossed his mind to put his foot in the door, but he was concerned that might cause more damage to Ms Toner. It was all happening very quickly. When Mr Boyle was thinking what to do the door stopped. Mr Boyle could not put a precise time on how long it was before the door stopped, but it was probably more than tens of seconds.

[67] The incident did not really come as a surprise. Mr Boyle was aware of at least one other person being knocked over by the doors closing. He was concerned about the possible impact of doors closing on the elderly or children. Mr Boyle was concerned about the speed of the doors closing and that there was no stopping mechanism. The doors would close at all costs.

[68] Mr Boyle said the concerns were raised by the Trades Union with senior management of Border Force, who then took up the matter with Glasgow Airport. Sometime later the speed of the doors was slowed down, but Mr Boyle could not say when that happened. D3 and D4 were no longer in operation, but Mr Boyle did not know the reason for this.

[69] Mr Boyle said there was a duty of care to any passenger in any difficulty and it was human nature to assist. If he had arrived first, before Ms Toner, he would have reacted in the same way.

7. Jonathan Watkins

[70] Mr Watkins was an Assurance Forensic Investigator with Hawkins of East Kilbride. His CV was production 5/16. Mr Watkins prepared a report dated 25 May 2018, production 5/7.

[71] Mr Watkins carried out a site visit, but D3 and D4 were out of commission and unable to operate.

[72] Mr Watkins gave evidence about the weight of D3 and D4 and the speed at which the doors closed and opened. That evidence was not satisfactory. Mr Watkins was making calculations as he gave evidence. At best, any measurements were estimates. None of these figures were contained within the report and the report did not set out the basis for the figures. No findings in fact could be made of that evidence.

[73] Mr Watkins was not an expert on security. He did not have previous experience of airport doors. His experience came from lifts and automatic industrial and personnel doors. The design of the system was outside his experience.

[74] Mr Watkins identified in his report issues with the systems manual, the MFlow Manual, production 6/1. Mr Watkins did not believe the designer, Mr Tipney, was the best person to comment on the manual. That should be someone independent.

British Standard BS EN16005

[75] There was an exclusion from the British Standard for doors in airports if the security need of the door was so great that the requirements for safety could be overridden.

[76] Mr Watkins said his interpretation was that the function of a door opening and closing safely would override any security requirement but, if the defenders could demonstrate the operation of the doors could perform better than the BS Standard, his

opinion would change. In summary, the defenders would still need to prove they were still complying with the overarching requirements of the Health and Safety at Work Etc Act 1974.

[77] When the anti-backtrack doors were activated, that was part of the security system. How quickly the doors closed would be determined by how far away was the risk.

[78] The movement of the door itself did not fall within the exclusion and was not exempt from BS EN16005. The defenders required to provide a door that did not continually injure a person in requiring to close.

[79] The door had no local control. Control was with the control room. If Ms Toner had had local control, the incident would not have happened. Ms Toner would not have been injured. Mr Watkins was identifying an alternative measure and not the suitability of such a measure, as matters of security were outwith his expertise.

[80] In his report Mr Watkins said the force required to cause injury to Ms Toner by the door was outwith his experience. He gave some evidence about forces that would be applied during the incident but no reliance could be placed on that evidence as that was outwith his expertise.

[81] In summary, it was the opinion of Mr Watkins that the initial contact of the door with Ms Toner may have complied with BS EN16005 but any more than one contact striking Ms Toner was not acceptable. Further, an authorised person such as Ms Toner, being a Border Force officer, should have had the ability to locally override the door as set out in the MFlow Manual.

[82] Mr Watkins' opinion as an expert witness was of assistance to the court but he had been hampered by the inability to test D3 and D4 in operation. At times he did stray beyond his area of expertise.

[83] Mr Watkins' opinion about the weight of the doors, the speed of the doors, and the force applied by the doors was not convincing.

[84] I was satisfied that reasonable measures could have been taken by the defenders prior to 12 November 2014 to prevent the door from repeatedly striking Ms Toner.

8. Kenneth Brown

[85] Mr Brown was the Health and Safety Assurance Manager at Glasgow Airport from 2008 until 2018, formerly a police officer with Strathclyde Police for 31 years.

[86] His duties were to provide competent advice to the management team on health and safety, carry out audits and ensure relevant standards were met.

[87] Mr Brown was aware of the proposal to introduce doors at customs. The main reason was to maintain security of baggage handlers.

[88] If a passenger back-tracked between D2 and D1, passing the threshold of door 1, the system closed D1, D2, D3 and D4 to stop anyone running from D1 and D2 into the baggage area.

[89] Mr Brown was aware of the incident on 12 November 2014 involving Mrs Cooper and the initial investigation form, production 6/23. Mr Brown was not aware of the incident involving Ms Toner until later as that incident was not reported at the time. Under the heading Investigation Checks in 6/23, Mr Brown wrote the summary. Mr Brown recorded in the summary:

> "Door operations tested and reviewed regularly. The speed and closure forces of doors 3 and 4 have been reduced".

[90] Mr Brown said that, notwithstanding what was recorded in the summary, it was not until a later date that the speed of closure of the doors was reduced by lowering the power

to Ecomode. By reducing electricity, the power of the doors and the speed of the doors were reduced. Mr Brown did not know when that happened, but it was probably after January 2015.

[91] The doors were tested at the time of the incident on 12 November 2014 by one of the Glasgow Airport Engineers. There was no fault with the doors. There was no fault with the operation of the doors.

[92] In about January 2015, following a letter intimating a claim on behalf of the pursuer, the operation of the doors was reviewed. There had also been a number of complaints from Border Force about officers being isolated with the closing of the doors.

[93] A number of engineering and health and safety personnel attended a site visit, opening and closing the doors and running in and out of the doors. Mr Brown let the door close on him. The door closed. He could feel the pressure but it was not sore. The door then released/opened.

[94] D3 and D4 were no longer in operation. Mr Brown was not aware of that until he attended a site visit with the pursuer's solicitors in 2018.

Note: D3 and D4 were disabled as set out in the Project Change Request dated 17 September 2015, production 6/2. It was security that was responsible for any changes.

[95] Mr Brown had viewed the CCTV footage following the incident. Mr Brown viewed the CCTV footage again in court. Mr Brown accepted Mrs Cooper had been a very short distance away from D3 when the door activated, less than a second. He accepted the incident should not have been able to happen. From a health and safety perspective, Mr Brown accepted some measures could have been put in place to reduce the risk as low as reasonably practicable, but security was not within his role and he would have to defer to the security experts.

[96] Although Mr Brown was the Health and Safety Assurance Manager he was not consulted by anyone about the acceptability of risk in the installation of the doors. Mr Brown said there were competent designers and installers who carried out cause and effect tests. There was no reason for him to be involved.

[97] Mr Brown assumed the designers took into account public safety in positioning alarms, but it could have been better. It might have been advisable to have had the warnings earlier, but that was for the designers, to meet their standards.

[98] Mr Brown was experienced in health and safety matters. From a health and safety perspective he properly made concessions that reasonable measures could have been taken which might well have avoided the incident involving Mrs Cooper and thereby the incident to Ms Toner, subject to any security considerations. It was of note the designers did not involve Mr Brown on any health and safety aspects when designing the insulation of the doors. Mr Brown said the onus for health and safety of the insulation and operation of the doors remained with the designers.

9. Peter Tipney

[99] Mr Tipney was a project manager with Human Recognition Systems ("HRS"). HRS provided biometric systems into aviation markets.

[100] Mr Tipney was the project manager from start to finish for the installation of the doors at Glasgow Airport in 2014. He was part of a team from design and installation. The installation was completed mid-2014 and went live around September 2014. Mr Tipney was the author of the MFlow Operations and Maintenance Manual ("the MFlow Manual"), production 6/1. The doors were to detect or deter people attempting to return airside from landside, deterring them with close barriers, sound tannoys and activated beacons. The

doors had been discontinued as an HRS product, phased out over a number of years, and were now only used at Edinburgh and Glasgow Airports.

[101] Mr Tipney spoke to the terms of the MFlow Manual. At 4.1.4.1 there was a table with MFlow scenarios and outcomes. FN008 had the following scenario:

> "Pax walk in wrong direction through D2i, they then continued to proceed towards Door D3i or D4i".

[102] The expected outcome for the doors was as follows:

> "If Door D3i or D4i are open they will close and lock in RAID mode.
> Remain closed and locked until control room takes action.
>
> If door D3i or D4i are open and there is pax in doorway:
>
> The door attempts to close in RAID mode. Upon impact with the pax the door will stop, hold its position for a few seconds, then attempt to close and lock.
>
> This cycle repeats until the pax clears the doorway. This allows pax to move in either landside or airside directions".

[103] RAID mode triggered the door to commence a closing cycle regardless of any person in the doorway. If there were sensors in the door RAID mode ignored the sensors and closed regardless, as it becomes a security event. The door remained closed until normalised (opened). That system of operation was by design.

[104] There was no break glass alarm for local power-down, as that would de-activate the security event.

Closing of doors

[105] Once the audio alarm/beacon/tannoys sounded the doors would close by 1-2 seconds later. Mr Tipney said it was an intelligence system. There was always latency in the system, so it would take 1-2 seconds before the doors would close.

[106] Mr Tipney gave evidence about the speed of the doors closing. That evidence was contradictory and confusing: "door doesn't really have a speed" "door has one speed" "RAID closes at normal speed" "close in RAID 4 seconds"and "close in non-RAID 6 seconds". That evidence was unreliable.

[107] Mr Tipney was referred to BS EN16005, production 5/9. Mr Tipney said that by design the permissible static forces on the doors could not exceed 150 N (newton) metres per second, with reference to paragraph 4.6.7.3, but he was then unable to express any further views, or give any further explanation about static or dynamic force saying: "it's not my role" "the door engineers will be able to answer". The evidence from Mr Tipney about any force on the doors was of no assistance to the court.

[108] Mr Tipney viewed the CCTV footage of the incident involving Mrs Cooper. He said the door operation at the time of the incident was consistent with the design. While Mr Tipney was familiar with BS EN16005 that was not his HRS responsibility but the responsibility of KONE who supplied the doors. Mr Tipney said there was an exclusion from BS EN16005 for doors used for the purpose of airport security. In RAID mode the BS standard did not apply.

[109] Mr Tipney was aware D3 and D4 were disconnected from the system several years ago as the doors were impeding Border Force operations which required officers to have access to both sides. Production 6/2 dated 17 September 2015 was a standard change control document to have D3 and D4 disconnected from the system. The change was implemented on 1 October 2015 following an exchange of emails, production 6/3.

[110] Mr Tipney said the focus for the designers was primarily on security, not on safety. Mr Tipney accepted what happened to Mrs Cooper was just one of those things. HRS gave guidance to Glasgow Airport on health and safety. It was up to Glasgow Airport to

implement the guidance. It would be wrong if the Glasgow Airport management team relied entirely on HRS for safety.

[111] Mr Tipney was an unimpressive witness. While he was the project manager for the installation of the doors and was the author of the MFlow Manual, he took no responsibility for the operation of the doors or matters of health and safety of the doors, suggesting responsibility was either with KONE or Glasgow Airport. At times answers to questions were simply Mr Tipney repeating what was stated in the MFlow Manual without any further explanation or reasoning. On the basis of his evidence, HRS took no responsibility for safety, only security aspects of the installation and without any input from Mr Brown at Glasgow Airport.

[112] Mr Tipney was generally unclear, inconsistent and contradictory in his answers. Mr Tipney was an unreliable witness. I rejected his evidence where this was inconsistent with other witnesses.

10. Kenny Welsh

[113] Mr Welsh was the Security Compliance Manager for Glasgow Airport, a position he had held for about 20 years. His role was to maintain the requirements of the Civil Aviation Authority (the CAA) and the Department of Transport.

[114] Mr Welsh was part of the project team for the insulation of the doors in 2014. There were two reasons for the installation. The existing security officer was restricted in what he could do and what powers he had and there would be a reduction in costs. There was a tender process. HRS was selected. The system was two-fold:

1. Doors
2. Video analytics that operated the doors. The CCTV was monitored 24/7 at the Airport Control Centre which had about 12 staff, all trained in security.

[115] Following the installation a 6 months Planned Preventative Maintenance (PPM) was put in place. There were also daily checks of the operation of D1, D2, D3 and D4 by security officers.

[116] Mr Welsh said he believed a risk assessment of the operation of the doors was carried out at the time of testing and commission, before the system went live. Mr Welsh said the outcome was a low risk for the operation of the doors and the system in general.

[117] After the incident on 12 November 2014, Mr Welsh carried out a review of the risk assessment to check the process was in order. What Mr Welsh described as a risk assessment was dated 14 November 2014, production 6/21.

[118] It emerged there was no evidence of any risk assessment having been carried out at the time of commission. Mr Welsh could not find this in November 2014 so he could not review the risk assessment. He had to carry out a risk assessment. Mr Welsh did not carry out a risk assessment in November 2014. Production 6/21 was not a risk assessment, but an appendix to a risk assessment. The form states:

> "Please use this as an appendix to any risk assessment where this equipment is used. This is a checklist of considerations for the equipment but an assessment of the actual operation should be in place".

[119] A risk assessment was about identifying sensible measures to control the risks of harm to people in the workplace. The document 6/21 did not meet the requirements of a risk assessment. Mr Welsh was experienced in security matters, not health and safety. Mr Brown was not asked to carry out a risk assessment. Mr Brown was not asked to carry out any review of risk assessment in November 2014.

[120] Mr Welsh was aware of the incident involving Mrs Cooper on 12 November 2014. He reviewed the initial investigation form, production 6/23. Mr Welsh investigated the

incident, reviewed the CCTV footage and spoke to members of staff. He completed the section of the form Investigation Checks.

[121] In answering a question on the form:

> "Was there a known risk and if so wasn't it controlled?"
>
> Mr Welsh had stated:
> "Door operations tested and reviewed regularly. The speed and closure forces of doors 3 and 4 have been reduced".

[122] Mr Welsh accepted that statement was not accurate as at the date he completed the form, which was on or about 14 November 2014. The speed of D3 and D4 had not been reduced at that date. The reduction in speed did not happen until around January 2015.

[123] The purpose of the doors was to deter and stop anyone back-tracking. The project team were aware the doors might hit passengers. At no time was the design to put passengers at risk, but Mr Welsh accepted there was a possibility of passengers being at risk. The doors were designed, within reason, to stop people from back-tracking. The doors were designed to stop someone walking or running from D1 through D2, D3 and D4. There was no specified speed. It was possible a person running at speed would be able to get through all the doors before the doors closed. Mr Welsh was of the view the doors were as safe as they could be and that any risks had been identified and addressed during testing and commission and before the system went live. Mr Welsh accepted he was a security specialist and not a specialist in health and safety.

[124] Mr Welsh was aware of the incident involving Ms McGrady in September 2014 when she was hit by a door. He remembered reviewing CCTV footage and explaining to Ms McGrady how the doors worked.

[125] Mr Welsh was aware of the incident on 27 September 2014 when the doors hit a passenger Mrs McNeish and the initial investigation report, production 6/22. Mr Welsh had no personal involvement with the incident.

[126] While Mr Welsh believed what was designed by HRS was a safe system, he accepted if there was a longer delay before the doors closed there would be less chance of the doors hitting someone; that if the doors closed more slowly there was less chance of the doors hitting someone or hitting someone as hard; and that if the doors had been mounted on the front of the partition passengers would see the whole door moving not just moving from the leading edge and that could potentially have reduced the risk of someone being hit by the doors.

[127] Before the doors were moved in front of the partition, sometime after November 2014, there had been a risk of a crushing injury to a finger when the door retracted to the central partition as a gap was created. HRS installed a brush down the side of the door to address the crushing risk. Once the doors were moved there was no risk of a crush injury.

[128] Mr Welsh was very matter of fact in his evidence. He was concerned about security and safety of the doors. Mr Welsh said Glasgow Airport was relying on HRS that the doors would be as safe as possible. While Mr Welsh said he had seen a risk assessment for the doors before the system went live in September 2014 and that the doors were assessed at "low risk", no risk assessment was before the court. Mr Welsh was able to speak to matters of security, but not health and safety. While Mr Welsh was doing his best to tell the truth, his recollection of events was sketchy at times and his evidence about risk assessment was unreliable and unsatisfactory. Mr Welsh properly accepted a number of measures could have been taken to have minimised the risk of injury to persons.

11. Robert Graham

[129] Mr Graham was an Automatic Door Technician with Bolton Gate Services, Bellshill where he had worked for 5 years. Before then he had worked as an Automatic Door Technician for KONE.

[130] Mr Graham installed the doors at Glasgow Airport in 2014. The doors were not commissioned until after Mr Graham had left KONE. About 6 months later HRS came to Bolton Gate Services to arrange for the doors to be serviced. They took on a servicing and maintenance contract for the doors on a 6 monthly basis.

[131] In non-RAID mode the doors complied with BS EN16005 with a maximum 140 N from stationary which Mr Graham tested with a force meter. BS EN16005 was the guideline for all automatic doors within EU. That guideline did not apply in RAID alarm when the door became a special function door, a security door.

[132] Production 6/8/4 was a testing sheet for compliance of D3 with BS EN16005 dated 24 September 2015. Mr Graham carried out the service. At PART 3 he had recorded a static entrapment of 98 N. He confirmed there was no mention of dynamic forces in the manual or on commission.

[133] Mr Graham said if the electric lock failed then there could be a function pad at the door. Members of staff would have their own wireless remote controls, to control the doors locally.

[134] In RAID the doors closed at a set speed incorporated into the system. As an engineer Mr Graham could not adjust that speed. In normal mode the doors would close in 8 seconds. In RAID mode all the doors move at the same speed.

[135] The standard BS EN16005, production 5/9 at pages 20 and 21, showed a table of permissible dynamic forces and a diagram showing the leaf force measurements. The dynamic forces were greater when the door started to move, the door slowing down as it closed. For a period of time up to a maximum of 0.75 seconds the dynamic forces could be up to 1500 N and could still comply with the standard. The static forces would not assist in assessing the dynamic forces of the door at the point of impact with Mrs Cooper.

Submissions generally

[136] Written submissions for both parties were lodged and expanded upon in oral submissions. These written submissions were of assistance to the court. The written submissions are referred to for their terms.

Submissions for pursuer

[137] The pursuer adopted the written submissions. The motion for the pursuer was to grant decree against the defenders for payment to the pursuer of the sum of £5,261.48 and to reserve the question of expenses. The pursuer claimed damages at common law and the Occupiers' Liability (Scotland) Act 1960 ("the 1960 Act") for failure to take reasonable care not to injure the pursuer in the particular circumstances of the case.

[138] It was accepted the specific circumstances of the case included that the doors fulfilled a security function at Glasgow Airport. That might mean it was reasonable to take risks that would be unreasonable absent the need to reduce the risk that security may be breached. Did the defenders take reasonable care in the particular circumstances of the case?

[139] D3 and D4 were heavy and moved quickly. Many members of the public passed through the doors. A proportion of those passing through the doors might be inattentive. A significant proportion of the passengers would be elderly, infirm, disabled, or children.

[140] Mrs Cooper was an elderly passenger who was struck by D3, causing her to fall to the ground and sustain a serious head injury. The defenders accepted this was a serious injury. There was no challenge to the pursuer's evidence that she sustained a back injury from being struck on more than one occasion by D3 while attending to Mrs Cooper. The nature and consequences of the pursuer's injury were not disputed. Quantum of damages was agreed.

[141] There was evidence from witnesses that the doors closed quickly and were potentially dangerous. The evidence of the incident involving Ms McGrady on 27 September 2014, heard under reservation, should be allowed. The incident was known to the defenders and in particular Mr Welsh.

[142] The defenders were aware that a passenger, Mrs McNeish, was struck by D3 on 27 September 2014 and knocked to the ground by the force of the impact.

[143] The defenders owed a duty of care to passengers and others, such as the pursuer, who used the customs channels in the course of their employment. It was reasonably foreseeable if an injured person was of immediate risk of further injury from power operated doors another person, such as the pursuer, may intervene in an attempt to prevent further injury or render assistance to the injured person. The defenders owed a duty of care to the pursuer in her capacity as a rescuer.

[144] When active in RAID mode D3 had a security function. D3 closed more quickly than for normal operation. The threshold safety sensors were deactivated. The door had no protective devices fitted to the leading edge of the leaf to stop the door, or reduce the speed

prior to impacting a person or obstruction. After the door hit a person or obstruction the door would not cease the attempt to close but would pause and then make continuous attempts to close. All these features were deliberate design decisions.

[145] It was also a design decision not to provide Border Force officers with the ability to deactivate the doors locally from the baggage hall side of the door either through a break glass switch, or a function pad at the door, or wireless remote controls. These decisions made by the designers and the defenders materially increased the risk of injury to persons when D3 was in RAID mode. It was accepted by the defenders that, when in security mode, the doors did not comply with BS EN16005. Mr Tipney said the doors were designed for security when in RAID mode. There was no evidence from Mr Tipney that any consideration had been given about safety of the operation of the doors. Mr Tipney said that was not the responsibility of the designers. That was not exercising reasonable care.

[146] Mr Welsh said a risk assessment had been carried out during the commissioning phase, but he could not locate that risk assessment in November 2014. No risk assessment was put before the court in evidence.

[147] A balance had to be struck between security performance and the level of risk posed to passengers: the higher the security performance, the greater the risk to passengers. In the absence of any objective assessment of either required security performance or the risk posed to passengers, no considered view could have been taken whether the balance between those factors was struck appropriately during the design and commissioning of the system. Even if such a decision was made there was no evidence who made that decision or how that decision was made. There was no consultation with Mr Brown, whose role was to provide competent health and safety advice to the management team, including Mr Welsh and his superiors.

[148] As specific examples of the balance between security performance against risk to passengers, it was generally accepted by the defenders' witnesses that modifying some features of the door would have reduced the risk of people being struck:

- If there was a longer delay between the lights and announcement being triggered and the door closing, or if the doors moved more slowly, passengers may have more time to react and get out of the way of the doors;
- If the warning beacons were more obvious in the sense of being closer to the eyeline of a person at the threshold of the doors;
- If the doors had been mounted on the baggage hall side of the partition, it would have been more obvious that the doors were closing;
- If D3 and D4 were simply not part of the system, they could not injure people;
- The logical control of the doors could have operated differently, minimising the large number of "false positives" generated by the system which shut the doors unnecessarily – a factor which multiplied the risk posed;
- Border Force officers could have had the ability to deactivate the doors locally, either through a break glass switch, a security token of some sort, or a remote control for the door.

[149] The defenders had not provided any reasoned justification for mitigations not having been put in place prior to 12 November 2014. The defenders had failed to satisfy the test of taking reasonable care.

Volenti non fit injuria and contributory negligence

[150] In *Steel* v *Glasgow Iron and Steel Company Limited* 1944 SC 237 the plea of *volenti* was said to be equivalent to an argument that the voluntary act of the injured person was a *novus*

actus interveniens which broke the legal chain of causation started by the defenders' negligence.

[151] LJ Clark (Cooper) at 246 stated it was a natural and probable consequence of a helpless person being put in danger that some able-bodied person might expose themselves to danger to affect a rescue. In such a case, the negligent act was a wrong inflicted not just on the person in danger but on the would-be rescuer. The rescuer's reaction to the emergency was as much a consequence of the negligence as any ordinary physical occurrence.

[152] The pursuer also relied on *Laird Lyne* v *United States Shipping Board* 1924 SC (HL) 37 to support the submission that the plea of *volenti* should be repelled and that the court should decline to make a finding of contributory negligence.

Submissions for defenders

[153] The defenders adopted the written submissions. The motion for the defenders was to grant decree of absolvitor.

[154] In all the circumstances of the case it had not been established that the incident involving Mrs Cooper and the pursuer's injury was attributable to any failure on the part of the defenders to take reasonable care.

[155] The defenders insisted on the objection to the admissibility of questions regarding an incident when Ms McGrady was struck by a door in September 2014. There was no record. The pursuer had not given fair notice of any incident involving Ms McGrady.

[156] Mr Watkins did not have the necessary experience or expertise to entitle him to give opinion evidence on the matters at issue in the case. In any event Mr Watkins was unimpressive in the manner of his evidence. He had a tendency to avoid giving a straight

answer and at times his opinion was based on speculation. The court should not place any reliance on the evidence of Mr Watkins or at least should treat his evidence with considerable caution.

[157] The defenders did not take issue with the pursuer's witnesses to fact. The defenders' witnesses were all credible and reliable. The court had to have regard to the events taking place 5 years ago. Mr Tipney acknowledged the limitations of his expertise, but he was of assistance to the court. He was an impressive witness. Mr Brown was quite candid in his evidence on various matters. In general he was a credible and reliable witness. Mr Welsh was candid in his evidence. He was confused as to the timing when the speed of the doors was adjusted.

Reasonable foreseeability

[158] The court required to consider reasonable foreseeability within the particular context that D3 was performing a special security function at the material time. D3 was closing as a result of being activated by the security system, in order to deter any unauthorised person or persons from gaining unauthorised access to airside. The issue was not whether powered sliding doors in general presented a reasonably foreseeable risk of injury but whether the doors, when performing that specific security function, presented such a risk and, if so, the level of risk and the likely seriousness of any such injury. That was part of the calculus of risk: *Phee* v *Gordon* 2013 SC 379 at paragraphs 26-28 and 36.

[159] The court had to consider what information was available to the defenders before Mrs Cooper's accident, so that an objective assessment could be made of what was reasonably foreseeable.

[160] In RAID mode the behaviour of D3 was in accordance with the design of the system. D3 operated as it was supposed to.

[161] There was evidence of three prior incidents involving Stephen Gordon, Donna McGrady and Mrs McNeish. There was no evidence when the incident involving Mr Gordon occurred. There was no record of the incident. The defenders maintained objection to the admissibility of the evidence of the incident involving Ms McGrady. The defenders were aware of the incident involving Mrs McNeish on 27 September 2014 but she accepted she had ignored warnings by continuing to walk through D3, expecting the door to open on the pressure of impact. "Behavioural Error" was recorded as the "Underlying Risk Factor". That incident had to be considered in its particular context and with Mrs McNeish only sustaining bruising to her knee and shoulder. While the defenders accepted that it was reasonably foreseeable that D3, while closing in RAID mode, presented a risk of injury, that had to be viewed in the context of the information giving rise to reasonable foreseeability. While Mr Welsh said a risk assessment of the doors had been performed at the time of commissioning of the system and that the outcome had been that the doors were assessed as low risk, it was accepted there was no other evidence of risk assessment before the court. That was not an end to the matter. The court had to have regard to all the circumstances.

[162] There were significant safeguards designed and built into the system. The effect of these was to reduce the risk of injury presented by the operation of the doors closing in the performance of their security function. Upon impact with a person, the door would stop and remain stationary briefly. That behaviour would repeat until the doorway was clear. The behaviour was explicitly designed to enable the person to move out of the way of the door. The motors which operated door 3 while it closed in RAID mode were, by design,

physically incapable of causing the door to exert more force than was permitted by BS EN16005.

[163] The area around D3 and D4 was monitored by staff in a remote control room. The control room staff had the facility to control the doors remotely from the control room, including the facility to open them. There were a number of warnings given to those approaching, or in the vicinity of D3, that the doors may close, that they were about to close or that they were closing including a flashing beacon, an audible warning, prominent red warning notices and the motion of the closing doors.

[164] Certain modifications were made to the security system after Mrs Cooper's accident. The speed at which the doors closed was adjusted, D3 and D4 were moved to the front of the central partition and D3 and D4 were ultimately taken out of operation. The fact that modifications were made after the accident did not indicate the defenders were negligent. There was no absolute duty of care on the defenders. This was a complex security system and, as experience grew, modifications were made over time.

[165] In order to consider whether there was a breach of duty of care the court, in assessing what a reasonable person would do, would use a calculus of risk. The court weighed up:

1. The likelihood of causing injury;
2. The seriousness of that injury;
3. The difficulty, inconvenience and cost of preventative measures;
4. The value of the activity that gives rise to the risk.

[166] On any objective assessment of reasonable foreseeability before Mrs Cooper's accident, the court should conclude the risk of injury presented by D3 when closing in RAID mode was low and that any injury was unlikely to be serious. Maintaining the security of the airside areas of the airport was a highly important function. The anti-backtrack doors formed an important part of that function. The operation of the doors in RAID mode was

important in order to deter backtracking. A number of safeguards had been incorporated into the operation of the doors in RAID mode. The system as operated at the time of Mrs Cooper's accident struck an appropriate balance between the foreseeable risk of injury and the measures in place to prevent injury. The defenders had exercised reasonable care in the implementation and operation of the system, taking into account the foreseeability of injury.

Volenti non fit injuria and contributory negligence

[167] The pursuer took it upon herself to place herself in a position where it was foreseeable she would sustain injury. The pursuer placed herself between Mrs Cooper and the moving door, because she wanted to shield her from the door which was continuing to attempt to close.

[168] The pursuer had other options in that situation. It would have been open to the pursuer to attend to Mrs Cooper without placing herself in the path of the door. If she was concerned about the door continuing to attempt to close against Mrs Cooper's feet or legs, the pursuer could have held back the door or asked a colleague to do so. The pursuer should be held to have voluntarily agreed to absolve the defenders from the consequences of her acts. The defenders relied on *Gloag & Henderson, The Law of Scotland, 13th Edition*, paragraph 25.29.

[169] In any event the pursuer was at fault and should be found to have been contributory negligent to the extent of 25%.

[170] Ultimately *volenti* was a jury question for the court to determine.

Note

[171] There is no dispute how the pursuer sustained injury in the incident on 12 November 2014. The claim in damages is at common law for failure to take reasonable care and in terms of section 2 of the 1960 Act. The law was not in dispute.

[172] At the time of the incident involving Mrs Cooper the doors were in RAID mode, performing a special security function. Questions of reasonable care and reasonable foreseeability have to be considered by the court in that context.

[173] The defenders state they satisfied the duties of reasonable care and that the injury to the pursuer was not reasonably foreseeable. The defenders also rely on the defence of *volenti non fit injuria* and plead contributory negligence.

[174] There was CCTV footage of the incident involving the elderly female passenger, Mrs Cooper, who was passing through D3 when she was struck by the door as it was closing in RAID mode, causing her to fall to the ground and sustain a serious head injury. That CCTV footage was shocking to watch, with the force of the activation of the door causing Mrs Cooper to fall to the ground.

[175] The CCTV footage did not show what happened to the pursuer but, on the unchallenged evidence of the pursuer and another Border Force officer Jim Boyle who witnessed the entire incident, there is no doubt this was a rescuer case. The plea of *volenti* is repelled. The defenders have not proved there was any contributory negligence on the part of the pursuer.

[176] The evidence about the incident involving Ms McGrady in September 2014 was heard under reservation. The defenders were on notice that any incidents involving the doors from the system going live in September 2014 and the index incident on 12 November 2014 would be relevant. Ms McGrady appeared on the list of witnesses for the pursuer,

lodged in process in May 2018. Mr Welsh was personally aware of the incident having viewed CCTV footage at the time and then spoken with Ms McGrady about the incident. There is no prejudice to the defenders. In all the circumstances the evidence of that incident is admissible. The objection is repelled.

Evidence of risk assessment

[177] The doors were security doors and when operating in RAID mode came within the exclusion from BS EN16005, but there was still a requirement on the defenders that the doors should operate safely.

[178] Mr Brown was the Health and Safety Assurance Manager from 2008 until 2018. Mr Brown said it was his responsibility to provide competent advice to the management team on health and safety, carry out audits and ensure relevant standards were met. Despite that role, Mr Brown was not consulted by anyone about the acceptability of risk in the installation of the doors before the system went live.

[179] Mr Brown said there were competent designers who carried out cause and effect tests on the doors at the time of commission and before the system went live. Mr Tipney, on behalf of HRS, accepted no responsibility for any health and safety measures for the operation of the doors. Mr Tipney said health and safety was the responsibility of the defenders.

[180] The only evidence about risk assessment came from Mr Welsh that he had seen a risk assessment at the time of testing and commission before the system went live. He said the operation of the doors and the system in general was assessed as low risk. Mr Welsh did not expand on that statement in evidence. That statement was of no assistance to the court in

the absence of seeing a risk assessment and the factors taken into consideration in demonstrating how the risk was assessed as low. No risk assessment was produced.

[181] It is extraordinary in a case of this nature that no risk assessment/s by the defenders was/were put in evidence.

[182] It is all the more concerning that as at 12 November 2014, less than 3 months after the system went live, Mr Welsh was unable to trace any risk assessment/s being carried out at testing and commission.

[183] The defenders averred on record that a risk assessment was performed when the doors were installed and commissioned in June 2014. There was no reliable evidence to support that averment.

[184] The absence of any risk assessment assessing the risk of injury to passengers and staff associated with the movement of the doors, particularly in RAID mode, at the time of commissioning and testing was unsatisfactory.

[185] It was unsatisfactory Mr Brown was not consulted at any time about any risk assessment prior to the system going live.

[186] Mr Welsh said he had carried out a review of risk assessment following the incident involving Mrs Cooper on 12 November 2014 but it transpired he did not carry out any risk assessment at all. It is of concern Mr Welsh gave evidence of carrying out a risk assessment when, on a plain reading of production 6/21, he had completed an appendix to a risk assessment with a different purpose and not a risk assessment. As the Security Compliance Manager Mr Welsh had no expertise in health and safety. Mr Welsh had expertise in matters of security. There was no evidence Mr Welsh was qualified to carry out any risk assessment on the safe operation of the doors.

Reasonable foreseeability and reasonable care

[187] The defenders were aware of an incident involving a member of staff, Ms McGrady, in September 2014 when she was struck on the arm sustaining a minor injury coming through D4 when the door started closing unexpectedly. Ms McGrady said she managed to get through the door before the door closed. The movement of the door was quite forceful. The door just kept moving. She got a fright as she was not expecting the door to close. Mr Welsh reviewed that incident. Mr Welsh reviewed CCTV footage of the incident and he had a discussion with Ms McGrady on how the doors worked. As far as Mr Welsh was concerned, and without consulting Mr Brown, the doors closed as intended. Despite the circumstances of the incident, no review of risk assessment was carried out.

[188] There was the further incident on 27 September 2014 involving a passenger Mrs McNeish. An investigation was undertaken. The initial investigation report was production 6/22. Mr Welsh was aware of the incident. The underlying risk factor was recorded as "Behavioural Error". The outcome of the investigation was that signage was reviewed with no requirement to change.

[189] The section of the initial investigation form under the heading "Recommended Level of Further Investigation" concluded:

- How likely is it to happen again? Remote
- Recommended Further Investigation: Minimal Risk.

The form was completed by Mr Leitch who did not give evidence.

[190] In September 2014 the defenders were on notice that the doors could close unexpectedly. The risk of injury to a person was reasonably foreseeable.

[191] There was no review of any risk assessment despite this being the second incident within the course of a month from the system going live. Mr Brown was not consulted for his advice on health and safety.

[192] No action was taken by the defenders to review any risk assessment until after the incident with Mrs Cooper on 12 November 2014, which was accepted by Mr Brown and Mr Welsh as being an incident involving serious injury to an elderly lady.

[193] Mr Welsh summarised the position of the defenders by saying the behaviours of the doors were addressed as they found them, that is from the experience of the doors being in operation. Put simply, the defenders reacted to incidents as and when they occurred. That was not satisfactory.

[194] It was Mr Welsh's evidence the defenders had relied on HRS that the operation of the doors would be as safe as possible. HRS adopted a contrary position, that it was the responsibility of the defenders that the doors would be as safe as possible. There was a significant gap in the health and safety processes and procedures of the defenders in relation to the safe operation of the doors. That was not satisfactory.

[195] The operation of the doors and in particular D3 in RAID mode was not safe for passengers or staff of the defenders on 12 November 2014.

[196] The incident on 12 November 2014 was reasonably foreseeable. Between the system going live and the incident on 12 November 2014 the defenders took no steps to review the assessment of risk that the doors might cause harm when in RAID mode and to identify and put in place appropriate and reasonable control measures to prevent that harm.

[197] A variety of reasonable control measures was identified in the course of evidence, generally accepted by Mr Brown and Mr Welsh subject to security considerations, which would probably have prevented the incident on 12 November 2012 involving Mrs Cooper

and in particular the incident involving Ms Toner. As examples, the doors could have moved at a reduced speed and still performed the security function. The doors could have been positioned in front of the partition and been more visible. Border Force staff could have been issued with wireless remote controls to control the doors locally. A function pad could have fitted to the doors airside. The defenders focused on security and not the safe operation of the doors. There was a failure by the defenders to take reasonable care in all the circumstances on 12 November 2014.

Decision

[198] The pursuer has proved on the balance of probability the defenders were at fault at common law for failure to take reasonable care and under section 2(1) of the 1960 Act.

[199] The pursuer acted as a rescuer. There was no basis for any finding of contributory negligence.

[200] The pursuer is entitled to decree against the defenders in the sum of £5,261.48. Parties were not agreed on the rate of interest to be applied from 16 October 2018. The pursuer sought 4% whereas the defenders proposed 2%. The differential is very small. The rate of interest to be applied is a matter for the discretion of the court. I will apply an interest rate of 4% from 16 October 2012 until payment.

[201] At the request of parties expenses were reserved. The Sheriff Clerk will fix a hearing on expenses.

APPENDIX

DIAGRAM CUSTOMS CHANNELS