Claim No: 042LR789

IN THE COUNTY COURT AT BASILDON

HHJ DUDDRIDGE SITTING AT THE COUNTY COURT AT SOUTHEND

B E T W E E N : -

DANIELLE RIX

Claimant

- and -

(1) STONEGATE PUB COMPANY LIMITED

(2) REGENCY SECURITY SERVICES (UK) LIMITED

Defendants

JUDGMENT

The following judgment was handed down in open court at the County Court at Chelmsford on 7 May 2024

Introduction

1. On 16 November 2018, C went on a night out with friends and former work colleagues to celebrate her recent change of job. During the evening, they visited the Popworld nightclub in Chelmsford. Whilst there, at about 2 am on 17 November 2018, C fell over, fracturing her left distal radius and scaphoid. C's case is that the floor where she was standing immediately before the accident was wet from spilt drinks: the accident happened when a member of the nightclub's security staff, who was rushing to the dancefloor to stop a fight that had broken out, barged into one of her friends, causing him to slip on the wet floor and collide with C, who then in turn slipped, lost her balance, and fell over.

2. D1 is the operator of Popworld and the occupier for the purposes of the Occupier's Liability Act 1957. D2 is the security company which supplied security staff under contract with D1.

3. C alleges that her injuries were caused by a combination of the floor being wet and slippery and the actions of the security staff. She therefore brings this claim against D1 under the Act and in negligence, and against D2 in negligence.

4. Each D puts C to proof of the cause of the accident and each denies breach of duty. Alternatively, each blames the other for the accident. D1 has formally brought an Additional Claim against D2 claiming a contribution amounting to an indemnity if D1 is found liable. Each D also disputes a number of the heads of claim contained in C's Schedule of Loss. Neither pleaded contributory negligence in their Defence. For this reason, although Ms Patel raised contributory negligence in her skeleton argument, D1 was not entitled to rely on it at trial.

5. D1's case is that, even if the accident happened as C described, it was not in breach of its duties under the Act or at common law because it had in place a reasonable system for dealing with spillages. D2's case is that its security staff are appropriately trained and licensed. In the course of responding urgently to an emergency, such as the need to break up a fight in a nightclub, they necessarily have to act rapidly in order to prevent harm to those involved and other customers. In such circumstances, it is impossible to avoid all physical contact with other people in the nightclub whilst moving urgently and the actions of its staff were reasonable, necessary and proportionate in the circumstances.

6. The principal issues I have to decide are therefore:

    a. The cause of the accident.
    b. Whether either (or both) D breached their respective duties of care.
    c. If liability is established against either D, the quantum of C's damages.
    d. If liability is established against both D, the apportionment of C's damages between them.

7. The trial took place over three days on 29 to 31 January 2024 but there was insufficient time to prepare and deliver an extempore judgment, so I reserved this judgment.

8. C was represented by Mr Johnson, D1 by Ms Patel and D2 by Mr Vaughan, each of counsel. I am grateful to them and to their instructing solicitors for their assistance.

Background

9. Although each D requires C to prove what caused the accident, neither led any direct evidence about how it happened as none of their witnesses saw or recalled it. The summary below is based on the evidence of C and her witnesses at trial. However, C's account has not been entirely consistent over time. I shall address the inconsistencies relied on by D in due course.

10. C was born on 8 February 1991. She was, therefore, 27 years old on the day of the accident and is now 33. She has a Bachelor's degree in Computer Gaming. On Monday 12 November 2018, she had started a new job as an SQL (a type of database) Developer for Kennedys Law LLP.

11. As mentioned above, on Friday 16 November 2018, C went out with a group of friends and former colleagues to celebrate her new position. Some of them, including C, met up at Joseph Koppel's house where they had a drink and got ready to go out. At about 7 pm, they went to an Escape Room experience where they stayed until shortly after 8 pm. After that they went to a bar called Be At One where they met Sean Kirwan who had not been at the Escape Room. They had drinks at Be At One and moved on at around 10.00 pm. They arrived at Popworld between 10.30 pm and 11.00 pm.

12. According to C's evidence, because she had been at the Escape Room earlier in the evening, she was wearing flat-soled boots. As I shall set out in due course, she has not always been consistent about how much if any alcohol she consumed during the evening but, in her witness statement, she said that she limited her drinking because she was due to attend an important birthday party the following day, which she was planning to drive to. She had two single vodka lemonade and limes at Be At One, and one shot of Tequila on arrival at Popworld. After that, she drank tap water for the rest of the night. It is possible that she also had something to drink at Mr Koppel's house but she was not asked about this because Mr Koppel gave evidence after her, and it

emerged from his oral evidence they had met at his house first. However, the effect of C's evidence is that she had not consumed any alcohol for about 3 hours before the accident.

13. Popworld has two floors open to the public. It opens from 9.00 pm until 4.00 am. The evidence shows that it has a total capacity of 785 visitors and a total of 555 came and went during the evening. The largest recorded number of visitors present at the venue at the same time was 352, at 1.00 am. It has been refurbished since the date of the accident.

14. C and her group spent the evening entirely on the ground floor, which contained a long bar and an open floor area, to one side of which was a separate, slightly raised dancefloor fitted with an underfloor coloured lighting system. As might be expected, dancing was not confined to the raised dancefloor, but any of the available space in the open floor area might be used for dancing, although the area in front of the bar would normally be occupied by people waiting to be served drinks. Two pillars, which at the time were decorated in coloured stripes, are situated a few feet in front of the bar at either end of the ground floor.

15. C's case is that, on arrival at Popworld, she and other members of her group noticed that the floor throughout the ground floor was extremely wet underfoot. As the weather outside was dry, this was presumably from drinks that had been spilt. C described an area of liquid covering most of the floor in front of the bar. Joseph Koppel told her he had slipped on the wet floor two or three times during the course of the evening, although C did not see him do so. In his evidence he said he had also seen other people slip. Another member of the group, Shannon Saunders, noticed an area of spilt liquid larger than a sheet of A3 paper towards the left-hand side of the bar and had seen a couple of people "*go over*" on the slippery floor. She reported this to the bar staff, who said there was not much they could do because of the type of floor and people spilling drinks constantly, but they would get somebody to look at it. However, this was not the area where the accident happened.

16. C divided her time between dancing and talking to friends. In her witness statement she said that, immediately before the accident, she was leaning against the pillar to the right of the bar (near the toilets and the entrance to the club) talking to one of her friends. In her oral evidence, she said she had been leaning on the pillar but had moved and was standing near to it. She did not see what happened but felt pressure from behind on her shoulder and then her back. She felt herself falling and tried to steady herself but slipped on the wet floor. Her foot came out from under her. She put out her left arm to save herself and landed on top of her left arm and hand. Sean Kirwan fell on top of her. In oral evidence she said that Mr Kirwan was about two inches taller than her, therefore about 5' 9", and "*on the larger side*". She later learned that one of the door staff had pushed past in order to break up a fight on the dance floor. In doing so, he had barged past Sean Kirwan, who slipped on the wet floor, lost his balance and fell into C, which was what caused her to slip and fall to the floor. C's friend Adam Shepherd helped Sean Kirwan to his feet and he said that the bouncer had barged into him, but C did not hear that. Whilst C's evidence at trial was that she had slipped on the wet floor after Sean Kirwan bumped into her, she has not always said that. I shall consider this aspect of her evidence further below.

17. As soon as C fell she felt pain in her left wrist. She was shocked and crying. She went with Shannon Saunders to the toilets to look at her injury. They went into the first cubicle, where they could see swelling in her left hand. C had to move two of her rings to her other hand because of the swelling. While they were there, a toilet attendant banged on the door, presumably because she suspected they were doing something illegal. They shouted out that C was injured but the toilet attendant came back two minutes later, banged on the door again and threatened to call security. C left the cubicle and apologised to the attendant, saying they had not done anything wrong. C and her friends then left Popworld together. They did not report the accident to anybody else before leaving and the toilet attendant did not report it. C says it was while they were outside that she learnt from Adam Shepherd that he had seen the bouncer knock Sean Kirwan over.

18. As they did not have a good mobile phone signal outside Popworld, they walked to Chelmsford Station, about 15 or 20 minutes away, where Shannon Saunders called C's husband and asked him to come and meet them. He came and took C to the Accident and Emergency Department at Broomfields Hospital where C was examined and told that she had suffered a fracture to her left scaphoid and left distal radius. She was given a Futuro splint and asked to attend the Fracture Clinic on 20 November 2018. On that date, the doctor was concerned that she might have a hairline fracture along the scaphoid bone and put her wrist into plaster, which remained in place until 10 January 2019.

19. On 18 November 2018, C reported the accident by email to Popworld. In that email she stated that the accident had happened at about 3 am on Friday 16 November. She said: "*I was near the bar area dancing when apparently a fight broke out not involving any of the members of my party. Bouncers rushed to separate them, however knocked into a member of my party who slipped on the wet flooring. He lost his balance and fell on top of me from behind. I put out my hands to protect myself. Unfortunately I had to leave as was in so much pain, ending up in Broomfields A&E department where I've discovered I've fractured my arm and possibly fractured my wrist as well (the swelling was too bad to tell on the X Ray), I have an appointment with the fracture clinic at Broomfields on Tuesday to check and to have a cast put on. I'm writing to inform you, I wouldn't want this to happen to anyone else as it ruined our otherwise really enjoyable evening. I also would like to review the cctv if possible as I had my back to the incident where my friend was knocked over by security, just to verify what I've been told.*"

20. On 27 November 2018, Mr Sparham-Simpson, who was at the time the General Manager of Popworld Chelmsford, responded in an email, in which he asked whether he could give C a call to obtain some information about the incident. He also stated: "*...Since receiving your email I've thoroughly investigated the situation. I can confirm that I've highlighted an altercation at around 2 am on the night in question. Could this be the time, not 3 am as you stated below? It's in the rough area that you describe in your email. Unfortunately you cannot see a great deal, other than two males & a*

female pushing each other & then the security getting involved. We were also especially busy on the night, making it challenging to see more detail. Please also be aware that due to a new GDPR ruling, we're not authorised to allow the General Public to view CCTV at any time. Please be assured I've spent a couple of hours reviewing and re-reviewing the footage." The email went on to offer a complimentary night out for C and up to 5 friends and to apologise for what happened.

21. C responded on the same day to confirm that the incident did happen closer to 2 am than 3 am and give an update on her injuries. She gave her phone number so that Mr Sparham-Simpson could telephone her. It appears from a further email she sent on 20 December 2018 that they spoke by telephone about two weeks before that date. In that email, C gave further information about her injuries and said "*I also still haven't heard anything from your insurance company yet*", which suggests that they had discussed C making a claim against D1's insurance policy. C did not get a response to that email and followed it up by letter on 24 January 2019 and email on 28 January 2019. The following day, Mr Sparham-Simpson responded saying that he had sent her communications to Head Office who would be in contact "*very soon*".

22. Although Mr Sparham-Simpson said in his first email that he had carried out a thorough investigation and reviewed the CCTV footage, that CCTV footage was not retained and, therefore, was not disclosed or made available to me as evidence. Other than reviewing the CCTV footage, it is not clear what investigations Mr Sparham-Simpson carried out at the time, although his witness statement in these proceedings refers to certain records retained by D1 and who was on floor duties that evening.

23. Following Mr Sparham-Simpson's email to C on 29 January 2019, it appears that D1's insurer contacted her on 14 February 2019, because a communication of that date is referred to in a letter she sent them on 24 February 2019, in which she provided them with personal information and details about the accident that they had requested. That did not result in any settlement of her claim.

24. On 29 May 2019, C issued a Claim Notification Form in which she described the accident as follows: "*At the time of the accident, [C] was at Popworld with a group of*

friends. She was standing and talking to her friend who was dancing. She had not been drinking. During the evening, a fight broke out behind [C] and her friends. One of the bouncers pushed through their group to get to the altercation behind them. [C]'s friend was pushed by the bouncer and he slipped on the wet floor and lost his balance. He fell onto [C]. who then fell and landed on her left wrist. This resulted in injuries and losses to [C]. [C]'s friend, Shannon reported to the bar staff that the floor was wet approximately 1 hour before the accident happened."

25. The Claim Notification Form did not lead to a settlement. On 2 November 2021, C issued these proceedings against both Defendants.

C's injuries

26. C suffered both physical injuries and psychiatric sequelae following the accident.

27. C relies on expert medical reports of Mr Cosker, Orthopaedic Surgeon, dated 5 January 2021, 26 January 2022 and 27 September 2022, and Dr Gibbons, Psychiatrist, dated 30 May 2021. D rely on the reports of Mr Eckersley, Orthopaedic Surgeon, dated 31 March 2023 and Dr Scott, Psychiatrist, dated 17 January 2023. The experts have met and prepared joint statements, which show that there is no material disagreement between the experts in each discipline, albeit Drs Gibbons and Scott diagnosed different anxiety disorders.

28. As set out above, C suffered a fractured left distal radius and scaphoid. On 20 November 2018, this was treated in the fracture clinic by application of a plaster cast which C wore until 10 January 2019. C subsequently developed a popping sensation under the base of her left thumb and locking on the side of her wrist. She received hand therapy which initially provided some relief, but the symptoms worsened again. She was diagnosed with De Quervain's tenosynovitis as a complication of the original injury. This was treated with an ultrasound guided steroid injection, which did not provide long term relief. On 29 April 2022 she had an operation to release constriction of the tendon sheath, followed by physiotherapy which finished in September 2022. In her oral evidence she confirmed that, apart from a scar on her left wrist, she has

fully recovered from her physical injuries. This is consistent with the joint statement of the orthopaedic experts, who agree that C had made a good recovery and will have no ongoing restrictions in terms of her personal, domestic, leisure and work activities, will require no further treatment and is not at any increased risk of premature arthritis as a result of the injury. They also noted that C's treatment was delayed by the effects of the Covid-19 Pandemic.

29. Following the accident C suffered symptoms of anxiety. Dr Gibbons diagnosed an anxiety disorder, including symptoms of agoraphobia, which was moderately severe for four months and continued at the time of examination on 24 May 2021 at a moderate level. C reported to her that her symptoms included: lowered mood; loss of interest and pleasure in activities; low energy; feelings of 'what's the point'; poor sleep, with dreams about falling; poor concentration, which was 50/50; reduction in social engagement; loss of confidence and self-esteem; some guilt because of the demands that she felt she put on others; feeling embarrassed, humiliated and abandoned; weight loss of half a stone; [feeling] anxious about going out on her own; feeling more vulnerable and concerned that she would have an accident; symptoms of agoraphobia; needing someone to be with her and [being] very fearful of public spaces; inability to travel on the tube.

30. Dr Gibbons recommended cognitive behavioural therapy (CBT). According to C's evidence, she undertook a course of ten sessions of CBT, which she found helpful.

31. Dr Scott diagnosed a Specific Phobia. C reported to her that she became very concerned after the accident about floors being slippery, associated with a fear of a further fall. She reported an incident at a birthday party when she became concerned that a floor was slippery and felt unsteady, which caused her to feel frightened. This caused panic, causing avoidance of these situations. The symptoms were predominantly those of anxiety associated with specific circumstances. Her anxiety and thoughts had improved following CBT.

32. In their joint report, the experts agreed that C's symptoms might have changed in the twenty months between their respective examinations, in particular as she had

undertaken the CBT recommended by Dr Gibbons in that period. They also agreed that the different conditions they diagnosed are both classed as anxiety disorders and have similar presentations with similar treatment recommendations.

33. Whilst I shall address quantum in more detail later in this judgment, C's Schedule of Loss and evidence referred to the following consequences of her injuries which are relevant to quantum.

34. C was anxious about taking time off work following the accident because she had only recently started working for Kennedys and thought she might lose her job. Therefore, she only took four days off work immediately after the accident. On her return to work, Kennedy's provided her with some adapted equipment to help her to perform her role. She took six half days from her annual leave to attend medical appointments and seeks damages for that loss of annual leave. She took a period of four weeks paid sick leave following her surgery in April 2022. She claims a total of 7 days past loss of earnings.

35. C was able to obtain private medical treatment under a private health insurance policy through her employment. She claims that she has a contractual liability to repay the insurer, Aviva, in the sum of £3,855.16.

36. C says that her injury affected the work that she could perform for Kennedys, causing her to miss out on opportunities to travel in the course of her work, including to Singapore and Hong Kong. When she joined Kennedys she was told that there would be an opportunity for her to study for a Masters Degree in Computing and Data Science at the University of London on a part time basis alongside her job but this was not possible due to her injury. She claims that obtaining a Masters Degree would have furthered her career and enhanced her earning capacity and seeks an award of £50,000 to compensate for the delayed opportunity to increase her earnings.

37. C's starting salary at Kennedys was £40,000 pa. In 2020, it increased to £48,000 pa. However, she had changed job shortly before trial and now works as a Data and BI

Developer for Farrers. In her evidence, she said that her salary is about £12,000 pa higher than it was at Kennedys.

38. As a result of her injury, C required assistance from her husband and mother with personal care and domestic chores. She claims a conventional award of damages for this care and assistance. However, in addition to this, her father caught Covid-19 in 2020 and was treated with oxygen at home. C claims that her husband assisted with her father's care during this period because she was unable to do so, and claims damages for that care and assistance.

39. C's injuries made changing the gears in a manual car painful. She and her husband each had their own manual cars. They exchanged her husband's car for an automatic so that C could drive to her place of work (which she continued to do during the pandemic, whilst her husband worked at home). C claims the cost of doing so.

40. I shall address other aspects of C's Schedule of Loss in due course but, at this point, I note that Mr Johnson informed me in his closing submissions that the parties have agreed general damages for pain, suffering and loss of amenity in the sum of £17,500.

Ds' Duties

41. Although C claims against D1 under the Act and in negligence, the scope of their duties is governed by the Act and the alternative claim in negligence adds nothing of substance to the statutory duties.

42. By s.2 of the Act D1 owed C the common duty of care to visitors, which is defined in s.2(2) as:

> "...a duty to take such care as in all the circumstances is reasonable to see that the visitor will be reasonably safe in using the premises for the purposes for which he is invited or permitted by the occupier to be there."

43. The duty is therefore not an absolute one, in that both the standard of care which the occupier must exercise, and the safety of their visitors which they should

thereby seek to secure, are qualified by reference to what is reasonable. By s. 2(4), the Court is required to have regard to all the circumstances in deciding whether the occupier has discharged the common duty of care to a particular visitor.

44. In this case, those circumstances include that the setting was a busy nightclub with a bar that served drinks that customers were permitted to take with them onto the dance floor or the other parts of the open ground floor where customers congregated, danced or otherwise moved around; the lighting in a nightclub setting would tend to be subdued and customers who came to a nightclub to dance, socialise, and consume alcohol, would not be expected to be particularly attentive to where they were putting their feet; the risks of customers spilling drinks in such an environment are obvious, as are the risks of customers slipping in liquid spilt onto a hard floor; in the circumstances which prevailed, it would be impossible in practice for D1 to stop all spillages but it would be reasonably practicable to implement measures to ensure that any spillages were promptly detected and cleaned up and/ or to put out appropriate warning signs until they were cleaned up.

45. The burden of proof is on C to prove how the accident happened and that it was caused by breach of duty on the part of D1 or D2. So far as D1's duties are concerned, in Ward v Tesco Stores Ltd [1976] 1 W.L.R. 810, which concerned a claimant who suffered injury after slipping in yoghurt in a supermarket, the Court of Appeal held that, where a claimant shows that an accident was "*...such as in the ordinary course of things does not happen if floors are kept clean and spillages are deal with with as soon as they occur...some explanation should be forthcoming from the defendants to show that the accident did not arise from any want of care on their part; and in the absence of any explanation the judge may give judgment for the [claimant]*." (per Lawton LJ). In other words, once the claimant establishes a *prima facie* case that the accident was caused by the occupier's negligence, the occupier has an evidential burden of showing that "*...[the] accident would have been at least equally likely to have happened despite*

a proper system designed to give reasonable protection to customers." (per Megaw LJ).

46. That decision was followed by the Court of Appeal in Dawkins v Carnival Plc (T/a P&O Cruises) [2011] EWCA Civ 1237. In that case, a passenger suffered injury after slipping on liquid spilt in a restaurant on a cruise ship. The Recorder found that the defendant had a proper system for dealing with spillages and dismissed the claim. The Court of Appeal set aside that decision, finding that, as the defendant had not called any evidence from the members of staff claimed to be implementing the system, the Recorder was not entitled to infer (from the existence of that system) that the spillage which led to the fall occurred only a few seconds, or a very short time before the accident. There was therefore nothing to suggest such closeness in time between the spillage and the accident as would, at a place where close observation was required, exclude liability. In my judgment, that case shows that it is not sufficient for the occupier to prove that it had adopted a reasonable system for dealing with spillages; it also had to call evidence to show that the system was being implemented at the time of the accident.

47. On the other hand, Apres Lounge Limited v Nicolle Wade [2023] EWHC 190 (KB) (Julian Knowles J. on appeal from a decision of the County Court), concerned an accident caused by slipping in a spilt drink in a bar. The trial judge accepted that the occupier had in place a reasonable system of pro-active inspection and clearing of spillages that meant, in practice, that the premises were checked every 10 to 15 minutes and found that that system was being operated at the time of the accident, but he nonetheless found that the accident was caused by the defendant's breach of duty. Julian Knowles J. set that decision aside, holding that the trial judge had imposed too high a standard of care. At paragraph 52, he said: "*Turning to the present case, here – unlike I think in* Ward *and* Dawkins – *there was direct and detailed evidence of the system which was being operated on the bar othat night. Having regard to the realities of running a late night bar, the system of floor inspections by several members of staff ... which the judge accepted was being done – was sufficient to fulfil the statutory duty lying upon the*

Defendant. Its system was proactive and not reactive. It was one of continuous monitoring..."

48. Understandably, Ms Patel emphasised that decision in her submissions to me, submitting that, in the case before me, D1 also had a proactive, not reactive, system for checking the floor and cleaning spillages which was sufficient to fulfil its duty under the Act. In my judgment, Apres Lounge is entirely consistent with Ward v Tesco Stores and Dawkins v Carnival (as is clear from the above quotation from the judgment of Julian Knowles J.) and turns on the trial judge's finding that the system in that case was in operation at the time of the accident. As discussed below, Mr Johnson submitted that, whatever D1's written policy and procedures required, it has not called sufficient evidence to show that they were being operated on the night of the accident in this case.

49. No authorities were cited to me concerning D2's duties. I agree with Mr Johnson's submission that they have to be determined by the application of first principles. Whilst D2's case is that it is unavoidable that security staff intervening urgently to break up a fight, or deal with some other emergency, may come into contact with other customers, it is also reasonably foreseeable that they may cause injury or harm to other customers if they do not exercise reasonable care in doing so. In my view, it is also reasonably foreseeable that such harm can include causing a customer (particularly one who is unprepared for the contact in question) to fall over or to slip by barging into or past them with too much force and without warning. It is also foreseeable that the floor might be slippery from spilt drinks. Therefore, D2's staff owed C a duty to take reasonable care to avoid such harm. I agree with Mr Vaughan that the standard of care must take into account that, when responding urgently to an emergency, the staff in question have to make split second decisions and cannot reasonably be expected to finely calibrate their contact with other customers. Furthermore, although it should be possible to shout a warning, in a busy nightclub it might not be possible in practice to shout loud enough to be heard over the background noise of music and conversation. The staff in question could only be expected to take

reasonable steps to forewarn customers that they are coming through and to avoid harm from physical contact.

50. However, in my judgment, an accident of the kind alleged by C is one that should not happen if security staff take reasonable care. Therefore, a similar evidential principle applies to D2 as to D1. If it is shown that an accident happened as a result of one of D2's staff barging into somebody in the course of their duties, that raises a *prima facie* case in negligence such that D2 has an evidential burden of showing that the accident was not caused by negligence. However, the question is narrower in D2's case as it does not rely on a system designed to avoid such accidents.

D1's documents/ system

51. D1's case is that, in a busy nightclub setting where drinks are served, it is practically impossible to prevent spillages and they are therefore inevitable. As set out in more detail in the following paragraphs, D1's case is that it had a reasonable written policy and procedures in place for dealing with various aspects of Health and Safety at Popworld, including dealing with spilt liquids, it provided regular training and refresher training to its staff in these policies and procedures, and it allocated responsibility for proactively monitoring and clearing spillages to specific members of staff each shift.

52. D1's case is that those policies and procedures were in force and being implemented on the night of the accident and, consistently with the authorities referred to above, it relies on them as satisfying its duty of care to C. D1 has disclosed a limited number of documents relating to that system and how it should have been implemented on the night of the accident and D1's witnesses gave evidence of a general kind about the training that was given and how spillages were to be dealt with under that system, but no specific evidence about the condition of the floor on the night of the accident or the accident itself.

53. The documents disclosed by D1 include the following extracts from D1's Risk Assessment Manual Version 3.0 dated May 2011 (which Mr Sparham-Simpson said was a nationwide Manual rather than one specific to the Chelmsford site):

    a. Risk Assessment BM008 headed "*Moving around the premises ("Slips, Trips and Falls")*".The items listed in bullet points in the box headed "*How do we currently control these risks?*" include: "*Staff clean up spillages immediately they are aware of them using appropriate methods as documented in the company "Spillage and Glass" policy*"; "*Staff trained to watch out for hazards and in safe clearance of any spillages/ contamination*"; "*"Clean as you go" policy in operation*"; "*Signage used to warn customers of any area where slipping hazard may exist*."
    b. Risk Assessment BM013 headed "*Cleaning Up Spillages During Trading Hours*". The list in the box "*How do we control these risks?*" includes: "*Staff trained to identify spillages and use hazard signage where appropriate*"; "*During busy periods sufficient numbers of glass collectors are specifically detailed to monitor floor throughout trading area for spillage hazards*"; "*Spillages mopped up immediately they are identified. Where possible, floor to be dried immediately using paper towels*." A further, italicised list under the subheading "*Controls below will also apply in sites with dancefloor areas*" includes "*Signage in place advising customers that drinks are not permitted on dancefloor"* and "*Door team monitor dancefloor to ensure drinks not taken onto area.*"
    c. Risk Assessment BM014 headed "*Cleaning/ Mopping Floors – General*", which contains general instructions for how such cleaning should be carried out, not specific to identification and cleaning of spillages.

54. The specific instructions that signage was to be in place informing customers that drinks were not permitted on the dancefloor, and that the door team would monitor the dancefloor to ensure that drinks were not taken there, were not implemented at the club at the time of the accident. Mr Sparham-Simpson said it was not possible to

enforce them in practice because the dancefloor was not effectively segregated from the rest of the ground floor.

55. D1 has disclosed its specific "*Spillages/ Broken Glass Policy*", which states "ALL BAR STAFF MUST BE AWARE OF AND ADHERE TO THE FOLLOWING PROCEDURE". The instructions in that policy include the following:

> "It is the responsibility of all team members; bar staff, glass collectors, management and door staff to be vigilant for any spillages whilst moving around the premises at any time. The procedure noted below should be followed at all times during the trading day.
>
> The Company operates a "clean as you go" system whereby any spillages/ glass hazards are cleared immediately they are found. To ensure hazards are found quickly during the trading day the floor area should be checked for spilt liquid/ broken glass at regular intervals throughout the trading day. This is generally done as part of the glass collection routine, although it is the overall responsibility of the Duty Manager to ensure that this check is carried out. Where door security staff are employed, they are also responsible for ensuring that the site team are made aware of any spillage so that action can be taken.
>
> ...
>
> If a customer reports having slipped on spillage in any area of the site it is the responsibility of the Duty Manager to inspect the area and to note on the incident report whether any liquid or other hazard is present. If nothing is evident this should be clearly noted. Any remedial actions taken should also be recorded fully on the incident report.
>
> If any spillage is detected it must be cleared up immediately with a mop and bucket, and either dried immediately with blue roll if possible or a wet floor warning sign placed over the area until completely dry. If the spillage covers an extensive area, or the surface has been made especially hazardous as a

result of the spillage then it should be cordoned off and access restricted until dry."

56. Although that policy referred to the door staff, it is common ground between D1 and D2 that, at the time of the accident, it was not given to the door staff, and they did not receive any training in it.

57. D1's case is that its staff received regular training on risk assessments, including on its Spillage and Broken Glass Policy. Popworld had only recently re-opened, having previously traded as "The Liquorist". Any new staff taken on before the re-opening would have received full induction, health and safety, e-learning and training on D1's spillage policy and risk assessments. Any staff who had previously worked at The Liquorist would have received refresher training on the slip policy, risk assessments and in respect of the new venue. However, the training paperwork dating from the opening of Popworld has not been disclosed and D1 states that it cannot be located as it was archived. D1 has, however, been able to disclose copies of some "Risk Person Training Records". For example, I note that Mr Partik is recorded as having successfully completed a number of training courses in 2018 and 2019. None of the course titles listed to in his record refers specifically to spillages or other slip and trip hazards, although it is possible that these were covered in the Health and Safety courses he undertook on 10 July 2018 and 18 June 2019.

58. According to D1's evidence, whilst all members of staff would look out for spillages and take steps to report them and have them cleared up when they were seen, specific responsibility for monitoring the floors was assigned to floor walkers, whose task was to patrol the floor checking for spillages and other hazards, clearing glasses and dealing with any other issues they found. In addition, the member of staff responsible for washing the glasses and returning them to the bar area acted as an extra "float" carrying out floor checks. During the night of the accident, Chloe Ritchie and Lewis Blake were assigned to monitor the floor area and collect glasses and Christian Partik was assigned to washing the glasses and was the floating floor walker. D1 has produced a copy of its roster for 16 November 2018 showing that Chloe and Lewis

were assigned to Ground Floor Zones 1 and 2 respectively and one of two members of staff called Christian was allocated to Glasses. If spillages were found, then they should have been cleaned up with a mop, which was kept in a cupboard near the bar, and dried with blue towel or placed a "wet floor" hazard sign over the area until it had dried.

59. I note that a manager would also carry out a daily floor walk of the entire premises to check that all areas were free of hazards, but, in my view, this is not specifically relevant to the detection and cleaning up of drinks that were spilt during opening hours.

60. D1 has disclosed a register signed by a number of members of staff on 17 November 2018 which states: "*I confirm that I have read the Company Policy with regard to Spillages/ Broken Glass; I fully understand and will adhere to this procedure at all times*." In her Particulars of Claim C alleged that "*...it appears to be seriously suggested that all of [D1's] staff were given a copy of the policy to sign for the first time on the afternoon before the Accident happened...this is a coincidence so unlikely that the Court can safely draw the inference that these documents were created as part of a "paper trail" to use in support of a defence of the claim*." That allegation appears to be based on a misunderstanding of the chronology, because 17 November 2018 was the same date as the accident, not the afternoon before it happened, and was also the day before C's email reporting the accident to Mr Sparham-Simpson. As C's email mistakenly stated that the accident happened on 16 November 2018, it is unlikely that the document was created as part of a forensic trail intended to show that D1's staff had received appropriate training shortly before the accident happened.

61. The effect of Mr Sparham-Simpson's evidence was that there was not a bespoke training session on this policy (for example, like the "toolbox talks" familiar in the construction industry). The written policy was placed behind the bar and the staff were asked to read it during their shift and sign the register to show that they had done so. However, a number of names, descriptions of position and the date "17/11/18" have clearly been written by the same person, which undermines the

register's reliability as a record that they read the policy on that date. Three names have been crossed out and there is no signature next to them although the date 17/11/18 appears against their names. Other members of staff have the date 17/11/18 written against their name, although they were not rostered to be at work that day. Mr Sparham-Simpson said they might have visited the club as customers on a day off, and read the policy while they were there, which seems rather improbable. In the light of those features of the document, I am not satisfied that the register is reliable evidence that the members of staff who have signed it necessarily did so on 17 November 2018. More importantly, in the absence of a bespoke training session at which an appropriate manager took other members of staff through the policy and supervised them while they read it, the mere fact that they may have signed the register does not mean that they had actually read the document. On the other hand, cleaning up spillages and, if necessary, posting hazard signs, are simple tasks that should not require any sophisticated training to execute: the more significant questions are whether D1 had effective procedures in place to identify and deal with spillages promptly when they arose, whether they were effectively communicated to the staff and whether they were in operation on the night of the accident.

62. D2 supplied security staff to D1 under a contract dated 6 October 2017. By Clause 4.3.9 D2 warranted that each Door Supervisor it provided: "*immediately reports to the manager of the Premises....details of any incident, accident or injury to or involving any person (however insignificant) occurring at or near the premises of which the Door Supervisor is aware and enters details of the incident accident or injury in the appropriate documentation supplied by [D1]*".

63. D1 did not make any written records of its own of any spillage monitoring or cleaning carried out by its staff. D2's disclosure included extracts from D1's "Incident Due Diligence Log" dated 16 November 2018, which was completed by members of D2's door staff. Internal page number 11 includes timed entries every thirty minutes, under the rubric: "Floor, Toilet, Stairs and Outside areas must be regularly checked for hazards such as spillages/ glass every day, and any hazards reported immediately to Duty Manager for action. Noise and litter problems must be remedied immediately."

The half-hourly entries between 21.00 and 01.00 were initialled, indicating that checks had been carried out at those times (but providing no further details of what, if anything, was found or done), but no initials appear after 01.00. Therefore, there is no documentary record that the ground floor was checked in the hour before the accident.

64. Although D2's staff appear to have been responsible in practice for logging these checks of the floor and other areas, the contract did not expressly require them to monitor and deal with spillages and D1's Spillages/ Broken Glass Policy does not appear in the list of documents that D2's staff were required to read in accordance with paragraph 1.2.2. of Schedule 2, Part 2 ("Standards of Service") to the contract. As I have mentioned above, it is common ground that it had not been provided to D2's staff at the time of the accident. D2's case is that it had no legal responsibility under contract to D1, or in tort to C, for monitoring or clearing spillages. D2's witnesses did, however, accept that they would inform D1's staff if they noticed any spillages and would occasionally help to clean them up if required, in order to be of assistance, even though that was not part of their formal duties.

65. Page 12 of the Incident Due Diligence Log refers to a fight at 01.55 and states "*2 males removed for fighting on the dancefloor. Removed from venue*." That is consistent with C's case that the accident happened at about 2 am. The same page contains a further report of a small scuffle at 2:40 which is not relevant to this case. Although the form contains columns headed "Name/ Badge No", "Signature" and "CCTV", the entries next to the two incidents that were recorded have been left blank. As a result, the security staff who were actually involved in the incident at 01.55 are not identified on the form and it appears that no steps were taken after C reported the accident on 18 November 2018 to identify or take statements from them. D2 has disclosed a more detailed incident report that was completed in respect of an unrelated incident but it was not considered necessary to complete such a detailed report for the incidents that were recorded on 17 November 2018.

66. As I have noted above, D1 did not retain and therefore has not produced the CCTV footage of the incident referred to in Mr Sparham-Simpson's emails. D1 has not disclosed any contemporaneous, written record of the thorough investigation he said he had carried out: for example, in the form of any notes of any interviews with the staff on duty on 16-17 November 2018, or of any other inquiries he made. He did not make a written accident report until 29 November 2018, over ten days after C first reported the accident to him. The report contains the following description of the accident:

> "[C] was near the bar area dancing when apparently a fight broke out not involving any of the members of her party. Bouncers rushed to separate them, however knocked into a member of [C's] party who slipped on the wet flooring. He lost his balance and fell on top of [C] from behind, she put her hands out to protect herself. Unfortunately [C] had to leave as was in so much pain, ending up in Broomfields A&E department where she discovered she'd fractured her arm and possibly fractured her wrist as well. At no point did [C] make a member of Team or Security aware of the situation, thus no First Aid was administered."

67. I note that the accident report suggests that C had confirmed that she stayed in the club for an hour after the accident, although there is no other evidence of that and it does not correspond with the account given by her and her witnesses. The report also records that Mr Shepherd was a witness to the accident, and his mobile phone number. There is no reference in the accident form to the CCTV footage that Mr Sparham-Simpson viewed.

The Witnesses

68. As I have mentioned above, the trial took place between 29 and 31 January 2024. I heard oral evidence from the following witnesses (the following list is not set out in the order that I heard their evidence, which was arranged according to their availabilty):

a. C gave evidence and called Joseph Koppel, Adam Shepherd and Shannon Saunders, who were with her at the time of the accident as set out above.
b. D1 called Phillip Sparham-Simpson, who, as set out above, was the General Manager of Popworld Chelmsford at the time, Ryan Rezazdeh who is now the General Manager but was the Bar Manager and on duty on the night of the accident, and Christian Partik, the member of staff who had responsibility for washing and drying glasses and being a floating floor walker on the night of the accident. D1 provided a witness summary from Lewis Blake, a member of staff who was responsible for walking the floor and collecting glasses on the night of the accident. That summary was based on a telephone conversation with D1's solicitors but Mr Blake was not called to give oral evidence and no hearsay notice was served. I give his evidence no weight insofar as it addresses disputed matters.
c. D2 called Paul Burmingham who was its compliance director at the time of the accident and is now its business director, Stacey Brown, who was formerly employed by D2 as a Door Supervisor at Popworld and was on duty between 22.00 and 04.00 on the night of the accident, and Craig Gillam, an employee of D2 who was the head Door Supervisor on duty on the night of the accident.

69. Neither Ms Patel nor Mr Vaughan submitted that C or her witnesses gave untruthful evidence or that they did not give evidence to the best of their recollections, although they did point out a number of differences in and omissions from their evidence, which they submitted undermined C's case. In my judgment, that approach to their evidence was reasonable and realistic. Although C's witnesses are all friends who, no doubt, would want to further her interests, they and C came across as sensible and realistic witnesses who acknowledged the limits of what they could remember and showed no obvious signs of seeking to embellish their accounts in order to support C. They did not take the opportunities presented in cross-examination to bolster their evidence but made appropriate and reasonable concessions about the things they had not witnessed and, on a number of occasions, they reasonably said they could no longer recall details which they had remembered better when they made their witness statements. The differences between their accounts varied in their significance but

were generally consistent with their different experiences or recollections of what happened: for example, Ms Saunders remembered that the member of the bar staff to whom she reported the spillage gave her a single hair tie, C remembered that it was two; Mr Koppel had not remembered that he had gone to the bar with Ms Saunders on that occasion until he was reminded of it in a conversation with her in the weeks before the trial and he said he had not heard her report the spillage; C and Ms Saunders recalled different areas of spilt liquid (neither of which was in the area where C fell over). There was possibly some overstatement by C and her witnesses of the extent to which the floor was wet: for example, I doubt that it was literally so wet that, throughout the evening, there was nowhere dry to stand apart from the toilets, as C said. But, in my judgment any such overstatement was because their evidence reflected their subjective impressions rather than being due to deliberate forensic exaggeration and, even if it was somewhat overstated, they were consistent in their evidence that the floor was very wet and slippery throughout the evening, causing Mr Koppel to slip on a number of occasions and see other people slip, Ms Saunders to see at least one and possibly two people slip (in oral evidence she was only sure of one) and to report a spillage larger than an A3 sheet of paper to a female member of the bar staff.

70. I am satisfied that C and her witnesses were all honest witnesses doing their best to assist the Court.

71. Similarly, Mr Johnson submitted that Ds' witnesses were generally honest witnesses doing their best to assist me. However, I accept his submission that Mr Partik's evidence that, in practice, the whole dancefloor was swept about every thirty minutes when the club was open, was so wholly implausible that it undermined his evidence as a whole. It was also contradicted by Mr Gillam who confirmed that, as one would expect, it would not be practically possible to sweep the whole floor in a busy nightclub.

72. I also accept Mr Johnson's submission that the real difficulty with Ds' witnesses is that none of them gave any direct evidence either about the circumstances of the accident

itself or about the specific conditions in the club on the night of the accident, including the condition of the floor, and the implementation of D1's spillage policy on that night. It is only C's witnesses that gave specific evidence about how the accident happened and the conditions in the club on the night. Ds' evidence dealt with general conditions in the club and expectations as to how D1's spillages policy should have operated, including on the night of the accident, rather than how it was actually being implemented on that night. Significantly, none of parties' witnesses gave evidence that they had seen or carried out any cleaning on the night of the accident, or had seen any "wet floor" hazard signs. Ms Saunders expressly stated in her witness statement that she did not see any such signs during the evening. Although both Mr Partik and Mr Rezazdeh were on duty on the night of the accident, neither gave any specific evidence about the circumstances on the night contradicting the evidence given by C and her witnesses. Notably, although the security staff were responsible for completing the inspection logs, Mr Gillam said that, in practice, they would be focussing on people, not the floor. It was not feasible to check for spillages when the club was busy because of the number of people on the dance floor, so they would not do so - although, if they saw a spillage, they would stand there and get somebody to clear it up.

73. That in itself does not mean that I am bound to accept the account given by C and her witnesses, not least because, if D1's spillages policy and procedures was being implemented diligently then it is unlikely that the floor was as wet throughout the night of the accident as C and her witnesses have described. That would not preclude Mr Kirwan and C slipping on some liquid that had been spilt only moments before and not yet detected and cleared; and C accepted that she did not know how long the liquid in question had been present. If it had only been there for a short period of time, D1's case is that it complied sufficiently with its duties of care by implementing a reasonable system for identifying and clearing spillages and the accident was not caused by any negligence on its part. On the other hand, if C and her witnesses are correct in their impressions of the general wetness of the floor (even allowing for some overstatement as a result of the subjectivity of those impressions), that suggests that D's procedures for identifying and clearing spillages were not being performed

diligently and makes it more likely that the accident was caused in part by Mr Kirwan and/ or C slipping on the wet floor. This is therefore a significant area of factual difference between the parties.

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74. Ms Patel submitted that Ms Saunders' evidence that the bar staff told her that there was not a lot they could do about the spillage she reported to them is implausible. I agree that it is unlikely that that would have shrugged off a report of a specific spillage in a blasé, unconcerned way. However, I note that Ms Saunders' evidence was not necessarily that they had been unconcerned about it, but that there was not much they could do because of the type of flooring and people constantly spilling drinks but they would get somebody to have a look at it anyway. In my view, that is consistent with the closing sentence of Mr Rezazdeh's statement, which (after referring to the allocation of members of staff to deal with spillages) said: "*I do not know what else we could have done at the premises in order to have dealt with spillages, which is an inevitable part of a venue such as Popworld where customers are purchasing drinks and walking around*." Ms Saunders' evidence is consistent with the member of the bar staff simply referring to the difficulty of controlling spillages inherent to the nature of the venue, rather than suggesting that she was unconcerned about the spillage Ms Saunders reported. I accept Ms Saunders' evidence that she saw and reported the spillage in question.

75. Subject to what I have said about possible overstatement, I also accept the evidence of C and her witnesses that the floor, or significant parts of it, were very wet and slippery throughout the time they were in the venue. In effect, D invite me to prefer D1's evidence about how their spillage procedures generally were, or should have been, operated over the specific evidence of C and her witnesses about the conditions in the club on the night, and to infer on the basis of D1's general evidence that the account given by C and her witnesses is mistaken. In the absence of specific evidence from any of Ds' witnesses about the actual conditions on the night, I prefer the honest, consistent and cogent evidence given by C's witnesses.

76. However, although they did not suggest that C or her witnesses were untruthful, Ms Patel and Mr Vaughan both submitted that, in the light of the inconsistencies in C's account, the various differences between the accounts given by her and her witnesses, and some gaps in her evidence, she has not proved her case that the accident happened in the way she described.

77. The inconsistencies in C's evidence include some inconsistent reporting of her alcohol consumption before the accident. The notes from the Accident and Emergency Department in the early hours of 17 November 2018 record that she had consumed alcohol prior to the accident. But the Claim Notification Form dated 25 May 2019 stated that C had not been drinking. Mr Cosker's reports dated January 2021, January 2022 and September 2022 each recorded that she had not been drinking. Dr Gibbons' report dated 30 May 2021 recorded that C "*was not drinking because she was going to a party the next day*". Dr Scott's report dated 17 January 2023 recorded that C recalled having two drinks before going to Popworld and a shot of Tequila when she got there, but "*she did not want any more after this*". In C's Particulars of Claim, she said she had consumed no more than 2-3 alcoholic beverages during the course of the whole evening and had not had any alcoholic drinks for 3-4 hours prior to the accident, because she needed to drive to an event the following day. This was consistent with her evidence that she had consumed 2 single vodka lime and lemonades before going to Popworld and a shot of Tequila on arrival and then drank only tap water after that. The significance of this evidence is whether C's alcohol consumption played any role in her accident. Her case is that it did not, because she had limited her alcohol intake that evening and had not consumed any alcohol for 3 or 4 hours before the accident: she was therefore not under the influence of alcohol when she fell. In my view, the apparent inconsistency between what Mr Cosker and Dr Gibbons recorded (no alcohol consumed) as against the other various accounts (limited alcohol consumed and none for 3 to 4 hours before the accident) is of no material significance when seen in the context of C's case that she was not intoxicated at the time of the accident, and does not undermine the reliability of her evidence.

78. C's description of the mechanism of the accident has also varied over time. The inconsistencies in that description are potentially more significant, as they go directly to her case that the accident was caused by breaches of duty by D1 and/ or D2. Ms Patel, in particular, drew attention to the fact that the expert report of Dr Gibbons dated 24 May 2021 contains the first written record of any report that C herself had slipped, rather than simply falling as a result of Mr Kirwan colliding with her. She had not mentioned this in her earlier accounts, including the following:

    a. The notes taken at the Accident and Emergency Department on 17 November 2018 record that "*another person fell on top of pt*." They do not mention either Mr Kirwan or C slipping on the wet floor.
    b. In her email to Mr Sparham-Simpson dated 18 November 2018, C said she was near the bar area dancing before the accident (which was itself inconsistent with her Particulars of Claim, which said she was loosely leaning against the bar, her witness statement, which said she was leaning against the pillar, and her oral evidence, which was that she had moved away from the pillar and was standing near it – she said the reference to dancing in her email had been mistaken and she didn't know why she had said it). In that email she said that the Bouncers had "*knocked into a member of my party who slipped on the wet flooring. He lost his balance and fell on top of me from behind, I put out my hands to protect myself...*" C did not say that <u>she</u> had slipped on the wet floor. However, it is fair to point out that she also did not expressly say that she had fallen, this being inferred from her description of putting her hands out and being injured.
    c. In a letter dated 20 November 2018 to C's GP, Mr Sohail, the Orthopaedic Registrar who saw C at the fracture clinic on that date, said C "*...was out clubbing on Friday night when somebody pushed her and she ended up falling onto her left outstretched hand...*" That letter did not refer to either C or Mr Kirwan slipping on the wet floor.
    d. Neither of D's emails to Mr Sparham-Simpson dated 27 November 2018 or 20 December 2018 referred to the condition of the floor or that she or Mr Kirwan had slipped on it. However, nor did either email contain any description of how

the accident happened inconsistent with C's case that Mr Kirwan and she had slipped.

e. In her letter to Mr Sparham-Simpson dated 24 January 2019, C said "*A bouncer pushed one of my friends who slipped on the wet flooring and fell into me from behind. As a result I fell forwards onto my left arm...*" That letter therefore did not mention that C had slipped on the wet floor.

f. In her Claim Notification Form dated 25 May 2019 C said *"...[C's] friend was pushed by the bouncer and he slipped on a wet floor and lost his balance. He fell onto [C], who then fell and landed on her left wrist*..." Again, that did not mention that C had herself slipped before or as part of falling.

g. Mr Cosker's report dated January 2021 records that: "*One of the bouncers pushed through their group to get to the altercation behind them, [C's] friend was pushed by the Bouncer, he slipped on a wet floor and lost his balance, he fell onto [C] who then fell and landed on her left wrist...*"

79. Dr Gibbons' report dated 24 May 2021 recorded that C "...*was pushed from behind. She slipped on the wet floor, put her hand out, and her friend fell on top of her*." As stated above, this is the first written record that C slipped, and it does not mention that Mr Kirwan slipped. Following that:

a. C's Particulars of Claim dated 21 February 2022 pleaded that the floor was very wet from spilt drinks and at paragraph 5 that: "*Suddenly and without warning, [C] felt some pressure on her back and realised that somebody was falling into her. Before she was able to take any steps to steady herself, she began to slip on the floor which was hard and slippery, causing her to fall over heavily...*" At paragraph 6, she pleaded that "*One of [D2's] Bouncers had roughly pushed...Sean Kirwan...In turn he had slipped on the slippery floor, causing him to place his hand on [C's] right shoulder and to fall into contact with her...Neither [C] nor Mr Kirwan were asked to move or given any prior warning of what was about to happen*..."

b. Dr Scott's report dated 17 January 2023 records that C told her she had slipped on the wet floor.

c. Mr Eckersley's report dated 21 March 2023 recorded that "...*bouncers shoved her friend who fell onto her causing both of them to fall over...She said there was water on the floor as well...*"

d. C's witness statement dated 15 April 2023 at paragraphs 21 to 24 gave a more detailed account of how she had fallen, stating that as she tried to steady herself "...*the floor was wet, and I slipped over – my foot had come out underneath me*", and that she subsequently learned that "*Sean had been forcefully pushed by the bouncer, and he had slipped on the wet floor and lost his balance and fell onto me*."

e. In her oral evidence, C said that she had tried to steady herself after Sean had collided with her but had felt her feet slipping out from under her as she did so. She could feel the wet, slippery floor under her boots. She fell on her knees and, afterwards, she noticed that her clothes around her knees, and the skin on her arms (she was not wearing long sleeves) were wet. She did not mention her clothes and arms being wet in her witness statement or earlier documents.

80. C's evidence that she had slipped was not directly corroborated by any of her witnesses. Mr Koppel did not see the accident. In his statement he said C had told hm that the security staff had knocked over Mr Kirwan who fell on her, causing her to fall. In his oral evidence, he said that she did not say she had fallen as a result of slipping. Mr Shepherd saw the accident. In his statement made in October 2021, he said he saw the bouncer knock Mr Kirwan and C to the floor. In his oral evidence, he said he saw the bouncer make contact with both Mr Kirwan and C and that was what caused them to fall over. He did not know which one of them the bouncer had made contact with first. He would not have been able to see what happened to their feet. He did not remember telling C outside what had happened. Ms Saunders did not see C fall and said she did not know what had caused her to do so. In her statement made in April 2021 she said that, when they went to the ladies' bathroom to look at C's arm, C told her that Mr Kirwan had fallen into her causing her to slip and land on her arm. In her oral evidence she said C had not told her about the bouncer, but said that Mr Kirwan had gone into her: she could not remember whether C had used the word slip or said

she had fallen due to the floor being wet, but her recollection was better when she made the statement.

81. In assessing the above changes in C's account about how the accident happened, I bear in mind the following:

    a. C was a truthful witness and I am satisfied that she believes that she slipped in the process of trying to steady herself.
    b. In Gestmin SGPS S.A v Credit Suisse (UK) Ltd [2013] EWHC 3560 (Comm), Leggatt J. (as he was) drew attention to the limitations of human memory, the possibility of genuine recollection being distorted by reconstruction in a forensic context and the need to found findings about disputed facts in contemporaneous documents and uncontroversial or established facts where that is possible.
    c. The accident happened suddenly and without warning. The impressions and therefore memories of C and those who witnessed the accident and its aftermath must necessarily have been formed very quickly in circumstances of some confusion. C must have been through the accident in her mind many times since, particularly when recounting it to her solicitors, the experts in this case and in preparation for trial. In that context, there will have been ample opportunity for the process of reconstruction referred to in Gestmin. That in itself does not mean I must disregard C's evidence, but that I must consider the possibility that it is mistaken.
    d. The contemporaneous documents bearing directly on how the accident happened are extremely limited, at best. Furthermore, I bear in mind that the records made in the Accident and Emergency Department and the letter from the Fracture Clinic contain only bare summaries of what happened. Those summaries were made in the context of seeking treatment, when the primary concern would have been to record the basic facts of the accident relevant to diagnosis and treatment rather than an exact blow by blow description of what happened. In that context, it is not likely that either C or the medical staff would have thought it important to explain, or to record, whether or not the

accident involved either Mr Kirwan or C slipping. That view is supported by the fact that, although neither the note from A&E on 17 November 2018 nor the letter from the Fracture Clinic dated 20 November 2018 mentioned slipping, C referred to Mr Kirwan slipping, and the floor being wet, in her email to Mr Sparham-Simpson between those two dates, on 18 November 2018. In my view, therefore, little weight can be placed on the absence of any reference to slipping in the medical records from 17 and 20 November 2018, which may simply be because it was regarded as an unimportant detail in the context of identifying and treating C's injury.

e. The absence of any reference to C slipping in the email to Mr Sparham-Simpson dated 18 November 2018, her letter to him dated 24 January 2019 and her Claim Notification Form is, obviously, potentially more significant but there are possible explanations for the omission. I note that the email dated 18 November 2018 did not (at least expressly) state that C was advancing any claim but that she did not want a similar accident to happen to anybody else. In that context, it is understandable that she might have thought the important details were that a bouncer had collided with Mr Kirwan, causing him to slip and knock C over. It is not uncommon in litigation of this kind that parties and their advisers do not appreciate the significance of some factual detail at the start of proceedings which assumes greater importance as they analyse the case later on. The descriptions of the accident given in the letter dated 24 January 2019 and the Claim Notification Form are summaries, in contrast to the more detailed Particulars of Claim, and it might have been thought that they sufficiently set out the most important details of the accident at those stages in the proceedings to show why D should be held liable. After all, if D had responded by settling the claim, there would have been no need for more detailed analysis of the precise mechanism of the accident.

f. The established facts in this case include that the floor was generally wet and slippery throughout the evening, as I have found above.

g. I accept that, although Ms Saunders could not recall at trial the conversation she had with C in the ladies' bathroom after the accident, she had a better recollection when she made her statement in April 2021. I therefore accept

that C told her at the time that she had slipped after Mr Kirwan collided with her. That shows that, immediately after the accident, C believed that she herself had slipped.

h. It is also of note that Dr Scott recorded that C had developed a specific anxiety about slippery floors causing her to fall, and recalled a specific occasion at a birthday party when she became frightened because the floor was slippery. That anxiety is more likely than not to have been grounded in C's experience of having been injured as a result of slipping on the wet floor.

82. Taking into account the above considerations, I find on the balance of probabilities that C did fall as a result of slipping on the wet floor as she tried to steady herself after Mr Kirwan collided with her. Based on the evidence as a whole, I also find that Mr Kirwan fell into her after a bouncer had barged into him whilst rushing to the dancefloor to break up a fight. That is consistent with what Mr Shepherd saw, even though he thought the bouncer had made contact with both Mr Kirwan and C, with C's evidence as to how she fell and that Mr Kirwan fell on top of her, and with Ms Saunders' evidence that she heard Mr Kirwan muttering and swearing about the bouncer after the accident.

83. Even if I am wrong in my finding that C slipped on the wet floor, that would make no difference to D1's liability if the accident was caused in part by Mr Kirwan slipping on the wet floor after the bouncer barged into him, causing him to fall into C, knocking her to the ground. However, Ms Patel submitted that the evidence does not show that Mr Kirwan slipped. Mr Kirwan did not give evidence, so there was no direct account from him explaining how the accident happened. Mr Koppel and Ms Saunders did not see how it happened. The effect of Mr Shepherd's evidence was that he could not say whether Mr Kirwan had slipped, and he could not remember telling C that outside the club. Mr Vaughan also submitted that the lack of evidence from Mr Kirwan was a significant omission which meant that it was a matter of supposition how the accident happened, albeit his focus was on whether the actions of D2's staff caused or contributed to it.

84. The lack of evidence from Mr Kirwan is unsatisfactory. However, I have to decide what happened on the balance of probabilities based on the evidence which is available. I have found that the floor was wet and slippery throughout the night, which increases the probability that Mr Kirwan slipped after the bouncer barged into him. I can place significant weight on C's account in her email dated 18 November 2018, which shows that the day after the accident she believed that Mr Kirwan had slipped on the wet floor and considered that detail significant enough to mention in her email. Although the lack of consistent evidence before me showing the origin of that belief is also unsatisfactory, C is unlikely to have invented it and it is more likely than not that it reflects what she was told very shortly after the accident. It is also unlikely that the person who told her invented the detail of Mr Kirwan slipping. Her evidence was that Mr Shepherd told her. That is inconsistent with his evidence but it is possible that, due to the passage of time, one or both of them no longer clearly remembers what happened or that someone else (perhaps Mr Kirwan himself) told C. However, I am satisfied that the contents of the email accurately reflect that Mr Kirwan slipped.

85. I therefore find that the accident happened as C claims: in the course of rushing to the dancefloor to break up a fight, one of the bouncers barged into Mr Kirwan. He then slipped falling into C, who in turn slipped as she tried to steady herself and fell to the floor, causing the injuries described above. There is no evidence that any warning was given before the bouncer barged into Mr Kirwan and I find that there was none.

Did either D breach their duty of care?

86. Consistent with my earlier analysis of the relevant law, the effect of my above finding is that C has established a *prima facie* case that the accident was caused by breaches of D1's duty under the Act and the duty of care D2's staff owed C at common law. As such, each D has the evidential burden of providing an explanation showing that the accident did not happen as a result of their negligence and/ or, in D1's case, was at least as likely to have occurred despite the implementation of a proper system designed to avoid such accidents.

87. As described above, D1 relies on a system which included a written policy for dealing with spillages which required all staff to be vigilant for spillages and deal with them if they were found, initial and refresher training of its staff in that policy, assignment of particular members of staff each shift to roles which included checking the floor for spillages throughout the evening whilst collecting glasses, and dealing with spillages immediately they were detected by mopping them up, drying the floor with blue roll and, if necessary, placing a "wet floor" hazard sign over the location of the spillage while it dried, and a pro forma Incident Due Diligence Report log supplied to D2's staff which contained an expectation that they would check the premises, including for spillages, every 30 minutes during opening hours.

88. Although D1's system did not require its own staff to check for spillages at defined intervals, it assigned two members of staff as floor walkers on the ground floor whose task was to walk the floor throughout the evening collecting glasses and checking for and dealing with spillages and other hazards, as well as a floating floor walker to assist alongside washing glasses. If properly and effectively implemented, such a system would, in my judgment, have been a reasonable one in all the circumstances, which would have complied with D1's duty under s.2 of the Act.

89. However, I am not satisfied that D1's policy was being properly implemented on the night, for the following reasons:

    a. The fact that the floor was, or significant parts of it were, wet throughout the night suggests that the policy was not being properly or effectively implemented.
    b. Although D1's witnesses all gave evidence that D1 provided regular training, and Mr Sparham-Simpson said they received training or refresher training (as appropriate) before Popworld opened two weeks before the accident, D1 has not produced any documentary evidence that its staff had received such training in the spillages policy before the reopening. It has not produced any records of such training predating the accident and the reason given, that those records were archived, is a surprising one given that the accident happened only relatively soon after such training is supposed to have taken

place. The Register showing that training was given on 17 November 2018 post-dates the accident and, for reasons I have given above, is not satisfactory evidence that the staff who signed it had actually read and assimilated the policy. It is not clear to me (although this was not explored in the evidence) why they would have needed to receive such training on 17 November if they had already received relevant training about two weeks earlier, which further undermines Mr Sparham-Simpson's evidence that there was such refresher training before Popworld reopened.

c. As I have already set out, although D1's witnesses gave general evidence about what the system required, none of them gave specific evidence showing that it was actually in operation, or how they operated it, on the night of the accident, or any other evidence contradicting C's evidence about the circumstances in the premises during that night. The written roster appears to show that Chloe Ritchie and Lewis Blake were assigned to monitor the floor area and collect glasses and Christian Partik was assigned to washing the glasses and was the floating floor walker but, given the implications of my finding that the floor was wet throughout the night and the unsatisfactory evidence about whether they had received relevant training before that night, I am not satisfied that the roster is sufficient evidence that the system was being operated properly in the absence of any evidence as to how they actually performed their roles on the night.

d. The Incident Due Diligence Report log appears to show that the floor was inspected by a member of the door staff every thirty minutes. However, consistently with the contract between D1 and D2, all of D2's witnesses said that they did not understand identifying and dealing with spillages to be part of their responsibilities, although they would report one if they did see it. Mr Gillam said it was not possible to see the floor in any event because of the lighting and the number of people in the club. In the light of that evidence, I am not satisfied that the log provides cogent evidence that D2's staff were checking for spillages every thirty minutes. In any case, it was not signed after 1.00 am and therefore does not provide any evidence that the floor had been checked in the hour before C's accident.

90. In my judgment, therefore, D1 has failed to discharge the evidential burden of showing that the accident happened without negligence on its part, or was at least as likely to happen despite the implementation of a proper system for avoiding such accidents.

91. D2's witnesses also did not give any specific evidence about how the accident happened. Mr Vaughan submitted that they were hindered because C did not report it at the time, which meant they could not carry out an immediate investigation. I shall address that submission further below. However, Ms Brown accepted that, when breaking up fights, she had a duty to use reasonable force to separate people and to be careful about bystanders, and that it was not reasonable to put somebody else at risk of injury, so that she had to be careful when moving somebody out of the way. She said it was difficult to avoid contact when moving through bystanders but she would shout a warning if they had their back to her. Mr Gillam, on the other hand, said he had not received specific training on dealing with fights. If a fight broke out he would receive a "Code Red" over his radio and get there as quickly as possible. There was nothing he could do to warn other people: it was practically impossible to shout a warning because of the noise and number of people present. He would not push people out of the way, but would barge through them with his shoulder. In his written statement, he had referred to "*light contact*" and "*brushing past*", but in oral evidence he said that, if a venue was full, it would be "*more than a barge*". The general impression created by his evidence was that he considered there was nothing practical that could be done to avoid fairly significant contact with innocent bystanders who might not be aware that security staff were coming through, but that was justified because worse injury could result if they did not intervene to prevent a fight that had broken out if, for example, the protagonists had bottles or glasses or some other article that could be used as a weapon.

92. As I have recognised above, It is not reasonable to expect security staff to make finely calibrated judgements about their actions when responding to an emergency. I therefore have some sympathy with their position. However, they nonetheless have a duty to take such care as is reasonable in the circumstances to avoid injury to others.

In my judgment, it should be possible to shout a warning, even if it would not always be heard, and to minimise the force used to move bystanders out of the way. In my view, Mr Gillam implicitly recognised that in his witness statement when he referred to "*light contact*" and "*brushing past*": in my view, he was there minimising the force that might be used, because light contact of that kind would be unlikely to cause accident or injury. On the other hand, a forceful barge might do so, depending on the circumstances.

93. The incident report of the fight does not show which members of staff were involved in breaking it up. There is no evidence from that person or any of D2's staff as to how much force they used or what steps, if any, they took to warn Mr Kirwan they were passing through or to minimise contact with him.

94. It is correct that C did not report the accident to the door staff before she left the club. Had she done so, it is likely that they would have called for medical assistance and carried out an immediate investigation into what happened, or at least taken a contemporaneous account from her and the security staff involved. It is unfortunate that that did not happen. However, I accept that C and Ms Saunders told the attendant in the toilets that C had had an accident. Mr Rezazdeh's evidence was that the attendant should have reported it. C notified Mr Sparham-Simpson of the accident the following day, but it is not clear what precise steps he took to investigate it other than to watch the CCTV recording. There is no evidence that he tried to obtain statements from the staff on duty. Part of the difficulty arises because the incident report of the fight did not identify the members of staff involved, despite there being boxes on the pro forma for that purpose which, presumably, were there precisely so that any incident could be followed up and further statements taken if required. It should have been possible to identify the members of staff if Mr Sparham-Simpson had made enquiries immediately on receipt of C's email dated 18 January 2018 but it appears that that was not done. In any case, they have not been identified and there is no evidence from them about the circumstances surrounding the accident. In my view, therefore, the inability to investigate is attributable in significant part to the failure of

D2's staff to record their details on the incident report and of Mr Sparham-Simpson to carry out prompt enquiries and/ or to obtain and record these details.

95. In the circumstances, I am not satisfied that D2 has satisfied the evidential burden of showing that the accident was not caused by negligence on the part of its staff in failing to give any warning that they were coming through and in barging Mr Kirwan out of the way with sufficient force to cause him to slip over and fall into C.

96. For those reasons, I find that the accident was caused by breaches of duty by both D.

Quantum

97. As mentioned above, the parties have agreed the award for pain, suffering and loss of amenity in the sum of £17,500.

98. Ms Patel and Mr Vaughan sensibly divided the submissions about the other heads of loss between themselves so as to avoid repetition of the same submissions.

99. The following items on C's Schedule of Loss are not disputed, or D submitted that C is formally put to proof but it is a matter for the Court whether C has proved her case, and I am satisfied that she has done so:

    a. £380 for damage to C's wedding ring.
    b. £600 for the course of 10 sessions of CBT.
    c. C's claim for gratuitous care and assistance provided directly to her: C claims a total of 540 hours at a discounted rate of £9.05, amounting to £4,887 for this component of the care and assistance claim.
    d. £458.60 for attending the hairdresser to have her hair washed.
    e. £245.96 on various aids and equipment to assist with her work.
    f. £200 for painkillers and other medical products.
    g. £30 for miscellaneous expenses, which C attributed to having to use premium rate telephone lines for some of her telephone calls.

100. C claims £900 for taxi fares but has only provided receipts to a total of £300. However, I accept her evidence that she spent more than this and £900 is a reasonable estimate of the total cost of taxi fares. I allow this sum. I also allow her claim for £250 for additional travel by car attributable to the accident.

101. C claims a total of 7 days loss of earnings. In closing, Ms Patel questioned why there were no payslips for her employment after April 2019. However, I accept that C took a total of 7 days unpaid leave as a result of the accident (4 days initially followed by 6 half days when she was receiving further treatment). I therefore award the sum claimed of £823.39.

102. The most controversial elements of C's claim, foreshadowed in paragraphs 35 to 39 above are:

a. £3,855.16 which she claims she has a contractual liability to repay to Aviva in respect of private medical treatment, together with the policy excess of £100.
b. The claim for £50,000 for lost earnings attributable to her being unable to undertake a Masters Degree in Computing and Data Science. C's Schedule of Loss states that she claims that sum pursuant to Blamire v South Cumbria HA [1993] PIQR Q1 and also refers, by way of footnote, to Ronan v Sainsbury [2006] EWCA Civ 1074.
c. The claim for care and assistance that C's husband provided to her father when he was ill with Covid-19 and required treatment with oxygen.
d. The claim for £6,000 to exchange her husband's Toyota Cruiser with an automatic vehicle.

103. I shall address those parts of the claim in turn.

104. By email dated 10 October 2022, Aviva sent Denise Doherty, who I presume works for C's solicitors, a schedule setting out details of the invoices for private medical treatment, to a total of £3,855.16. That appears to be the only documentary evidence C has produced in support of her claim. The email from Aviva states "*Thank*

you for your email...Please find attached an updated schedule showing our new figure of £3855.16." Unfortunately, the contents of the email to Aviva (to which they responded) do not appear in the bundle. C has been unable to disclose the contract (which I understand was between Aviva and Kennedys). Ms Patel submitted that there was no evidence that C had a contractual liability to repay this sum, which was a benefit of her employment, and it was not the kind of insurance contract where a right of indemnity could be inferred. Mr Johnson responded that C had claimed this sum in a Schedule of Loss verified by a statement of truth and that should be the end of the matter. Furthermore, there was no other reason why Aviva should have sent the Schedule. I accept that submission: Ms Patel did not suggest any reason Aviva should have sent the Schedule to C's solicitors, and I cannot think of one, unless there was an obligation to seek to recover these sums from D and refund them. I therefore accept that C has a liability to refund this sum (presumably, contingent on being able to recover it from D). I also accept that she paid the policy excess.

105. So far as the Masters degree is concerned, C relied on a letter from her manager at Kennedys dated 19 November 2021 which stated, amongst other things, that "*At some point during 2019 and pre the Covid restrictions [C] had expressed an interest in pursuing further studies that would have helped develop her career further and a discussion about her joining a Masters in Computer and Data Science at the University of London as a part time student took place and I explored how the firm could potentially help fund some of her costs to assist in her career development*." There is no other evidence that Kennedys would have helped C fund that Masters course and it is not clear how far the conversation went. It appears to have happened after the accident, but it is not clear what was known about the extent of C's injuries at the time of the conversation, which might be relevant to causation. More importantly, there is no objective evidence that completion of such a Masters course would have enhanced C's earning capacity or furthered her career prospects. C's evidence was that the Masters would teach her Python and other programming languages. She would not have changed her job but would have been able to perform it better and that would enable her to get promotion. But, in my view, this is not self-evident, since it may be that experience in the field is as valuable or more valuable to

employers than a Masters degree. Whilst there is no evidence about this, it is notable that C's earnings at Kennedys increased by 20% (to £48,000) in 2020 and that she was able to command a further £12,000 on moving to Farrers (albeit that might to some extent reflect their location in Central London). Those increases in salary support the view that C's experience in computer science is valuable in itself.

106. Mr Johnson said that C does not seek a Smith v Manchester award because she has not suffered a permanent disadvantage in the employment market as a result of her injuries. Blamire is authority for the proposition that, where the court is satisfied that a claimant has suffered, or will suffer, loss of earnings as a result of an injury, but there are too many uncertainties and imponderables to make a conventional assessment of the loss based on a multiplicand and multiplier, it may instead assess them as a global award based on a rough estimate of the damages. Ronan affirms that principle but states that the court should be careful to distinguish between such damages and Smith v Manchester awards, which are made on a different basis. However, it is clear that the Court must be satisfied that the claimant has suffered the loss in question.

107. C's claim is really for the loss of opportunity to further her career and her earning potential by taking a Masters Degree whilst working for Kennedys and with their financial support. She has not sought to undertake such a course since the accident. Covid-19 might also have had an effect on or delayed her ability to complete such a course, if she had started it in September 2019 or September 2020 (although it is likely that it would have been run remotely). On the limited evidence available to me, I am not satisfied either as to the probability of that opportunity actually happening or, given that C has since been able command higher salaries than her starting salary with Kennedys, that it would have materially enhanced her career or her earning potential. I therefore do not allow this head of her claim.

108. The claim for care provided by C's husband to her father is an unusual one. Mr Johnson relied on Lowe v Guise [2002] EWCA Civ 197 to support it. In that case, C had provided gratuitous care to his disabled brother before he was injured. The Court of Appeal held as a preliminary issue that he was entitled in principle to recover damages

in respect of his inability, as a consequence of his injuries, to continue to provide a substantial part of that care. In his judgment at paragraph 27, Rix LJ said:

> "...in my judgment an injured claimant who works albeit gratuitously for his family, a fortiori or at any rate within the nucleus of a family home, does suffer loss, the loss of being able to contribute the value of his service to the needs of his family. Just as the wife's care of her injured husband, or the husband's care of his injured wife, can be and is to be valued in pecuniary terms, even though gratuitously provided, and is to be compensated, through the injured person's claim, as the provider's loss, so it seems to me that the injured claimant's loss of the ability to contribute his or her service to the needs of the family is a real loss suffered by the claimant, or transferred by the claimant by reason of his or her injuries on to another member of the family household who in turn is obliged to contribute his or her service...Of course the carer does not expect or at any rate is willing to forego compensation for the service, for he contributes it willingly to the family: but if he is deprived by another's fault of the ability to make that contribution or that financial sacrifice, the value of that can still be assessed as his loss."

At paragraph 38, he said:

> "The present case, however, is one where, as must at present be assumed to be correct, the disabled brother is part of the household and one whose care had, prior to the accident, been the appellant's prime responsibility. That care was not a mere gratuitous favour bestowed on a third party, but was a responsibility of his own, adopted by him and owed to his brother, but also to his mother with whom he shared the household. When he lost the ability to care for his brother for more than 35 hours per week, he lost something of real value to himself (as well as to his brother) which was his contribution to his family's welfare, and his loss imposed a corresponding obligation on his mother to make good by her own care what he was no

longer able to provide. In my judgment the appellant is entitled to claim in respect of the loss of his ability to look after his brother. Since he will maintain his state allowance, he has suffered no loss so far as that allowance is itself concerned. But he has suffered a loss nevertheless because, even though his care was provided gratuitously, it can and ought as a matter of policy to be measured in money's worth. To the extent that his mother has by her own additional care mitigated the appellant's loss, it may be that the appellant would hold that recovery in trust for his mother."

109. The significant facts in that case are that the injured claimant had an existing responsibility to care for a disabled family member, who was part of his immediate household and for whom he was the primary carer at the time of the accident. The tortfeasor had to take the claimant as she found him, which was with that existing obligation in place, and therefore to provide compensation for the consequences of his inability to perform that obligation as a result of the accident, including in respect of the gratuitous services performed in substitution by a different family member. But, in my view, it is one thing to compensate a claimant (or the substitute caregiver) for the loss of the claimant's ability to perform some existing obligation or responsibility: it is another to require the tortfeasor to provide compensation in respect of some future family responsibility, however unforeseen at the time of the accident. In one sense, it is generally foreseeable that any claimant might at some future point acquire a responsibility to care for another family member because of illness, misfortune, old age or other circumstances but, in my view, that does not mean that the tortfeasor (or their insurer) should be required to provide compensation in respect of such life events. Covid-19 was, of course, a uniquely unforeseeable catastrophe. In my judgment, the consequences of C's father catching Covid-19 were neither sufficiently proximate to the accident nor sufficiently foreseeable to fall within the principle in Lowe v Guise and C is not entitled to recover this aspect of her claim.

110. I accept that C found it difficult to operate a manual car because of her injury and it was therefore reasonable for her to part-exchange her husband's car – which she said was the more valuable – to purchase an automatic. However, there is no

documentary evidence to support C's case that the additional cost was £6,000. C's evidence was that they had changed the Toyota Urban Cruiser for a Mercedes A class which cost £15,000. When she looked at Autotrader she had noted there was a £6,000 difference between a manual car and the Mercedes she bought. But she did not produce any documentary evidence of the searches on Autotrader or other evidence, such as Glasses Guide, to show that there is a £6,000 difference in price between otherwise equivalent Mercedes vehicles where the only difference is that one is manual and the other is automatic. Although I accept that, in general, automatic cars tend to be more expensive than their manual equivalents, the price of second hand vehicles is highly sensitive to age, mileage, model and other features. Therefore, it is not self-evident that the automatic car C purchased was £6,000 more expensive than a manual equivalent and the onus is on C to produce sufficient evidence to prove this aspect of her claim. Furthermore, C accepted that there was an element of betterment when purchasing the Mercedes but there is no evidence quantifying this, or its impact on the future value of the car when C comes to sell or part-exchange it in due course. In all the circumstances, I am not satisfied that she has proved this head of loss.

111. On that basis, the damages I award are as follows:

a. General Damages: £17,500;
b. Care and assistance provided to C: £4,887;
c. Various out of pocket expenses listed above: £3,064.56;
d. Past loss of earnings: £823.39;
e. Sum due to Aviva and policy excess: £3955.16.

112. The grand total of those sums is £30,230.11. C will be entitled to interest at appropriate rates but I will invite counsel to check my calculations and seek to agree the interest which is due on the damages.

Apportionment

113. Although D1 and D2 each suggested that they were not liable for the accident, none of the parties sought any particular apportionment, essentially leaving it to me.

114. It is well established that an apportionment between separate tortfeasors should be based on the court's assessment of the causative potency of their respective torts and their respective culpability for the injury or loss.

115. It might be possible to argue about whether (a) the action of the bouncer, which triggered the accident, had greater causative potency than the slippery floor; and, on the other hand, (b) D1, which had primary responsibility for the safety of its visitors, was more culpable than D2's staff who were responding to an emergency. However, as the parties have not addressed any substantive arguments to me about apportionment, I do not think it appropriate to try to fine tune the apportionment between the two defendants. In my judgment, their respective liabilities should be apportioned in the ratio 50:50.

116. That concludes this judgment.

HHJ DUDDRIDGE

7 May 2024