SUPREME COURT OF QUEENSLAND

CITATION:	*Reck v Queensland Rail* [2005] QCA 228
PARTIES:	**NIGEL RONALD RECK** (plaintiff/respondent) **v** **QUEENSLAND RAIL** (defendant/appellant)
FILE NOS:	Appeal No 8928 of 2004 SC No 60 of 2002
DIVISION:	Court of Appeal
PROCEEDING:	General Civil Appeal
ORIGINATING COURT:	Supreme Court at Mackay
DELIVERED ON:	24 June 2005
DELIVERED AT:	Brisbane
HEARING DATE:	24 March 2005
JUDGES:	McPherson JA, Fryberg and Holmes JJ Joint reasons for judgment of McPherson JA and Holmes J; separate reasons of Fryberg J, dissenting in part
ORDER:	**1. Appeal dismissed with costs** **2. Cross-appeal dismissed with costs**
CATCHWORDS:	NEGLIGENCE – Duty of care – Employer and employee – Safe system of work – Whether employer had a duty to instruct and warn where risk of injury was obvious and known to employee *National Coal Board v England* [1954] AC 403, cited *Podrebersek v Australian Iron & Steel Pty Ltd* (1985) 59 ALJR 492, referred to
COUNSEL:	S C Williams QC, with M T O'Sullivan for the appellant J R Baulch SC for the respondent
SOLICITORS:	McInnes Wilson for the appellant Taylors Solicitors for the respondent

[1] **McPHERSON JA & HOLMES J:** The plaintiff Nigel Ronald Reck, who is the respondent to the appeal in this Court, was successful in obtaining judgment in the Supreme Court for damages against the defendant appellant his employer Queensland Rail in the sum of $644,756.08. The judgment for that amount was arrived at after reducing the amount of the assessed loss sustained by the plaintiff from $893,083 on account of what the learned judge considered to have been

contributory negligence on the plaintiff's part, which his Honour assessed at 25%. On the appeal, the plaintiff has lodged a cross-appeal against that finding and the consequent reduction of the damages awarded to him.

[2] On the determination of that appeal by the defendant, we are content to adopt the reasons of Fryberg J dismissing the appeal. However we have formed a view differing from that of his Honour with respect to the question of contributory negligence. In beginning his descent from this series 3100 locomotive from a height of some two metres above ground level, the plaintiff was obliged to: (1) open the cabin door on his left; (2) grasp the handrail on his left with his right hand, after rotating partly, the other rail with his left hand; and (3) descend the ladder backwards, ie facing towards the cabin of the locomotive. The process of descending that was required in some ways resembled that commonly undertaken by mariners in descending companion ways on ships. What made the second stage more difficult was: (a) the presence of the slight lip or sill at the edge of the cabin, which served to help seal the door when closed on the air conditioned cabin; and (b) the fact that the lintel of the doorway was not high enough to permit him to pass through it without ducking his head. The process could, however, be safely carried out in a way that is demonstrated on the defendant's training video (ex 33).

[3] Unfortunately the video showing the correct manoeuvres was not brought into existence until some time after the incident in which the plaintiff was injured by a fall in the course of "exiting" the cabin of the defendant's locomotive. It was the defendant's failure to instruct him in the dangers associated with alighting from the locomotive that resulted in the finding of negligence or breach of duty against the defendant. It ought to have been made clear to the plaintiff that he should not protrude his head out of, but should remain wholly within, the cabin, until he had a firm grip with both hands on the security hand rails on either side, so that he had "three point contact", as it was described in evidence. There is no good reason for disturbing that finding even though, as emphasised by Mr Williams QC for the defendant, locomotives with doors of this design had been used for over 700 years of "man hours" without an accident of this type happening before this one. The plaintiff, he said, had successfully done it a thousand times or more during the past three and a half years before this incident occurred.

[4] The trial judge found that the probable cause of the plaintiff's fall was that his right foot tripped on the raised lip or sill while he was leaning out of the doorway before he had a proper grip on the handrails at either side. The defendant ought to have instructed the plaintiff about the risks of doing this because it involved his having his centre of gravity outside the cabin before he had a secure grip. "I am satisfied", said his Honour:

> "that had the plaintiff been properly informed of the danger of leaning out of the locomotive before taking hold of the handrail and shown how to exit safely on the balance of probabilities the accident would not have occurred. In any event had the defendant given such information and instruction the defendant (*sic*, ? the plaintiff) could not have complained if he failed to follow those instructions."

His Honour continued:

> "Being aware of the existence of the lip and the problems associated with exiting the locomotive, Mr Reck would be unlikely to have fallen forward out of the locomotive if he had been taking reasonable

> care for his own safety. Having successfully negotiated this access system on hundreds if not thousands of previous occasions without mishap it follows, in my view that the plaintiff was not taking proper or reasonable care for his own safety in the manner of his attempted exit from the locomotive. In my view, the plaintiff must bear a significant portion of the blame for his own accident. I accept the submission of counsel for the defendant that contributory negligence should be assessed at 25%."

It is this finding that the plaintiff challenges in his cross-appeal.

[5] Reduction for contributory negligence in the damages awarded involves an assessment of the plaintiff's share in the responsibility for the injury and loss sustained. As a general rule an appellate court does not interfere with the discretion exercised by the judge who tried the case: *National Coal Board v England* [1954] AC 403, 421. In *Podrebersek v Australian Iron & Steel Pty Ltd* (1985) 59 ALJR 492, 493-494, the High Court said:

> "A finding on a question of apportionment is a finding upon a 'question, not of principle or of positive findings of fact or law, but of proportion, of balance and relative emphasis, and of weighing different considerations. It involves an individual choice or discretion, as to which there may well be differences of opinion by different minds': *British Fame (Owners) v MacGregor (Owners)* [1943] AC 197 at 201. Such a finding, if made by a judge, is not lightly reviewed."

[6] Those observations apply to the reduction by 25% of the plaintiff's damages in this case on account of his failure to take care for his own safety. Earlier in the same decision, their Honours had said (at 493):

> "The question was whether, in those circumstances and under those conditions, the appellant's conduct amounted to mere inadvertence, inattention or misjudgment, or to negligence."

[7] It would be possible here, as in many other circumstances, to characterise the plaintiff's conduct as coming within one or more of the first three of these categories rather than the last. However, given the obvious risks of injury if he fell as he did, it is in our view impossible to acquit the plaintiff of all the blame for what happened or to ascribe it simply to "mere" inattention on his part. The dangers of falling such a distance and the severe consequences of doing so were obvious to him on this occasion as on any of the many other instances on which he had alighted from the cabin of the locomotive. He cannot claim to have been unaware of them. It may be that familiarity in doing so had bred in him a degree of contempt for his own safety. In any event, his Honour's conclusion about the plaintiff's share in the responsibility for what happened is not such an unreasonable appraisal or exercise of discretion as to render it liable to review on appeal. We would not disturb it.

[8] It follows that the cross-appeal should, like the appeal in this case, be dismissed with costs.

[9] **FRYBERG J:** On 26 August 1997, the respondent, a locomotive driver, was injured when he fell more than two metres from the door of his locomotive onto the ballast which supported the railway track. At the time the locomotive was stationary at a siding. It was one of four attached to a coal train hauling coal from the Bowen basin to terminals near Mackay. The respondent and his co-driver controlled all four locomotives from the one cabin. The remote control equipment needed to do this left no room for a toilet in the cabin. The respondent was on his way to the toilet in another locomotive when he tripped over a raised lip[1] on the floor at the doorway and fell out the door. Dutney J found the appellant liable in negligence for the respondent's injuries, but found the respondent guilty of contributory negligence. The appellant now challenges the former finding and by cross appeal, the respondent challenges the latter.

[10] Access to the 3100-series locomotive was cramped. The doorway was only 1.68 m high. The door was hinged at the left and opened inwards. To reach the ground, the driver had to descend a narrow-runged, inward-sloping ladder attached to the side of the locomotive. Beside the door were two hand rails, each 55 mm from the edge of the door cavity. The respondent felt the access system was "awkward"; he "personally felt it was like I needed to be a monkey with longer arms to reach the handrail" when exiting the cabin. His Honour described the process:

> "The driver must first open the door. He does this by pulling the door towards himself as he stands to the left of the door as he faces out. The door is hinged on the left. When there is no platform, the locomotive can only be safely exited by descending the ladder backwards. When the driver is facing the opening he must, either turn around, position himself with his heels protruding over the door sill and reach back for the handrails, or, more likely, turn and reach for the left hand handrail with his right hand in one motion."

[11] The raised lip on which the respondent tripped was 28 mm high. His Honour described the fall:

> "Mr Reck's recollection is that he opened the door, moved forward to grasp the handrail, tripped on the lip in the doorway and fell. At the time of the fall Mr Reck was reaching towards the handrail. Mr Reck could not recall which foot connected with the lip but logic suggests it must have been his right foot since he would have to have been standing to the right of the door as he faced it and reaching for the left handrail with his right hand. I found Mr Reck to be a credible witness and I accept his account of what happened."

The lip formed part of the mechanism by which the door was sealed to prevent ingress of coal dust. His Honour found that at the time he tripped the respondent had bent forward with his head out of the doorway, thus putting his centre of gravity over the sill and outside the locomotive. Such a manoeuvre would have enabled the respondent to see the handrail more easily.

[12] Perhaps surprisingly, Dutney J did not find the appellant guilty of negligence in failing to provide the respondent with a safe place of work. However that aspect of the matter need not detain us, because the respondent does not challenge his Honour's failure to make such a finding.

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1 Or as the trial judge described it, "[T]he movement of the foot was arrested by the lip."

[13] His Honour's finding was that the defendant was negligent in failing to provide a safe system of work. He recorded in his reasons for judgment, "The access system for the 3100 is acknowledged to be dangerous." He found that the defendant knew generally of the risks associated with the use of the access system. He held that having regard to the recognised problems with the access, there was a duty on the defendant to train drivers in the safe ingress to and egress from the locomotive. The respondent had been given no such training, although after the accident the defendant prepared a safety video entitled "Accessing and Egressing Locomotives". That video dealt with a number of safety issues, including the importance of three-point contact when using access systems. His Honour summarised the evidence (which he plainly accepted) about such contact:

> "Dr Grigg expressed the view that 3 point contact was possible when exiting this class of locomotive by using the external door handle as a third point until the handrail is successfully grasped. This would make it very difficult to move the centre of gravity over the will [*sic*] prematurely. If this was done it would be difficult to move the centre of gravity over or outside the sill prematurely."

He held the defendant negligent in not warning the respondent of the risk involved in having his centre of gravity outside the cabin before he had a secure grip on the handrail and in failing to instruct the respondent in the proper way to use the access system so as to avoid that risk. He held that if the respondent had been properly informed of the danger of leaning out of the locomotive before taking hold of the handrail and shown how to exit safely, the accident would, on the balance of probabilities, not have occurred.

[14] On appeal the appellant did not really resile from its acknowledgement that the access system was dangerous, although it preferred to express the concession as one "that there was some awkwardness involved in exiting locomotives of this type." It submitted that it had no duty to train the respondent in egresssing the locomotive because the danger was obvious and the respondent was aware of it. It submitted that the standard of care demanded of an employer varied "with the simplicity of the task and the patency of the possible risks". The trial judge set the bar too high in holding the appellant negligent in failing to instruct and warn the respondent of the manner in which he should have exited the locomotive when that was a simple and uncomplicated task undertaken by drivers without serious incident over many years and on many thousands of occasions. It further submitted that in any event, any such negligence was not causative of the respondent's injury because the respondent already appreciated the dangerous position in which he placed himself to reach the handrails. Additional instruction and warning would have made no difference. Moreover the factual basis for the finding of contributory negligence was inconsistent with the finding that the accident would not have occurred if the respondent had been properly informed of the danger. That basis was, implicitly, that the plaintiff knew or ought to have known of the risk of exiting as he did. Such knowledge reinforced the submission that any failure to instruct or warn was not causative of the accident.

[15] I would reject the appellant's first submission. An employer is not relieved of a duty to provide training in methods of avoiding risks inherent in its system of work simply because the risks are obvious and are known to its employees. In the present case, although the risk was obvious, the remedy was not. The risk derived from the combination of a number of design features of the locomotive: the raised lip, the

low height of the doorway, the inward-opening door, the absence of a landing outside the door, a ladder not visible to the person exiting the cabin and, of course, the height of the cabin, to name some of them. The remedy, as his Honour found, was a method of egress involving three-point contact so as to avoid having the centre of gravity outside the cabin before the driver had a secure grip on the handrail. Mr Williams QC for the appellant trivialised that remedy by describing it as putting one hand on a rail before the other and having both hands on rails before you put your head out. He submitted that it was obvious that this was what should have been done and that no instruction was needed. I accept neither that characterisation nor that submission.

[16] Given the design features just described, devising a method of egress which would consistently satisfy the criteria described by his Honour while not creating other unreasonable risks was not something which could be assumed to be among the skills of a train driver. In the absence of a specific line in the job description, train drivers cannot be taken to be experts in human movement, ergonomics or kinetics, much less industrial safety. It is true, as Dutney J found and Mr Williams emphasised, that this was the only incident of a driver falling forwards out of the locomotive after tripping on the door sill despite some 700 use years for this class of locomotive; and that the respondent must have entered and exited the locomotive hundreds if not thousands of times in the period of almost 3½ years prior to the accident. However that history does not demonstrate that either the respondent or other drivers had the skills to devise a proper method of egress. It does not even demonstrate that they were using such a method.[2] On the contrary, the respondent (who was approximately 180 cm high) testified that he would generally duck down, put his head through the door to look for the handrail and reach forward for it. That evidence was unchallenged. He said in cross-examination that he believed that from a position inside the locomotive he could not have reached the handrail. Although Dutney J made no explicit finding as to the respondent's usual method of egress, he found him to be a credible witness. There is no reason not to accept his evidence. The history referred to above might have been relevant to the probability of a fall when using the method which the respondent had devised for himself, but it does not demonstrate that his was a proper method of egress. It was not. In the circumstances of this case the duty to provide a safe system of work required the respondent to devise a proper method, train its employees in its use, instruct them to use it and take reasonable steps to ensure its instruction was implemented. His Honour rightly found that the respondent breached that duty.

[17] The appellant's second submission was that even if the duty was breached, the breach was not proved to have caused the damage. Mr Williams described his Honour's finding to the contrary as "a leap of faith". However he did so by characterising the duty simply as one to warn or instruct the respondent about the method of egress. He submitted that the respondent did not give evidence that if he had received that instruction he would have done something differently. I doubt whether such evidence, given with the benefit of hindsight, would have added much to the strength of the respondent's case. There was no suggestion that he was a disobedient employee and no reason to think that he would not have followed an instruction given to him. Even if he ought to have appreciated the danger of falling, the fact that he still exited the cabin in a dangerous manner does not prove the

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[2] Dutney J observed in a footnote that there were other instances of drivers stumbling, but none of them actually fell.

contrary. Moreover, in the circumstances of the case, proper instruction required training. Training to perform an action involves more than issuing warnings and giving commands. It requires the employer to demonstrate and explain the action, and then to have the employee practice it until it becomes automatic. That is one way of reducing the risk of injuries due to inadvertence. The finding that on the balance of probabilities, had the appellant performed its duty the accident would not have occurred, was justified.

[18] There is however more force in Mr Williams' submission that there is inconsistency between that finding and his Honour's finding of contributory negligence. His Honour dealt with the topic of contributory negligence in one paragraph:

> "[34] Being aware of the existence of the lip and the problems associated with exiting the locomotive, Mr Reck would be unlikely to have fallen forwards out of the locomotive if he had been taking reasonable care for his own safety. Having successfully negotiated this access system on hundreds if not thousands of previous occasions without mishap it follows, in my view that the plaintiff was not taking proper or reasonable care for his own safety in the manner of his attempted exit from the locomotive. In my view, the plaintiff must bear a significant portion of the blame for his own accident. I accept the submission of counsel for the defendant that contributory negligence should be assessed at 25%."

[19] It is not altogether clear why the fact that the respondent had successfully negotiated the access system many times previously should mean that he was not taking proper or reasonable care for his own safety on the occasion in question. On behalf of the respondent Mr Baulch SC submitted that the conduct should be regarded as inadvertence at worst. That may be a fair description of the respondent's state of mind in relation to tripping on the lip, but his Honour's reference to "the manner of his attempted exit" probably relates to bending forward with his head outside the cabin. As Mr Williams submitted, implicit in the characterisation of that conduct as contributory negligence are findings that the respondent knew or ought to have known of the risk which that conduct entailed and that he failed to take reasonable care for his own safety by undertaking it.

[20] I have come to the conclusion that, while there may be some tension between the findings, there is no inconsistency. Inconsistency would result only if one adopted a theory of causation which required the identification of a single proximate cause of the accident. Our law adopts no such theory. It is in my judgment theoretically possible for the conduct of both the appellant and the respondent to have caused the accident, and for their conduct to be characterised as negligence and contributory negligence respectively. The question raised by the cross-appeal in this case is whether the respondent's conduct ought to have been so characterised.

[21] This is a case where the relevant conduct of the respondent (putting his head outside to look for the handrail while exiting from the cabin) was the very thing against which it was the duty of the appellant to guard. The respondent had no reason to think this method was particularly risky, given the number of times which he had used it previously. Of course, the consequences of a fall were potentially disastrous; but that was true whatever the method of egress. If his use of this method contributed to the accident, his responsibility for the damage in my

judgment pales into insignificance by comparison with that of the appellant. Having required the respondent to work in a place to which the access was dangerous, it bore a particular responsibility to ensure that the system of work was designed to minimise that danger. Having regard to the respondent's share in the responsibility for the damage, it is not in my judgment just or equitable to reduce the damages recoverable by him.[3]

[22] Neither side suggested that the case ought to have been characterised as one involving the loss of a chance[4] and the trial was not conducted on that basis.

[23] Dutney J assessed the respondent's damages in the sum of $993,308.41. He reduced that sum by 25% by reason of his finding of contributory negligence and by a further amount of $100,225.22 for a workers compensation refund. There is no challenge to that further deduction. It follows that there should be judgment for the respondent for $893,083.19.

[24] I propose the following orders:

1. Appeal dismissed with costs.
2. Cross-appeal allowed with costs.
3. Set aside the judgment of Dutney J given on 20 September 2004 in the amount of $644,756.08 and in lieu thereof order that there be judgment for the plaintiff for $893,083.19.

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3 *Law Reform Act 1995*, s 10(1)(b).

4 *Malec v J C Hutton Pty Ltd* (1990) 169 CLR 638; *Poseidon Ltd & Sellars v Adelaide Petroleum NL* (1994) 179 CLR 332.