THE HIGH COURT

[2016 No. 4075 P.]

BETWEEN

AOIBHE NAGHTEN (A MINOR)

SUING BY HER MOTHER AND NEXT FRIEND

TERESA CROWLEY

PLAINTIFF

AND

COOL RUNNING EVENTS LIMITED

DEFENDANT

JUDGMENT of Ms. Justice O'Hanlon delivered on the 25th day of July, 2018

Background to the case

1. The infant plaintiff was born on 16th February, 2005 and the accident the subject matter of the within proceedings occurred at a temporary ice skating facility which operates between mid-November and the end of January from 10am until 10pm, operating ten fifty minute sessions scheduled during those hours.

2. There was just one marshal in charge of the main ice skating area who had directed the participants to exit at the end of the session. The plaintiff's case is that there were at least 35 people in the mouth of the exit, all approaching at different speeds. A corpulent person leaning against the railing moved backwards, bumped into the infant plaintiff, knocked her onto the ground and while she was on the ground another skater came in quite fast and skated over her hand with the blade of the skate causing significant injuries to her hand.

3. The infant plaintiff suffered injuries to her fingers on her right hand and has permanent scarring as a result.

4. It is accepted on behalf of the infant plaintiff that one of the inherent risks and one of the joys of skating is the prospect of falling.

5. The defendants filed a defence including a full traverse, denying liability and alleging *volenti non fit injuria*. It is argued on behalf of the plaintiff that it is incumbent on the defence to prove, and that the onus of proof rests with the defence, to show if there can be a voluntary assumption of risk by an infant. Also if the concept exists at this point in time.

6. The plaintiff has accepted that there was a voluntary assumption of risk when one partakes in a sport such as ice skating, in the same way as this would apply to a hockey or rugby match.

7. The case is made on the basis that the infant plaintiff did not accept the risk nor did she contract out of the risk when the rink would be overcrowded and that the area of egress where they were challenged was certainly overcrowded.

8. The argument is also made on behalf of the infant plaintiff that she did not voluntarily relinquish the risk that there would be adequate and effective supervision. One marshal was in attendance on the day in relation to this adult ice rink and was nowhere to be seen in relation to where the accident occurred. He was dealing with a separate fall which occurred in the body of the ice rink itself.

9. Fourthly, on behalf the plaintiff, it is claimed that there was no proper risk assessment or safety audit carried out.

10. The plaintiff's case is that the safety statement indicates that the capacity of this ice rink for skaters is 465 people but that they have reduced the capacity to 350 people in the interest of comfort and safety. In relation to its risk assessment, the likelihood of slipping is deemed by the defendants to be unlikely.

The evidence of Aoibhe Naghten

11. The infant plaintiff was born on 16th May, 2005 and is a first-year student at a second level school in the City of Dublin.

12. The infant plaintiff told the court that she was ten years old at the time of the accident, that she had gone skating before and that she was quite a good skater. She indicated that she lives near Blanchardstown, that she had been there before that, and that her mother had paid for her.

13. The plaintiff confirmed that she received no safety briefing on the day and that there was no penguin video. At about 2 p.m., her mother was very close to the rails and she said that her mother was not very good at skating. They were all to go to Exit 1 and everyone skated to the exit which was very packed. She said that there was one marshal on the rink wearing a red jumper who made the announcement to skate towards the exit. She could see her mother and sister and she described about fifteen people arriving to the exit with other people waiting to leave. She said the people were moving at different speeds and more people were coming. She described a man slipping. He had stuck himself out and was standing holding onto the rails but came back into her path and she fell onto the ground in between a lot of people. A girl skated over her hand and the blade part went over her hand and fingers.

14. Her sister Kerri then came to her assistance. She described her hand as being covered in blood and very sore and felt that her fingers were ready to fall off, it was so sore. She said that her mother brought her to a first aid officer having had very bad pain, that she did everything that the first aid person required her to do and that she had had a tetanus injection before the accident. She said that there was nothing that she asked her mother to do that she did not do.

15. The infant plaintiff explained to the court that she went to the appointments, looked after the hand as best as could be done, that she had tried to get the injury better and that the scar on the hand is permanent. The infant plaintiff was then taken through the various photographs and diagrams in the booklet contained in the report from Mr. O'Carroll, the plaintiff's engineer. Photograph 2 shows the ice marshal wearing a red jumper and the infant plaintiff identified him and the time and date 30th December, 14:58:29 at

the top left hand corner of the photograph. Photograph 3 showed the ice marshal in the red jumper on the right hand side.

16. Her mother was identified in photograph 4 and she agreed that she was going to the exit, holding onto the railing and that she made her way to the exit ahead of the infant plaintiff.

17. Photograph 5 showed the ice marshal with the yellow arrow over his head going in some direction and the witness confirmed that he was going to investigate another fall.

18. This witness also identified the man in photograph 7 at p. 10 of 19 who bumped into her and confirmed that there was no marshal seen anywhere in that photograph, that the yellow arrow in figure 7 and 8 pointed to her sister Kerri and she identified herself in figure 9, coming between the gentleman leaning against the railing at the left hand corner, as the little girl in the white top.

19. The witness identified the man who bumped into her in figure 10 as being just in front of her. She confirmed that figures 9 and 10, the people to the right of the photograph, were waiting to exit and that that was the direction they were all heading in.

20. This witness confirmed with reference to photographs 11 and 12 that she was falling behind the gentleman with a blue and white geansaí on or some sort of jumper and that she was a bit obscured by the various people in the photograph. She confirmed that photographs 13 and 14 showed her falling and that one of her hands was up behind the gentleman in the red jacket.

21. This witness clarified, with reference to photographs 15 and 16, that the skater went over her hand.

22. Figures 17 and 18 were obscured and there were people congregating to her right hand side in those two photographs.

23. She confirmed that, with reference to photographs 19 and 20, her mother and her sister were with her.

24. Photograph 21 showed her sister and herself and showed that there was no marshal in that photograph, nor did one come to her assistance when she fell in the ice rink.

25. This witness confirmed that the contents of photographs 23 and 24 probably depicted events after the accident and confirmed further that there was nothing she could have done to avoid the accident. Three further photographs were put to the plaintiff taken on 30th December, showing the exit from the ice rink and people waiting to come into the ice rink. The plaintiff then showed the court her injury to her right hand.

Cross-examination of the infant plaintiff

26. This witness confirmed under cross-examination that she had been to the Blanchardstown skating rink three or four times with the same company, that it was the same as before, that it was a seasonal rink, that she had been there for the second time that season and described herself as a proficient skater. It was put to her that the penguin safety video was played but she denied seeing it. She explained to the court that the person in question came out and then her side hit off him.

27. She was questioned in relation to the photographs and she agreed that in general, the ice rink was not packed but that the exit was quite packed. She agreed that where she had the accident there was a separate group from the queue for the exit, that it was not one continuous queue, and that she had not reached the queue.

28. This witness gave evidence that the man came out and that the side of her body hit the side of his body and that it was a very small touch and that she spun round and fell on her back and that she was not going fast at that stage. She agreed that the lady behind her skated into her. She agreed that she got very good first aid and that she was advised to go to the hospital the next day and went. She did not go to her normal GP but went to a GP in Leixlip and she agreed that the ice rink was very packed and she was shown figures 14/19. She said that there were more people at the exit but that the ice rink in general was very packed, and she said that some people had already left the ice rink. She agreed that in general terms the ice rink was not packed but that the exit area was quite packed and where she had the accident there was a separate group from the queue for the exit, that it was not one continuous queue and that she had not reached the queue for the exit.

29. This witness was shown figure 2 and she agreed that there was an arrow highlighting the marshal and that the marshal's role is to help people who fall and to stop people messing. She had not fallen on this session and did not need the help of the marshal. The video which it is argued runs continuously prior to each session was shown to the court and this witness said that she did not see that video then or in any other occasion. She described how her family group started together and then went off and did their own thing.

30. Under re-examination she confirmed that she had been travelling in the direction of the arrow for the exit and that sometimes people cut one another out and that enough to in this circumstance to knock her over and that the gentleman in question came out and hit the side of her body. Photograph 15 referred to clarifying the situation that there were 281 people in the session and that there were 346 people ready to start the next session and she confirmed that that was the case and that there was never more than one marshal in the ice rink.

31. This witness disputed what was put to her in terms of the contention that there were two people in yellow jackets present and she said that there was no warden on the ice when the accident happened; she said she still had to queue to get off the ice and that there was a crowd of people and the blood was pooling in her hand.

32. The foregoing was with reference to photograph 6 through to 8.

33. With reference to stills 20-21 it was put to this witness that she never joined the queue at that point and she said she was turning around in still 21 to see where her sister was.

34. She was asked about still 19 and it was put to her that she looked as if she was about to put her hand on the barrier and by still 20 she had done this and she agreed with that. She said that there were still people coming in to where they were congregating.

35. This witness confirmed with reference to stills 17 and 18 there were still people skating on the ice and, with regard to 19/20, 21 and 22, she noted that they were skating in the direction of the exit at different speeds.

36. This witness was re-examined with reference to the still at time 14:58:57, which she says marks her position on the faded photograph and she confirmed she was in a queue and never saw the yellow jackets.

37. With reference to stills 9 through to 19 figure 6 she confirmed that the girl with the long hair and the white top in that photograph that she saw her and that in figure 10/19 figure 7 she was then in the centre and figures 8, 9 and 10 she noted her presence in the centre and she said it appeared so, that she had left the barrier and gone off to skate away. With reference to stills 9 or 10, she said she was not in a mad rush towards the exit but that the exit was 'happening at that time'. Kerri Naghten, sister of the infant plaintiff, confirmed that it was very crowded, that all the skaters were going towards the exits at different speeds, and that there was no marshal at the exit.

Evidence of Teresa Crowley (mother of the infant plaintiff)
38. The witness confirmed that she had been there once before and she believed that she paid between 20 and 25 euro. She explained that it was a pop-up rink at Christmas, that she was not able to skate herself, that she did not see any video and had never seen one before that event. She confirmed that she was not offered a helmet or gloves, that there was only one marshal and that the skaters all go in the one direction.

39. On the right hand side, this witness confirmed that there was an adjoining rink for children, that the ice rink itself was crowded with people queuing outside only the one exit and that she made her way to that exit. She described congestion as shown in photographs 6-8, that she wanted to get out of the exit, that that was the exact scene at the exit and that there were different levels of skaters there. She confirmed that she went there for the enjoyment factor and confirmed that she herself was at the railing. She further confirmed that she was very well treated as was her daughter and that first aid was afforded them. The first aid officer calmed her daughter and she offered to pay for that service. She got the first appointment she could for her daughter with a general practitioner in Leixlip and explained that her own doctor is in Manor Street. She felt that the accident occurred when one skater pushed his bottom out and she also confirmed that her daughter had gone back with her friend after the accident. She said that she was shocked there was a lot of blood, that she could not sleep and that she thought that her child's fingers were going to fall off. She described the area in question, the locus of the accident, as congested. The next day was New Year's Eve and she brought the child to hospital. Dr. Smith in Leixlip was the doctor. She saw her own general practitioner Dr. Kamar on 8th January, nine days after the accident. She was asked where she booked the ticket to go to the skating event and she thought that she had booked them either in the shopping centre or at the event area itself. This witness did not see any safety video.

Neil O'Carroll, consultant and forensic engineer
40. This witness studied ten provinces in Canada going over three territories and he said that there were 18,000 ice rinks in the world and half of those were in Canada. He inspected the locus, prepared drawings and looked at the material on installation provided. He said that there was very good quality video evidence, that there was an engineering drawing from the defence, that footage had been made available to him and that his report was based on the foregoing, the video evidence as well as inspection of the locus a couple of years later when he took measurements.

41. With reference to the video on the 30th December, 2015 between 14:48 p.m. and 15:09 p.m., he put the accident as occurring at 14:48 p.m.

42. This witness exhibited static photographs with less than one second between them and described the skaters moving in a clockwise direction. This witness gave evidence that since the accident a barrier had been moved half a metre, with the effect of making the main area bigger and the children's skating area smaller. With reference to p. 46, he said that there were 281 people present on the ice rink and that at 3:10 p.m., there were 346 people with bookings for that session when the accident occurred at 281 people.

43. The evidence given to the court by this witness in relation to the 281 people is that this would give three and half square metres per person. This witness believed that this was dangerous and unsafe, and while 360 is deemed appropriate in the safety statement supplied by the defendant, this witness deemed that to be unsafe. He noted that the defendants will say that they could theoretically have 465 people on that ice rink at any one session in accordance with Ice Risk Managers Association ("IRMA") documentation. It would allow for only two metres per skater. This witness considered that either 350 or 400 people on the rink at a session would mean that it would be far too crowded to be safe. He noted from his investigation that before the accident, there had been 347 people, that at the time of the accident 281 and after the accident 346 people on the rink.

44. He noted that the defendants contend that tickets can be bought in the shopping centre, at the locus or online.

45. This witness noted a video screen mounted on a wall hidden from plain sight despite the fact that the monitor was 26 inches wide when he inspected the premises. The monitor had the sound turned on but there was a lot of noise in that area.

46. This witness confirmed that there are no regulations governing this activity and that therefore one looks at best practice. In his opinion, it would be standard to have three exits and three entrances. He said that firstly, more than one exit and entrance is needed and secondly, that there should be no more than 104 patrons at any session at the total maximum, with 83 as a maximum figure on the main rink. He said there should be three marshals present.

47. This witness disagreed fundamentally with the IRMA guidelines because he argues that these represent one side of the industry only, i.e. owners. This witness felt that the Canadian guidelines were more recent and he argued that in this jurisdiction two metres per skater is clearly unsafe.

48. In his second report he noted that the actual size of the particular rink in question had been increased by one metre in length since the drawing of same was given to him by the other side and he said that the barrier had been moved to elongate the main ice rink by one metre. He described each panel therein as being two metres in length.

49. He referenced the dimensions as 34 metres long and 32 metres wide and he said that that was about 3.35 metres per skater.

50. As for causation of this accident, this witness felt that congestion was causative and that the skater, i.e. the infant plaintiff, had nowhere else to go. This witness felt that the marshal ought to have focused on the exit, that it was necessary to have more than one exit and he pointed to massing of people in the exit in photograph 2. The conclusion he came to therefore was that as regards causation overcrowding was a cause of the accident and also the fact that there were not enough exits nor was there sufficient supervision of the exit process.

Cross-examination of Mr. N. O'Carroll
51. It was put to Mr. O'Carroll that he obtained the Canadian standards from the internet. He then said that it was easy to obtain them, they were available, that availability was an important characteristic of a standard and he said he could not find standards from another jurisdiction. He found no other standards about ice rinks.

52. He said that there were no ice skating standards directly applicable in Ireland. This witness confirmed that it was the first occasion for which he had looked up ice skating standards, that this was the first case he had dealt with concerning ice skating, he described himself as present as a safety engineer and that the same principles apply and that there are special relevant features. This witness made the point that the particular topic here was the safety aspect of the event in question and that these are always domain specific and that there is always domain specific information which has to be looked up and that one cannot know absolutely everything about everything but that the general principles of safety engineering is what he is expert in, hazard analyses and accident investigation.

53. This witness then referred to the case in question involving an accident which happened to occur on an ice rink and that he therefore looked for the missing information and found it in the Canadian standard.

54. He went on to confirm that he had a degree in mechanical engineering from Trinity College Dublin and a diploma in engineering computation from DIT. He described himself as a fellow of the Massachusetts Institute of Technology where he studied safety engineering and he said that he had qualifications from the North Western University in Illinois in accident investigation. This witness described himself as having a certificate in health and safety management. This witness argued that the principles of hazard analysis and accident investigation are the same from road traffic accidents, from overcrowded halls, from crowd control and that the distinct feature of the ice rink is the low friction surface that they were operating on and that the principles are the same and that there is some specific domain knowledge which he obtained from research.

55. This witness said that the Ontario Recreational Facilities Association Inc. ("ORFA") was the only one he found specifically relating to ice rinks and these were standards about recreation facilities, crowd control, the number of people one was allowed to have in the place concerned and the supervision requirement.

56. In relation to the Irish Rink Managers Association guidelines which are British standards and followed in Ireland. This witness argued that these were not standards as such and while he agreed that they were used in Ireland he felt that best practice was illustrated better in the Ontario guidelines and he said that there is no particular obligation on us to go to the United Kingdom standard or guideline, that we have to look at best practice throughout the world. He said patrons attending ice rinks in Ireland deserve the best practice standard of care throughout the world and that we do not look for the lowest common denominator we can find. At one point he stressed was that the Irish Rink Managers Association guidelines appear to represent just one stakeholder and is not as all-encompassing as the ORFA. He gives his opinion in his capacity as an expert on this point. He compared this with the United Kingdom's standard which only allows one to have 2 square metres per skater which would allow close to 500 people on the particular ice rink in question here which he said was clearly unsafe and he felt that that undermined the IRMA standards somewhat. This witness said with reference to the photographs figure 7 and figure 8 that there were clear hazards and that the plaintiff suffered a loss as a result of that hazard. He said we were looking at the egress process and that there was crowding in the area of egress.

57. This witness said that in the area of approach most of the patrons are approaching the exit there is crowding and that crowding has resulted in someone being knocked down and resulted in a following on patron being unable to avoid the person on the ground and that is where the injury occurred.

58. He explained this further by saying that there is a group of people gathered in that area approaching the exit which has created a congestion as a result of which the plaintiff was knocked to the ground and following on behind that another patron skated in and because of that congestion was not able to avoid the person on the ground. It has to be looked at in context and the context he described as an ice rink with a very low coefficient friction, basically slippy, and that we are looking at people travelling faster than they would normally would travel and if you take a walking speed at 1.4m per second looking at the video footage these skaters are travelling between 2 and 4m per second and that this is just the normal flow there are people going much faster.

59. He described them as travelling faster than they would normally would on a surface which is difficult to stop on in footwear where they are balanced on a blade that is unusual for them to manoeuvre in and he said he was 100% confident that what we are looking at there is overcrowding which lead to an accident.

60. With reference to figure 6 this witness said that he believed that because there was congestion at the exit the girl in the white top in figure 6 decided to go around again and have another skate.

61. This witness then described the man, the yellow arrow pointing to him in figure 6 standing on the side of the barrier and he felt that this person was preparing to exit and that he was in the area where the queue is forming. He later conceded however because this particular individual is not moving he is not in the queue, but he expanded on this by saying that the term queue is probably not the best term because it is not dynamic enough and he said one could refer to procession or flow or stream. He refers it as more of a flow or stream in towards the exit and he said perhaps the word queue is a little bit too static.

62. This witness agreed that frames 9, 10, 11 and 12 are all in the same second, as are 13, 14 and 15. He referred to the dynamic nature of this and describes the man in the picture as doing more a rotation. If you look at figure 7 through to figure 14 of a little over 90 degrees and then his bottom is sticking so there is a 90-degree arch. This witness disagreed that the particular individual could not have moved more than a couple of centimetres and thinks that he could have because the angle he moved in is quite noticeable in that second and he said that meant that he had moved noticeably fast. This witness said normally he would do an ergonomic drawing of this, rotating the subject and measuring it but that he did not have those tools here so anything he would do would not be in the realm of an expert and he thought probably about 150mm or 6 inches and he said he was making an imprecise stab at that. He said it was no more than 6 inches and that his movement appears to have caused the collision. He said 6 inches or it could be less. He pointed out that he did not have the appropriate tools with him to give a totally accurate calculation but that it could be 6 to 9 or 10 inches perhaps.

63. It was put to this witness the entirety of the ice rink shown in figures 9 and 10 with a man leaning on the railings with both hands moved 6 inches when the plaintiff is skating right behind him and then their two bodies brush against each other and she falls, but he insists with reference to this that it follows on with her on the floor and another skater coming in and being unable to avoid colliding with her.

64. This witness says there was a chain of events, the man was in the area while not part of the procession, was in the path of the procession or what was referred to earlier as the queue. The girl fell on the ground and then the actual loss event was the third patron coming into the area not having anywhere to go and running over her finger. She fell to the ice because a man moved by about 6 inches, a man whose hands were on the barrier moved about 6 inches and she was close to him that their bodies came into contact and she fell. He describes the man in the area while not part of the procession or what we previously referred to as the queue and he said that was one of the events. The girl fell to the ground and then the actual loss event was the third patron coming

into the area not having any where to go and running over her finger. He argues that while she could have taken other routes the choices are constrained by the flow of the patrons in the circle which is anticlockwise around and she could not have taken any number of routes in his opinion. He makes the point that it is difficult to stop as well unless you are quite experienced. He says that while she was better than average she was not a skilled skater in terms of someone who can stop on a sixpence and spin around and have complete control.

65. This witness clarified that a man moving 6 inches as she was passing by is not the negligent part of this but he said the question that has to be asked is what controls were in place to make sure that such an occurrence would be less likely to happen and whether if it had happened that the severity of the loss would be less and those controls such as reducing the number of people on the rink or having more supervision or having more points of egress could have been improved. He felt that by preventing people congregating at the barrier in the place where people are approaching the exit by telling the man to move along in the context of the environment and that they are on ice skates in a very low friction surface and wearing novel footwear to them and travelling much faster than they normally are travelling where they are not fully in control of their motions. So it is in that context that these hazards need to be avoided.

66. This witness then refers to the IRMA good practice guide under the title Ice Rink Etiquette and says that it further advises against standing still or gathering on groups on the ice as this presents a hazard. He says that hazard is clear, obvious for foreseeable and easy enough to avoid. He says that although there is not a particular regulation on this, he said there apply hazard analysis techniques. He says that the men at the barrier are a collision hazard for the flow of people towards the exit and he said that there was a man in red hoodie beside the man who bumped into the plaintiff and he said while he did not believe he was directly involved in knocking the child down he believed he was part of the congestion in the path of the stream of the people towards the exit and a control would be to have a marshal to move people along so they do not contribute to the hazard. He stressed his expert opinion that there was not enough supervision, it was overcrowded and there were not enough exits to ensure safe egress and he refers to p. 12 of 14 of the IRMA document which he says highlights accessing and exiting the ice path under the title "General Management of Health and Safety".

67. It was put to this witness that for the 2 p.m. session on the occasion in question at the ice rink the total number of tickets sold was 281. This witness opined that it was likely that 281 was the number present because one would hardly buy a ticket and not turn up. Mr. O'Carroll says that the 281 figure is the figure one uses to calculate the ice loading. He explained that to get a repeatable count of the exact number of skaters at the time of the fall was not possible because no single view captures the entire area and that counting from various overlapping views is difficult. He indicated that the defence engineer Mr. Tennyson under estimated the number of skaters on the ice at 111 skaters. He felt that using such a figure to gauge ice loading is flawed and that the ice loading should be calculated based on the steady state number of patrons on the ice which is approximately 213. It should not be done based on the number of patrons remaining after the exiting processing had started.

68. This witness referred to congestion at the egress point being caused by too many people on the ice having to exit too few egress points caused by to high an ice loading prior to the commencement of the egress process. This witness convinced that this congesting lead to the accident. He took the main area as 77% of the total area for that calculation. He said that if the number of children was 23% in the small rink the ice loading would be higher. He describes that as an assumption and he described taking the number of people potentially on the ice and dividing them by the area to get the ice loading. He said it comes out at about 3.4m² per skater which is in and around the steady state figure and it accounts for concentration at the egress point.

69. This witness was asked about Mr. Tennyson's calculation in his report dated 26th November, 2017 para. 3 and this witness explained in his report that he felt that it was an underestimate of the skaters and he said it was difficult to do the calculation because the shots he was relying on had different time stamps on them and that they were not perfectly synchronised.

70. This witness clarified that the main rink is 748m² and that the Blanchardstown ice rink was 948 square metres or approximately 7,000 square feet i.e. half the size of the recommended Canadian specification which would give 100 square feet or 9.38m² paired skater.

71. This witness felt that the Ontario guidelines showed were best practice. It was important to go to best practice and not the lowest common denominator.

72. Mr. O'Carroll felt that the IRMA guidelines were not as all-encompassing and that ORFA guidelines were more widely available because he said he was not able to download the UK standard. He said with reference figures 7 and 8 in his expert opinion they show overcrowding, a clear hazard there where the plaintiff suffered a loss as a result. In approaching the exit in the area where most patrons were approaching there is crowding and a group had gathered there leading to congestion and where the plaintiff fell and another skater skated in and was not able to avoid the person on the ground. He added that if the surface had been a normal concrete surface it would be so congested and he referred to 1.4 metres per second as normal walking speed for an individual but that two to four per second was in this scenario, the skaters speed. He noted that it was difficult to stop on the surface and one had to balance on a blade and that the overcrowding lead to the accident. He said that the incident showed a chain of events and figure 8 was eight metres from the exit point. He disagreed that the plaintiff was following a train of patrons. He said she was joining in the queue. He said the gaps were not like a queue for tickets at a cinema, rather that there was a stream of people going to the exit and having to stop causing congesting at the exit causing problems further along. He noted that if a person is not able to exit in accordance with these stills that that person therefore goes round the rink again. But he said the plaintiff was in the line to go out where everyone was getting ready to go out but instead of going out was stopped because they could not get out. He said for example the girl in the white top shown in the stills decided to go around again because she could not get out. He said the man in figure 8 was standing at the side of the barrier and it appears that he was preparing to join the queue.

73. He said he could not be very specific as to whether he had joined the queue or not. He also said that if one looks at the figures 21 and 22 to compare congestion at the exit and he said that because that particular gentleman was not moving he was not in the queue. He described it as a procession, flow, stream rather than a queue and said that the word queue was too static.

74. Figure 10 showed a man with his two hands on a barrier, figure 11 showed that the man had lifted his hand off the barrier and figure 12 was in the act of falling and has fallen at that stage and that figure 11 showed part of the flow with the gentleman in question turning around and by figure 11 he is looking around to see what has happened. He said that with reference to figure 11 he did not think that he could see the plaintiff but by figure 12 she had fallen.

75. This witness put stills 9, 10, 11 and 12 all in the 55th second, and he referred to figures 13, 14 and 15 showing seven frames in the click of a finger as it were, showing the dynamic nature of it and he said that all happened very quickly. He agreed that with reference to figure 10 the man had his two hands on the railing and the plaintiff was about to go behind him, and agreed that in figure

11 the plaintiff was behind the man but that one hand was coming out, and figure 12 showed what appeared to be the plaintiff falling and him turning around and he said that it was more than a rotation rather than a distance between figure 7 to 14. A little over 90% showing his bottom sticking out and he could calculate the ark of one side of the man moves to the other side, the other side of him also moves, that his bottom is not over his feet and he thinks that he could have moved more than a couple of foot into the ice rink but that he had not looked at how many seconds. He said that his movement appears to cause the collision and that six inches would be at the lower end of the movement and then it could be between six inches and nine to eleven inches but that he did not have the necessary tools in court to do the calculation. He said that one event in the chain led to the accident and the plaintiff was on the floor when another person collided with her and that the man was in the critical position in the flow to the exit.

76. He described this man as in the path of procession or queue and that the third patron did not have anywhere to go and therefore ran over the plaintiff. He said that the man's hands were on the barrier he moved six inches and their bodies went into contact with one another and she fell and he was asked if the plaintiff had left one foot more between herself and this man would the accident have occurred and he said that if she had been further away from him but he said it was difficult to stop unless you are quite experienced and she was not a skilled skater but that she probably better than average and that it was difficult to change direction quickly and she does not seem to be able to stop very quickly.

77. This witness stated that it was because the man had moved that this occurred and he asked what controls were in place to make that less likely to happen and he mentioned reducing the number of people on the ice and increasing the points of egress and preventing people congregating at the barrier were issues which would have assisted. He felt that the man ought to have been told to move along. He took into account that ice skaters were on a low friction surface and were fast moving and could not control their motions and that the plaintiff was wearing shoes that she was not used to and he said that any engineering handbook would analyse the hazards and put in controls. He referred to the Health and Safety at Work, 2005 and said the same principle was applied as in any hazard analysis, if a person is in charge of an event. He said one would find general advice about a hazard and how to eliminate same. He referred to the ice rink manager's appendix 5 dealing with etiquette and that people ought not stand still or gather in groups in the middle of the ice and that such a hazard is clear obvious and foreseeable and easy to avoid. He said that there were not specific regulations applying hazardous analysis to this. He said that the person in the red anorak was also a hazard because he believed he was part of the hazard and congestion and that a control would be to move this man along and he said it is not in the report but it is part of the hazard analysis process but it was not good to sit with one's bottom against a barrier and that he was close to sitting.

78. He said that common sense should apply to the supervision of access and egress and that supervision of egress points was necessary and that there was not enough supervision in this case. This witness said that it was likely that the number of people on the ice was dictated by the fact that 281 tickets were sold and he compared this with a GAA stadium where one would look at the maximum number due to attend and calculate the number of stewards required on that basis. He also said that 281 is the figure one would use to calculate the ice loading. He said that 77% of the total area would be 213 people this was with reference to the larger rink and that if the number of people in the children's part was 23% then the ice loading would be higher but he said that was an assumption but if you ignore the barrier you would still get 3.5 metres square.

79. With reference to figures 6-8, showing a shot of the exit, the plaintiff is seen looking back at the incident with 35 people on the area of 120 square metres, 35 people giving 3.4 metres per skater and he said that there was in or around a steady state figure.

80. This witness was referred to Mr. Tennyson's report of 26th November, 2017 at para. 3 and he said he tried to use his method but was unable to get the figure 111 skaters but he said the time stamps were different and not synchronised and that one would need to use a steady state incident and not Mr. Tennyson's calculation. He said one looks at the steady state figure and the number of people then and therefore one can assess the area. He said it was very important to note the number of people around the incident at the time and that the problem had already occurred and that supervision of the area was required. He took account of the fact that all were concentrated in one small area.

81. This witness said that the ORFA guidelines show that nine metres per square per skater is recommended, that would be a 100 people, 83 on the main rink and he said 100 square feet per skater would give you nine metres square and that the main rink is 748 metres squared (see p. 96). This witness said that the Ontario guidelines suggest nine square metres approximately per skater but he said the stand alone requirements recommended strongly a 100 square feet per skater. He agreed that the tent where this event took place is not a building. This witness said that the defendants did not comply with the general thrust of the RNA guidelines and he said if the patron profile is largely inexperienced that that suggests there should be a larger space needed per skater and he was not in agreement with the general advice of these standards and believe there were problems with that standard and he made five points:

- Firstly, he said the number of people on the ice rink should be adjusted vis-à-vis the experience or otherwise of the patrons.
- Secondly more than exit route was required.
- Thirdly, supervision by staff provides the best customer safety.
- Fourthly, there must be a minimum number of rinks staff.
- Fifthly further consideration of high risk activities you would give rise to a higher increase in rink staff.

This witness accepted that the Blanchardstown rink complied with the IRMA guide regarding numbers and that the Blanchardstown exceeds the guide of three metres per skater from the IRMA guide.

82. This witness believes overall that the Ontario guidelines represent best practice for ice rink management and that one should seek to offer those standards.

Under re-examination

83. It was put to this witness that it was potentially misleading to show us static photographs and people arriving at speed to the exit and where it is clearly a video of the exit points to seconds in timing and he said on the basis of that he believes there was congesting, causing a tail-back, taking into account the different abilities of ages and speeds of those coming in towards the exit, and taking into account the fact that one was talking about a tent structure rather than a solid structure in terms of looking at access and egress from the building and supervision. He felt that it was a hazardous situation that is leaving aside any guidelines because there on the basis that there was no supervisor present and he said the man standing at the barrier was holding onto the

barrier was one event in the chain and that nobody had helmets or gloves or ice masks and that there was only ice marshal where there had been two ice marshals eighteen minutes prior to the incident and that the plaintiff in question followed her mother and sister and that supervision was not seen at the time of the accident. He also pointed out that the session was technically over and that the girl in the white top skated around again and that there was no supervisor arresting her or stopping her.

Evidence of Mr. Bill Cremin

84. Mr. Cremin described himself as a 50% owner in the particular venture concerned and that he had been involved in this business for the last eleven years and that last year he operated four ice rinks serving 190,000 customers at Blanchardstown, Cork, Waterford and a fourth venue and that they operate from November to January as a seasonal activity. He said that they follow the IRMA guidelines and that in 2007/2008 UK suppliers introduced him to the IRMA guide. This witness said that he ensures or allows a 50% greater ice space per skater over and above the IRMA guidelines and that the maximum is 350 persons in Blanchardstown. He said he did not have incident report forms with him but that he had consulted them and this was a simple fall/loss of balance and he said a large number of people fall and they have an ice pack and some sympathy and with a small number of patrons it is a little more serious. This witness described having ten to fifteen staff at the time, one person on security two on ticketing and the rest between ice marshals, maintenance, helpers and first aid and personnel in the skate exchange area. On 30th December, 2015 he said there were twelve staff approximately not including security and two people around the exit area and he agreed that there two men with yellow jackets at the exit area.

85. This witness said that the exit area was the key area and was important to keep everyone calm and slow moving and that nobody gives chase and that once there is an announcement then they have two seconds to come off the ice and there can be no rushing from the ice pad to the floor.

86. He said that three to four inches down from the ice pad surface he said a mishap is likely at that point where they have one foot on the ice and one foot not on the ice and that it is deliberately narrow at that point to allow them to hold on to railings in effect. He noted one exit for beginners and one exit from the main rink and he said it is safest way of coming off the rink and that if you had two exits there would be a double hazard and that the gate is two metres wide and that over session there are hundreds of exits off the session.

87. He confirmed that 281 tickets were sold for that session and all the ticket staff come off at the same time if they come mid-way during a session and the children will get every second out of it. He said that the man resting on the barrier that type of scenario would be seen a lot and that it was normal for people to rest along the barriers. He also said it was normally people would go in anti-clockwise direction and he said there would be one marshal to help people who might fall and that if there were five or six children forming a train the marshal would ask them to stop. He said a group of people around the barrier he would ask them to intervene if they were going too quickly. He said that in general people were reasonably well behaved and he said that in 2008 he commissioned a video showing a penguin, a safety item and that at the end of the session there would be a public address a system announcement and the music was turned off and they were asked to go to the exits in an orderly manner and the marshal's job was to guide that and help them manage the exit rather than to interfere. He said that there were ten minutes to the change of session. Helmets are optional and that there would be fifteen to eighteen sets of safety gear and that the penguin video tells patrons to bring their own but that he cannot compel people to use them and the exception would be that they sell a gloves and scarf set at relatively low cost on the website. He said that on the ice marshals can be fluid and there would be one devoted to first aid.

88. Under cross-examination this witness said that the company was profitable and very much driven by volume with fixed costs and he said there is no big age limit on the beginner's ice rink there is a separate queuing area for families with children. He said that it depended on one's degree of competence rather than age whether one would go to the bigger ice rink or smaller and that the smaller one is swept and is not as slippy. He said that he paid €125,000 for insurance last year and that there had been a number of claims and he said that people buy a ticket at 48 to 50 euro for a family group and that after five to ten minutes his obligation is done and that a lot of people leave before the end of the session up to twenty minutes beforehand.

89. This witness also explained that while 281 tickets were sold that it does not necessarily mean that all of those people were on the ice at the same time and he said many of the tickets bought would not be availed of and that it would not be unusual for people to buy a ticket and not turn up. He also made the point that a lot of adults who buy tickets might decide that a shorter period of time than the full session is sufficient for them but children tend to stay for the entire session.

90. This witness said that he sees a lot of people holding onto the barriers and that they rest along the barriers. He said he agreed that there was a general system whereby skaters go in an anti-clockwise direction.

91. This witness described the marshals as having two roles, firstly just to keep general control over the activities and they are dressed in red to be visible and would stop for example children forming a train on the ice rink and such like, or would intervene to prevent people chasing or to prevent people gathering around a barrier or indeed people travelling too quickly on the ice. Their second role would be to help people who might fall. This witness asserted that there was a safety video, one in the skate change area on the inside at a height and the other at the back of the first hut where people are queuing to go into the ice rink, played on a continuous loop.

92. To end the session, evidence was given that the music is turned down and the announcement is clear and tells people that the session has ended and to make their way in an orderly manner towards the exit. The role of the marshals at that point is to guide. Sometimes children continue to skate when they see people gathering at the exit and the marshals are told not to intervene with that because that helps the marshal as the people go off in an orderly fashion.

93. This witness said that there would have been two marshals on duty but where one has to leave the rink to bring someone to first aid that would leave a period of time where there would only be one marshal and it would be up to the ice marshal to notify the manager of an incident and they would bring someone else in.

94. According to the defence evidence that there were only 111 people on the rink at the time of this particular accident, this witness confirmed that one ice marshal was all that was required in accordance with the guidelines and that between 70 and 199 skaters, the IRMA document at p. 5 specifies one as the minimum number of marshals for those numbers.

95. Under cross-examination this witness clarified that neither rink has an age minimum that that the smaller rink is usually for beginners and the larger one for more experienced skaters and that one chooses one's rink based on competence rather than age and the smaller rink is not resurfaced, it is swept so that it is not as slippy.

96. This witness agreed that his company was not in a position to assess the competence at all of the skaters other than after the

session had commenced in a very cursory way by way of observation. This witness described a lot of adults clinging to the barriers at the start of the session but that this minimises as time goes on. He accepted that in the two-hour period around the time of this accident there were 974 paid-for patrons. This witness pointed out that a lot of people leave the ice rink before the end of a session.

97. This witness did not accept the accident was caused in any way by virtue of the fact that there was only one exit. This witness also said that there were two marshals present at the time when the patrons were leaving the ice rink and he said there were two security personnel i.e. the stewards who were ensuring that the people step off the ice rink in an orderly fashion. These stewards were not wearing ice skates but can get on to the ice in their shoes.

98. This witness was asked for his safety statement documents which provides that it sets out the responsibilities for the security stewards and the witness replied that he did not have it with him. This witness said that he did not think that the accident had anything to do with congestion at the exit from the rink.

99. This witness accepted that you would have a cartoon moment if the scenario put to him by counsel were found to exist in that if 37 people were in the courtroom and all headed to the door different shapes and sizes some walking some running funnelling in and someone falls, would he consider it safe. This witness argued by contrast that what one saw when the patrons were leaving the ice rink was an orderly queue.

100. This witness was asked about the pleading blaming the mother of the infant plaintiff as being at fault for not supervising her child and alleging that her injuries were more serious because the mother had not arranged for her to be properly treated in relation to them and it was conceded

101. This witness made the point that when the ORFA use a figure of nine square metres they also know that the Canadian public have learnt to skate at an earlier stage and some of them can figure skate, they are more agile, they move faster and they need more room and they are not allowed to figure skate in the public skating but it has to be considered. This witness denied that his evidence and the tone of it was that he was suggesting that these recommendations were really to do with curling, figure skating and hockey in large stadium but that in regard it was put to him that he would not see people skating, playing ice hockey carrying children and he said no to that and he said he agreed that you would not see people engaged in figure skating with headphones and eating food etc. It was put to him therefore that these regulations specifically exclude figure skating and p. 8 of the recommendations "the following items are not permitted on the ice surface. No food or drink permitted on the ice surface". "No figure skating, no headsets, no carrying of children to be permitted, no sitting on boards or loitering". It was put to this witness that this sets out what is not permitted on the ice and that this is consistent with the type of the guideline that would be given to the scenario in Blanchardstown which you have said is utterly irrelevant. He agreed that these rules are similar but that the ice area is not.

102. This witness was then asked about the two gentlemen in the yellow jackets who were described as standing with their hands in the pockets. He denied that he was attempting to assert they had some relevance to the ice supervision, but he did make the point that one of them does mount the ice at a later stage and he clarified his answer by saying that their primary function is to stand in the gangway outside the ice pad and to direct the stream of skaters straight to the skates off department which is about five metres away and that that is their primary function. You can see him directing with his hand.

103. It was then put to this witness that the additional footage which was produced during the cross-examination of Mr. O'Carroll at which he was present, which showed the video footage of the exit to the premises covering the two security men at the locus and this witness identified the time at 13:57:53 in relation to this it was put to this witness that the safety statement provides very clearly that the stewards in the yellow jackets have to be given a document that sets out the roles and responsibilities and it is put to him that it was sought in discovery and was not given. This witness said that he had seen one but it is a new one, a recent document, but he denied seeing one in relation to the time of the accident. This witness agreed that he had not seen such a document relating to the time of the accident and agreed that he had not interviewed either gentleman. He was asked if he is saying they are relevant to this accident did he speak to them as part of his fact finding endeavours or at any stage or did he look at their documented responsibilities as set out in the safety statement and did he seek such documentations and he answered in the negative to all of these matters.

104. He agreed that they were not listed as relevant in the incident report document that the two marshals were the ones who were listed 14:58 and that as people were coming off the ice rink he was directing them off the ice pad to the skate off and he agreed that although there were people massing on the left hand side this gentleman walked away to the right and he agreed with that. It was put to him that there were people massing to the right and his answer was that the flow was still working but that he agreed that this steward was not in view and that all these people there at the exit point were coming through and he said he did not know where the steward was, he thought he had gone onto the ice pad.

105. It was put to him he was not on the ice pad and at 15:27 he agreed that this steward had gone on to the ice pad and that he was standing talking into his walkie talkie. He was asked did he see a fight on the ice rink and he denied seeing such and he was asked had he checked this and he said no and he was asked what was going on the ice rink with that group because it had never been shown to the plaintiff and he said he did not know and he also said he did not know what this man was doing. It was put to him that this man was not listed anywhere as a witness and that this witness had never spoken to him.

106. With reference to p. 6 of the document and to this witness's own report which states "the ORFA indicates the need for only one exit other than for machinery and emergencies". It was put to this witness that in fact the section that deals with this on p. 6 of the document tends to say the contrary because best practice specifically mentions overcrowding and preventing patron injuries to the recommendation for multiple access and egress points and he explains this by saying that at one side of the rink the long side you would have three exits for egress two exterior doors. Then at the bottom you would have the machinery access route that one exit is used for skates off, two is used for emergency and a fourth for machinery.

107. This witness is then referred to p. 7 of the document which says and recommends in respect of the average ice surface all public skating programmes have various levels of supervision and that the primary objective of such supervision is to ensure the safety of patrons and he agrees that as the numbers increase the requirements for on ice supervision would also increase and he says you have also consider the supervision has to cater for longer travel distance because of the large area of ice and that you need more supervision to get people off quickly and this witness reverting back to the point of the two stewards agreed that they did not have any hand act or part in relation to the on ice supervision immediately prior to her fall.

108. With reference to the IRMA document in Mr. O'Carroll's report and in his oral evidence which it is asserted here was not tested and cross-examination on this, that the number of skaters allowed based on that document on the Blanchardstown ice rink allowing for two square metres per skater would be 484 skaters including children on that rink and he agrees with calculation. He agreed that

the IRMA recommendation guidelines from a safety perspective that two square metres per skater is acceptable and if the logic of that were to be followed with would he agree with Mr. O'Carroll that the guideline would then tell the ice rink operator that it was safe to have 484 skaters on the ice rink and he agreed with that. He said it was prepared to endorse that standard because he had seen it in operation in Dundrum and he had seen the density of two metres squared per skater and that he had inspected the Dundrum rink some years ago. This witness did not accept that the IRMA document was produced for ice rink owners, that it was harder to access, that it was of greater antiquity and that every recommendation demonstrates it to have no credibility as a document. He said it was not there for the general public, it was there for professionals, safety auditors, potential facility managers, people who have business with ice rinks. It was put to this witness then that Mr. O'Carroll was not challenged on his evidence that it is a nonsense to say that 484 people could safely access and skate in those circumstances. It is put to him that his evidence to the court as an expert is not credible that it would be fine and his response was that the bulk of the people were skating at the same speed. He said that while he did not check the actual skate he was told that it was not a figure skate, it was a blue rental skate.

109. This witness is then referred to s. 10 of the Health and Safety at Work Act, 2005 that the safety statement attaching affects the defendants and incorporates that act. He agreed that he did not look into the type of training they were giving with regard to the safety of children and patrons and he said that when he looked at the video he could see that they were good skaters and he observed them helping people who fell. His opinion was that no matter what training a marshal would have received it would have no effect on this accident. Mr. O'Carroll's view that Aoibhe was struck at about eight metres from the exit and Mr. Tennyson said it was nine metres that he did check it.

110. This witness agreed that travelling at a normal speed of two to three metres per second, the skater would have approximately two minutes to cover the distance of eight metres and that that was Mr. O'Carroll's incontrovertible evidence but he said the skater in question did not start at the point where the man is standing and that the skater was further to the left coming from the left so had a full view of what was ahead of her.

111. It was put to this witness that Mr. Aaron Daly who gave first aid said that the skates were considerably more sharp than normal skates because they were figure skates involved in this accident. He says that he can say what he was told that there was no evidence that they were figure skates and that he was told they were rentals. It was put to this witness that it was always accepted that children can fall but that what is required that reasonable steps be taken for the safety of children and the witness agreed that he believed that allowing 484 people on the rink would be safe and he added that in this case they factored it with a generous factor of safety above that.

112. This witness under re-examination clarified that you do not have to join up to get the guidelines from the ORFA that you just go back to the client to get it. This witness agreed that Mr. O'Carroll by a report dated 11th December, 2017 commented on both of Mr. Tennyson's reports, the one of the 4th and 5th and the one of 26th of November and while that report is dated 11th December last it was sent to the solicitor on 25th April past and he said he agreed in the affirmative that he saw it after that date and that if his solicitor got it on 25th April he could not have been sent to him before that.

Submissions on behalf of the plaintiff

113. The plaintiff's special damages are €500 which cannot be agreed. The court is asked to note that none of the marshals who were present on the day are being called to give evidence, despite being on the schedule.

114. It was decided therefore not to put in any written submissions by both sides.

115. This witness accepted that the mother of the infant plaintiff did not have any responsibility with regard to the accident because she was not in the vicinity of where it occurred and he accepted that Aoibhe's mother had no role in her falling or in stepping on her with blades and in the context of that then he felt that she should not feel responsible for this accident.

116. A Mr. Danny Raleigh was listed as a witness and was described by this witness as an ice marshal. Aaron Daly summoned to the scene to give first aid, it was clear from the evidence that Aaron Daly was not an ice marshal actually on the rink at the time of this accident. James McDonnell is described by this witness as both a supervisor and an ice marshal, but he is described to the court as someone who has actually left to go to Canada, but this witness described him as being on duty, as having signed in, and as having been a supervisor and that he was on the premises preforming his duties, but that his duties did not require him to be there at that time and he accepted that this gentleman is listed as an ice marshal on the date of the accident. This witness described the marshals as people who were very competent skaters themselves and he agreed that there was nobody in Ireland doing training in relation to ice rinks and that they relied on picking up the best standards they could in the IRMA Guide. He accepted that he had 974 people in a two-hour session with a twenty-minute turnaround on the occasion of this accident, but he said they do not have the twenty minutes for the actual turnaround because the ice is resurfaced as well so there is about ten minutes to remove the patrons from the ice rink, in practical terms and sometimes faster and the number of 974 is described as considering the group coming off and the next group coming on. This witness did not disagree that the only member of staff on the rink at the time of the accident was Mr. Raleigh he agreed that Mr. Raleigh worked a twelve-and-a-half-hour shift.

117. This witness did not accept that there ought to have been two marshals on the ice rink at the time of the accident. This witness referred throughout his evidence to two marshals on the day in the plural, and said there would always been more than one marshal on duty at the time in case they needed more than one, he said that on the premises there would have been four marshals on the day.

118. The witness's own safety statement which stated "during the skates sessions, ice marshals have the responsibility of ensuring public safety" and he agreed with that and that they were responsible on the day for public safety and in particular for the safety of Aoibhe. The plaintiff's mother, the plaintiff and her sister all said they did not see the safety video and this witness said the audio announcement is played in the event that people did not see the safety video and the audio announcement is very clear and there is no music played while it is played and it is played a number of times before the patrons get on the ice rink.

119. The two security stewards are not on the list of witnesses and this witness is asked for sight of the safety document itself which says "every steward and security person will receive a written copy of their role and responsibilities". He explained that the security men are provided by an outside contractor, i.e. managing the door and managing what he calls key hinge points. This witness clarified that ice marshals having a specific instruction to ensure the safety of visitors while the stewards and/or security and/or other staff all would have a role in the direction and management of people outside of the ice rink.

120. In the safety statement this witness accepted that he was aware of a statement in it that company management has ultimate responsibility for the health and safety of the workplace and we shall endeavour that it is reasonably practicable to comply with that responsibility. The safety statement itself states that it will be prepared in accordance with the requirement under the Safety, Health

and Welfare at Work Act, 2005, Construction Regulations 2006, General Application 2007 and the relevant codes of practice. This witness confirmed that in figure 6 of 8 a faded photograph, 6 of 8, the one with the two security men, that there was no sign of any supervisors on the ice but he claimed that if one looked at the video evidence afterwards it shows a different picture and he confirmed that the two security men did not move on to the ice at any stage and that in the frame they are not looking at the ice rink, nor were they wearing skates and he said because the infant plaintiff in this case was up so quickly they did not move on to the ice, but he said in an immobilisation or leg issue or back issue they would have been on to the ice very quickly.

121. This witness indicated that the marshal was on the ice rink in the centre of the ice rink at the point when this accident occurred or that he may be at the upper end of the quadrant of the ice rink and he agreed that it is an issue of reasonable care. This witness accepted that he was not sure where the marshal was and that he was not coming to give evidence, but he obviously was not on the ice rink and that it may have been that he was called away from the ice rink, but he accepted what was said in that regard. Mr. Cremin pointed out that there is an emergency exit and there are multiple exits around the premises off the ice rink.

122. It was put to this witness that Canada has the most ice rinks and that it ought to be looked at as the best standard and that the IRMA document is not as current and is impossible to get hold of and is produced for the benefit of ice rinks operators and owners. He notes in the IRMA document the necessity for operators to "assess the risk of their activities prior to determining supervision levels".

Evidence of Mr. Barry Tennyson

123. Mr. Tennyson described himself as civil engineer with 40 years' experience and ten of those in design on construction in British Columbia and six months' experience in Ontario Canada. He has a university granted Health and Safety Management Certificate and over 30 years in accident investigation in Ireland. Mr. Tennyson produced a drawing handed into court showing the comparative dimensions of a Canadian ice rink and the rink in Blanchardstown and Mr. O'Carroll ranged by one metre in dimension in terms of accuracy. The Canadian ice rink is designed first and foremost as a hockey rink which is also used for other ice skating twice the size roughly of the standard hockey rink. He said it was 1461 square metres 56 metres by 26 metres. The building code in Canada determines the width of the escape corridors and doorways on the exterior of the building and the fire code determines the number of people you can get into a particular room and how long it takes for them to travel from the furthest point in the room to the remotest exit taking into account that one exit might be blocked and ORFA guidelines are very clear on this. They were instructing the manager to consult the two codes before determining the load, the occupant load. When they determine the figure then they must go to the risk manager with those figures for sign off. All of those things would need to be considered before on decides how many people one allows on to the rink pad. He said "to the exit" means the building exit, not the ice pad exit. Access and egress covers any point in the ice pad to the furthest exterior door of the building as per the ORFA code requirements and his conclusion on the figures was that Blanchardstown rink had a quicker evacuation time and that that why they needed two exits the one in use and the emergency exit on the edge of the ice pad. He said once they reached that point, the skaters can turn left or right and they have a choice of four exits to the building.

124. This witness said that the Blanchardstown rink complied with the guidelines in the IRMA and in relation to the issues raised by Mr. O'Carroll engineer in terms of the numbers of skaters Mr. Tennyson counted at the time of the incident 111 people on the rink and he referred to p. 5 of 10 of the guidelines in relation to "ratio of rink staff basic guidelines table". He refers to "minimum number of rink staff during normal conditions" and he said that would mean one marshal would be required on the ice pad and at the time therefore of the incident and that it complied with IRMA guidelines for skaters.

125. Regarding exits, he says that IRMA booklet does not tell you how many exits are required because each facility is unique.

126. Regarding supervision, it just said one marshal was required and they also had security staff, off the pad, directing skaters to the skates off room which can be seen in the video and he refers to the two men in the yellow vests positioned he says deliberately where the skaters are stepping down off the pad so that the skates wobble so he is in a good place. He says that they reduced the number as a max of 350 in Blanchardstown so there is a factor of safety in this and therefore they complied with the IRMA guidelines in the three respects.

127. This witness disputed the contention of Mr. O'Carroll that skating was a high risk activity and he said that the IRMA guidelines referred to high risk activities as something other than normal for example ice hockey, figure skating, short track speed skating, curling that these are not normal but special activities.

128. Regarding this witness's first report dated 4th May, 2017 he corrected on p. 2 line 1 the following UK best practice for ice load is two metres squared per skater rather than three metres as stated in his report which is a typographical error. In his second report of 26th November, 2017 p. 2 para. 4 he said the Tennyson estimate of 111 skaters at the time of the incident is more accurate. This equates to a skating load of 776 instead of 999 and he said that then gives you seven metres squared instead of nine metres squared which he says would be close to the ORFA guidelines.

129. Under cross-examination this witness said that he had never given evidence as an expert in a Canadian court. Mr. Cremin accepted as Managing Director of the company involved in this accident that the company owes a duty of care to the plaintiff and she was ten years old at the time of the accident. He accepted that there was duty of care and that it is only breached when there is negligence. This witness accepted that if the duty of care was broken and reasonable care was taken and an injury followed and that this could give rise to damages and he accepted that. In that context he saw he function as to show that the manager had taken reasonable care in the safety management programme. He accepted his duty was due to the court to give impartial evidence and opinion.

130. This witness said that had not time although he had been on site and had been given a walk around tour so he could not possibly examine everything, when he was asked about whether he had time to view all the relevant facts and a case was then given to him and a copy handed to the court in the case of *Louise Byrne v. Ardenheath Company Limited* (Court of Appeal) [2017] IECA 293 and he recalled that this refereed to a case concerning Mountview Shopping Centre. It was pointed out to him in the Court of Appeal that Irvine J. rejected his evidence and dismissed the appeal. He gave evidence in the case about access to an egress from a carpark, design components and the occupiers liability was rejected by the Court of Appeal. Paragraph 31 of that decision:

> "It was my experience as a trial judge that the effectiveness of the assistance offered by expert witnesses in almost all disciplines, whether that evidence was in respect of the standard of care proposed or a party's compliance therewith, was frequently compromised by the fact that, all too often, their opinions all too often appeared to correspond too favourably with the interests of the parties who retained them".

131. Paragraph 32 of the judgment continues:

> "I mention these facts because they highlight the need, particularly in cases where the court is not dealing with a complex specialist field of activity, for the trial judge, not only to consider the expert evidence tendered by the parties but to bring ordinary common sense to bear on their assessment of what should amount to reasonable care. The present case would, in my opinion, fall into that category insofar as it concerns the care to be expected of the owner of a shopping centre car park for visitors seeking to exit the car park on foot."

132. Paragraph 35 of the said judgment:

> "Whilst evidence was given by Mr. Tennyson regarding 'desire lines', … a factor referred to by the trial judge in his judgment, it is important to note that there was no worn track or 'desire line' going down the grassy slope between the small car park and the footpath evidencing the demand of pedestrians to exit the small car park otherwise than by using entrance number 4.
>
> Material also is the fact that there was no evidence to suggest that it would not be reasonable, in the context in which that word is used in the Act, to expect pedestrians and vehicles to share the same entrance such as those numbered 1 and 4 in this case. Further, there was no evidence that such use was in breach of the planning permission granted for the shopping".

133. Paragraph 37:

> "Core to the liability finding of the trial judge was his conclusion that there was a 'design fault' in the smaller car park, in that, unlike the larger car park, it was not served by a pedestrian only entrance."

134. Midway down para. 38 Irvine J. continues to say:

> "I cannot identify any credible evidence upon which the trial judge could validly have concluded that there was a 'design fault'".

135. The judgment continues:

> "he fact that, all too often, opinion appears to correspond too favourably with the interest of the party who retained them".

136. The witness did not agree that he had given expert evidence not for the benefit of the Court but that he had presented to favourably with the interests of the defendants solely at heart where he had not assimilated all the relevant facts.

137. This witness explained that the original hearing was before Hanna J. on 3rd May, 2017 and that he was retained either the same day the 3rd or the next day which was the 4th May, 2017.

138. Correspondence was then handed into this Court showing that the plaintiff as far back as the 23rd June, 2016 advised the defendants that they the plaintiff were retaining an engineer and that they sought a joint inspection. The plaintiffs note that the defendants furnished maps and documentation but on 25th April, 2017 in correspondence the plaintiff's solicitors wrote to the defendant saying that the documents they had furnished were not sufficient to prepare a report. The report was only furnished to the defendant some days before the hearing.

139. This witness confirmed that he came into court on 5th May, and that the report was the previous day, the 4th May, and he confirmed that he had no interview with the plaintiff's engineer Mr. O'Carroll, no joint inspection, no interview with the plaintiff and he produced no report at that time. This witness agreed that he had not exchanged reports but that he reviewed the file papers, the video extracts, the statements and the report of Mr. O'Carroll.

140. This witness contended that he was aware that he must independent and impartial and that he felt that he had done that and he said he had not heard the evidence of Mr. O'Carroll he had his report. It was put to this witness that his assertion that even if there was more than one exit point as concluded by Mr. O'Carroll, the incident could still have happened and that that falls below the standard expected of an expert such as himself as it is not about whether accidents could or could not happen, it is about reasonableness and reasonable care and foreseeability. He said it is all about risk and that he is an expert in risk management. It is put to this witness Mr. Cremin had said that two exits would double the risk and that Mr. Tennyson felt that reducing the number of exits reduces the risk factor associated with exiting this particular ice rink. This witness replied that the step at the exit is a risk because skaters are stepping down to a non-firm surface and they are on a knife edge skate going from ice to non-ice and this is a higher risk than skating on ice. This witness still held the view that there were still be congestion at two exits. This witness agreed that the accident happened half of minute before the exiting was concluded and the exiting was three and half minutes and the incident occurred half a minute after it started. He put the exiting time at three minutes and twenty five seconds and it was put to him that over 200 people were on the rink were able to exit in that time and he said there were not 200 people on the rink there were 111. He said they were not 200 people that he counted them i.e. the number who exited through the gap, that step down off the ice pad and in three minutes 25 seconds and he came up with a figure of 150. Over a three minute twenty five second span. With reference to the worksheet and the graph of the number of people who were booked in between the hours of 10:30 and 21:00 this witness was asked about the Wednesday how many had booked in on that day and the calculation on the plaintiff's side was that that there were 1,700 and figures were put in evidence 211, 265, 347, 281, 346, 248, 284, 230, 221 and 267 and at an average of €16.00 per person this would give €50,000 just for that day. This witness said he did not look at the cost. Counsel then put it to this witness that in the light of his evidence that the plaintiff's side had tried to google the IRMA having googled good practice guide and it refers to the Ice Rink Managers Association which is the IRMA and that one is then directed to a site https://www.icerink.org.uk. Then one is referred to a site for "ice rink operators only" and Mr. Tennyson said that after those steps you then go into the search box and the first item is the IRMA home page and click on that and that you get the present page. It was then pointed out one then needs a password and that Mr. O'Carroll's point was that it was very difficult information to access.

141. By contrast it was put to this witness to get the ORFA guidelines one did not need the rink owner's permission or passwords or anything of that sort. His response to this was that if he was doing a safety audit for the rink in Ireland he would not know about the ORFA document he would be concentrating on UK practice and that if he wanted to get ice rinks Ontario he would get the document without a password.

142. This witness accepted that the ORFA strongly recommended that load capacity for an average ice surface be set using a calculation of 100 square feet per skater and that that was 9.3 square metres and that the calculation would help control ice

condition and he interprets this as meaning if you put in fewer people fewer skaters then you would not have to recondition the ice more frequently and you can use those people for supervision and he deduces that it is important to realise that load also applies to ice conditions. In terms of their recommendation then that all public skating programmes would have ice supervision as per a table "patrol to skater". One to 59 persons. One ice patrol. 60 to 119 persons. Two ice patrol. 100 to 160. Three ice patrol. And it is put to this witness that that relates to average ice surfaces for all public skating programmes in Ontario. He agreed that that was the recommendation for the standard ice hockey sized pitch. The numbers of attendees were put to him as follows: 347 were booked and at 2pm, 281 and he agreed with that that is what the booking documentation showed. At 15:10 346 and he agreed that that was the booking figure. It was put to him that as an expert evidence that some people might have been tired and nervous and that you might not always have that number attending that he had no evidence of that with regard to the day of the accident and his response was that the matter of bookings does not relate to the number of people you see on the main rink. He said that he looked at the bookings and he found fewer people at 1 o'clock and at 3 o'clock and he found fewer people than at the 2 o'clock session and he said that he was expecting 100 at least to be the number who exited in three and half minutes but rather it was 150 and that tells him that the bookings do not relate to the ice load. It was put to him in relation to that that he had calculated that there were 111 on the ice rink at the time he'd indicated to the court and he agreed that that meant that he had said 150 had left in the three and half minute period but he said the accident occurred.

Medical evidence

143. The medical report of Dr. Charles Smith of Ryevale Medical Practice, Pound Street, Leixlip, County Kildare, dated 8th January, 2016, sets out that the plaintiff suffered multiple lacerations to her right hand and a 1.5-inch long laceration to the dorsal aspect of her right middle finger as well as lacerations to the dorsal aspect of her right index finger and thumb. The patient suffered an ice burn to her right thumb. The patient was shocked by this accident and in pain. The patient was treated on 31st of December, 2015 at the Emergency Department, Children University Hospital, Temple Street, Dublin 1. The plaintiff had one GP visit and three specialist visits in respect of this incident at the dressing unit, Children University Hospital, Temple Street, Dublin 1. The plaintiff's wounds had to be cleaned and washed out in hospital and paper stitches were applied to close the wounds, which were then dressed with bandages. The right middle finger had to be placed in a splint and strapped to the right index finger as the right middle finger laceration involved the middle knuckle. The plaintiff was treated with regular Nurofen and Calpol, to help alleviate her pain. The plaintiff continued to complain as of 8th January, 2016 of pain in the right hand where the lacerations occurred. The nature of the plaintiff's injuries and their dressings have prevented the patient from being able to write or to participant in sports.

144. Clinical findings on examination on the aforesaid date show that the plaintiff's right hand has a number of dressings with a splint to prevent any movement of the right middle finger so that the wound on the middle knuckle can heal, with dressings also in place on the right index finger and thumb. A full physical examination of the right hand was not performed so that the patient's dressings and splint were not disturbed.

145. The accident has effected the plaintiff causing mild mental health difficulties as well as profound difficulties in the area of reaching, manual dexterity, and lifting and/or carrying. As of the date of this report it is anticipated that the patient would continue to attend the dressings clinic in the Children's University Hospital for treatment of her injuries and the patient continues to require regular analgesia to help alleviate her pain. A full recovery was expected as of the aforesaid date, within six months of the date of the accident with no complications or further specialist reports recommended or expected. The patient is described as right handed and had not been able to write in school for a considerable period following this accident and was unable to participant in sports for a considerable period. The plaintiff's quality of life is detrimentally effected. The plaintiff has scarring at the site of these injuries on her right hand which are permanent and very noticeable, across her thumb, index finger and middle finger. This Court has been shown the plaintiff's right hand with a permanent a very noticeable scar is visible across her thumb, index finger and middle finger.

Findings of fact and conclusions

146. By way of background, this case was listed previously on 3rd May, 2017 before another judge and Mr. Tennyson, engineer who gave evidence on behalf of the defendant, was retained either on that day the 3rd or the following day i.e. 4th May, 2017. It is clear that as far back as the 23rd June, 2016, the plaintiff advised the defendants that they, the plaintiffs, were retaining an engineer and they sought to have and arrange a joint inspection. While the defendants furnished maps and documentation, the plaintiff's solicitor wrote to the defendant's solicitor by letter dated 25th April, 2017 indicating that the documents furnished by the defendants were not sufficient to enable their engineer to furnish and prepare a report. This court notes that that report was only furnished to the defendant some days prior to the original hearing date.

147. Mr. Tennyson then indicated that he came into court on 5th May, 2017 and he confirmed he did not have an interview with Mr. O'Carroll, the plaintiff's engineer, nor did he have any joint inspection, nor did he have any interview with the plaintiff and he produced no report at that time. Instead this witness agreed that while he had not exchanged reports, he had reviewed the file papers, the video extracts, the statements and the report of Mr. O'Carroll.

148. When the matter was previously listed before an another judge, the defence argued that they needed to get an engineer's report and that hearing had to be aborted after three days and the Judge then awarded the full costs to date against the defendants and in favour of the plaintiff.

149. Normally there would be a joint inspection, the engineers are obliged to comply with S.I. 391, and where usually two experts come to an agreement on certain matters and then it should be clear from their reports the points they agree and then again those points with which they disagree clearly. In the view of this Court what happened in this case meant that the length of the trial was greatly elongated and the attendant costs greatly increased as a result. What appears to have occurred in this case was that Mr. Tennyson had sight of Mr. O'Carroll's report was not present for Mr. O'Carroll's evidence that he could then prepare his report commenting on Mr. O'Carroll's report.

150. The court is also highly critical of the fact that a Mr. Danny Raleigh was listed as a witness for the defence and was described as an ice marshal but was not called to give evidence. Mr. Aaron Daly gave first aid and again he was not called as a witness in this case. It was clear from the evidence that he was not an ice marshal actually on the ice rink at the time of this accident.

151. Mr. James McDonnell was described as both a supervisor and an ice marshal but the court was told by Mr. Cremin the defendant that this witness had actually gone to Canada to work, yet Mr. Cremin described him as having been on duty, as having signed in and as having been a supervisor and that he was on the premises on the date of this accident but that his duties did not require him to be there at that time although he accepted that that gentleman was listed as an ice marshal on that date. This Court takes the view that the engineering evidence is of some benefit but that the court is not obliged to pose standards which might apply in Canada or indeed in England or elsewhere. This evidence is in relation to what happens in other jurisdiction and is extremely enlightening as a guide but this Court recognises that Ontario circumstances are very different to those which pertain in this country in terms of the type of locus at issue in this accident. In addition, the court notes that the English standard document relied on by the defendants is

a document for use by owners/managers rather than by all parties who might be involved in such an enterprise either as patrons or otherwise. The court accepts what Mr. O'Carroll says about the English guidelines in that they are extremely hard to access and the court accepts his evidence on this point. In that regard, Mr. Tennyson's reliance on those guidelines must be viewed with some caution in conjunction with the other items already referred to concerning his evidence.

152. Notwithstanding that, and taking into account the basic issues which the court must decide upon, the case is about a ten-year-old child at the time of this accident suffered permanent scarring to her hand of a significant degree. The case is made on her behalf that she did not contract out of the risk of being on an ice rink or of the exit from same being overcrowded, nor did she voluntarily relinquish the risk that there should be adequate supervision. The point is well made that there was no proper risk assessment or safety audit.

153. Insofar as the court has obtained some guidance from the evidence of Niall O'Carroll, consultant and forensic engineer, this court notes the extensive research this witness had conducted into this area, where he freely admitted that he had not previously examined such a case. He made the point very validly that he is involved in the general principles of safety engineering and that is what he is expert in i.e. hazard analysis and accident investigation and he makes the statement that the principles are the same and regardless of the type of accident some specific domain knowledge which one can obtain from research, which is what he did. This witness gave clear evidence that in his view the accident occurred when the infant plaintiff fell to the ground and then the actual loss event was that the third patron came into the area and not having anywhere to go ran over her finger while wearing ice skates. This witness explains that one has to look at what controls were in place to make sure that the accident as it happened would be less likely to happen and whether if it happened that the severity of the loss would be less and he gives a number of pointers. Having heard all the evidence, it is quite clear that the cohort of persons using the ice rink know great variety in the level of attainment of expertise as skaters, with the great variety of ages. This witness pointed out that the number of people on the ice rink ought to be adjusted vis-à-vis the experience or otherwise of the patrons. Having heard all of the evidence, this Court is of the view that the number of people who purchased tickets i.e. 251 people for this particular ice skating slot, has to be taken as the potential number and assessment of the safety requirements including supervision ought to be made based on that figure of tickets sold. In addition, the court accepts the evidence of this witness when he makes the point based on solid reasoning that more than one exit route is necessary. It is common sense having considered this evidence in detail that the managers of such a facility have to account of various levels of capacity, skating speeds and supervision to ensure safe exit from the ice rink.

154. Staff supervision is described as providing the best customer safety. The evidence of Mr. Cremin, in the view of this court, showed that the approach to the level of supervision and manner of supervision was very casual indeed. This witness attempted to persuade the court that the two stewards who were outside the ice rink were conducting the work of marshals although he did resile from this position. It is quite clear, and it is a clear fact that when this accident occurred, there was only one ice marshal in the rink at the far end attending to someone who had had a fall. The person who gave first aid was not present he was on duty but he was certainly not in the area of the locus. While Mr. Cremin in his evidence referred to stewards in the plural it is quite clear that there was only one steward present on the ice rink at the time of this accident. This Court noted that when Mr. Cremin was asked about the documentation which should be shown to staff such as stewards or the safety statement which was sought on discovery, he gave a very answer saying he did not have that document with him. No reasonable explanation was given by him in respect of these matters, nor was there any in respect of the lack of witnesses on his side in relation to this incident.

155. Mr. Cremin admitted that he had not seen documents setting out the roles and responsibilities of the stewards for example, nor had he interviewed either gentlemen, nor had he looked at their documented responsibilities which should be set out in a safety statement, nor had he sought such documentation.

156. This Court accepts the evidence of the infant plaintiff and her mother that they did not hear the penguin video, nor did they see it.

157. The evidence of the plaintiff's witnesses was that there was overcrowding especially at the exit area.

158. The court then asks the question what caused the particular injury to this child. This court accepts the view of Mr. O'Carroll engineer that it was not the rather large gentleman who turned who caused this accident rather it was the fact that the third party skated into this accident when the infant plaintiff was on the ground and having no means of escape because of the overcrowding skated over her hand causing her injury. In the view of this court this accident was reasonably foreseeable in circumstances where on the plaintiff's evidence there were 1,700 people booked into the various sessions throughout the day on the date of the accident and 974 people over a two-hour period with a twenty-minute turnaround on the occasion of this accident. Ten minutes is about the time allocated for patrons to exit the ice rink so that the ice is then resurfaced as well in the interlude, so in practical terms and as a matter of common sense, this court takes the view that it is highly probable that an accident would occur such as befell the plaintiff given the conditions and time constraints involved. This court takes Mr. Tennyson's point that this is not a high risk sport compared with other more elaborate forms of skating. This court finds that it preferres the evidence of Mr. O'Carroll to Mr. Tennyson and that his evidence gave a clear guide to the court, without us having to adopt standards of Canada for example, or England for that matter. The common law duty of care exists and the principles of health and safety apply. The defendant persisted in elongating these proceedings but the court accepts that there was a breach of the duty of care and negligent management of the ice rink at the time of the accident which allowed this incident to occur. There was a casual approach taken by the defendants. The court accepts Mr. O'Carroll's evidence on behalf of the plaintiff to the court and he sets the time of the accident as 14:58 p.m. with reference to the video and he says that the video clips are static prints of less than one second each and for that reason it is extremely difficult to get an accurate view of the number of persons present on the ice rink. He said prior to the accident from his examination of these stills, there were 347 people present at the time of the accident the actual time he said there were 241 people present and that at 3:10 p.m. 346 people have been booked in for that session. He also made the point that three and half square metres per person for a number of 281 people is a dangerous and unsafe situation. He said that the IRMA guidelines would deem 360 people to be safe in such circumstances and up to 465 persons but that would only leave two metres per skater. This witness deemed that three marshals ought to be present. His thesis was that there should be more supervision therefore, more exits, more points of egress to prevent the massing of people at the exit or congregation at the barriers with a person there to move such people congregating or massing at barriers, along to the exit.

159. In terms of proofs, he referred to figures 7 and 8 and as set out in para. 78 of this judgment he pointed to overcrowding at the exit as a clear hazard.

160. Mr. Cremin referenced 281 as including people who did not turn up to skate although they might have been booked into this particular session. He did not disagree under cross-examination that there were people massing to the right at the exit. He said there was one marshal on the rink at the time when the patrons were leaving and then there were two stewards but he admitted that he did not know where one of the stewards was and further clips were shown after the accident which had not been shown to the

plaintiff and he denied seeing a fight occurring on those stills and he said he did not know what that man was doing and he said he had never spoken to him.

161. It is clear that there was a breach of s. 10 of the Health and Safety at Work Act, 2005.

162. This Court concludes that the defendants have failed to take reasonable care and were negligent in the safety and management of this rink and that the accident was reasonably foreseeable in all the circumstances. This Court notes the medical evidence in the form of a report which it was agreed could be handed into the court and the court has viewed the infant plaintiff's hand and awards the sum of €65,000 in respect of the damages.