THE HIGH COURT

[2010 No. 5534 P.]

BETWEEN

FELIX MOOREHOUSE

PLAINTIFF

AND

THE GOVERNOR OF WHEATFIELD PRISON, THE MINISTER FOR JUSTICE, EQUALITY AND LAW REFORM, IRELAND AND THE ATTORNEY GENERAL

DEFENDANTS

JUDGMENT of Mr. Justice Bernard J. Barton delivered on the 15th day of August, 2017

General

1. Constructed in 1989, Wheatfield was the first purpose built work and training correctional facility in the State. It was established with the objective of fostering the rehabilitation of prisoners in a caring environment concomitant with the mission statement of the Irish Prison Service (IPS).

2. The educational and vocational facilities provided include a school, laundry, restaurant as well as self-contained computer skills and industrial skills workshops where externally accredited European norm and City and Guilds courses are offered to prisoners commensurate with their vocational needs and abilities. Prisoners wishing to avail of these facilities may apply to transfer from other prisons to Wheatfield.

3. On arrival, each prisoner is interviewed by the nurse manager who completes an Irish Prison Service (IPS) Nursing Committal Interview (NCIF) Form. This is followed relatively quickly by a vocational interview which is conducted by the Industrial Training Manager (ITM), who completes an IPS Work and Training Committal Interview Form (WTCIF). If found suitable the prisoner is offered a choice of educational and vocational courses.

4. Doing nothing in Wheatfield is not an option; every prisoner is assigned to school or his chosen course. If found to be unsuitable or if he fails to participate in or cooperate with the rehabilitation programme to which he has been assigned the prisoner is sent back to the prison from which he transferred. Unless excused for some good reason, such as illness, prisoners are not permitted to doss in their cells during schooling or course training hours; they may attend the course or the school or the gym or engage in some other designated activity but when called to do so by the class officer they must move off the cell landing.

5. Save in exceptional circumstances, such as where there is a medical concern that a prisoner might not be physically or mentally fit to participate in one or more of the work and training courses on offer, information on personal/medical status obtained at the NCI is not shared with the ITM or other training staff at any time.

6. In 2008 an assumption was made by the non-medical prison staff that any given prisoner could be using illicit drugs and / or could be on a methadone treatment programme facilitated by the prison. It was not unusual for upwards of a quarter of the prison population to be using illicit and/ or controlled drugs; at the time, intermittent screening of prisoners for drugs was undertaken by way of urine sampling.

7. Literacy problems and learning difficulties are also features common to the prison population; prison officers and training staff proceed on the working assumption that a significant proportion of prisoners under their care have such difficulties; the Plaintiff was one such prisoner.

8. Born on the 14th September, 1982, the Plaintiff is separated and has two children. His childhood home was a halting site in Carrickmines, County Dublin. He was illiterate and innumerate on leaving school aged eleven when he went to help out in his father's scrap metal business and with his horses. The only vocational training he received involved attendance at a practical welding course in Bray Co. Wicklow, run by FAS for members of the travelling community on foot of which he obtained a certificate in practical welding.

9. In addition to his educational and social disadvantages, all aspects of the Plaintiff's personal, family, social and vocational life have been blighted by habitual drug abuse which commenced when aged 18 as result of which he developed an addiction to heroin which cost between two and three hundred Euro per day.

10. Against this background it is perhaps unsurprising that the Plaintiff fell into criminality and has been convicted of serious offences for which he has served several terms of imprisonment, the most recent of which was for aggravated burglary and during which the trial in these proceedings took place.

11. On the 27th November 2008, while also serving a sentence for burglary in Wheatfield, the Plaintiff's misfortunes took a turn for the worst when he suffered a traumatic amputation to the fingers of his left hand while using a GEKA Minicrop sheer and punch machine in the metal welding workshop of the prison; liability for the accident is fully contested.

12. Although there was controversy between the parties on a number of matters concerning the circumstances leading up to, at the time of and after the accident, the Court considers that on any view of the evidence the following issues, observations and findings, discussed in greater detail later, maybe usefully identified and stated at the outset:

> (i) The cutting/cropping and punch facilities constituted dangerous parts of the GEKA Minicrop which required guarding to minimise or avoid the risk of injury; the opening to the cropping facility was designed and fitted with an adjustable device known as a hold down guide which also served as a safety guard (the guide-guard);
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> (ii) At the time of the accident the Plaintiff's left hand was in the pathway of the shear blades of the machine, the guide guard had been removed; the identity of the individual and responsibility for the removal of the guide-guard was in question;

(iii) The Plaintiff and Jonathan Nicholson, the Industrial Training Instructor (ITI) with responsibility for supervision and training in the workshop, denied removing the guide-guard;

(iv) If fitted and properly adjusted, the guide-guard would have prevented any part of the Plaintiff's hand entering the cropping compartment to the point where it would have been in the path of travel of the shear blades; the injuries could not have been sustained had the guide-guard been so positioned;

(v) The guide-guard was not a fixed guard; it was adjustable and removable without the use of a tool;

(vi) The cropping facility could be operated without the guide-guard in position; consequently, the cropping blades were exposed, accessible and clearly visible to the operator and anyone supervising the operation of the machine;

(vii) Shortly before the accident a problem had arisen when two other prisoners were using the cropping facility as a result of which the steel flat or stock bar (steel bar) which they were trying to cut jammed between the cropper blades;

(viii) Following report to him of the problem, ITI Nicholson removed the steel bar; whether or not the machine had been completely switched off by him, it had not been not locked out in a way which prevented it from being restarted;

(ix) The machine was supplied and fitted with a lock out facility in the form of a pad lockable device; in practice, this was not utilised prior to the accident by either the training staff or by those servicing the machine and was not fitted on the day of the accident;

(x) On the afternoon of the accident there were thirteen prisoners present in the welding workshop; whether the Plaintiff was actively participating in his course or whether he had been assigned to sweeping duties because the available welding booths were already occupied was in question; the Plaintiff claimed he was on his welding course;

(xi) The instruction and supervision ratio of staff to prisoners considered appropriate by the IPS was eight to one; whether or not Prison Officer Vincent Maher was in the workshop with ITI Nicholson on the afternoon of the accident was in question; the Plaintiff claimed he did not see him there at any time before the accident; Officer Maher said he was present and gave instructions to the Plaintiff;

(xii) At the time of the accident neither ITI Nicholson, Officer Maher or any other member of the prison staff was present in the work and training area where the Plaintiff and the other prisoners were working; the period of absence was in question; The Plaintiff claimed that the area was unsupervised for 10 or 15 minutes at least whereas ITI Nicholson and Officer Maher claimed it was a matter of minutes;

(xiii) Whether or not the Plaintiff had been instructed and trained in the safe use and operation of the GEKA and whether or not shortly before the accident he and others in the vicinity of the machine had received instructions from ITI Nicholson and/or Officer Maher not to go near it was in issue; the Plaintiff claimed that he had received neither training nor instructions; ITI Nicholson and Officer Maher claimed he had received both;

(xiv) Had such instructions been given they were confined to prisoners in the vicinity of the machine; those working elsewhere in the workshop would not have been aware that the machine was out of order and was not to be used; significantly, prisoners who had been trained and had demonstrated competence in the operation and safe use of the cropping facility could use the GEKA without seeking permission to do so;

(xv) At his request, the Plaintiff commenced a structured methadone programme on the 16th September; he had been using illicit drugs before commencing the programme and had smoked heroin while on transfer to Wheatfield.

(xvi) As a matter of probability, he continued to use illicit drugs both before during and after the accident; details of the type, quantity and level of illicit drugs used were not canvassed with the Plaintiff;

(xvii) Whether the dose of methadone administered on the day alone or in conjunction with other illicit drugs would have had an effect on the Plaintiff's cognitive and psychomotor functioning material to the cause of the accident was in question;

(xviii) The commencement dose was 20 ml per day and was increased by 10 ml in stages during the month of October until the 4th November when it was increased to 60 ml per day and administered daily to the Plaintiff up to and including the date of the accident;

(xix) The Plaintiff's historical reporting to his medical advisors and to the Court concerning the commencement date, dose increase intervals, amounts and time of Methadone administration was inaccurate and misleading, however, in this regard he fairly accepted in general the factually correct information when it was put to him;

(xx) While taking part in the methadone treatment programme prisoners are advised and required not to use other illicit drugs, the Plaintiff accepted that such a request had been made of him; ITI Nicholson and Officer Maher were aware of the programme but were unaware that the Plaintiff was a participant; they operated on the assumptions in relation to drug use and illiteracy referred to above;

(xxi) Methadone is usually administered to prisoners by medical staff in the prison clinic/ dispensary between 9.30 am and 10.30 am but could take until lockdown at mid-day; administration can commence a little later at weekends; the accident occurred on a weekday.

(xxii) Prisoners are required to consume the dose at time of administration and are monitored to ensure consumption, generally by being seen to swallow and then being asked to speak;

(xxiii) Prisoners are individually assessed by the dispensing nurse before the methadone is administered to ensure that it is safe to dispense it; the prescribed dose may be withheld, delayed or reduced depending on whether or not and, if so, to what extent signs of intoxication or ingestion of illicit drugs are manifest;

(xxiv) Urine drug screening was routinely carried out shortly after admission to the prison. Samples taken from the Plaintiff

tested positive on the 4th and 23rd of September for cannaboids, benzodiazepines and opiates, the latter test result being after commencement of the programme while on the initiating dose;

(xxv) A post-accident entry in the Plaintiff's medical notes dated 20th January, 2009 records that a urine sample taken at the time tested positive for 'cannabis, benzos, opiates and methadone'. It is probable that if a urine test had been carried out on a sample taken from the Plaintiff on the day of the accident it would have tested positive for some or all of these substances;

(xxvi) There were no urine drug screening test results recorded between the 23rd of September 2008 and the 20th January 2009; the testing which was undertaken identified but did not quantify drug levels;

(xxvii) When stabilised on methadone, it does not follow from a positive result for cannabis and or benzodiazepine that 24, 48 or 72 hours later that the concentration of those drugs in the system is such as would produce a meaningful impact on the level of psychomotor functioning; with all such drugs assessment of the individual for effect by direct conversation, personal interaction and observation is clinically significant.

(xxviii) Any prisoner reporting being unwell or showing signs of intoxication or of being 'strung out' is not permitted to enter the workshop but is returned to his cell and, if necessary, referred for medical attention;

(xxix) Cognitive and psychomotor function maybe affected to a greater or lesser extent by the presence, quality, quantity, time and type of illicit drugs and/ or methadone in the system; whether the Plaintiff was stabilised on a methadone dose of 60 ml at the time of the accident was in issue;

(xxx) The provisions of the Safety, Health and Welfare Work Act, 2005 and the Safety, Health and Welfare at Work (General Application) Regulations 2007 S.I. No. 299/2007 applied to the prisoners when working in the prison workshops;

(xxxi) The Safety Statement in force for the prison workshops at the time of the accident was drawn up in 2003 contained a risk assessment relevant to machinery; a General Metal Workshop Standard (MS1) was issued in June 2007 but neither were machine specific. Whether the relevant statutory requirements had been complied with was in issue;

(xxxii) The focus of the workshops was on training and up skilling rather than on production;

(xxxiii) The metal/ welding workshop is self-contained and incorporates an office, toilet facilities, store/ stock room, as well as a work and training area; prisoners, whose names are recorded on a list, have to be admitted individually and are required to wear personal protective equipment at all times while in the welding workshop;

(xxxiv) Metalwork machines, including the GEKA, tools, welding equipment, ten ordinary and three auxiliary welding booths were located in the work and training area of the workshop;

(xxxv) The removal of or making adjustments to the guide-guard was restricted to ITI Nicholson and the servicing engineer; training on the safe use and operation of the machine included information about the purpose of the guide-guard together with an instruction that the machine was never to be used without the guide guard in place;

(xxxvi) Individual lockers were provided for prisoners to store their personal protective clothing and equipment(PPE), which included gloves and steel capped boots; whether the Plaintiff was wearing runners or his work boots when admitted to the workshop and whether runners were removed and boots fitted before he was taken to hospital was in question;

(xxviii) Prisoners were checked/ patted down before leaving the workshop to prevent the unauthorised removal of tools or other materials, such as weapons. In addition to work and training requirements, supervision of the prisoners was also necessary for reasons of security;

(xxix) Had there been supervision in the work and training area of the work shop at the time of the accident it is highly unlikely that the accident could or would have occurred;

(xxx) Work and training sessions took place in the morning from 9.30

am to 12 am and in the afternoon from 2 pm to 4 pm; the Plaintiff had not wanted to attend the afternoon training session on the day of the accident, the reason for this was in question;

(xxx) A P19 is a disciplinary report which maybe written by any prison officer. Once brought to the attention of a governor a determination on the report must be made within seven days and may include a determination as to whether or not a disciplinary hearing is required; in such event another governor adjudicates on the case and, if appropriate, a sanction is imposed;

(xxxi) The Plaintiff's uncontroverted evidence was that if he did not leave the landing and go down to his course on the afternoon of the accident he was threatened by the landing class officer with a P19 report, a threat which, on the Defence evidence, was indicative of malingering by the Plaintiff;

(xxxii) Photographs of the GEKA taken by the ITM Austin Stack shortly after the accident show the work piece stop bar fitted in position to the back of the machine; whether the stop bar was missing at the time of the accident was in question;

(xxxiii) A Governor's parade takes place every morning between 9 and 10.30 am. Prisoners are entitled to attend and bring any complaints or other issues of concern which they may want addressed to the attention of the Governor;

(xxxiv) When prisoners have mastered horizontal welding, they progress to vertical welding; the Plaintiff was still engaged in horizontal welding at the time of his accident.

(xxxv) Certificates of competency in the different types of welding are issued once sufficient levels of competency have been reached and demonstrated in front of an external verifier. A training record is kept by ITI Nicholson, generally filled in on a Friday.

(xxxvi) The record for the Plaintiff shows that he attended the welding course over four weeks commencing week ending 42 and that he received induction, safety video, and safety training, including manual handling, as well as guillotine training;

(xxxvii) On the 20th August 2007, Lister Machine Tools Services removed, cleaned, turned, tested and reset the clearances between the shear blades of the machine;

(xxxviii) On the 8th January, Lister's service engineer reversed and refitted the bottom blade and removed the top blade for grinding and sharpening and reset the clearance between them;

(xxxvii) At the request of the Governor a post-accident investigation was carried out by Chief Officer O'Connor; the results of the investigation were not made known to the Court and neither the Governor nor Chief Officer O'Connor gave evidence;

(xxxviii) The IPS official witness report form to be completed by staff in the vicinity of an accident requires the witness to address relevant key issues outlined on the reverse side of the form. The issues identified in respect of injuries involving equipment were:

(a) Whether the work method employed was in accordance with the prison safety statement;

(b) Whether any defect was noticed with the equipment prior to the accident and;

(c) The relevant comments of the injured party, if any, together with other information considered relevant;

(xxxix) ITI Nicholson prepared a statement in the days following the accident which addressed some of these issues, however, at the request of the Governor he submitted a shorter statement in which he omitted any reference to these issues An official witness report form was completed by Officer Maher dated 3rd December, 2008 in which he also omitted any reference to these issues, this statement was written in almost identical terms to the second statement submitted by ITI Nicholson;

(xl) Although he attended the Plaintiff immediately after the accident and took photographs of the GEKA shortly thereafter, ITM Stack was not invited to make a statement by Chief Officer O'Connor or by the Governor, however, subsequent to completion of the investigation he did make a statement dated 20th February, 2009, which addressed some of these issues in response to a request from the State Claims Agency;

(xli) No satisfactory explanation was proffered to the Court in respect of the following;

(a) why the original statement submitted by ITI Nicholson was not found to be acceptable by the Governor,

(b) why a shorter statement was required instead the first statement which he had submitted;

(c) why, in the absence of an instruction or a direction from the Governor, ITI Nicholson chose to omit any reference in his second statement to the relevant issues addressed in the first, or

(d) why statements devoid of any detail relevant to the issues of causation, liability and fault were received and accepted for the purpose of an enquiry into what appears to have been the most serious accident since the establishment of the prison;

Background to the Accident

12. The Plaintiff underwent a NCI on the 28th August when he transferred from the Midlands Prison to Wheatfield. The NCIF completed at the time records the Plaintiff's occupation as "welding trade"; his education level as "junior/intermediate certificate"; leaving school age at '14' and shows tick marks against the headings "read" and "write". Contradictory information appears on the WTCI form completed on the 4th September by ITM Austin Stack, this records school leaving age at '10' and standard of education reached as "primary".

13. The Plaintiff was offered educational and training options at the work and training interview conducted by ITM Stack. Having regard to his preference and previous welding experience, he was assigned to the European norm 287 level 1 practical welding course which he commenced in week 42 and attended for the following four weeks before being absent for several weeks due to an ingrown toe nail; the accident occurred on his first day back on the course in circumstances about which there was considerable controversy.

The GEKA Minicrop Machine

14. Given the evidential conflict between the parties concerning and surrounding the circumstances of the accident, particularly with regard to precisely how the Plaintiff sustained his injuries while using the GEKA, it is considered desirable and appropriate to a full understanding of the issues involved that the purpose, relevant functions and operations of the machine should be described in some detail.

15. Engineers were retained by both parties and gave evidence, Mr. Barry Tennyson on behalf of the Plaintiff and Mr. Paul Romnel on behalf of the Defendant. There was broad agreement between them on the relevant engineering specifications: the GEKA was designed and manufactured to perform a number of punch and shear functions one of which was to cut or crop the steel bars; instruction and training of prisoners attending the Euro norm 287 welding course was confined to the controls of the machine and use of the cropping facility; other functions were not included, a failure criticised by Mr Tennyson.

16. The cutting or shearing action of the cropper is performed by two opposing blades, one passing the other. The lower blade is fitted in a fixed position to the bed of the machine. The upper blade, driven from above by a powerful hydraulic ram, moves down towards and passes the lower blade, facilitated by a gap which is typically set at 0.7mm. The blades are not equidistant from one another.

17. Viewed from the in-feed side of the machine, the upper geometric blade is fitted so that the distance or gap between the blades

in a resting position increases from 12 millimetres on the left up to 60 millimetres on the right thus creating a shear action between the two blades when the shear function is operated by pressing the operation foot pedal placed on the floor close to the operator, the machine is designed to perform up to 16 strokes a minute.

18. Lister Machine Tools have a contract to provide maintenance services for the machine which includes servicing of the blades; a pre-accident service was carried out on 20th August 2007 and a post-accident service was carried out on the 8th January 2009 during which the bottom blade, which has 4 sharp sides, was reversed; the upper blade, which has 2 sharp sides, was removed for grinding and sharpening;

19. On the Defendants case the gap and the manner in which the cut is performed by one blade passing the other is particularly significant in the context of reconciling the damage caused to the glove worn by the Plaintiff at the time of the accident and the Plaintiff's account that his left hand was placed on top of a steel bar which he was trying to cut at the moment when his fingers were amputated.

20. Following a comparison between the damage to the accident glove, the dorsal aspect of which remained essentially intact, with damage caused to a glove used in a reconstruction which was almost identical, and damage caused to a glove placed on a steel bar which was cropped, Mr Romnel formed the opinion that the Plaintiff's hand could not have been positioned on top of a steel bar at the fateful moment, moreover, his hand and glove were palm upwards at the time. The evidence given by him to explain why the accident glove and the glove used in test 2 was not completely severed was that the 0.7mm gap set between the 2 blades facilitated the remaining glove material being forced into it as the upper blade passed.

21. Mr Tennyson suggested that this scenario rather depended on which of the blades at the time performed the actual cutting action; if it was the bottom blade then the hand was palm down, furthermore, the Plaintiff's hand could have turned before the stroke of the upper blade, a proposition with which Mr Romnel disagreed as there was insufficient clearance between the blades to permit the gloved hand to turn. With regard to blade wear or sharpness it was improbable in Mr Romnel's view that one blade was significantly more worn than the other, such would indicate a serious fault but there was no evidence that that was the case.

22. Returning to the operation of the cropper, depressing the foot pedal at any stage stops the stroke and the upper blade returns to its rest position until the pedal is depressed again. The shear blades are contained within the machine. They are protected from the in feed or operator's side by the adjustable guide-guard and on the output side by a moveable flap which lifts to allow the work piece to exit for placement against an adjustable stop bar fitted to the back of the machine. The adjustment of the stop bar facilitates and determines the length of the steel bar section to be cut; when a section of steel bar is cropped the cut, section falls free and the flap closes. The Plaintiff's evidence was that the stop bar was missing at the time of his accident an assertion hotly disputed by the Defendants.

23. As the description suggests, a device which acts as a hold down guide and safety guard fulfils a dual purpose. It is designed so that it can be adjusted to accommodate the different thicknesses of steel bars introduced into the machine to be cropped into pieces for use by the prisoners for welding. The adjustment and removal of the guide guard can be performed without the use of tools; accordingly, it was not a fixed guard. Mr Tennyson's opinion was that it should not have been possible to operate the cropper facility without the guide-guard being in place. The fact that it was possible to do so rendered the facility particularly dangerous.

24. Generally measuring two or two and a half metres in length and six or ten millimetres in depth by 75 millimetres in width, steel bars of other dimensions can also be accommodated in the facility; the length of flats required for the welding course was 300 millimetres with uniformity of length being facilitated by the appropriate adjustment of the stop bar. Adjustable stops were also fitted to the bed of the machine to provide lateral guidance of the work piece as it is moved into the cropping compartment.

25. The forces involved in the shearing action result in the guillotining of the steel bar which ultimately breaks. The shearing process causes the bar on the feed side of the machine to be driven in an upwards direction. To counter this reaction the guide -guard is adjusted to within a millimetre or two millimetres of the upper surface of the steel bar. When so adjusted a guarding function is created which prevents any part of the operator's hand passing between the guide-guard and the work piece and entering the machine. At the time of the accident a warning sign was attached to this device which stated, "Do not work without stops in place". Subsequently, a pictogram was fitted which showed the shear blades behind.

Controls
26. The machine is fitted with an emergency stop switch located slightly below and to the left of the bed of the cropper. A control panel is located below and slightly to the left of that which consists of a number of control switches, namely, a green power 'ON' button, a red power 'OFF' button, as well as switches for the 'Punch', 'Shear' and 'Jog' functions together with an isolator switch which is fitted with a padlock facility; when engaged and fitted, this locks the machine out and prevents it from being restarted and used. The practice prior to the accident was not to use this facility. A power isolation switch was located in the workshop office, however, operation of that switch results in the loss of power to all power-driven machines in the workshop.

Induction and training
27. The plant and equipment in the workshop covers a wide range of multidisciplinary engineering and fabrication uses comprising different types of welding, cutting, rolling, milling, pillar drilling, finishing and bench grinding machines as well as guillotines, brake presses, and minicrops.

28. As different courses at different levels are offered, prisoners require instruction and training in the use of plant and equipment particular to the level and course being undertaken; the person responsible for the day to day instruction and training of prisoners in the welding workshop, including induction, health and safety training, was ITI Jonathan Nicholson; he gave evidence at the trial.

ITI Jonathan Nicholson
29. ITI Jonathan Nicholson joined the Irish Prison Service in 2004. He holds an impressive number of welding, inspection and training instruction qualifications which were included in the materials made available to the Court. He was responsible for the safety of the Plaintiff and the other prisoners assigned to work and train under him. He struck me as someone who enjoyed his role and was proud of his achievements in the rehabilitation of prisoners.

Introduction to the Workshop Courses and Induction
30. Introduction to the workshop course involves meeting with and making sure the prisoner understands the services being offered. The prisoner is familiarised with the workshop and is allocated his own PPE which is provided to him following which he is taken to the induction area, a small partitioned classroom within the workshop, to watch a series of induction video tapes and DVDs which include health and safety information, the use PPE, the operation of machines and manual handling.

31. Each prisoner is given a set of earphones with which to listen to the induction videos at the conclusion of which he is questioned to ascertain his comprehension of the safety, health and welfare aspects of the material viewed. Induction in this form was considered particularly appropriate by the IPS as it had the advantage of conveying in pictorial format information on safety and health issues for prisoners with low levels of literacy or who, like the Plaintiff, were illiterate.

32. Induction time varies from two to three days depending on the individual. No prisoner is permitted to commence a course in the workshop without having undergone the induction programme or without wearing personal protective equipment which includes steel cap boots and industrial safety gloves.

33. Once the induction videos and DVD's have been seen and the ITI is satisfied that a sufficient comprehension of the safety material has been acquired, the prisoner is walked around the workshop and shown where the various processes are carried out. Every prisoner is individually familiarised with the workshop machinery, tools, equipment and lay out; restricted areas to prisoners are also identified.

34. In order to minimise the risk of a prisoner being a danger to himself or others it has been the policy of the IPS since the establishment of Wheatfield that no prisoner is permitted to enter the workshop if reporting unwell or of being sedated, exhibiting signs of being strung out, drowsy or intoxicated; in such circumstances, the prisoner is returned to the cell by a class officer.

35. ITI Nicholson is not copied with the WTCIF but is made aware of the name and course to which the prisoner has been assigned following that interview. In 2008, it was not his practice to assess the level of literacy of individual prisoners on assignment to the workshop though such an assessment would arise in circumstances where a prisoner was moving from a completely practical course, such as that to which the Plaintiff was assigned, to one with an academic element. Because the Plaintiff had been assigned by ITM Stack to the wholly practical European norm 287 course his level of literacy was unknown to ITI Nicholson or Officer Maher.

European Norm 287 Level 1 Course

36. Prisoners commence this course carrying out horizontal welding using the manual metal arc process which is explained and demonstrated. Instruction is on a one to one basis. The prisoner is warned about dangers involved in the process and the necessity of wearing his PPE at all times. The risk of fire and burns and sources of heat are identified. Prisoners progress from horizontal welding to vertical welding. The Plaintiff was still carrying out horizontal welding at the time of his accident.

37. Understanding the operation of the cropping facility of the GEKA is incorporated into training because this is the machine which cuts the steel bars used by prisoners participating in a welding course. Instruction and training on the safe use and operation of the GEKA is given to two or three prisoners at a time. Mr Tennyson was critical of this practice, suggesting that this training ought to have been on a one to one basis. Although not strictly part of the welding course, an ability to use the shear facility of the GEKA was considered part of the prisoner's training in general enabling them to cut their own welding materials without depending on or waiting for others to do that for them.

38. A prisoner who is running low or has run out of steel flats and has satisfied ITI Nicholson that he has reached a level of competency in knowledge, use and operation of the cropping facility of the GEKA, is permitted to use the machine to cut steel bars into flats without first seeking permission to do so. Whilst prisoners generally informed the ITI of their intention, his evidence was that a failure to do so would not result in reprimand.

39. Training in the use of the cropping facility generally takes place in the second or third week after commencement of the European norm 287 Level 1 course. The training of the prisoner involves an explanation of the purpose of each of the switches on the control panel as well as the emergency stop switch. The use of the switches is demonstrated and the prisoner is invited to follow the procedure. The presence and purpose of the guide-guard is identified; the prisoner is given an instruction that the GEKA is never to be used without it and that it is never to be removed.

40. Because different thicknesses of steel bar, generally ten millimetre or six millimetre, were cropped on the machine, an explanation for and demonstration of the guide-guard adjustment mechanism is given; this was accompanied by an instruction that any adjustments were only to be made by ITI Nicholson or the service engineer.

41. The purpose and reason for the back stop and the presence and function of the cutting blades are also explained and demonstrated to prisoners. The danger presented by the shear blades is explained and visualised. To facilitate a view of the shear blades the guide-guard is adjusted to its maximum height but not removed from the machine. Once visualisation of the blades has taken place, it is readjusted and reset in the desired functioning position.

42. When so adjusted the prisoner is shown how to cut a piece from the steel bar, prisoners are shown to how to switch on the machine and how to activate the chosen operation by use of the foot pedal.

43. Following a series of cuts the ITI demonstrates the emergency shutdown procedure. The prisoners are required to use the cropper facility and perform the emergency stop procedure under supervision. The operation of the emergency stop button is explained. Depressing the button turns off all power; it is necessary to turn the button in order to release and reset the function.

44. ITI Nicholson gave evidence that the Plaintiff had received and completed the appropriate induction training, had been provided with a locker and PPE, had been familiarised with the workshop layout plant and equipment, had received instruction and training in the use, operation and dangers connected with the cropping facility of the GEKA, had been supervised using the machine and had demonstrated his competency to use the cropper safely. He had no issues with the Plaintiff; on the contrary, he described him as a nice mannerly lad who gave no him no reason for concern; he was 'no bother'.

The Accident

45. ITI Nicholson gave evidence that at the time that the Plaintiff was admitted to the workshop on the afternoon of the accident he spoke with him; there were no signs of intoxication or of being 'strung out' on drugs. The Plaintiff was assigned to sweeping duties as he had arrived late; all of the welding booths were by then occupied. When a problem with cropping steel bars developed in the GEKA, he extracted the steel bar which had jammed in the machine; he turned the machine off by pushing the emergency stop button and had engaged the isolator switch.

46. He gave instructions to those prisoners in the vicinity, including the Plaintiff, that no one was to touch the machine because it was out of order; he told them that he was going to the office to get an out of order tag for the machine. He was only gone a few minutes and had just finished a short call in his office with Governor Walsh when he was alerted to the accident.

47. There was an almost complete conflict of evidence offered in relation to induction and training, particularly with regard to the GEKA and in relation to the accident circumstances.

The Plaintiff's Account
48. The Plaintiff gave a very particular account of the circumstances in which he came to be in the workshop, what it was he was doing and how it was being done at the time of the accident. In relation to the actual occurrence of the accident it was the only direct account available to the Court which, if accepted, meant that he was performing a permissible function as part of his welding course at an unguarded and dangerous machine at a time where he did not want to be in the workshop and was adversely affected by methadone.

49. Of the many matters in controversy between the parties, the resolution of the issue as to how and in what circumstances the accident occurred is fundamental to the outcome of the case since on the Defendant's case whatever the Plaintiff was doing, the accident occurred in a way and manner otherwise than as described by him in circumstances where he had been advised the reasons why and had been instructed not to use or go near the GEKA on the day.

50. On his evidence, he did not want to be in the workshop that afternoon. He had received his daily dose of methadone at 11.30 am. It had made him feel very sleepy and drowsy; in general, he could not think straight on methadone. He was still feeling tired when the prisoners on the landing were called to go to their respective courses at 2 pm. He told the class officer he did not want to go, that the methadone had made him sleepy that morning but the class officer responded by threatening him with a P19 disciplinary report, accordingly, he left the landing and went down to the workshop.

51. He was late getting there; on arrival at approximately 3pm he spoke with ITI Nicholson who was the only member of the prison staff that he saw in the workshop up to the time of the accident. He was wearing PPE except his boots; although wearing runners he was nevertheless admitted to the workshop.

52. He had been welding for a short time when he ran out of metal flats. As far as he was concerned there was no reason why he should not use the GEKA to cut more steel flats; other prisoners had been told to use the machine by ITI Nicholson for that purpose, he had watched them do so. No instruction or training in its use and operation had been given to him; moreover, he had no recollection of seeing the safety video or DVD's, rather he was put straight onto welding. He could not read the health and safety warning signs or notices in the workshop or on machines because he was illiterate and innumerate.

53. Shortly before the accident he noticed a problem when the GEKA while it was being used by another prisoner. A piece of steel which the prisoner was trying to cut kept jamming, the machine wouldn't cut it properly and was making noises; the steel bar bent a bit until the machine ultimately cut through it at which stage it was his turn to use it. It was no part of his evidence that he had seen ITI Nicholson extracting the bar or dealing with a problem, as far as he was concerned there was no reason why he should not have used the machine.

54. He picked up a steel bar which he estimated was about two or two and half metres in length but otherwise had the same dimensions as the steel bar seen in the engineers' photographs being held into the machine by Mr Romnel except that he was able to hold the end of the bar he intended to cut with his right hand. He presented the bar to the cropper by pushing it with his right and guiding it with his left hand. There was no stop bar on the machine so he had to judge the length of steel that he wanted to cut by eye. Another prisoner, Mr. Ducie, was standing beside the machine; he helped the Plaintiff to judge the required length and saw him cut the first piece before turning to walk away just as the Plaintiff went to cut a second flat.

55. Once again, he needed to judge the required length by eye. He pushed the bar with his right hand guiding it with his left. He wasn't quite happy with the position and moved the bar towards the right-hand side of the opening to the cropper. Somehow his left hand got caught in the machine, possibly because of a steel splinter on the bar. He was shouting for help but nobody came. He knew from watching other prisoners that pressing one of the buttons on the control panel would turn off the machine so he tried to stop it by reaching over with his right hand. He did not see the emergency stop button but managed to push what he identified as a green button, there was no response; the next thing he knew was that the blade came down on his fingers.

56. The Plaintiff recalled that he ran from the machine screaming; there was blood coming from his fingers. Other prisoners came to his aid and wrapped his hand in a cloth. He was taken to the office where he was attended to by prison staff. He had very little memory of anything after that until he woke up in hospital. When he did so he noticed that he was wearing his industrial boots; he deduced that a member of the prison staff must have removed his runners and put on his boots before he was taken to hospital.

57. On his account, the accident involved a three-stage process, firstly his hand got caught, secondly, he called out for help which did not come and thirdly, the blade came down unexpectedly on his fingers.

Training; Safe use and operation of the GEKA; Instructions not to use the GEKA
58. The Plaintiff accepted that he had a good relationship with ITI Nicholson who had trained him in welding and had complimented him on the standard of his work, however, he rejected the suggestion that he had been fully trained and instructed in the use and operation of the cropping facility of the GEKA; he had never used the GEKA before the date of the accident. He had been trained in and had only carried out welding. He rejected the suggestion that he had been told that the machine was out of order or that he had not been instructed by ITI Nicholson not go near the machine nor did he accept that he had been assigned to and had been on sweeping duties that afternoon.

59. He rejected the suggestion that within a minute or so of ITI Nicholson going to his office to get an out of order tag that he had approached Officer Maher enquiring as to whether the machine was out of order or that he had been told by him that it was and that he wasn't to use it; if such evidence was given by Officer Maher then that was a lie because he had not seen Officer Maher in the workshop at any time before the accident. Nor did he accept that the accident happened within a few minutes of ITI Nicholson leaving the workshop; the Plaintiff's evidence was that he was gone 10 or 15 minutes.

Guarding and the Stop Bar
60. The Plaintiff confirmed that at the time of the accident the opening to the cropper was as shown by reference to engineering photographs, namely with the guide-guard removed but rejected any suggestion that he was responsible for its removal. He had not seen that done by anyone and had not been trained or instructed how to do so; the device wasn't something he had noticed one way or the other. He also rejected the suggestion that the stop bar, seen in photographs taken shortly after the accident by ITM Stack, was fitted to the machine at the time.

Position of hand

61. Whilst he accepted under cross examination that it was possible his left hand may have been palm upwards when the blade came down, his recollection was that it was palm downwards on the steel bar as demonstrated in the engineer's photographs. It was also put to him that no bar was found in the machine after the accident and that he was not cutting a piece of steel at all, suggestions which the Plaintiff also rejected.

62. I took it from these suggestions, from the nature of the damage caused to the glove which he was wearing and the explanation for the damage to the glove offered by Mr Romnel, that the accident had happened while the Plaintiff was doing something other than cutting a bar and that whatever he was doing it involved the accidental or deliberate placing of his hand into the cropper which he then activated.

63. In answer to a question from the Court, the Plaintiff said that when he finished manoeuvring the bar into the desired position his left hand was in the pathway of the blade; it was at that moment that 'his foot went on the pedal'.

Prison Officer Maher
64. Vincent Maher joined the prison service in 2004 and was serving in Wheatfield at the time of the accident. He had worked in different sections of the prison, including the metal workshop, from February 2008. He had experience as a class officer but had been assigned to the welding workshop at the time of the accident. His role was to assist ITI Nicholson and to supervise the prisoners both in relation to the security and course participation.

65. His duties involved assessing the fitness of prisoners to be let into the workshop; if a prisoner was unwell or was otherwise in what he described as "the right frame of mind" by which he meant 'strung out' or 'intoxicated', he would send the prisoner back to the landing. He had never had any issue in this regard the Plaintiff whom he described as well behaved and complicit with course requirements; he had seen the Plaintiff using the GEKA when attending his course.

66. With regard to the accident circumstances, his evidence was that the Plaintiff was assigned to sweeping duties. He chit chatted with the Plaintiff in the workshop, he seemed fine; he did not see the Plaintiff do anything in the workshop that afternoon other than perform sweeping duties. Shortly before the accident two other prisoners, Jonah Nay and Eoin McLoughlin, encountered a problem when using the GEKA. The steel bar they were trying to cut jammed in the machine. They tried to free the bar but were unable to remove it.

67. ITI Nicholson was called to deal with the situation; he eventually managed to free the bar by pulling it out through the back of the machine. [This was at variance with the evidence of ITI Nicholson who said that he had to push the bar out]. Having freed the bar ITI Nicholson turned off the power, engaged the isolation switch and pressed the emergency stop. He then informed prisoners in the vicinity of the machine, including prisoners Nay, McLoughlin and the Plaintiff that he was going to the office to get an out of order tag, that the machine was out of order and that it was not to be used by anyone.

68. Of some significance in relation to the issue concerning the circumstances of the accident was evidence given by Officer Maher to the effect that before he left to go to the office ITI Nicholson also instructed him that no-one was to use the machine, an instruction which ITI Nicholson mentions in his first statement and which was corrected in long hand to add Officer Maher's name.

69. Despite this instruction Officer Maher did not stay in the vicinity of the machine until ITI Nicholson returned with the tag; instead he left and proceeded to walk around the work and training area performing his supervisory duties. While doing so he remembered that there was a shortage of welding rods so he decided to go and collect these from the workshop store.

70. From his position in the work area at that point he had to pass the GEKA to get to the store which was only 40 to 50 paces away. As he approached he noticed that the Plaintiff was still in the vicinity of the machine; the Plaintiff asked him if there was something wrong with it, he replied there was, that it was out of order and that it wasn't to be used. The Plaintiff moved on and continued with his sweeping duties.

71. To the best of his recollection the guide-guard was still fixed in position on the machine at the time when he left to go to the store. He was in the process of collecting the welding rods when he heard a scream; this was the first inkling he had that something untoward had occurred. He had only left the Plaintiff a couple of minutes earlier.

72. Officer Maher was one of the officers who assisted the Plaintiff after the accident; he described the Plaintiff as being in terrible pain, in shock and shouting. The Plaintiff was calling for his mother and kept repeating that he was sorry and that he knew he shouldn't have been using the machine.

73. ITI Nicholson and ITM Stack gave evidence that they were in the office with the Plaintiff after the accident and had heard him repeatedly apologise to ITI Nicholson for going near the machine when he knew that he had been told not to do so. Given the Plaintiff's absence of memory in relation to what had happened in the office afterwards, the evidence of these witnesses as to what he may have said is uncontroverted.

Post-Accident Investigations into the Accident Circumstances
74. Shortly after the Plaintiff was taken to hospital, ITM Stack went back into the work and training area to ensure that the GEKA was safely decommissioned and cordoned off; in the process, he took a number of photographs which were proved in evidence. One of these photographs shows the guide-guard placed to one side of the opening; another shows the work piece stop bar fixed in position on the back of the machine.

75. As the person charged with responsibility for the oversight of the workshops in the prison, ITM Stack expected to be invited by the Governor to carry out an investigation into the accident circumstances, however, that task was entrusted instead to Chief Officer O'Connor. Later on, the day of the accident, ITI Nicholson attended a meeting with the Governor at which he was requested to make a statement. It was apparent that he was in a state of shock at the time so it was decided that he should be afforded a number of days leave to recover.

76. During the following weekend ITI Nicholson prepared a detailed statement which he submitted on return to work. In this statement ITI Nicholson outlined events material to causation and fault which occurred prior to as well as after the accident. He referred to a problem having been brought to his attention with the GEKA which he investigated and that having dealt with it he switched off the machine. He then instructed Officer Maher and those prisoners in the vicinity of the machine, including the Plaintiff, that it was out of order. He went to the office to collect an 'out of order' notice which he intended to attach to the machine.

77. Subsequent to the accident Officer Maher informed him that shortly after he had left to get the notice, the Plaintiff appeared to

be in contact with the machine; seeing this Officer Maher told him to stay away from it. Describing events in the office after the accident he referred to the Plaintiff repeatedly apologising to him saying *"I'm sorry Mr. Nicholson, you told me not to go near it".*

78. The Governor read this statement and having done so handed it back to ITI Nicholson with a request that he should submit a shorter statement; on his own evidence ITI Nicholson was given no indication or direction by the Governor as to what material in the first was to be omitted from the second statement.

79. Following his conversation with the Governor, ITI Nicholson spoke with Officer Maher. They discussed the accident circumstances. Questions concerning their possible role featured in the discussion which included consideration as to whether or not there was anything which either of them could have done to prevent the accident. On their evidence neither had any regrets about their actions; as far as they were concerned the entire responsibility for the accident lay with the Plaintiff.

80. ITI Nicholson prepared a shorter statement on his office computer in which he omitted all references to causation or liability. Officer Maher wrote his account on an official Witness Report Form in which he made a statement in almost identical terms to that of the short statement prepared by ITI Nicholson.

81. The explanation for the almost identical wording between the two statements was that Officer Maher had sight of ITI Nicholson's statement or had access to the computer on which it had been prepared when he was writing his own account, something which, in my view, most likely explains why Officer Maher also omitted any reference to the relevant information referred to on the reverse side of the form and to which his attention had been drawn by the wording on the face of the form.

82. Its seems extraordinary, notwithstanding his responsibility for general oversight of the workshops, his attendance on the Plaintiff immediately after the accident and his inspection of the accident scene, at which he took photographs, that ITM Stack was not invited to make a statement in connection with the investigation being carried out by Chief Officer O'Connor although he did make a post investigation statement addressed to the Governor in connection with the claim following a request on behalf of the State Claims Agency in which he referred to the remarks made by the Plaintiff in the office in the immediate aftermath of the accident.

83. No satisfactory explanation was proffered to the Court as to why ITI Nicholson's first statement was not considered acceptable by the Governor or why he had been requested to submit a shorter statement, nor was ITI Nicholson himself in a position to assist the Court when invited to do so as to why he decided, in the absence of any request or direction by the Governor, to omit any reference in the second statement to matters which concerned questions of causation or liability either before or after the accident, omissions which were also made by Officer Maher for the reasons already mentioned.

84. By the time of the trial, ITM Stack had been promoted to the rank of Assistant Governor. Acting in that capacity his evidence was that in the context of an investigation into a serious accident as much detail as possible was desirable and ought to be provided. He had not been involved in the investigation of the accident and could not comment or offer an explanation as to why a shorter statement material to the investigation was requested from ITI Nicholson or why he had not been invited to conduct it or had not been invited to make a statement for that purpose. Neither the Governor nor Chief O'Connor gave evidence in relation to any of these matters or otherwise.

85. I pause to observe that ITI Nicholson subsequently made a third statement which was not seen by the Court, objection to the admission of which was taken by the Plaintiff on the grounds that it contained hearsay evidence.

86. The short statements made by ITI Nicholson and Officer Maher were confined to how each first became aware of the accident, how they went to the aid of the Plaintiff, how they noticed he had sustained a serious injury to the fingers of his left hand and that he was screaming, and how they and others were involved in obtaining medical assistance for the Plaintiff before he was removed to hospital.

87. Although both statements make reference to the fact that the Plaintiff was screaming significantly, neither makes any reference to what, on their evidence, was a repeated apology in the office. The second statement of ITI Nicholson and the statement of Officer Maher are bereft of the detail given in their evidence touching on questions of causation, liability and fault.

88. ITI Nicholson invited the Court to take account of his first statement on the basis that this was made voluntarily and contained information which he wanted to give notwithstanding his inability to offer an explanation as to why, when preparing the second statement, he had decided to omit any facts concerning these issues other than that the statement was to be confined to the bare facts of what had happened.

89. The acceptance by Officer Maher that his statement followed a discussion with ITI Nicholson, which included consideration of their respective roles in connection with the cause of the accident, and that it had been written with the benefit of access to ITI Nicholson's statement was only extracted after a lengthy and detailed cross examination.

90. In circumstances where the Governor handed back a statement which contained detailed information potentially relevant to matters of causation, liability and fault with a request that a shorter statement should be submitted, where he and or Chief Officer O'Connor subsequently received and accepted statements bereft of any detail in relation to such issues and where notwithstanding his role ITM Stack was not invited to make a statement for the purposes of the investigation into what was by then the most serious accident which had occurred since the establishment of the prison, serious questions arise as to the nature and purpose of the investigation undertaken by Chief Officer O'Connor, particularly with regard to responsibility.

91. Whether liability was investigated or considered at all and, if so, whether or not and how any conclusion was reached or was to be reached in the absence of detailed information from the witnesses concerned relevant to that issue which they had to offer and why such information and detail was apparently not required, is unknown to the Court.

Conclusion in relation to post accident investigations

92. In relation to these matters suffice it to say that with particular regard to the circumstances immediately preceding and following the accident as may have a bearing on questions of causation, liability and fault, the Court was left with the distinct impression that in meeting a likely claim of significant potential there was an almost immediate realisation that the system of work adopted by the IPS for the health and safety of prisoners undertaking courses in the prison workshops would be called into question and that this resulted in an approach to the defence of the claim which might euphemistically be described as a 'circling of the wagons'.

93. While I accept the Defendant's submission that the circumstances of and surrounding the making of statements by ITI Nicholson and Officer Maher in particular are not relevant to the cause of the accident, in my judgement they are relevant in relation to the

assessment of the probative value of the evidence given by them, particularly concerning events which are said to have occurred immediately before, at the time of and immediately after the accident. For these and the foregoing reasons the Court is warranted in approaching such evidence with circumspection.

Conclusions; Assessment of the Plaintiff
94. Written and oral submissions, which it is not intended to summarise, were made on behalf of the parties and have been read and considered by the Court. That the Plaintiff experiences and has experienced memory difficulties was readily apparent from his evidence and the way in which that was given, difficulties which may be attributable one suspects, at least in part, to his drug addiction.

95. Whatever the reason certain aspects of the Plaintiff's evidence were variously inconsistent, inaccurate or contradictory; he did not impress me as a witness on whose evidence alone the Court could rely, nevertheless, this view has to be tempered not only because of his genuine memory difficulties but also by virtue of his acceptance when the record was put to him in respect of some though not all facts material to his claim that he was either mistaken, could not remember or was wrong.

96. This observation is particularly pertinent in circumstances where the Defendants have called his credibility into question and have invited the Court to dismiss these proceedings on a number of grounds not the least of which is that he intentionally misled the Court and others acting or retained on his behalf in relation to matters fundamental to his claim.

97. The onus of proof in this regard rests with the Defendants. Having had an opportunity to observe his demeanour as he gave his evidence I am not satisfied that the Plaintiff intentionally set out to mislead the experts to whom he spoke or this Court especially when, as they must be, the obvious deficiencies in his memory, educational and social background circumstances are taken into account.

98. By way of example the Plaintiff had no recollection of seeing the videos or of undergoing induction training but accepted that he had been provided with his own PPE and locker, that he had been spoken to individually at occasion when he sought admission to the workshop, that he had been assigned and had undertaken welding work and that he had been complimented on the quality of his work by ITI Nicholson, however, he did not accept that he had received any training or instruction in the safe use and operation of the GEKA, insisting that he had only ever undertaken welding. Although he had seen a steel bar jamming in the machine shortly before he went to use it he had no recollection of seeing ITM Nicholson freeing the bar.

99. ITI Nicholson's evidence was that the Plaintiff had an average attendance on the course, which he estimated at between 50 and 70%, before going absent on what transpired to be medical grounds. Induction was carried out in accordance with procedures which included viewing of safety videos and DVDs. Manual handling training was given by ITM Stack and the Plaintiff was trained in basic welding moreover, he had been fully instructed, trained and supervised in the safe use and operation of the GEKA. I accept this evidence and the record of the Plaintiff's attendance on the course, such as it is.

Conclusion on training in the use and operation of the GEKA cropping facility
100. On my view of the evidence, given the level and the percentage attendance over the period, it is highly improbable that the Plaintiff would not have been instructed in the safe use and operation of the cropping facility of the GEKA particularly as use of this facility was an integral part in producing the materials required for his own welding work.

101. It has to be recalled that the purpose of this course was not just to up skill but was ultimately to give the Plaintiff a practical qualification that he could utilise vocationally on release from prison. It follows that the Court does not accept that the Plaintiff's source of knowledge in relation to the use and operation of the cropping facility was confined to watching other prisoners, something which he undoubtedly did, but rather arose as a result of information, training and use of that facility received and undertaken by him under the supervision of ITI Nicholson. I accept his evidence and find that the Plaintiff was cooperative, understood and carried out instructions and training given without issue. If it had been switched off in the way described by ITI Nicholson, it is highly unlikely that the Plaintiff or, if not him, another prisoner would have known how to restart the GEKA without having received proper instructions and training on how to so. Furthermore, I am satisfied that whether or not the Plaintiff was assigned sweeping duties on the afternoon he was entitled to use the GEKA without obtaining permission to do so.

Effect of Methadone/Illicit Drugs.
102. It is common case and agreed between Dr. Sean O'Domhnaill, Consultant Psychiatrist and Psychotherapist who prepared a report and gave evidence on behalf of the Plaintiff and Dr. Mike Scully, Consultant Psychiatrist, who prepared a report and gave evidence on behalf of the Defendants, that had a urine sample been taken from the Plaintiff on or about the date of the accident, it would likely have tested positive for all or some of the illicit drugs identified in the tests of urine samples taken before and subsequent to the accident, however, there was a material disagreement between these experts as to whether the dose of methadone prescribed to the Plaintiff on the morning of the accident alone or in combination with other illicit drugs which were likely to have been in his system would have had a material impact on his cognitive functions and psychomotor performance.

103. Dr O' Domhnaill's evidence was that the Plaintiff would not have been stabilised, that his performance and cognitive functions would have been affected and for the reasons given that he would have been prone to acting impulsively, views which were not shared by Dr Scully.

104. It is not surprising that the sedatary effects of prescribed medication or illicit drugs alone or in combination can be contra indicators not just for activities such as flying or driving but also for the use of dangerous equipment, plant or machinery.

105. The Plaintiff accepted, when the record was put to him, that he was mistaken about the accuracy of information which he gave Dr. O'Domhnaill concerning the date on which he had commenced the methadone programme, the dosage amounts administered and the intervals between dosage increases. It is clear from the report which he prepared that Dr O'Domhaill relied on the accuracy of the information given to him in the preparation of his report and in giving his opinion, nevertheless, for reasons which he explained, he gave very particular and detailed evidence as to why his opinion remained unaltered.

106. Whilst in his view the Plaintiff would have been able to understand instructions and would have been able to perform basic chores such as sweeping or cleaning or the simpler aspects of manual vocations such as gardening, his tendency towards impulsive behaviour and the effects of the medication on the cognitive functioning and psychomotor performance would have been such that he should not have been let near, let alone use any dangerous equipment or machinery.

107. There was a considerable disagreement between Dr. O'Domhnaill and Dr. Scully as to what constituted 'stabilisation' of patients on a methadone programme though they were agreed that one of the purposes was to assist the patient to fight or resist addiction

and in the process to be able to function and lead as normal a life as possible including going to work and carrying out the daily activities of living performed by those in society not affected by addiction, tasks which include driving.

108. In the opinion of Dr. Scully 'stabilisation' of the patient on a given dose of methadone from a pharmacokinetic point of view is generally achieved, depending on the individual, between ten and fourteen days from commencement of that dose. Dr. O'Domhnaill did not agree and considered that 'stabilisation' would not have taken place within such a short time frame, two months was not unusual and there were patients whom he knew of who had not stabilised after years.

109. Dr. Scully's evidence was that the pharmacokinetics involved was not a matter of opinion but of medical science. The Plaintiff's dose had been increased to 60 ml on the 4th November; there was no doubt that by the date of the accident he would have been pharmacologically stabilised, indeed well before that date. He accepted that stabilisation is also understood in a wider sense involving associated outcomes with treatment and in his view; this was the sense and the context in which the term was used by Dr. O'Domhnaill.

110. In passing I note that the Plaintiff was also examined and reported upon by Dr. Burns, Consultant Psychiatrist, who prepared a report made available to the Court dated 15th July, 2014, in which he recorded the Plaintiff advising that the dose of methadone being taken at the time of the accident was 80 ml per day. This information is factually incorrect; if it were correct the Plaintiff was at a significantly increased risk of impaired attention, perception and psychomotor responses.

111. Particularly having regard to the Plaintiff's background of drug abuse and previous methadone treatment, which was a significant factor to be taken into account in terms of tolerance, Dr Scully's opinion was that neuroadaptation would have occurred in the Plaintiff's case not later than 14 days after the increase in the dose to 60 ml on the 4th November, accordingly, methadone was unlikely to be the cause of any sedation manifesting in sleepiness or drowsiness or otherwise, moreover, in this case there was no evidence of a pharmacodynamic interaction between the maintenance dose of methadone at 60 ml and whatever illicit drugs the Plaintiff may have been taking at that time, some of which he explained would not interact with methadone in any event.

112. I think it pertinent to observe at this juncture that from the time of the accident until the Plaintiff's present solicitors took over carriage of these proceedings in 2013 there is no mention in the pleadings or medical records, reports or elsewhere in the materials available to the Court, nor was any mention made by the Plaintiff at the joint engineering inspection carried out on 13th February, 2009, that methadone and/or drugs were possibly implicated in the cause of the accident; accordingly, while his evidence was otherwise, it may reasonably be inferred that the Plaintiff did not himself consider such had any role to play at that time; he was not on his own in that regard.

113. Methadone and in particular increasing the dose is potentially dangerous for the patient especially other illicit drugs are also being used; there is a risk of an overdose or even death. It follows that treatment invariably commences at a low level. The dose is increased, generally by 10 ml over a period of time until a dose is reached which has the effect of attenuating symptoms of withdrawal, usually achieved between 50 and 60mls. The Plaintiff was still experiencing some symptoms when reviewed on the 4th November so his dose was increased to 60mls, which suggests that in so far as he was using illicit drugs then such were insufficient to prevent symptoms of withdrawal about which he was complaining at that time.

114. Against this background it is hardly surprising that when a prisoner attends the methadone clinic/dispensary in the prison they are assessed individually with a view to determining whether it is safe to administer the dose prescribed. A prisoner showing signs of intoxication or of being strung out resulted in the administration of the dose being delayed or reduced as appropriate. Where administration takes place the prisoner's consumption is monitored, the prisoner is required to swallow and then speak in order to ensure the dose has been ingested.

115. As already stated, it was IPS policy that any prisoner showing signs of sedation, intoxication or of being strung out is not permitted to enter the workshop. The Plaintiff spoke with and was assessed by ITI Nicholson before he was admitted on the afternoon of the accident. Assessment of prisoners is understandable on a number of grounds not the least of which is that permitting a prisoner exhibiting signs of sedation, intoxication, or of being strung out on drugs to a workshop containing dangerous equipment and machinery would be foolhardy in the extreme, constituting as it would a risk of injury to themselves and others.

116. It was submitted on behalf of the Plaintiff that as he did not want to attend the workshop and as the methadone had made him sleepy that morning and that he was tired he should not have been required to go down to the workshop and should not have been permitted to enter it or undertake work there with dangerous machines; the fact that he was permitted to do so was negligent and a breach of statutory duty.

117. Evidence was also given on behalf of the Plaintiff by a former UK Prison Governor, Mr Roger Outram. He was nothing short of condemnatory of a prison policy which permitted known drug abusing prisoners to operate dangerous machinery in a prison workshop, an opinion apparently founded upon his own attitude towards drug addicts and upon the premise that the Plaintiff had just taken methadone.

118. From his experience prisoners on regular doses are usually irrational, irresponsible, and vacant, "*you can see it in their eyes*"; he would not have allowed prisoners thus affected to work on a typewriter never mind machinery; giving them instructions was like "*telling a three-year-old not to eat cake*", the place for them was in their cell.

119. Referring to the Plaintiff's participation in the workshop course his opinion was that the Plaintiff wasn't competent because he was illiterate and an addict, he was unable to think in a cohesive and comprehensive way, a view he held of drug takers generally; as a Governor his evidence was that "*...I'd neither the time nor the enthusiasm for weeding out the one or two that might be competent to work in that sort of arena*", and of the Plaintiff he "*wouldn't have put him in a knitting room*", he was untrained irresponsible and useless, terms which, in fairness, he went out of his way to point out were not intended to be offensive to the Plaintiff.

120. With regard to supervision of prisoners in general, his opinion was that they had to be supervised at all times and that the work and training area of the work shop should never have been left unsupervised even for a short time; there were obvious security as well as health and safety reasons.

Conclusion on the effect of Methadone/Illicit Drugs

121. I accept the evidence offered on behalf of the Defendants that a prisoner who presents to a workshop exhibiting signs of being unwell or of being inebriated in any form would be refused entry and would ultimately be returned to his cell by a class officer, accordingly, the Court finds that as the Plaintiff was admitted to the welding workshop following a conversation with ITI Nicholson it

is highly unlikely that he was exhibiting any such signs at the time.

122. Similarly, it being accepted that the Plaintiff took his dose of methadone that morning, most likely between 10 and 10.30 am, the Court finds that there were no contraindications apparent to the dispensary nurse when the Plaintiff presented himself for and was administered the prescribed dose of his medication.

123. Turning to the conflict on the medical evidence, the Court was urged to prefer the evidence of Dr O'Domhaill not just because of his vast knowledge and experience in the area concerned, and about which there is no doubt, but also because, unlike Dr Scully who was contracted by the Defendants, because he was a truly independent expert called to assist the Court.

124. With regard to making a decision on the particular issue under consideration the Court is in my view entitled, indeed, must take into account the fact that Dr. Scully's contract was to provide professional medical services to prisoners in Wheatfield and as such that he was responsible for the medical health welfare and any necessary medical treatment required by them.

125. In the particular circumstances of this case I consider it particularly significant that Dr Scully clinically assessed and treated the Plaintiff prior to this accident in the knowledge that the Plaintiff, like other prisoners in his care, was attending work and training facilities in the prison. From their evidence and the way in which they gave it, I am quite satisfied that both he and Dr O'Domhaill are conscientious and caring physicians and that had Dr Scully, as the treating physician, any concerns about the medical capacity of the Plaintiff to attend and participate in the welding workshop at any time he would have raised and acted on those concerns, there is no evidence of such.

126. Accordingly, in so far as there is a difference of opinion between them, the Court is entitled to prefer and accept the evidence given on this issue by Dr. Scully. It follows and the Court finds that the administration of methadone alone and or in combination with other illicit substances which may likely have been ingested by the Plaintiff played no material role in the cause of the accident.

127. Whatever the policy towards prisoners such as the Plaintiff may have been in the United Kingdom when Mr Outram was a Governor, having regard to the foregoing conclusions, to the duties of this State towards prisoners and the policy of facilitating rehabilitation which has long since been adopted, I regret but feel compelled to say that I found his evidence to be of limited, if any, assistance.

128. On my view of the evidence it was laudable that the State, through the IPS, should attempt to offer the kind of rehabilitation facilities provided in Wheatfield, furthermore, I am satisfied and find that there was no good reason why the Plaintiff should not have been admitted to the workshop on the day for the purpose of attending all aspects of the course to which he had signed up, and this irrespective of the duties to which he may have been assigned.

Conclusion on the Accident

129. Prisoners are instructed in the use and operation of the cropping facility so that they cut steel bars into sections which they use for welding. Once a prisoner has satisfied ITI Nicholson as to his competency in the safe use and operation of the cropping facility of the GEKA, the prisoner was free to use the machine without seeking permission although it was usual for prisoners to advise ITI Nicholson of their intention to do so; his evidence if a prisoner failed to advise him would not result in a reprimand.

130. Having regard to the nature of the problem which developed when prisoners Nay and McLoughlin were using the cropping facility attributable to a bluntness of blades, subsequently confirmed and dealt with by Listers in January, 2009 and which resulted in the bar which they were attempting to cut becoming jammed, it is probable that ITI Nicholson's attention would have been drawn to the problem and that he would have responded by dealing with it in the way described. I accept his in this regard. I also accept his evidence corroborated by the evidence of Officer Maher that prisoners in the vicinity of the machine, including prisoners Nay and McLoughlin were instructed to stay away from it, that he was going to the office to get an out of order tag and that before he left to do so he instructed Officer Maher that no one was to use the machine.

131. Although there were thirteen prisoners on courses in the welding shop that afternoon there is no evidence that any prisoners other than those in the immediate vicinity of the machine were told by ITI Nicholson that the machine was out of order and was not to be used. The fact that he did not inform other prisoners of the problem and that he knew trained prisoners could use and operate the cropping facility without seeking permission is consistent with the realisation on his part that in his absence a prisoner who had not heard his instruction might attempt to use the machine; this is also consistent with his instruction to Officer Maher that the machine was not to be used. I am also satisfied and find that Officer Maher was present in the workshop on the afternoon of the accident.

132. The Plaintiff denied that he was in the vicinity of the machine when ITI gave the instruction. Unless the Plaintiff was present at the time he, like other prisoners in the workshop who were not in the vicinity, would have been unaware that the machine was not to be used. When ITI Nicholson left the work and training area to go to his office I have little doubt that he and Officer Maher did not expect, if they considered it at all, that the time involved in getting the tag would have been more than a few minutes. Coincidentally with his arrival in the office the phone rang, it was Governor Walsh with whom ITI Nicholson then had a conversation.

133. ITI Nicholson having left to get the tag, Officer Maher proceeded to walk around the workshop performing supervisory duties. While doing so he decided to go into the store room to get some welding rods, something which I am satisfied was not then an essential task. Why Officer Maher left the GEKA notwithstanding the express instruction given to him that no one was to go near or use the machine was never satisfactorily explained.

134. Nevertheless, I am satisfied and find that whatever the reason, had Officer Maher remained at or near the machine it is probable to the point of near certainty that the accident could not and would not have occurred. Whatever about his ability to give effect to the instruction had he remained at or near the machine, once he left the work and training area and went into the workshop store the instruction could not have been implemented, moreover, the work and training area was then left unsupervised.

135. In the circumstances reliance on the IPS policy of establishing trust between prisoners and staff was clearly ill-advised in the circumstances. ITI Nicholson and Officer Maher were aware that some of the prisoners would not have heard the instruction and that any trained prisoner unaware of the problem might attempt to use the GEKA when both were away.

Did the Plaintiff get an instruction not to go near or use the machine?

136. Whether the Plaintiff was present in the vicinity of the machine when ITI Nicholson gave his instructions is at one level critical since, irrespective of what Officer Maher did thereafter, had the Plaintiff been present he would have been aware that the machine was out of order and that it was not to be used. The Plaintiff accepted that had he heard such an instruction he would have obeyed

it as he had done at all times previously. His evidence was that he wasn't present and hadn't heard it.

137. This would be consistent with Officer Maher's evidence that the Plaintiff asked him whether there was something wrong with the machine, an unlikely enquiry if he already knew that to be so. Whether or not any such conversation took place between the Plaintiff and Officer Maher is in question; for the following reasons, I am not satisfied that it did.

138. It is quite clear that ITI Nicholson and Officer Maher discussed the circumstances of and surrounding this accident prior to the making of their official statements and that their discussion centred in part around whether there was anything either or both of them could have done or should have done in order to have prevented the accident. The evidence concerning that conversation given by Officer Maher was that ITI Nicholson told him that there was nothing more he could have done as he had given instructions to the Plaintiff which he had acknowledged that he understood them.

139. The evidence in this regard is, in my view, entirely self-serving. It is clear that ITI Nicholson had given an express instruction to Officer Maher to make sure that no one used the machine in circumstances where prisoners in the work shop other than those in the immediate vicinity of the machine would have been unaware that there was anything wrong with it.

140. It would have been a reasonable assumption by both men that the investigation into the accident circumstances would likely touch on how the accident occurred in circumstances where Officer Maher had been instructed to make sure that nobody used the machine. The fact that Officer Maher and ITI Nicholson corroborated each other's account in this regard does not determine the outcome.

141. Absent an operative interlock on the machine, the only way in which its use and operation could have been prevented once ITI Nicholson left the workshop was for Officer Maher to stay by or remain in the vicinity of the machine until the ITI returned; he did not do so. In the context of an investigation into the accident it is highly likely that both of these witnesses would have appreciated that the absence of an instruction to the Plaintiff would, putting it mildly, be problematic.

142. Finally, the Plaintiff was described by ITI Nicholson as being cooperative in every respect, a man who did his work well, gave no reason for concern and as he put it was 'no bother'. The Plaintiff fairly accepted that if he had been given an instruction he would have had to follow it and that he would have done so. There was no evidence or any suggestion that the Plaintiff was not fully cooperative and compliant with the instructions which had been given to him previously while attending the course.143. Furthermore, on the evidence of ITM Stack it is likely that if the Plaintiff was seen by other prisoners doing something wrong it is likely that they would have intervened to stop him, behaviour which ITM Stack described as "self-policing" and this apart altogether from the consequences for the Plaintiff or any prisoner if seen to transgress by those supervising him.

Conclusion on whether the Plaintiff received instructions not to go near the GEKA
144. The prisoners knew that engaging in an unauthorised activity, particularly anything dangerous, would have negative consequences, including prohibition from further attendance on the course, accordingly, and having regard to the Plaintiff's profile presented both by Officer Maher and ITI Nicholson as a willing and cooperative prisoner up until the day of the accident as well as the negative consequences for him for any disobedience, it is in my judgment highly unlikely that he would have disobeyed an express instruction not to go near or use the machine and the Court so finds.

145. In coming to this conclusion, I have not overlooked the evidence of Officer Maher, ITI Nicholson and Assistant Governor Stack that when they attended the Plaintiff in the office shortly after the accident he repeatedly apologised for having gone near the machine when knew that he ought not to have done so. It is common case that the Plaintiff was in excruciating pain and in shock after what happened to him; it is not surprising in the circumstances that he has very little recollection of post-accident events until he woke up in hospital. It follows that the evidence of these witnesses is uncontroverted.

146. However, a conclusion that his remarks are consistent only with having received an instruction to that effect does not necessarily follow; such remarks are also consistent, and on my view of the evidence, are more likely attributable to the training and instructions on the safe use and operation of the machine given to him so recently by ITI Nicholson.

Responsibility for removal of the Guide-Guard
147. It is common case that the guide guard had been removed shortly before the accident and had been placed to the side of the cropper opening as seen in the photographs taken soon after the accident by Assistant Governor Stack. In such a position, the guide guard and the cropper blades would have been visible to anybody, including the Plaintiff, approaching the machine. It is hardly surprising, having regard to his instructions and training, that the Plaintiff said in a shocked and agonised state that he knew he ought not to have been near or using the GEKA. However, there was nothing in his remarks, described as an apology to ITI Nicholson, that he had removed the guide-guard.

148. Apart altogether from an adjustment to the guide guard in order to free the steel flat which had jammed when the GEKA was being used by prisoners Nay and McLoughlin, it appears that the only way to properly ascertain and deal with the problem which had caused that difficulty was to remove the guide guard; the only people authorised to do that were ITI Nicholson and Lister's service engineer. I am satisfied that unauthorised removal of the guide guard by a prisoner would have resulted in very negative consequences for him including not being permitted to attend further in a workshop or continue on a course. Furthermore, I have little doubt that prisoners, including the Plaintiff, would have been aware of such consequences for the reasons explained by Assistant Governor Stack.

149. Although I am satisfied that he had a perfectly good reason to do so, ITI Nicholson denied that it was he who removed the guide guard which if true begs the question as to whether it was the Plaintiff. As to that I seems to me to be highly improbable that from the time he entered the workshop to commence his welding course until the date of the accident that the Plaintiff saw the guide guard being removed from the machine, indeed, Officer Maher was not sure that he had ever seen the guide guard-removed or the machine without the guard.

150. On the evidence of ITI Nicholson there is no room to doubt that the prisoners were forbidden to interfere with the guide-guard in any way. Whilst it may have been adjusted by him in the course of training prisoners so that they could understand its purpose and could visualise the cropping blades, removal was not demonstrated in the course of training.

Conclusion on removal of the Guide-Guard
151. For all these reasons, I accept the Plaintiff's evidence and find that he had not seen the guide-guard being removed and had not been instructed or trained how to do so. Consequently, the Court finds, as a matter of probability, that whoever was responsible for the removal of the guide-guard, it was not the Plaintiff.

Statutory Requirements – Guarding.
152. It was agreed between the parties that the provisions of the Safety, Health and Welfare at Work Act, 2005 (the 2005 Act) and the provisions of the Safety, Health and Welfare (General Applications) Regulations, 2007 (the 2007 Regulations) apply to the workshops in the prison. There was a safety statement in force at the time of the accident which predated the relevant legislation. Section 22.16 of that Safety Statement dealt with hazards presented by machinery; the risk rating was specified as being high. Control measures required, amongst other things, that all machinery used was to conform to the appropriate legislation and machinery safety standards such as BS 5304 (Code of Practice for Safety of Machinery). Machine guarding was also to comply with the requirements under the fifth schedule of the Safety, Health and Welfare at Work (General Applications) Regulations, 1993. These regulations were repealed by the 2007 Regulations.

153. Section 22.16 of the Safety Statement also made references to a number of regulations, including the European Communities (Machinery) Regulations, 1994 and IPS safety standards which included a General Metal Workshop Standard known as "MS1".

154. Section 16 of the Safety Statement provided for standard operating procedures and safety standards. Some 41 different types of activity and equipment is specified but there is no standard operating procedure for the GEKA. Following the coming into force of the 2005 Act, a safety management system approach to risk management throughout the entire prison service was undertaken and was ongoing at the time of the accident by which stage the 2007 Regulations had come into force. The risk assessment review process relevant to the GEKA and other machinery commenced in September, 2008; a machine specific risk assessment of the GEKA was issued on the 16th June, 2009, this clearly post-dates the accident. Mr. Tennyson was particularly critical of the hazard identification and purported risk assessment provided at s. 22.6 of the Safety Statement 2003, describing it as generic and insufficient.

155. MS1 is a safety standard for the metal workshops in the Prison Service. Amongst its many provisions is a requirement that where unauthorised use of machines is possible, all machines should have lock start controls. Although the GEKA appears to have been manufactured and supplied around 1989 it was fitted with a lock start control in the form of a device around the isolator switch designed to accept a padlock. On the defence evidence this device was not utilised either by ITI Nicholson or by Listers when servicing the machine. A post-accident protocol requires utilisation of a lockout system when the guard is removed from the machine.

156. MS1 also provided that where machinery could not be protected by a fixed guard there was a requirement for a locking device which prevents the machinery from being started unless the guard is in position and ensures that the guard cannot be opened until the machine has come to rest.

157. The guide guard is not a fixed guard; there was no interlocking device which would isolate power from the cropper blades on removal of the guide-guard, however, utilisation of the lockout device by a padlock prevents the machine from being restarted. I am satisfied and the Court finds that had this device been utilised on the day the accident could not and would not have occurred.

158. Mr. Tennyson was particularly critical of the guide guard; it was easily removable and the machine could then be operated without it being in place, something which was highly dangerous. He suggested that instead of knurls designed to be turned by hand in order to remove the guide-guard there ought to have been hexagonal nuts requiring the use of a tool.

159. Regulations 33 and 34 of the 2007 Regulations Safety are concerned with guard protection devices and connection to energy sources. Regulation 33(c) requires an employer to ensure that "*where there is a risk of physical contact with moving parts of work equipment which could lead to accidents, those parts are provided with guards or protection devices to prevent access to danger zones or to halt movement of dangerous parts before the danger zones are reached.* Subparagraph (f) provides:

> *(i) "guards and protection devices where required under subparagraph (e)—*
>
> *(ii) are of robust construction,*
>
> *(iii) do not give rise to any additional hazard,*
>
> *(iv) are not easily removed or rendered inoperative,*
>
> *(v) are situated at sufficient distance from the danger zone,*
>
> *(vi) do not restrict more than necessary the view of the operating cycle of the equipment,*
>
> *(vii) allow operations necessary to fit or replace parts, and restrict access for maintenance work only to the area where the work is to be carried out, if possible, without removal of the guard or protection device.*
>
> *(viii) warning devices on work equipment are unambiguous easily perceived and understood."*

160. Mr. Tennyson criticised the warning devices on the machine as being inadequate in this regard and were, in essence, useless to somebody who, like the Plaintiff, was illiterate. When properly adjusted the guide guard prevents any part of the operator's hand from reaching or touching the shear blades, however, on any view of the evidence the guide guard was easily removed and rendered inoperative.

161. Regulation 34 requires an employer to ensure that:

> *(i) "all work equipment is fitted with clearly identifiable means to isolate it from all its energy sources, and the reconnecting of the work equipment to its energy sources poses no risk to the employees concerned."*

162. It is clear from the evidence that the machine was fitted with a clearly identifiable device to isolate it from its energy source by use of a padlock but this was not utilised.

163. It was submitted on behalf of the Defendants, relying on the decision of this Court in *Saleh v. Moyvalley Meats (Ireland) Ltd* [2015] IEHC 762, that the adoption of a lockout system post-accident is not of any great relevance to determining whether or not there was negligence at the time of the accident. This decision follows a long line of authority even antedating the Factories Act 1955. See *Christie v. Odeon (Ireland) Ltd* [1957] 91 ILTR 25 where at para. 29 Kingsmill Moore J. stated:

> *"It is of little avail to show, after an accident has happened, that such and such a precaution might in the*

circumstances have avoided a particular accident. The matter must be considered as it would have appeared to a reasonable and prudent man before the accident."

164. In my judgment, the pre-accident practice of not utilising the lockout device by fitting a padlock when the guard was removed for servicing or other reasons provides no excuse or defence in law to an allegation of negligence and breach of statutory duty in circumstances where the manufacturer and/or supplier of the GEKA provided a device the purpose of which was largely if not wholly concerned with the health and safety of those using, operating or servicing the machine.

165. The adoption of a lockout protocol post-accident is not, in the circumstances of this case one of being wise after the event. On the contrary, the GEKA was supplied with a lockout safety device the utilisation of which was obviously required of those responsible for the safe use and operation of the machine; it was folly to permit a practice which rendered it nugatory. See *Bradley v. CIE* [1976] I.R. 217. Although there was an isolation device in ITI Nicholson's office which, if activated, would have prevented the machine from being restarted and operated, this was not utilised most likely because doing so would have resulted in a simultaneous shutting down of power to other machines dependant on power in the workshop.

Conclusion on Breach of Statutory duty

166. If an accident occurred in the way manner and circumstances contended for by the Plaintiff I am satisfied having regard to the reasons given and the findings made that there was a breach of statutory on the part of the 1st, 2nd and 3rd Defendants in failing to comply with the provisions of the 2005 Act with regard to requirements relating the provision of a Safety Statement and Risk Assessment under that Act and with regard to the duties owed to the Plaintiff and the 2007 Regulations, in particular regulations 33 and 34. However, as stated earlier in this judgement, the fundamental question in controversy between the parties which goes to the very core of the case made by the Plaintiff concerns the circumstances of the accident, in particular the way and manner in which the Plaintiff says that it occurred. The law requires the Plaintiff to establish, on the balance of probabilities, the case which he makes against the Defendants at the centre of which is the description of an accident which has given rise to the injuries and loss in respect of which he seeks to recover damages from the Defendants.

A deliberate or accidental happening?; presence of a steel bar and position of the hand; Conclusion.

167. In the absence of finding a steel flat in or on the machine immediately after the accident and having regard to the opinion of Mr. Romnel following the results of a number of reconstruction tests carried out by him that the Plaintiff's hand was palm upwards and that there was no steel bar at the time of the accident it was submitted on behalf of the Defendants that the Plaintiff had acted deliberately or with reckless disregard for his own safety. Accordingly, the Court should apply the doctrine *ex turpi causa non oritur actio* and they rely on the decision of this Court in *Anderson v. Cooke* [2005] IEHC 221. Although this defence was not raised specifically in the amended defence it was pleaded that the Plaintiff was the author of his own misfortune.

168. The Defendant's submission was largely based on the findings and opinion of Mr. Romnel but was also founded on evidence that no steel flat had been found on or in the machine in the aftermath of the accident. It is clear from the evidence led on behalf of the Defendants that apart altogether from prison staff, prisoners were also involved not only in being of assistance to the Plaintiff but generally with tidying up and shutting down activities in the workshop following the accident. Against that background it could not be safely concluded that there was no steel bar or that such was not being used by the Plaintiff when he sustained his injuries.

169. In regard to Mr. Romnel's reconstruction tests a number of observations are called for. The tests undertaken on the GEKA were carried out after the servicing of the blades post-accident; the service engineer was not called to give evidence as to the condition of the blades, particularly in relation to wear, as found immediately post-accident; the extent of wear on the respective blades is unknown. As to which of the blades actually performs or performed the cutting and therefore the resulting damage seen in the accident and test gloves is unascertained.

170. It is evident that the accident glove is severed in such a way that the glove material constituting the fingers of the glove remains attached to the hand section of the glove on the dorsal side only; it follows that if the Plaintiff's hand was resting on a steel bar or flat, as was his evidence, his four fingers could not have been amputated without the glove material being completely cut away on the dorsal side. The fact that the severed damage was seen to be on the palmer side which was replicated in a glove presented palm upwards in the second test carried out by Mr. Romnel led him to conclude that the Plaintiff's hand was most likely palm upwards at the time of the accident and not positioned palm downwards on top of a steel bar.

171. In test number one Mr. Romnel placed a glove on a steel bar palm downwards and positioned these securely, with the use of the guide-guard, into the cropping compartment. He executed the cropping operation which included cutting the steel bar. The glove was severed almost completely, something which had to have happened in order for the upper blade to make contact with and cut the steel bar beneath.

172. In his opinion, the fact that the dorsal side of the subject glove and the test number two glove still remained attached to the glove fingers was explained by the 0.7 millimetre gap set between the upper and lower blades into which that material was forced when the upper blade passed, an explanation which I accept. Whatever or however it happened, Mr. Rommel's opinion was that the accident did not occur in the way or manner described by the Plaintiff, namely with his hand positioned palm downwards on top of a steel bar when the cropping operation was activated.

173. Although Mr. Romnel tested a glove which was offered palm up without a steel bar being present beneath, a test on a glove palm downwards with a steel bar underneath was not carried out. However, it would appear highly likely for the same reasons given to explain the results of test number two that the remaining or catching material between the glove fingers and the glove hand on a test carried out with a glove palm downwards would be the same but with the remaining or connecting material of the glove being found on the palmer side, that material also being forced into the gap between the two blades.

174. A number of different explanations for the damage seen on the subject glove consistent with the Plaintiff's account of the accident were postulated by Mr. Tennyson; the Plaintiff's hand may have turned over or was not properly positioned on the steel bar or may have slipped off the bar from where his hand may have been positioned with the fingers protruding beyond the machine end of the bar. I accept Mr. Romnel's opinion that the clearance, even at the widest part between the blades in the cropper, would not permit the Plaintiff's hand to turn from a palm down to a palm upwards position with, as the Plaintiff put it, a steel bar in the machine. One of the explanations proffered by Mr. Tennyson to explain the almost complete severing damage to the palmer side of the accident glove was that this was indicative that the bottom/fixed blade had performed the cutting function with the upper blade being the blunt and acting rather like a clamp.

175. Whilst Mr. Rommel acknowledged that this explanation was theoretically possible, he considered it highly improbable. This was not a case where the top blade was blunt and the bottom blade was sharp; on the basis of the servicing documentation it was a

matter of probability that both blades were blunt. The bottom blade, which has four sharp surfaces, had to be reversed. The upper blade, which has only two sharp edges, was taken away for grinding and sharpening. If it was the case that only one of the blades had become blunt that would indicate a defect in the operation of the machine for which there was no evidence. The blades were intended to work together, consistent with the fact that both blades had to be dealt with in the post-accident service. 176. On my view of the evidence it is highly probable to the point of near certainty that whether the Plaintiff's hand was palm upwards or palm downwards, if the cropper blade was to make contact and cut the bar, which the Plaintiff says he was using, it would have been necessary for the blade to cut through the glove almost completely as demonstrated by the damage to the glove in test number one.

177. I accept the submissions made on behalf of the Defendants that the Court is not concerned with nor should it seek to resolve the issues between the parties by engaging in speculation. Insofar as the question as to the circumstances of the actual accident, in particular the way and manner in which it occurred is concerned, that like any other question of fact, has to be decided on the evidence.

178. On my view of the evidence the Plaintiff's account of what occurred in the moments before he suffered the amputation injuries to the four fingers of his left hand does not stand up to scrutiny. On the Plaintiff's account, Mr. Ducie, who attended Court over a number of days but did not give evidence, was present when the Plaintiff successfully executed the first cut from the steel bar; he then turned and had just begun to walk away when the accident occurred.

179. If the Plaintiff's hand had become jammed in some way in the machine as a result of which he tried to press buttons on the control panel and was shouting out for help one would have expected other prisoners, including Mr. Ducie, or Mr. Nicholson, who was in his office close by or Mr. Maher, who was in the store, to have heard and answered his call; the Plaintiff says nobody came. The response of prisoners and staff to the accident was almost immediate, I consider this aspect of the Plaintiff's account of what happened in the moments before the accident to have been unlikely and the Court so finds.

180. That any delay between the Plaintiff's hand being caught and the operation of the blade might be attributable to an uncovented stroke or to a defect in the foot pedal, which featured in earlier investigations, are was equally improbable; I accept Mr. Romnel's evidence that a definitive defect in the foot pedal or in the operation of the machine resulting in an uncovented stroke would be a very serious matter which would have to be dealt with to ensure the safe use and operation of the machine. There is no evidence of any post-accident remedial work carried to the machine concerning problems of that nature.

181. I found the Plaintiff's evidence concerning the absence of the back stop and the necessity of having to judge a length of steel bar to be cut by eye with the assistance of Mr. Ducie to be unconvincing and incorrect. No reason emanated from any of the evidence as to why it would have been necessary to remove the stop bar at the back of the machine. It was certainly not suggested to the Defence witnesses that after the accident they had refitted the bar and that Assistant Governor Stack had then photographed the machine with the bar in position.

182. This contrasts with the inference which the Plaintiff sought to have the Court draw from his evidence that he was wearing his PPE boots when he awoke in hospital after the accident notwithstanding that he had been admitted to the workshop wearing runners, the inference being that his footwear must have been changed by prison staff when he was unconscious. I am quite satisfied that the Plaintiff would not have been admitted to the workshop without wearing the required PPE, including his boots.

183. With regard to the Plaintiff's evidence that the backstop was missing, the Court finds that the position of the guide-guard to the side of the entrance to the cropper and the position of the back stop as shown on the photographs taken by Assistant Governor Stack shortly after the Plaintiff was taken to hospital represent the positioning of those items at the time of the accident; accordingly, I reject the Plaintiff's evidence that the back stop was missing.

184. The Plaintiff was very carefully cross examined as to the positioning of his hand on the bar at the moment when the accident took place. He was definitive that his gloved hand was on the bar palm downwards at the moment when the accident occurred. I am not overlooking the possibility discussed between Mr. Tennyson and the Court that the Plaintiff's hand may have been at the very end of the bar with the fingers extended at the moment when the machine was operated. However, on his account he had manoeuvred the bar into the desired position to cut a workable piece. If that were so the distal end of the bar would have been protruding out the back of the machine whereas it would have had to have been proximate to the blades given the location of the amputations.

185. Accepting Mr. Romnel's evidence as being a more likely explanation for the damage seen on the accident glove, if the Plaintiff's hand had simply slipped off a bar before or at the time when the cropper was operated the severed damage to the glove would most likely have been to the dorsal side. However, the damage to the accident glove is on the palmer side, furthermore, the damage to the accident glove and the positioning of the amputations is consistent with the Plaintiff's hand being straight rather than at an angle at the time when the blade descended.

186. For all these reasons, the Court finds that the Plaintiff's left hand was not resting on a steel bar at the time when he operated the machine and further finds that the Plaintiff's hand was palm upwards when the blade of the cropper descended, an action which resulted from his pressing the floor pedal.

Decision

187. Whatever the Plaintiff was doing and whether or not that involved a deliberate act, the Plaintiff has failed to satisfy the Court on the balance of probabilities that the accident occurred in the way, manner and circumstances described in evidence. Accordingly, having failed to discharge the onus of proof cast upon, the Court is required to dismiss his claim and will so order.

188. I have read the medical reports which were admitted in evidence and prepared on the Plaintiff's behalf. As stated at the outset, there is no doubt that the Plaintiff has suffered very serious and permanent injuries which have affected him psychologically as well as physically. However, having regard to the findings made and the conclusions reached an assessment of damages in respect of these injuries does not fall for consideration. Had it been necessary to do so I will add for completeness sake that the Court would have found the Plaintiff guilty of contributory negligence and breach of statutory duty for which in all the circumstances of the case he would have had to bear a heavy apportionment of fault.

189. Having failed to discharge the onus of proof cast upon him the Court is required by the law to dismiss the Plaintiff's claim and will so order