FIRST DIVISION, INNER HOUSE, COURT OF SESSION

[2022] CSIH 25
PD1159/15

Lord President
Lord Woolman
Lord Pentland

OPINION OF THE COURT

delivered by LORD CARLOWAY, the LORD PRESIDENT

in the reclaiming motion

in the cause

DEBBIE WARNER

Pursuer and Respondent

against

SCAPA FLOW CHARTERS

Defenders and Reclaimers

Defenders and Reclaimers: Smith QC; Brodies LLP
Pursuer and Respondent: Milligan QC, Pugh; Digby Brown LLP

10 May 2022

Introduction

[1] Lex Warner tragically drowned during a diving expedition on 14 August 2012. Following a proof, the Lord Ordinary determined that the defenders were responsible for

the death. He did so consequent upon earlier procedure which held that the pursuer's claim on behalf of Mr Warner's son was not time barred under Article 16(1) of the 1974 Athens Convention relating to the Carriage of Passengers and their Luggage by Sea (2019 SC (UKSC) 1). The defenders now reclaim (appeal) the first instance decision.

[2] Mr Warner died whilst undertaking a deep dive to an un-named wreck which was located to the north-west of Cape Wrath. He was an experienced technical diver and a member of the Dark Star group of divers. It comprised nine men. They chartered the defenders' vessel, the *Jean Elaine*, to take them to the wreck site. The defenders were simply a trading name of an individual, namely Andrew Cuthbertson. Prior to entering the water, Mr Warner was walking across the deck of the vessel in heavy diving gear. He was wearing fins on his feet. He tripped and fell. Unknown to him, the fall had caused a serious injury to his liver. During the dive, the pain from that injury caused him to panic. He attempted a rapid ascent, during which he drowned.

[3] The pursuer pleads three grounds of fault against the defenders. First, they failed to carry out a suitable risk assessment, notably in respect of persons walking on deck in diving equipment. Secondly, there were insufficient handrails to assist the deceased when moving across the deck to the exit point for the dive. Thirdly, the defenders should have had a system which directed divers not to walk across the deck when wearing fins.

[4] The Lord Ordinary made clear findings in fact with which this court will not interfere. He found fault established in respect of the risk assessment and system cases. The handrails case failed.

[5] The Lord Ordinary's opinion is carefully reasoned. The issue is whether it is correct in law. The principal question concerns the standard of care. Did the defenders' duty to those on board extend to prescribing, monitoring and controlling the manner in which the

divers put on their equipment and made their way from their seated positions to the exit point? A subsidiary question arises on whether it was sufficient that a safe method of walking on deck had been provided by way of handrails and a deckhand, even if it was not strictly enforced by the defenders and not always adopted by the divers.

[6] Two points bear mentioning at the outset. First, there was no specific reference to the maxim *volenti non fit injuria* ("to one consenting no wrong is done") in the pleadings, although sole fault was pled. Secondly, the averments of contributory negligence were not insisted upon.

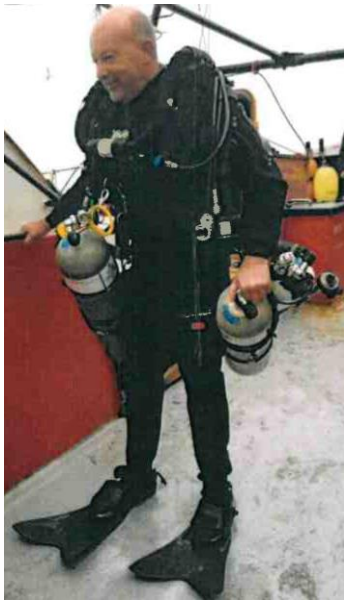
Agreed or undisputed facts

[7] Certain facts were agreed and many others were not ultimately disputed. Technical diving is a specialist sub-category of recreational diving. It enables divers to reach much greater depths than those which are possible with SCUBA gear. A technical diver must equip himself with special fins, a re-breather system, a dry suit, and additional air and gas tanks, two of which are attached to the side of the body. The gear as worn by Mr Warner is shown in the images below. These were taken during the investigations which followed the accident. The re-breather system is the yellow backpack.

[8] The Dark Star divers contracted with the defenders to take them to and from the dive site. The vessel was a converted fishing boat. Each diver chose a seat on deck, where his gear would be stowed and at which he would equip himself preparatory to a dive. Mr Warner's seat was at "a central location on the boat" (Opinion para [7]). This was on the wooden bench which is shown in the above photograph. It is in the centre of the vessel. The exit point for the dive was on the starboard side (which is to the left, looking at the photograph) and further towards the wheelhouse, a rear window of which is shown on the top left of the third photograph above. The photograph shows a red and white cowling which covers a passageway leading below deck. There was a short walkway between the cowling and the wheelhouse beyond it. The cowling had a horizontal handrail on its starboard side.

[9] The route to the exit point from Mr Warner's seat using handrails involved the diver sliding along the bench towards the cowling, standing up, and holding onto the handrail on the cowling with his right hand. He would then turn to his left and hold onto a further

handrail, again with his right hand, which was attached to the wheelhouse, all as shown in the following photographs:



The exit would then be immediately in front of the diver. The total distance from Mr Warner's seat to the exit, using that route, was about three metres.

[10] Mr Warner did not use that route. Instead he took a shortcut. He did not overbalance while rising from his seat. He fell when he tripped on his fins while walking directly across the deck from his seat to the exit point. The trip occurred about one metre away from his seat. Tripping on fins is a "known inherent risk" (Opinion para [110]). He did not use the handrails or ask for the assistance of the deckhand, namely Allan Stanger, who was standing next to him. Immediately afterwards, Mr Warner blamed himself for his trip.

[11] Mr Warner suffered an intra-abdominal haemorrhage. That injury began the sequence of events leading to his death. At a depth of around 50 metres, he began to experience pain. This caused him to attempt to make an emergency ascent in an anxious and panicked state. This affected his breathing. He became unable to retain his breathing mouthpiece and drowned.

The other evidence

[12] With one limited exception, the Lord Ordinary found all of the witnesses who testified to be credible and reliable. The exception was that he did not believe Mr Cuthbertson when he said that, during the voyage, he had repeatedly warned the divers to use the handrails. That was not supported by the other witnesses, including the deckhand. The Lord Ordinary commented that certain expert witnesses on both sides had expressed views on the extent of the duties that might be incumbent upon the defenders. As that was a matter for the court to determine, the Lord Ordinary did not take them into account.

The divers

[13] A number of the divers gave evidence. In general, they were all very experienced. They spoke highly of Mr Cuthbertson. They had no concerns about the safety of the vessel as a dive platform, or Mr Cuthbertson's operation of it. There had been no shortage of handrails. Each diver chose his seat on the vessel. The divers described how they each "kitted up". According to Neil Plank, no skipper gave instructions on how to gear up. Putting on fins after gearing up was not an option. Doing it at the exit point would have caused too many problems. Obtaining assistance meant relying on someone else. Fins were put on before walking to the exit. This was cumbersome, but divers were used to it and the distances on deck were short. It was the safest and easiest way to proceed. Experience and common sense dictated how things were done. Everyone on board was responsible for safety. If Mr Cuthbertson had instructed that fins should only be put on at the exit point, that instruction would have been obeyed, but the group might not have chartered his vessel in future.

[14] Paul Mee always put his fins on first, as it was very difficult to do so after putting on all the other gear. Mr Mee had been between Mr Warner and the cowling. He had stood up before Mr Warner. He had held onto the handrails before crossing to the exit point some four steps away. The deckhand had been available to help. Matthew Phillips said that it was common sense to use the handrails.

[15] Paul Warren put his fins on last, but when he was still at his seat. The deckhand had been there to assist. There was only a short period of some twenty minutes within which the divers had to be in the water. This was why there was no two stage process of putting the gear on, going to the exit point and then putting fins on. That would have added five minutes per diver. Falls were rare. Jaymes Brown said that Mr Cuthbertson had told the divers to use the handrails. A skipper would not tell a technical diver when to put his fins on. It was a matter of personal preference but he, like most others, put them on after his suit. Walking to the exit point involved ability and practice, but there was no alternative and it happened on every vessel. Putting fins on at the exit point would not be practical.

[16] Greg Marshall said that the handrails were of limited use. The deckhand would provide assistance if asked. There was no standard practice on when to put fins on. He put them on after his dive weights. Walking in fins was not dangerous. The diver shuffled along without raising his feet. Putting fins on at the exit point was not feasible.

[17] The police statements of two other divers were produced. They suggested that there had been no pre-dive briefing.

The crew

[18] Mr Cuthbertson had skippered vessels for many years. He was interested in recreational diving. He had many qualifications and significant experience. His vessel was

certified by MECAL (the Marine Engineers Certifying Authority Limited). He saw his role as being to get the divers to where they wanted to be. With a group of experienced divers, he was a taxi-driver only. He did not tell the divers how to move about.

[19] Mr Cuthbertson accepted that he had a responsibility for the safety of those on board. He had assessed risks on board, including that to the divers as they walked to the exit point. That is why there were handrails. A fall of the type which occurred was "quite unlikely, and if it did happen, not likely to cause any injury more serious than a broken arm" (Opinion para [45]). At the start of the trip, Mr Cuthbertson would give those on board a safety briefing. Divers, including Mr Warner, were repeatedly told to use the handrails. Every diver put his fins on at an early stage in the gearing up process. He would tell inexperienced divers without instructors not to walk in fins, but not experienced divers. The advice given by the Professional Association of Dive Instructors, that fins should be put on last, was for novices.

[20] It had been two full steps from where Mr Warner had been sitting to the exit point. Mr Warner had shuffled along the bench before standing up. Mr Warner's accident could not have been prevented. Mr Cuthbertson could not have foreseen what happened. There had been the odd fall previously. These had usually been sideways. Mr Warner had fallen forwards. There had been handrails beside Mr Warner. If used and followed, there would have only been one unsupported step to reach the exit. Mr Warner had chosen to move directly towards the exit without using the handrail route.

[21] Allan Stanger, the deckhand, had had some experience of SCUBA diving many years previously, but none of technical diving. His task included looking after the divers. One aspect of this was to help them to stand up or to walk about the deck, if they so requested.

Mr Warner had stood up "right in front of him", taken one or two steps and then tripped. Putting on fins was a matter of personal choice. Some divers put them on first, some last.

Experts and other witnesses

[22] The pursuer called two persons to give opinion evidence. The first was Ian Biles, a master mariner, naval architect and marine surveyor. He concluded that Mr Cuthbertson had not carried out a risk assessment in accordance with the Marine and Coastguard Agency, Marine Guidance Note – small vessels in commercial use for sport or pleasure …" (MGN 280) because there had been no formal or documented assessment completed. The Professional Association of Diving Instructors' *Open Water Diving Manual* noted the risks of walking in diving gear and counselled the use of handrails and avoiding walking in fins, which should be put on immediately before entering the water. A risk assessment would have identified procedures to reduce the risk of falling by providing a general safety briefing before a dive, including a clear understanding of the procedures to be used and the risks involved. The skipper was much more than a taxi driver. The divers may have been happy with the vessel, but they did not understand the risks. The skipper should stop any operation on board if it was unsafe. He should have foreseen the hazard and put appropriate mitigation in place. Responsibility could not be delegated to the divers. A safe system, such as the use of two deckhands, was needed. Importantly, Mr Biles accepted that technical diving was not within his sphere of expertise.

[23] The second expert was Kevin Casey, a retired director of diving operations and a diving consultant. He too had observed that there had been no formal or documented risk assessment. Walking in fins was dangerous and divers should be assisted to do so by the use of two deckhands, one on either side. The skipper was in charge of safety and had to

enforce his safety requirements. Divers should not have been allowed to walk in fins on deck unaided. Fins should have been put on immediately before entering the water, as recommended by PADI and the British Sub-Aqua Club. Mr Casey had not undertaken any technical diving himself. He accepted that each diver had responsibility for his own equipment and that the order of putting on diving gear depended on the individual. Mr Cuthbertson should have noticed that Mr Warner would have to walk three metres, assessed that activity and thought of ways of mitigating the risk, including the use of an extra deckhand and the provision of more handrails. The skipper ought to have discussed safety with the divers and reinforced any requirements.

[24] The defenders called Frank Murray, a retired HM Principal Inspector of Diving. In his view the skipper was responsible for the safety of the vessel. Although the Guidance Note recommended a pro-active approach to safety in relation to work activities on board, that did not apply to the activities of guests such as divers. Mr Cuthbertson had assessed the risk of a diver falling on deck and considered that it would be adequately dealt with by providing a non-slip surface, removing obstructions and providing handrails, coupled with advice to the divers to use them. A deckhand was available to assist, if requested. That was, in Mr Murray's opinion, compliant with the guidance. The handrails, which were fitted at the time of the fall, allowed Mr Warner to move safely to the exit point. The PADI Manual was written for inexperienced divers using simpler equipment. The equipment used in technical diving made putting on fins just before entering the water a difficult task. Mr Murray had never seen a skipper requiring this to be done. Dives had to be carried out in accordance with tight timescales, which might be compromised by a requirement to put on fins immediately before entry into the water. MACAL had certified that the handrails on the vessel were adequate for diving trips.

[25] The defenders also called Martin Woodward, the managing director of the National Dive Centre in Leicestershire. He expressed the view that the core role of the skipper was to provide transport to the dive location, put the divers in a position to dive safely and to recover them. He would let the divers get on with their activities. Divers all had their own ideas about what to do, although, if the skipper saw something which he thought was dangerous, he ought to step in. In technical diving, most divers put on fins when sitting down and kitting up. There was no issue with the handrails; the arrangements being the same as on all other boats. It was also possible for divers to hold onto other structures and to ask the deckhand to assist. The PADI and BSAC advice not to put fins on until the last minute was not specifically directed at technical divers. If he had seen divers at the Centre walking in fins, he would have warned them about the risks. According to Jim Smith, a retired ship surveyor, the vessel had been certified as "satisfactory".

The Lord Ordinary's reasoning

[26] The Lord Ordinary found that it was unnecessary to consider whether there was a lack of handrails such as would constitute a defect in the vessel. Mr Warner had not used the handrail which was in his immediate vicinity when he tripped. This was the one on the starboard side of the cowling, which he could have held onto and made "sensible use of with his right hand while taking one available route" to the exit point (Opinion para [111]). If it had been necessary to do so, the Lord Ordinary would have concluded that there was no defect in the vessel. The ship's surveyor had given uncontradicted evidence that the handrails were enough to ensure the safety of those on board. A person could reach a handrail without taking more than one step.

[27] The Lord Ordinary held that the defenders were required, under regulation 7 of the Merchant Shipping and Fishing Vessels (Health and Safety at Work) Regulations 1997, to carry out a risk assessment in relation to persons on board. The duty at common law to take reasonable care required the defenders to consider "whether any aspect of the environment on board, or the way in which it was proposed to carry out the planned dive support operations, gave rise to any risk … and what, if anything should be done to minimise it" (Opinion para [125]). The Lord Ordinary rejected an analogy with the occupiers of open spaces, in which the activities could not effectively be controlled. Rather, the correct comparator was with the operators of facilities, such as swimming pools and golf ranges, in which the activities could be supervised and controlled. In such situations:

> "the operator ought in the exercise of reasonable care to carry out an assessment of whether the proposed activity may be carried out in a way which poses a risk to the person doing it or others, and, if so, take appropriate steps to control any such risk, as by having rules of conduct and enforcing them" (Opinion para [125]).

[28] The Lord Ordinary held that the defenders were doing much more than acting as a taxi driver. They would not operate when the environmental conditions rendered diving or dive preparations unsafe. They controlled the movement of the vessel when divers were preparing to enter the water. They provided a non-slip and unobstructed deck upon which to walk. They provided handrails. They supplied the services of a deckhand to be called upon in the course of the divers' preparation and movement towards the exit point. If Mr Cuthbertson had seen a diver do something on deck, which he considered to be dangerous, he would have stepped in and warned about, or stopped, whatever was going on.

[29] The risk assessment failed to identify, as was well-recognised in maritime and diving circles, that walking on deck in fins is inherently risky (Opinion para [127]). Experienced

divers would be aware that the PADI and BSAC advised against it. The risk increased for technical divers owing to the weight of their gear. Although not referred to in his summary of the evidence, the Lord Ordinary recorded in his reasoning that Mr Casey had said that the risk of walking on deck in fins was such that no professional commercial diving operation would have countenanced it (Opinion para [127]). Mr Woodward would have admonished anyone walking in fins at his dive centre. The defenders were negligent in having a system of dive preparation in which most gearing-up places were remote from the exit point, and which left it to the divers to decide how, and at what stage of preparation, they made their way from their seats to the exit point.

[30] The defenders ought to have had a policy of avoiding or minimising walking in fins. They ought to have discussed this with the divers at the outset of each trip, and invited dialogue on how to minimise or avoid such a practice. The process of gearing-up was a matter of personal preference. Divers who wished to put their fins on early in the process could be accommodated at seats close to the exit point. They could then be assisted compulsorily by the deckhand via a short, designated and handrail-assisted route to that point. Divers who were happy to put their fins on last, could gear-up at a more remote seat, and then walk to the exit and put their fins on there. No single and inflexible system of operation had to be implemented on every trip, regardless of individual circumstances. Had such a system been in place, the likelihood is that Mr Warner would not have fallen at all, or if he had, he would not have sustained so serious an injury.

Submissions

Defenders

[31] The Lord Ordinary wrongly concluded that walking in fins on deck represented an

unacceptable risk. There was no obligation upon the defenders to direct divers not to do so. The appellate court is in as good a position to determine what inferences should be drawn from the primary findings in fact (*AW* v *Greater Glasgow Health Board* [2017] CSIH 58; *Woodhouse* v *Lochs and Glens Transport* 2020 SLT 1203).

[32] The inference drawn by the Lord Ordinary was unreasonable. The divers' unchallenged evidence made it clear that putting on fins first and then walking to the exit point was almost invariable practice. This was not an employment situation in which an employee had no choice but to follow his employer's directions. It was a leisure activity and it was the divers' choice to participate. How to enter the water was a matter of judgment for the individual diver, who was experienced and knew his own capabilities and gear. Both 'fins first' and 'fins last' posed a risk. Fins last involved putting fins on after the diver had put on extremely heavy gear. The divers were all vastly more experienced in technical diving than any of the parties' experts. The PADI and BASC guidance was aimed at SCUBA, rather than technical, divers.

[33] The Lord Ordinary had not made it clear what vessel operators ought to do. The experts did not subscribe to his view. It had not been put to the divers. It did not address the limited time window during which the divers had to get into the water. The Lord Ordinary had not explained what the outcome of a risk assessment would have been. The pursuer's experts declined to engage with what an assessment would have revealed. What the Lord Ordinary had concluded, about what it would have identified, was unworkable. He did not say that the established practice of walking on fins ought to have been prohibited. He had laid down what an assessment would have produced for a leisure industry when that was not the pursuer's case and it had not been put to the divers.

[34] Not every accident is someone's fault. The skipper could not ensure that no accident ever occurred. The risk and seriousness of injury and the amenity value of the activity all had to be taken into account (*Sutton LBC* v *Edwards* [2017] PIQR P2 at para 21, citing *Tomlinson* v *Congleton BC* [2004] 1 AC 46 at para [52]). Not every risk required to be eliminated (*ibid* para [42]). Warning Mr Warner of the risk of falling when walking in fins would not have told him anything which he did not already know (*ibid* at para [48]). This was a leisure activity. The divers had the option of not boarding the vessel. The defenders' obligation differed from that of an employer (*Kennedy* v *Cordia (Services)* 2016 SC (UKSC) 59 at paras [108] and [112]). It was a matter for the divers to decide how to move about the deck.

[35] The Lord Ordinary's reasoning was illogical. He accepted that no single and inflexible system of operation required to be implemented. That contradicted his decision that only a 'fins last' approach ought to be taken. His finding, that the practice of walking with fins on should have been avoided or minimised, was a recognition that 'fins first' was an acceptable practice in certain circumstances. He failed to address how far, and in what circumstances, it would be permissible for divers to walk in fins. That failure made it impossible to know whether Mr Warner had acted in a permissible manner, or whether Mr Cuthbertson ought to have directed him to stop. It was possible to argue that walking on deck was minimised as far as Mr Warner was concerned. He was positioned close to the exit when he fell. He slid along the bench towards the exit. Using the handrail would have been a precaution which was available to him.

[36] In order to constitute negligence there had to be a failure to take reasonable care. The Lord Ordinary failed to apply that test. An employer was not liable if he followed generally accepted practice (*Baker* v *Quantum Clothing Group* [2011] WLR 1003). Knowledge

of a risk did not mean that certain steps had to be taken (*Doherty* v *Rugby Joinery (UK)* [2004] ICR 1272). It was difficult to see how Mr Cuthbertson could realistically have controlled the actions of the divers. Directing the divers as to how to gear-up, on pain of returning them to shore, would have resulted in divers not hiring the vessel. The Lord Ordinary's approach would require any organiser of a leisure activity, in which participants brought their own equipment and had a high degree of experience, to monitor the behaviour of those participants to an unacceptable degree. The responsibility for how the divers carried out their activities was not that of the defenders.

Pursuer

[37] There was no proper basis on which the court could interfere with the decision at first instance. The Lord Ordinary did apply the correct test. He did not say that "fins last" was the only acceptable way of kitting up. The evidence of the divers was irrelevant in so far as it related to the defenders' duties on what happened on deck. There was a distinction between what happened in the water and what occurred on deck. Mr Cuthbertson had accepted that there was a need to warn divers constantly to use the handrails. He had been disbelieved when he said that he had done that. The defenders had not identified a material error of law. The Lord Ordinary had the benefit of seeing and hearing the witnesses, including a demonstration of the diving gear and how it was put on and worn. These advantages should not be underestimated (*Woodhouse* v *Lochs and Glens Transport*). An appellate court should be slow to interfere with the conclusions of a Lord Ordinary (*Muir* v *Glasgow Corporation* 1943 SC (HL) 3; *Henderson* v *Foxworth Investments* 2014 SC (UKSC) 203). The risk assessment process was no different from the court's exercise in assessing negligence at common law. The Lord Ordinary correctly put himself into the position of a

skipper. The question he had to answer was a jury one (*Muir* v *Glasgow Corporation* 1943 SC (HL) 3 at 8). The defenders' grounds of appeal failed to disclose any basis upon which it could be said that the Lord Ordinary: was plainly wrong; had made some other identifiable error of law; had made a finding of fact with no support in the evidence; or had demonstrably misunderstood relevant evidence.

[38] There was no reason to suppose that the Lord Ordinary had not applied the test of reasonable care. He made his consideration of that plain when looking at the need for a suitable and sufficient risk assessment. Common practice was merely a factor to be considered (*Cavanagh* v *Ulster Weaving Co* 1960 AC 145). The fundamental fallacy underlying the reclaiming motion was the suggestion that, because the divers thought the system was a reasonable one, the Lord Ordinary had to come to the same conclusion. The opinion of witnesses to fact could not be determinative of a question that was for the court, including what was reasonably foreseeable and what therefore amounted to negligence.

[39] There was no dispute on whether a duty was owed; rather the defenders had argued that it had been fulfilled. The defenders accepted that a system was needed. They said that it included Mr Cuthbertson constantly telling divers to hold onto the handrails. The Lord Ordinary found Mr Cuthbertson to be incredible on this point. As a result, there was no evidence that there was any safe system on board the vessel.

Decision

[40] Many of the defenders' criticisms of the Lord Ordinary, whilst understandable, are not persuasive. He did apply the standard of reasonable care. In order to do so, he had to put himself, as he attempted to do, into the role of the defenders, decide what risks arose from their operation of the vessel and determine what mitigatory measures ought to be

taken in the exercise of their duty to take reasonable care for those on board. The *dictum* in *Muir* v *Glasgow Corporation* 1943 SC (HL) 3 (Lord Thankerton at 8), which sets the standard of care at that of the reasonable person in the role of the defenders, remains sound. The Lord Ordinary was not bound by the views of any expert. As he pointedly commented, it was not for an expert to express a view on what the standard of care required. In any event, none of the experts had any expertise in operating a technical dive support vessel.

[41] In determining that a number of expedients might have mitigated the risk of falling, the Lord Ordinary did not say that only a 'fins last' approach should be taken. As the defenders recognised, he accepted that 'fins first' could be accommodated. He did consider the limited time window for the dive. There is little difficulty in understanding what the Lord Ordinary decided about the various expedients and how they could have been implemented. He regarded these as feasible even if the divers considered them to be impracticable. There was no need, given the evidence which the divers had given, for the Lord Ordinary to have put his view on what expedients should have been adopted specifically to them. The fact that implementing safety measures might result in the defenders' operation being less popular was not a point which he regarded as having much significance.

[42] What the divers actually did, whilst constituting evidence of practice, could not preclude the Lord Ordinary from deciding that their practice was sufficiently dangerous in terms of the risk of serious injury as to require the defenders to prohibit it. Practice is not determinative (*Cavanagh* v *Ulster Wearing Co* 1960 AC 145, Lord Keith at 161-162 commenting on *Morton* v *Wm Dixon* 1909 SC 807, Lord Dunedin at 809). The Lord Ordinary was correct in rejecting the analogy of the control of open spaces, although his alternative analogy of sporting arenas is equally inapt; the distinguishing feature here being the skill

and experience of the participants. All of that having been said, there are significant flaws in the Lord Ordinary's reasoning as it advanced towards his conclusion.

[43] Defining the standard of reasonable care requires the judge, as the hypothetical reasonable person in the position of the defenders, to weigh various elements. The equation notably, but not exclusively, involves evaluating the risk of any accident occurring, the seriousness of any potential injury, the practicality of any specific precaution, and the effect of any prohibition on the activity in question. It is in carrying out this exercise that the court considers that the Lord Ordinary has erred.

[44] First, the Lord Ordinary does not appear to have given the practice of the divers in walking, what was (at least in Mr Warner's case) a very short distance to the exit point in fins, any weight at all. Although by no means determinative, evidence of what those experienced in diving operations regarded as appropriate in the knowledge of the risks involved cannot be ignored. Where persons of skill and experience consider that a reasonably safe course is to walk in fins for a short distance, preferably using a handrail and possibly with the assistance of a deckhand, rather than walking without fins and pausing at the exit point to put them on, that must be of some value in the equation. It ought to be given some weight. There is a sense of unreality in an untutored skipper of a vessel being expected to devise a system of finding out which diver was a 'fins first' person, which was 'fins last' and taking it upon himself to allocate seats at relative distances from the exit point, telling experienced divers how and when to walk on their fins and ensuring that the services of a deckhand were used even if they were neither required nor wanted. These divers were far better placed than the skipper to decide upon what constituted a reasonably safe system of moving a very few metres along an unobstructed and non-slip deck which was provided with adequate handrails.

[45] Secondly, the Lord Ordinary held that the defenders' (ie Mr Cuthbertson's) risk assessment did not recognise sufficiently that walking on deck in fins was inherently risky. Mr Cuthbertson said, and was not disbelieved or found unreliable on this point, that he had recognised the risk to divers when making their way to the exit point. That is why he provided the handrail and offered the assistance of a deckhand. It is far from clear why the Lord Ordinary did not consider that, given the defenders' limited role of carrying out their own operations on board, navigating with reasonable care and providing a safe vessel for the dive, the steps taken by them did not meet the required standard of care. This is especially so given the absence of any assumption by the defenders of any greater responsibility. There is, in short, a fundamental problem with the Lord Ordinary's conclusion. The problem focuses on whether, when setting the standard of care, the defenders had any substantial responsibility for the divers' movements, from the point at which they began to gear up, beyond providing them with a safe vessel (including handrails) and taking reasonable care in the navigation of the vessel during its passage to, at, and passage from, the diving site.

[46] The fundamental question remains one of whether the standard of care extended to prescribing, monitoring and controlling the manner in which each member of a group of highly skilled and experienced technical divers put on their diving gear and moved to the exit point. Even if it did, was it sufficient that the defenders did provide a safe means of reaching the exit point, albeit one which Mr Warner elected not to use?

[47] The risk of falling, when walking in fins, was obvious to the divers, albeit that the prospect of sustaining a serious injury was not high. There was evidence of some previous falls. Although the Lord Ordinary speculates on certain potentially serious consequences of a fall, the risk, after all, was limited to a person falling over himself onto a deck. The risk

would obviously increase if an available handrail and/or deckhand assistance were not used. As with the other divers, Mr Warner knew this.

[48] Some assistance on the standard of care, which is required outwith the sphere of employment and in relation to known risks when engaging in leisure pursuits, can be gained from *Tomlinson* v *Congleton BC* [2004] 1 AC 46. A question arose of "whether people should accept responsibility for the risks they choose to run" when a person is "freely and voluntarily undertaking an activity which inherently involved some risk" (para [44]). Lord Hoffman said this (at para 46):

> "A duty to protect against obvious risks or self-inflicted harm exists only in cases in which there is no genuine or informed choice, as in the case of employees whose work requires them to take the risk, or some lack of capacity, such as the inability of children to recognise danger … or the despair of prisoners which may lead them to inflict injury on themselves" (*ibid* at para 46).

[49] The court, whilst being aware of the comments on the use of this *dictum* more recently, but in other contexts, in both England and Wales (eg *White Lion Hotel* v *James* [2021] QB 1153) and in Scotland (eg *Phee* v *Gordon* 2013 JC 379), broadly agrees with Lord Hoffman's approach. The defenders had a duty, both under the 1997 Regulations and as part of their general duty of care, to assess the risks of injury to persons on board their vessel. The statutory assessment, in so far as relevant to non-employees, related to risk arising from the defenders' acts and omissions. An assessment of the risk of a diver falling, as a result of tripping over his own fins, would have had to take into account the fact that the risk of tripping was not great and that of serious injury was even less. More importantly, it would have had regard to the fact that the persons best placed to assess and deal with any risk were the technical divers themselves and not the defenders. The defenders coincidentally did have some experience of diving generally, but they were not

technical divers and, contractually or otherwise, they had not assumed any responsibility for the divers' operations which started, not when the divers entered the water but, at the latest, when they took their seats and began to gear up. In assessing the actions of the divers, the defenders did not have the requisite knowledge or experience to dictate the manner of gearing up or the extent to which movement in fins ought to be permitted when wearing or carrying specialist diving gear on deck. The suggestion that the divers, going about their leisure activity, would subscribe to the uninformed views of the skipper of the vessel which they had chartered, is unrealistic and places an undue burden upon him.

[50] It was sufficient in the exercise of reasonable care for the defenders to have provided a safe means of moving from the seat to the exit point in the form of a non-slip and unobstructed deck, handrails and a deckhand. They did this. Mr Warner, who was well aware of what was an obvious and inherent risk, chose not to use the provided means. That was a matter for his choice in the context of a leisure pursuit in which he, and not the defenders, was the skilled and experienced person. The defenders did not require to give such a person "frequently repeated warnings" (Opinion para 108) about a risk of which he was already aware. Mr Warner made an informed choice to put his fins on at his seat and to walk in them across the deck to the exit point without using the handrails or the deckhand. In these circumstances, the court disagrees with the Lord Ordinary on what was required to meet the standard of care to be applied on the facts found proved. Fault or neglect on the part of the defenders in terms of Article 3.1 of the Athens Convention is not established. The reclaiming motion must be allowed. The interlocutors of 3 and 16 September 2021 will be recalled and decree of absolvitor pronounced.