HIGH COURT OF AUSTRALIA

FRENCH CJ,
GUMMOW, HEYDON, CRENNAN AND BELL JJ

GEOFFREY LAWRENCE KUHL APPELLANT

AND

ZURICH FINANCIAL SERVICES AUSTRALIA LTD
& ANOR RESPONDENTS

Kuhl v Zurich Financial Services Australia Ltd [2011] HCA 11
4 May 2011
P31/2010

ORDER

1. *Appeal allowed.*

2. *Set aside the orders of the Court of Appeal of the Supreme Court of Western Australia made on 24 March 2010 in favour of the first respondent and in their place order that:*

   (a) *the appeal be allowed;*

   (b) *the orders made by Wisbey DCJ on 22 January 2009 in favour of the first respondent be set aside; and*

   (c) *judgment be entered against the first respondent in the amount of $265,000.*

3. *The first respondent pay the appellant's costs of the appeal and in the courts below.*

On appeal from the Supreme Court of Western Australia

Representation

B L Nugawela with M A Tedeschi for the appellant (instructed by Taylor Smart)

J E Maconachie QC with J R Criddle and H M O'Sullivan for the first respondent (instructed by SRB Legal)

J E Maconachie QC for the second respondent (instructed by Jarman McKenna)

CATCHWORDS

Kuhl v Zurich Financial Services Australia Ltd

Negligence – Duty of care – Appellant injured while using high-pressure vacuum hose – Injury occurred after hose passed to appellant – Supplier of hose also directed and supervised appellant – Concession by first respondent of duty of care made in court below – Whether duty of care was dependent on increased risk.

Negligence – Breach – Supplier of hose failed to install break box and failed to issue instructions not to pass hose while power was on – Relevance of subsequent changes to safety systems – Whether changes inordinately expensive or disadvantageous.

Negligence – Causation – Whether evidence as to precisely how injury occurred is necessary before causation can be found – Relevance of ordinary human experience – Relevance of agreement on quantum of damages.

Evidence – Implied admission or circumstantial evidence permitting adverse inference – Trial judge concluded that appellant had withheld evidence in examination-in-chief – Whether trial judge erred in failing to provide reasons for that conclusion – Whether trial judge erred in failing to provide appellant with opportunity to respond to criticism.

1 FRENCH CJ AND GUMMOW J. On 19 November 1999 the appellant ("Mr Kuhl") suffered injuries in the course of his employment with Transfield Construction Pty Ltd ("Transfield"). Pursuant to s 93E of the *Workers' Compensation and Rehabilitation Act* 1981 (WA)[1], Mr Kuhl was barred from bringing a claim in negligence against Transfield. In the District Court of Western Australia, Mr Kuhl brought an action in negligence against WOMA (Australia) Pty Ltd ("WOMA") and Hydrosweep Pty Ltd ("Hydrosweep"), amongst other parties. Both companies were deregistered after Mr Kuhl's injury but before he commenced proceedings. Pursuant to s 601AG of the *Corporations Act* 2001 (Cth), in the place of WOMA and Hydrosweep stand their respective insurers, the first and second respondents.

2 Mr Kuhl was unsuccessful in his action against both insurers before the District Court (Wisbey DCJ)[2] and on appeal to the Court of Appeal of the Supreme Court of Western Australia (Martin CJ and Newnes JA; Wheeler JA dissenting)[3]. For the reasons given below, there was insufficient evidence to be satisfied on the balance of probabilities that there existed the relevant duty, breach or causation for Mr Kuhl to be successful in his action in negligence, and the appeal to this Court should be dismissed.

The facts

3 Mr Kuhl commenced employment with Transfield in September 1999. He cleaned reactor grid floors at a plant owned and operated by BHP Billiton in Port Hedland, Western Australia. The reactors cooked "fines", small pieces of iron ore, which changed the composition of the fines into hot briquetted iron (HBI). Mr Kuhl had the task of entering the reactors, breaking up any solidified waste material with a jackhammer or sledge hammer and then removing the accumulated fines and other waste using a vacuum. Those who undertook these tasks were colloquially known as "reactor rats".

4 The evidence accepted by the trial judge as to the relationship between Transfield, WOMA and Hydrosweep was as follows:

(a) By November 1999, Transfield was solely responsible for cleaning out the reactors, including using the vacuum hose. A Transfield employee, known as the "hole watcher", would look through a window into the

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1 Now the *Workers' Compensation and Injury Management Act* 1981 (WA).

2 *Kuhl v Zurich Financial Services Australia Ltd* [2009] WADC 4.

3 *Kuhl v Zurich Financial Services Australia Ltd* (2010) 194 IR 74.

reactor whilst it was being cleaned to monitor the "reactor rats" and test gas levels. Transfield also had supervisors on site and those supervisors would allocate the work to each employee and conduct meetings to discuss, amongst other things, safety prior to each shift.

(b) WOMA provided a vacuum truck, the vacuum hose and other equipment relevant to the vacuuming system. WOMA would set up the equipment and supply two operators for the system; one to operate the truck, the other to check and maintain the line. WOMA would also assist in clearing any obstructions in the vacuum hose when Transfield employees were unable to do so.

(c) For a period in November 1999, Hydrosweep supplied a vacuum truck and two operators to WOMA for use at WOMA's direction.

5 The vacuum hose used at the time of the accident was flexible, but awkward to use. It was attached to a stand pipe, or manifold, running up the side of the 128 metre tall building, which was in turn connected by hose to a vacuum truck positioned at ground level. The vertical distance from the truck to the manifold connection for the reactor in which Mr Kuhl was injured was some 32 metres. The horizontal distance from the manifold connection to that reactor's entry point is unclear, but was probably between 20-30 metres.

The accident

6 At about 4.30am on 19 November 1999, whilst Mr Kuhl was vacuuming the relevant reactor, a blockage occurred in the hose. Mr Kuhl left the reactor so as to try to free the blockage. The evidence at trial was that blockages frequently occurred in the hose, sometimes up to 20 times per night. Some blockages were cleared by Transfield employees shaking the hose, hitting the blockage with a shovel or using other similar measures. Blockages that could not be fixed were then dealt with by WOMA employees or people provided for the use of WOMA, sometimes by cutting the hose and then taping it back together, or by reversing the suction. Except when the hose was cut or the suction reversed, the vacuum truck would remain on during the process of attempting to clear the blockage. This was done to assist with the unblocking and to enable one to know whether the hose had successfully been unblocked.

7 On this occasion Mr Kuhl was unsuccessful in unblocking the hose and Mr Kelleher then attempted to do so. Mr Kelleher was an employee of Hydrosweep but was provided for the use of WOMA under WOMA's direction. On this night the vacuum truck in use was provided by WOMA, and Mr Kelleher was operating the truck and attending to blockages. After attending to the blockage, Mr Kelleher made a gesture to Mr Kuhl that was interpreted by Mr Kuhl as indicating that the hose had been unblocked. The blockage had not

actually been removed but that is not relevant to the issues in this appeal. Mr Kelleher then passed the hose back to Mr Kuhl when, some indeterminate but proximate time after, Mr Kuhl's arm was sucked into the hose. Both Mr Kuhl and Mr Kelleher struggled to free Mr Kuhl's arm, and were eventually successful in doing so.

8 An important point for this appeal, which will become evident later in these reasons, is that there was very limited evidence as to what happened. Mr Kuhl's evidence in examination-in-chief was as follows:

> "What happened when the hose was handed back towards you? – My arm was caught in it, in the end, opening of it, whatever you want to call it.
>
> If you could just describe in your own words to the court, how was the hose passed back towards you? – Passed direct –
>
> What was the physical action? – Just passed directly back to me. I moved it a bit to the side to grab it as it was the only way to do it and the next thing my arm was gone.
>
> Which arm? – Left, sucked in.
>
> And how far was your left arm sucked into the hose? – Up to my shoulder."

Mr Kuhl was not cross-examined and there is no other evidence as to how his arm came to be caught in the hose.

9 The only other person who could have witnessed what happened was Mr Kelleher. His evidence, in examination-in-chief, was as follows:

> "Would it be fair to say that you passed it directly back towards him? – No, in front.
>
> Okay. Did you see how his hand came to be caught in the hose? – No."

Later in cross-examination, Mr Kelleher gave the following evidence:

> "The way you described it to his Honour a moment ago … was [that] you passed the hose sideways to [Mr Kuhl]. Was that right? – Yeah. Out in front.
>
> Out in front, so that when you passed the hose to Mr Kuhl, the open end of the hose which had the suction at it, was facing away from Mr Kuhl? – Yeah, yeah.

And in front of him? – Yeah. That's as I remember."

10 The trial judge accepted Mr Kelleher's evidence that the suction inlet of the hose was directed away from Mr Kuhl as the hose was passed to him. That finding was not challenged in this Court and Mr Kuhl at no stage pleaded that Mr Kelleher was negligent in the manner in which he passed the hose.

11 A notable aspect of the evidence in this case was that the defendants called no witnesses and challenged little of the evidence given in Mr Kuhl's case. As plaintiff it was for him to lead evidence of facts sufficient to prove, directly or by inference, on the balance of probabilities that WOMA owed to him a duty of care, that the duty was breached, and that the breach of the duty caused his injuries.

The reasons of the trial judge

12 In the District Court, Wisbey DCJ found that Mr Kuhl failed to establish that Hydrosweep owed him a duty of care or was negligent. That finding is not the subject of a challenge in this Court. With respect to WOMA, the trial judge found that the responsibility for training Mr Kuhl and providing him with a safe system of work was that of his employer, Transfield. The trial judge accepted that WOMA owed Mr Kuhl a duty of care, but held that the duty owed was to "provide a vacuum facility suitable for the purpose, which did not constitute risk of injury to those exercising proper care in its use"[4]. The vacuuming facility was suitable for its purpose and the possibility of injury occurring in the circumstances of the case was not reasonably foreseeable. In any event, the trial judge was not satisfied by Mr Kuhl "as to how and why his arm was drawn into the suction inlet" and, accordingly, it was not "possible to identify a relevant breach, and causally relate the incident to it".

The reasons of the Court of Appeal

13 In the Court of Appeal, Newnes JA, with whom Martin CJ agreed, held that there was no evidence to find that WOMA owed Mr Kuhl a duty to provide a safe system of work, nor any evidence "that WOMA had, or purported to exercise, any authority to supervise or direct the Transfield employees in that work". The evidence only established that it was Transfield who owed the relevant duty alleged by Mr Kuhl.

14 Newnes JA then considered whether WOMA was under a duty to instruct Mr Kelleher not to pass the hose to another worker whilst it was under suction.

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4 [2009] WADC 4 at [40].

His Honour rejected that argument on the basis that there was no evidence of any increased risk of injury when the hose was being passed as opposed to being used to vacuum as intended. The importance of this issue for the questions of duty and breach is explained later in these reasons.

15 Newnes JA then made the observation that the lack of evidence as to how precisely Mr Kuhl's arm became caught in the hose was a "surprising feature" of this case. That observation is then important for understanding what Newnes JA said when considering Mr Kuhl's submission that changes made to the hose post-accident indicated that there existed at the time of the accident a practicable method of reducing or eliminating the risk of injury. His Honour said[5]:

> "The fact that precautions were taken after the accident must not distract attention from the enquiry whether before the accident a reasonable person would have taken those precautions.
>
> The submission on behalf of Mr Kuhl that the risk of injury could have been avoided by simple and inexpensive modifications to the vacuum system seems to me to run into the immediate difficulty that *in the absence of evidence as to precisely how the accident occurred*, it is not apparent that the modifications suggested by Mr Kuhl were likely to have prevented the accident.
>
> In any event, *in the absence of evidence that passing the hose under pressure involved any increased risk of a person coming into close proximity to the suction end*, I do not consider that it can be said the failure to implement those measures before the accident demonstrates a breach of duty". (emphasis added)

As will appear, we agree with what appears in this passage of his Honour's reasons, and this should be determinative of the appeal to this Court.

16 Wheeler JA dissented, finding that there was a reasonably foreseeable risk of injury in the passing of the hose as a matter of common sense and that there were reasonably practicable means of designing the hose so as to eliminate or reduce that risk. More is said of her Honour's reasons later.

Duty of care

17 At trial Mr Kuhl alleged that WOMA owed him a duty "to take reasonable care" for his safety "whilst he was engaged in carrying out his duties at the HBI Plant for [Transfield], not to expose [him] to any risk or injury or damage of

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5 (2010) 194 IR 74 at 89 [84]-[86].

which WOMA, its servants or agents knew or should have known and to take reasonable measures to ensure the system of work provided to and/or for [him] was safe". As noted earlier in these reasons, the trial judge formulated a narrower duty and that duty seems to have been accepted by the majority in the Court of Appeal. Wheeler JA, on the other hand, formulated three possible duties at a detailed and narrow level of specificity.

18 Before this Court, Mr Kuhl formulated the relevant duty owed in a number of ways. First, he repeated that formulation pleaded in the District Court. Second, the relevant duty was said to be one to ensure, as far as reasonably practicable, that the hose was conveyed safely back to Mr Kuhl after it had been unblocked by employees or servants of WOMA. Third, it was said that WOMA had a duty to ensure that the powerful hose was as safe as it could reasonably be, in the event that an accident occurred.

19 Two things must be said as to the formulation of a duty of care and its scope and content. First, there is an inherent danger in an action in negligence to look first to the cause of damage and what could have been done to prevent that damage, and from there determine the relevant duty, its scope and content[6]. In *Koehler v Cerebos (Australia) Ltd*[7], McHugh, Gummow, Hayne and Heydon JJ observed that

> "to begin the inquiry by focusing only upon questions of breach of duty invites error. It invites error because the assumption that is made about the content of the duty of care may fail to take fundamental aspects of the relationship between the parties into account."

Earlier in *Vozza v Tooth & Co Ltd*[8], Windeyer J, when considering allegations of a failure to take reasonable care to provide suitable plant and equipment or devise and maintain a safe system of work, said:

> "The vigorous assertion of [these phrases] may sometimes obscure for juries the essential simplicity of the issue in a common law action for negligence. It may seem that, because an accident has happened and a workman has been injured, his employer is liable for damages if it can be

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6 *Vairy v Wyong Shire Council* (2005) 223 CLR 422 at 443 [60], 461 [126]; [2005] HCA 62; *Roads and Traffic Authority (NSW) v Dederer* (2007) 234 CLR 330 at 353 [65], 406 [270], 408 [283]; [2007] HCA 42; *Stuart v Kirkland-Veenstra* (2009) 237 CLR 215 at 247 [85], 258-259 [127]-[128]; [2009] HCA 15.

7 (2005) 222 CLR 44 at 53 [19]; [2005] HCA 15.

8 (1964) 112 CLR 316 at 318; [1964] HCA 29.

shown that, by some means, the accident might have been avoided. That is not so."

His Honour was, of course, stressing that any duty owed cannot be to safeguard a worker completely from all perils. His warning is, however, equally apt for considering the question of duty more generally. That is not to say that regard cannot be had to the pleaded negligence before consideration is given to the scope and content of a duty. Findings as to the formulation of the duty of care will necessarily depend upon the alleged negligence and the evidence led at trial[9].

20 The approach by Wheeler JA as to the formulation of the duty is an example of the perils in first considering causation and breach to determine the relevant duty of care. Her Honour considered a number of possible actions WOMA could have taken and how effective each would have been to avoid the injury suffered by Mr Kuhl. She concluded that a break box on the hose[10] would have been the most appropriate, that it would have reduced the risk of injury and that, therefore, WOMA owed Mr Kuhl a duty to have installed a break box. Such an approach runs the risk of predetermining the outcome before considering the first important step; whether WOMA owed Mr Kuhl a duty of care to begin with and, if so, what was the scope and content of that duty. Those questions are determined by considering reasonable foreseeability and the "salient features" of the relationship between the plaintiff and defendant[11]. Even if it can be said that there was some reasonable course of conduct the defendant could have engaged in that would have avoided the injury suffered by the plaintiff, the defendant will not be liable unless there can first be established the existence of a duty of care with the relevant scope and content.

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9 *Agar v Hyde* (2000) 201 CLR 552 at 578 [64]; [2000] HCA 41.

10 The break box was described as a valve, or flap, which could be opened so as to allow the entry of air, thus reducing or eliminating the suction generated at the end of the hose.

11 *Graham Barclay Oysters Pty Ltd v Ryan* (2002) 211 CLR 540 at 597-598 [149]; [2002] HCA 54. See also *Perre v Apand Pty Ltd* (1999) 198 CLR 180 at 253 [198]; [1999] HCA 36; *Sullivan v Moody* (2001) 207 CLR 562 at 579-580 [50]-[52]; [2001] HCA 59.

21 The second point is that the formulated duty must neither be so broad as to be devoid of meaningful content[12], nor so narrow as to obscure the issues required for consideration[13]. With respect to the latter, Gummow and Hayne JJ in *Graham Barclay Oysters Pty Ltd v Ryan*[14] said:

> "A duty of care that is formulated retrospectively as an obligation purely to avoid the particular act or omission said to have caused loss, or to avert the particular harm that in fact eventuated, is of its nature likely to obscure the proper inquiry as to breach."

22 Different classes of care may give rise to different problems in determining the nature or scope of a duty of care[15]. In many cases a duty formulated as being one to take "reasonable care" may suffice for the finding of duty in that particular case. Cases that involve the duty of a solicitor to his or her client to exercise professional skill in accordance with the retainer[16], the duty of a motorist towards other users of the road[17], or the duty owed by an occupier of land to an entrant with respect to the condition of the premises[18], ordinarily involve no real controversy over the scope and content of the duty of care; these are considered at the "high level of abstraction" spoken of by Glass JA in *Shirt v Wyong Shire Council*[19]. But where the relationship falls outside of a recognised relationship giving rise to a duty of care[20], or the circumstances of the case are such that the alleged negligent act or omission has little to do with that aspect of

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12 *Vairy v Wyong Shire Council* (2005) 223 CLR 422 at 447 [73].

13 *Modbury Triangle Shopping Centre Pty Ltd v Anzil* (2000) 205 CLR 254 at 290 [103]; [2000] HCA 61; Fleming, *The Law of Torts*, 9th ed (1998) at 117-118.

14 (2002) 211 CLR 540 at 611 [192].

15 *Sullivan v Moody* (2001) 207 CLR 562 at 579 [50].

16 cf, as to third parties, *Hill v Van Erp* (1997) 188 CLR 159; [1997] HCA 9.

17 *Imbree v McNeilly* (2008) 236 CLR 510 at 528 [49]; [2008] HCA 40.

18 *Thompson v Woolworths (Qld) Pty Ltd* (2005) 221 CLR 234 at 243 [24]; [2005] HCA 19.

19 [1978] 1 NSWLR 631 at 639. See also *Vairy v Wyong Shire Council* (2005) 223 CLR 422 at 432 [25]-[26]; *Jones v Bartlett* (2000) 205 CLR 166 at 194 [100]; [2000] HCA 56.

20 See, eg, *Perre v Apand Pty Ltd* (1999) 198 CLR 180; *Cole v South Tweed Heads Rugby League Football Club Ltd* (2004) 217 CLR 469; [2004] HCA 29.

a recognised relationship which gives rise to a duty of care[21], a duty formulated at too high a level of abstraction may leave unanswered the critical questions respecting the content of the term "reasonable" and hence the content of the duty of care[22]. These are matters essential for the determination of this case, for without them the issue of breach cannot be decided. The appropriate level of specificity when formulating the scope and content of the duty will necessarily depend on the circumstances of the case.

The duty owed by WOMA to Mr Kuhl

23 To the extent that Wheeler JA formulated the duty as one to provide a hose with a break box, that was too narrow a duty and risked obscuring the issues in this case. So too is the second formulation of duty proposed by Mr Kuhl.

24 The first formulation of duty proposed by Mr Kuhl, on the other hand, is too broad in light of all the circumstances of this case. Mr Kuhl may have been exposed to many risks in undertaking his duties which had nothing to do with WOMA, such as risks from the fines being, at times, very hot or from the work being conducted in a confined space. WOMA could not have a duty to undertake *all* reasonable measures to avoid *any* risk to Mr Kuhl of which it knew or ought to have known. To the extent Mr Kuhl alleges WOMA owed a duty to provide and maintain a safe system of work, that was rightly rejected by the trial judge and the Court of Appeal on the ground that there was no evidence that WOMA assumed responsibility for or had control of the work done by Mr Kuhl[23].

25 That is not to say that WOMA owed no duty to Mr Kuhl. The evidence established that WOMA provided the truck, set up the hose, was responsible for any blockages in the hose, and was to provide two personnel, one for unblocking the hose and the other for supervising the operation of the truck. The hose provided had suction operating at 1,500 pounds per square inch (some 50 times more powerful than a common household vacuum cleaner), had a diameter of four to six inches and was strong enough to suck up lumps of solidified iron ore material larger than six centimetres in diameter and, indeed, to suck up Mr Kuhl's

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21 See, eg, *Modbury Triangle Shopping Centre Pty Ltd v Anzil* (2000) 205 CLR 254; *Thompson v Woolworths (Qld) Pty Ltd* (2005) 221 CLR 234; *Koehler v Cerebos (Australia) Ltd* (2005) 222 CLR 44; *Vairy v Wyong Shire Council* (2005) 223 CLR 422.

22 *Jones v Bartlett* (2000) 205 CLR 166 at 213 [167].

23 (2010) 194 IR 74 at 75 [2], 86-87 [70]-[71]; cf *Koehler v Cerebos (Australia) Ltd* (2005) 222 CLR 44 at 53 [21].

arm with such force that it took two men to free him. The hose extended over a total distance of up to 60 metres from the truck.

26 From this evidence it can hardly be said that it was not reasonably foreseeable, in light of the power of the hose, that a person using the hose might suffer injury if WOMA did not take reasonable care in providing appropriate equipment. It can also be inferred that WOMA had assumed some responsibility in relation to the vacuuming facility above and beyond that of a non-manufacturing distributor of a product to an end user[24]; it provided operators and ongoing assistance with the running of the vacuuming system. WOMA exercised a level of control over the vacuuming facility both in its ability to turn the truck off and with its responsibility for clearing blockages. WOMA was not responsible for the training of Mr Kuhl nor was Mr Kuhl subject to WOMA's control. However, the supervision of the vacuuming facility by WOMA's servants, and its obvious knowledge that persons like Mr Kuhl would be using the vacuuming hose for the purpose for which WOMA provided the hose, indicates that it was reasonable to require WOMA to have persons like Mr Kuhl in contemplation as people who might be put at risk by WOMA's negligence in providing and operating the vacuuming facility. There are also no considerations of indeterminacy or incoherence that tend against a finding of duty on the part of the WOMA.

27 The critical question in this case concerns the scope and content of the duty owed by WOMA. The evidence outlined above supports the finding of a duty to take reasonable care to provide a hose, truck and vacuuming facility that would not subject foreseeable users of the hose to an unreasonable risk of injury. This duty concerns the condition of the equipment and is no different in substance to the duty formulated by the trial judge, except for the trial judge's additional requirement that the user of the hose be "exercising proper care"[25]. Although there was some debate in this Court as to the appropriateness of that additional requirement, the requirement itself adds nothing more stringent to the duty formulated. Even a foreseeable user of the hose exercising proper care would necessarily include a worker who may, upon undertaking repetitive tasks, be inadvertent at times[26]. Contrary to the submission of Mr Kuhl in his third formulation of the duty proposed to this Court, there was no requirement for a specific duty to ensure the hose was as safe as it could reasonably be in the event

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24 See *McPherson's Ltd v Eaton* (2005) 65 NSWLR 187.

25 [2009] WADC 4 at [40].

26 See *Czatyrko v Edith Cowan University* (2005) 79 ALJR 839 at 843 [12]; 214 ALR 349 at 353; [2005] HCA 14.

of an accident. There is no reason to confine the duty only to situations immediately following an accident.

28 WOMA's responsibility for the operation of the truck and the unblocking of the hose would also place a corresponding duty on WOMA's employees and agents to take reasonable care in carrying out those functions so as to avoid causing injury to others in the vicinity who could have foreseeably suffered injury, such as Mr Kuhl. Such a duty might encompass a situation where a person for whom WOMA is vicariously liable negligently passed the hose to a user in such a manner that the user's arm was sucked into the hose. But that was not the allegation in this case.

29 Within the context of the duty so formulated, questions as to the safety of the hose itself, such as whether the hose should have included a break box or a handle, would then fall for determination when dealing with breach and causation. But an issue whether WOMA should have instructed users of the hose not to pass it under suction does not relate to the condition of the hose itself.

30 The negligence asserted by Mr Kuhl of a failure by WOMA to issue prior instructions not to pass the hose under suction does not readily fall within the formulated duty to take reasonable care in unblocking the hose and operating the truck. That duty concerns the manner in which that conduct is undertaken, whereas the negligence asserted concerns an omission on the part of WOMA to take further steps to avoid injury to persons while the hose was being passed. The common law requires "some broader foundation than mere foreseeability" before a duty to act, as opposed to a duty to take reasonable care when acting, will be imposed[27]. The absence of evidence as to the contractual relationship between Transfield and WOMA is an impediment to the identification of a "special relationship" that would give rise to a duty on the part of WOMA to take steps to prevent injury to a Transfield employee when the hose was being passed. But on the assumption that the evidence was sufficient to give rise to an inference of such a special relationship, the issue remains whether the scope and content of the duty owed by WOMA to Mr Kuhl would include a duty to take *additional* reasonable precautions with respect to the passing of the hose so as to avoid causing injury to those receiving the hose. It is that duty as formulated that would be required for Mr Kuhl to then be able to allege that WOMA's failure to warn was negligent.

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27 *Sutherland Shire Council v Heyman* (1985) 157 CLR 424 at 479; [1985] HCA 41; *Pyrenees Shire Council v Day* (1998) 192 CLR 330 at 368-369 [101]-[102]; [1998] HCA 3; *Modbury Triangle Shopping Centre Pty Ltd v Anzil* (2000) 205 CLR 254 at 266 [28]; *Roads and Traffic Authority (NSW) v Dederer* (2007) 234 CLR 330 at 348 [51].

31 For the scope and content of the duty to include the taking of additional reasonable precautions with respect to the passing of the hose, it must be reasonably foreseeable that the act of passing the hose was itself more dangerous, or bore a higher risk of injury, for the person to whom it was being passed than the mere use of the hose. This must be so as it has already been established that WOMA owed Mr Kuhl a duty to take reasonable care to ensure that the equipment provided would not subject a person using the hose to an unreasonable risk of injury, and to take reasonable care when undertaking its activities. To extend the scope and content of the duty to include a duty to take additional reasonable precautions to avoid causing injury when the hose was being passed necessarily requires there be some additional risk in the act of passing. If it was not reasonably foreseeable that the passing of the hose exposed the receiver of the hose to any greater risk than when it was used for its intended purpose, there is no occasion for the scope of the duty to extend beyond that already owed to the user of the hose.

32 It is in this context that the following passage in the judgment of Newnes JA is to be understood[28]:

> "The risk of injury from coming into close proximity to the suction end of the hose ... was obvious and, as [the trial judge] found, Mr Kuhl was acutely aware of it. There was no evidence of a greater risk that a person's body would come into closer proximity to the suction end inherent in passing it under pressure from one worker to another than in the ordinary operation of the hose, even if it was dropped. There was, as counsel for WOMA submitted, no evidence that the hose under pressure was not inert but was prone to significant or sudden movement caused by the pressure which would have made the handing over of the hose more hazardous, nor was there evidence of any other characteristics that were likely to lead to an increased risk of injury. Had the hose had any such characteristics it would have been a simple matter for Mr Kuhl to have led evidence of them. There was no such evidence."

It is also important that the trial judge found that Mr Kelleher did not pass the hose in a negligent manner and in fact passed the hose so that the suction end was at all times pointed away from Mr Kuhl.

33 Before this Court Mr Kuhl adopted the reasoning of Wheeler JA that, as a matter of common sense, the passing of the hose involved an increased risk of injury, such that evidence to that effect was not required. Wheeler JA compared

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28 (2010) 194 IR 74 at 87 [75].

the situation to the passing of an operational chainsaw, which would be an inherently risky activity[29]:

> "The risks of a slip or clumsy movement are increased because there are more people involved in the movement and, of course, there are risks of 'miscommunication' about the way the manoeuvre is to be performed."

But the operation of the hose cannot relevantly be compared to that of a chainsaw. Injury could only occur from the hose if the body was to come in contact with the opening at the suction end, which pointed only in one direction and was four to six inches in diameter.

34 There was no evidence at trial as to how Mr Kuhl's arm became caught in the hose. Such evidence could have established facts from which it could then be inferred that the passing of the hose was more dangerous, but without such facts no inference can be made. At its highest, the evidence was that the hose was awkward to handle, but again that alone cannot be used to then infer that passing must necessarily be riskier than vacuuming. There was also no evidence that the hose acted in any unpredictable manner when dropped, such as would increase the risk of the suction end coming into contact with someone being passed the hose. Without this evidence, no inference can be made to find that there was an increased risk in passing the hose. If there was no increased risk, then the duty owed by WOMA would not require any additional steps to be taken by WOMA respecting the passing of the hose.

35 In any event, even if the duty did so extend, as these reasons explain, there was insufficient evidence to show that WOMA breached any duty, or that such a breach caused the injuries of Mr Kuhl. It is to these matters that we now turn.

Breach of duty

36 At trial Mr Kuhl's allegations, as summarised by the trial judge[30], were that WOMA was negligent in failing to:

> "(i) warn the plaintiff of the danger of body contact with the suction inlet;
>
> (ii) ensure the plaintiff was adequately trained in the proper operation of the vacuum hose;

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29 (2010) 194 IR 74 at 77 [14].

30 [2009] WADC 4 at [4].

(iii) instruct the plaintiff in the safe operation and handling of the vacuum hose;

(iv) provide proper supervision; and

(v) provide a vacuum hose with a protective mesh guard over the suction inlet, appropriate grip handle, and capacity to terminate suction."

Paragraphs (i) to (iii) can be immediately dismissed because it was not established, for the reasons given earlier, that WOMA had a relevant duty that would encompass these measures. Paragraph (iv) did not appear to be pressed by Mr Kuhl in the courts below, nor before this Court, and in any event would similarly fall outside of the duty found to have existed. With respect to par (v), the evidence at trial established that following Mr Kuhl's injury there was a trial placement of a protective mesh guard over the suction inlet, but it was found to be impractical and impeded too greatly the ability of the vacuum to suck up the waste material. A nozzle, attached to the suction end, incorporating a grip handle was also tried but found to be too cumbersome and led to other safety concerns, mainly to do with ergonomic issues. A reasonable person in WOMA's position would not, therefore, have implemented these measures in response to the risk of injury posed.

37 In this Court, Mr Kuhl relied only on two measures that WOMA should have taken prior to the accident; the failure to do so being the relevant breach of duty. First, WOMA should have issued an instruction not to pass the hose from one person to another unless the vacuum suction was turned off. Secondly, WOMA should have installed a break box onto the hose. Mr Kuhl did not allege that WOMA was vicariously liable for any negligence on the part of Mr Kelleher or Mr Atkinson, a WOMA employee on site who directed Mr Kelleher as to the work to be undertaken.

38 At trial, counsel for Mr Kuhl led evidence as to modifications to the hose and system of vacuuming post-accident to support a finding of breach of duty. Evidence of measures adopted by a defendant after the accident may be relevant in some circumstances when determining whether it was reasonably practicable to adopt such measures. Gibbs J in *Nelson v John Lysaght (Australia) Ltd*[31], with whom Stephen and Mason JJ agreed, said:

> "The onus of proving that it was unreasonable not to take the precaution, of course, lay on the [plaintiff]. However, when the [defendant], which must have had full knowledge of the nature, cost and practical

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31 (1975) 132 CLR 201 at 214-215; [1975] HCA 9.

> consequences of the new installation, gave no evidence, and by its counsel asked no questions, to suggest that it was inordinately expensive or in any other way disadvantageous, the jury was entitled to infer at the very least that the advantages of the method which the [defendant] has since adopted were not outweighed by any disadvantages."

39 Here, the first respondent, standing in the place of WOMA, with full knowledge of the nature, cost and practical consequences of the break box, gave no evidence, nor did its counsel ask any questions, to suggest that implementing the break box would have been overly burdensome or impractical. The evidence of Mr Collins, a safety adviser with BHP Billiton but at the time of the accident a trades assistant working as a "reactor rat", was that a break box was installed on the hoses by WOMA and Transfield some seven to 10 days after the accident. The break box was installed at a join or connection in the hose, approximately 10-15 metres from the suction inlet. The nozzle, incorporating a grip handle, which had been given a trial, had also featured a break box but, as noted above, was too cumbersome and placed strain on the user's back. Mr Collins described the break box as "a really good safety device", that was made using materials and personnel already on the site.

40 It is unclear whether instructions were given by WOMA following the accident not to pass the hose under suction. Mr Collins initially suggested such instructions were given, but when cross-examined by counsel for the first respondent, he conceded that such an instruction was not to be found in the safety procedures document he had drafted.

41 Whether or not any such instruction was issued in relation to passing the hose under suction, finding a breach of duty requires more than proof that the measure was reasonably practicable. What was said in *Nelson v John Lysaght (Australia) Ltd* is relevant to the proof of reasonable practicability. But what is required to establish a breach is that a reasonable person in the defendant's position would have foreseen that his or her conduct involved a risk of injury to the plaintiff or to a class of persons including the plaintiff, before determining what a reasonable person would have done in response to the risk[32].

42 As explained earlier in these reasons, a difficulty in Mr Kuhl's case is that he must establish that it was reasonably foreseeable that a failure to warn not to pass the hose under suction risked causing a person in his position some injury above and beyond the risks associated with such a person using the hose for its intended purpose of vacuuming up the waste in the reactor. It is foreseeable that use of the hose itself, with its high suction, could cause injury. But that does not

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32 *Wyong Shire Council v Shirt* (1980) 146 CLR 40 at 47-48; [1980] HCA 12.

mean that the hose must not be under suction whenever in use; if so, there would be no way in which the hose could then be used for its intended purpose. Therefore, before WOMA could be expected to take any additional measures to avoid a risk of injury when the hose is being passed, it must first be established by the plaintiff that there was a foreseeable risk of injury that was greater than when normally using the hose. That was not established in this case.

43 Also of importance is the finding of the trial judge, adopted by Mr Kuhl in the appeal to this Court but towards another end, that the risk of injury from having a body part sucked into the hose was obvious. In assessing the standard of reasonable care, the obviousness of the risk is necessarily a factor and the more obvious the risk, the less required of the reasonable defendant to avoid or reduce that risk[33]. To this may be added the evidence at trial that blockages frequently occurred and were often dealt with by Transfield employees without the suction being turned off. From this evidence it may be inferred that it was impracticable to turn the suction off whenever a blockage occurred and the hose may need to have been passed, such that a reasonable person in the defendant's position would not issue such an instruction. With respect to none of these matters was there evidence upon which to make a finding that a failure to issue an instruction to only pass the hose while not under suction was a breach of any duty owed by WOMA to Mr Kuhl.

44 With respect to the break box, as has been acknowledged in these reasons, it was reasonably foreseeable that use of the hose entailed a risk of injury. In these circumstances, several inferences may be made from the evidence. First, that there was a reasonably foreseeable risk that a failure to install a break box could cause injury to a person like Mr Kuhl, and that such a risk, given the power of the hose, was not insignificant or "far-fetched or fanciful"[34]. The second inference is that, the break box later having been installed and evidence not having been adduced by the first respondent to suggest this course was impractical, a reasonable person in WOMA's position would have installed the break box. However, that does not lead to the conclusion that Mr Kuhl must succeed in the appeal to this Court. The issue then becomes whether he has established, on the balance of probabilities, that the failure to install the break box caused his injuries. It is to that issue that we now turn.

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33 *Romeo v Conservation Commission (NT)* (1998) 192 CLR 431 at 456 [56], 481 [131], 489 [157]; [1998] HCA 5; *Woods v Multi-Sport Holdings Pty Ltd* (2002) 208 CLR 460 at 503-504 [144]; [2002] HCA 9; *Swain v Waverley Municipal Council* (2005) 220 CLR 517 at 564 [140]; [2005] HCA 4.

34 *Wyong Shire Council v Shirt* (1980) 146 CLR 40 at 47.

Causation

45 To satisfy the element of causation on the case presented for Mr Kuhl to this Court, it would be necessary to identify the action which, on the available evidence, the trial judge could conclude ought to have been taken; that action, if failure to take it is to be accounted negligent, must be such that the foreseeable risk of injury would require it to be taken, having regard to the nature of that risk and the extent of injury should the risk mature into actuality; and it would be necessary that the trial judge could conclude as a matter of evidence and inference that, more probably than not, the taking of that action (here the installation of the break box) would have prevented or minimised the injuries the plaintiff sustained[35].

46 When dealing with the question of causation, Wheeler JA addressed the trial judge's observation of the lack of evidence by Mr Kuhl as to how his arm became caught in the hose. Her Honour said[36]:

> "The only inferences open, then, appear to be that, in the process of passing a heavy, awkward hose, with very powerful suction, the appellant: misunderstood how Kelleher expected him to take it (it being too noisy for express verbal communication); or took it clumsily; or slipped; or simply misjudged how far away his arm should be in order to avoid getting caught."

With respect to the first inference, there was no evidence that there was any miscommunication between Mr Kelleher and Mr Kuhl, other than the miscommunication as to whether or not the hose was unblocked. But whether or not the hose still had a blockage, Mr Kuhl's arm could still be drawn in. The other inferences posited by her Honour are certainly possibilities, but that does not mean that Mr Kuhl has satisfied his burden of proving that the failure by WOMA to install a break box caused his injuries.

47 First, the evidence at trial concerning the break box was that it was installed some 10-15 metres from the end of the hose and it would only work to stop the suction when manually operated. That being so, on the morning in question, Mr Kuhl's arm would still have been sucked into the hose. There was no evidence as to how quickly Mr Kuhl, in circumstances where his arm was caught in the hose and he was trying to pull his arm out, would have been able, if

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35 *State of Victoria v Bryar* (1970) 44 ALJR 174 at 175 per Barwick CJ, McTiernan, Owen and Walsh JJ concurring.

36 (2010) 194 IR 74 at 77 [11].

at all, to operate the break box to stop the suction. One could infer that Mr Kelleher or another worker would be able to operate the break box in these circumstances, as Mr Kelleher came to the aid of Mr Kuhl soon after noticing that his arm was stuck in the hose. But even then, there would be an interval in which Mr Kuhl's arm was stuck in the hose.

48 That necessarily begs the question, at what point did Mr Kuhl sustain the full extent of his injury? If it was immediately upon his arm being sucked into the hose, then the break box would have done nothing to prevent the injury. If it was the time during which his arm was in the hose, there is no evidence upon which to make a finding as to how long his arm would likely have been in the hose had the break box been installed. Finally, it may have been the act of pulling his arm out of the hose that caused the injury, but again there is no evidence upon which to infer that Mr Kuhl would not have attempted to first pull his arm out, instead of trying to move 10 to 15 metres to activate the break box or waiting for someone else to do so. These unanswered questions indicate that this Court cannot now establish what it was that caused the injury to Mr Kuhl; there is no evidence from which the necessary inferences could be drawn.

49 So much seemed to be accepted by counsel for Mr Kuhl. However, he submitted that common sense dictates that, in any event, failure to install the break box materially increased the risk of injury and that if there was medical evidence to be led as to the cause of the injury, it was upon the respondents to lead that evidence.

50 That submission appears to be based on what was said by Dixon J in *Betts v Whittingslowe*[37]:

> "[B]reach of duty coupled with an accident of the kind that might thereby be caused is enough to justify an inference, *in the absence of any sufficient reason to the contrary*, that in fact the accident did occur owing to the act or omission amounting to the breach of statutory duty." (emphasis added)

But, as Kiefel J noted in *Roads and Traffic Authority v Royal*[38], the observation of Dixon J must be considered in light of the circumstances of that case where, as Dixon J also said[39], "the facts warrant no other inference inconsistent with liability on the part of the defendant". There is no reason, neither from the evidence adduced at trial nor as a matter of logical inference, to find that the

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37 (1945) 71 CLR 637 at 649; [1945] HCA 31.

38 (2008) 82 ALJR 870 at 897 [139]; 245 ALR 653 at 688; [2008] HCA 19.

39 (1945) 71 CLR 637 at 649.

break box would have avoided or lessened the injury suffered by Mr Kuhl. It was not the only inference that could be made.

51 The absence of evidence in this regard recalls what was said by Windeyer J in *Vozza v Tooth & Co Ltd*[40]:

> "To speak of a jury using their experience, common sense and common knowledge means nothing unless they be given facts to which they can apply their experience, common sense and common knowledge."

It was incumbent upon Mr Kuhl to satisfy the trial judge that the installation of the break box would have avoided or lessened his injuries. Without any evidence, medical or otherwise, to support such a conclusion, there could be no finding that any negligence on the part of WOMA was causative of the damage suffered by Mr Kuhl.

52 With respect to the failure to issue an instruction not to pass the hose under suction, the absence of any evidence as to how Mr Kuhl's arm came to be caught in the hose is important. The "only inferences open" of which Wheeler JA spoke are not, in fact, the only inferences open on the evidence. As the first respondent submitted in this Court, it is not even clear from the evidence that it was due to the act of passing the hose that Mr Kuhl's arm became caught in it. The evidence of Mr Kelleher, accepted by the trial judge, was that he had passed the hose to Mr Kuhl, with the suction inlet directed away from Mr Kuhl, then looked away, and only later noticed that Mr Kuhl's arm was stuck in the hose. Certainly, it is possible that the hose slipped, or that Mr Kuhl took it clumsily, or that Mr Kuhl misjudged how far away his arm should be in order to avoid it getting caught, but it is also possible on the evidence that Mr Kuhl commenced using the hose as he would have had it not been passed, and in the process somehow had his arm sucked in.

53 Mr Kuhl relied on *Hamilton v Nuroof (WA) Pty Ltd*[41] for the proposition that precise evidence which indicated how his arm was sucked into the hose was not necessary. That case concerned the duty of an employer to adopt a safe system of work. The decision has been said[42] to indicate that it may be

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40 (1964) 112 CLR 316 at 321.

41 (1956) 96 CLR 18; [1956] HCA 42. cf *Commissioner of Main Roads v Jones* (2005) 79 ALJR 1104 at 1109 [26], 1111 [40]; 215 ALR 418 at 424-425, 427; [2005] HCA 27.

42 Glass and McHugh, *The Liability of Employers in Damages for Personal Injury*, (1966) at 43-44.

unnecessary for a plaintiff to show exactly how the injury occurred if there be a defect in the system of work and it is clear that the injury arose out of the defective system. However, in the present case, as noted above, there was no evidence that WOMA assumed responsibility for or had control of the work done by Mr Kuhl as an employee of Transfield.

54 The remarks of Dixon CJ and Kitto J in *Hamilton*[43] that the exact cause of the bucket of hot bitumen spilling onto the plaintiff need not be ascertained for a finding of negligence need to be understood in that context. There was sufficient evidence in *Hamilton* to find that the act of passing a bucket of hot bitumen upwards and above one's head was an unsafe system of work. In those circumstances, the only inference that could be made was that it was because of the unsafe system of work that the bitumen was ultimately spilled onto the plaintiff. It was also a clear matter of common sense that lifting a bucket of hot bitumen above one's head increased the risk of injury when compared to carrying the bucket in other ways. In this case, there was no duty on WOMA to provide a safe system of work for Mr Kuhl, nor was it so obvious that passing the hose led to a greater risk of injury than mere use of the hose.

55 Even accepting an inference that, given the short time between the passing of the hose and Mr Kuhl's arm becoming stuck in it, the act of passing had something to do with the accident, it still was necessary for there to be some evidence from which to conclude or infer that had WOMA issued a warning or an instruction not to pass the hose under suction, that instruction would have been followed. However, the evidence at trial was in such a state that one could properly infer it was likely such an instruction would not have been followed on the morning in question. The evidence of Messrs Kuhl, Kelleher, Collins, Rogosic and Rachman, all personnel familiar with the process of cleaning the reactor and using the hose, established that the hose frequently had blockages and that these blockages were frequently dealt with by the "reactor rats" or persons nearby without turning off the vacuum truck. Accordingly, it is unlikely that when dealing with the blockage in this case, without need for the hose to be physically cut or the suction reversed, that the truck would have been turned off prior to the hose being passed. There is no other evidence to suggest that any instruction to turn the truck off would have been followed. Accordingly, Mr Kuhl has not established that any breach on the part of WOMA caused his injuries.

Order

56 The appeal should be dismissed with costs.

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43 (1956) 96 CLR 18 at 23-24.

HEYDON, CRENNAN AND BELL JJ.

The factual background

57 The BHP HBI plant in Port Hedland contains reactors used in the production of iron. Transfield Construction Pty Ltd ("Transfield") was responsible for cleaning the reactors out. The plaintiff was one of Transfield's employees. Among his tasks was the task of entering the reactors and using a powerful vacuum hose to remove waste materials. The vacuuming equipment used by Transfield for the operation of the vacuum hose was supplied and set up by WOMA (Australia) Pty Ltd ("WOMA"), which also supplied two operators. Ordinarily one of the operators operated the vacuum truck to which a hose conveyed the waste materials extracted and the other checked and maintained the hose. The power which created the vacuum enabling the waste materials to be sucked from the reactors through the hose to the truck was supplied by a suction-creating power unit mounted on the truck. WOMA was responsible for directing and supervising the operators, and for setting up the vacuum hose and clearing blockages in it.

58 At about 4.30am on 19 November 1999, while the plaintiff was vacuuming a reactor, the hose became blocked. The plaintiff came out of the reactor and endeavoured to unblock the hose but was unable to do so. Mr Kelleher, an employee of Hydrosweep Pty Ltd ("Hydrosweep"), was nearby. That company had supplied another vacuum truck and two employees to WOMA, one of whom was Mr Kelleher. On that night this second vacuum truck was not in operation and the second employee was not present. Not only was Mr Kelleher operating the truck, he was, the trial judge found, "attending to line blockages"[44] in relation to the truck supplied by WOMA. Mr Kelleher attempted to unblock the hose. The trial judge found that Mr Kelleher passed the hose "sideways to, in front of, and with the suction inlet directed away from the plaintiff", who was standing a metre or two to Mr Kelleher's right-hand side[45]. It was not alleged that Mr Kelleher did this negligently. The plaintiff's left arm was then sucked into the hose, causing him quite severe injuries.

The plaintiff's case

59 Although the plaintiff's case on duty of care was put more ambitiously, one question is whether the evidence on which the plaintiff relied supported the

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44 *Kuhl v Zurich Financial Services Australia Ltd* [2009] WADC 4 at [22].

45 *Kuhl v Zurich Financial Services Australia Ltd* [2009] WADC 4 at [22].

proposition that WOMA owed him a duty to take care to provide a hose, truck and vacuuming facility that would not subject those who might foreseeably use the hose to an unreasonable risk of injury in relation to uses to which it was reasonably foreseeable that the hose might be put. If so, the plaintiff's case was that that duty was breached in that WOMA failed to issue instructions not to pass the hose while the power was on, and in that WOMA had failed to install a break box 10 or 15 metres from the head of the hose which could be employed to break the vacuum pressure at the hose end by letting air in. The plaintiff contended that each breach caused his injuries.

The trial judge's attack on the plaintiff's evidence

60 *The trial judge's finding.* The trial judge said[46]:

> "The plaintiff was less than expansive when describing how his arm was drawn into the vacuum hose, and I formed the view that for whatever reason he was reluctant to say precisely what happened. I accept the essentially unchallenged evidence of Mr Kelleher that the suction inlet was directed away from the plaintiff as the hose was passed to him, and I am left to infer that some subsequent action by the plaintiff caused his arm to be drawn in by the suction force.
>
> I am satisfied that the plaintiff was acutely aware of the necessity not to allow any part of the body to come into contact with the suction inlet. Not only does the plaintiff accept that, but the associated risks were obvious."

61 What was the "less than expansive" evidence of the plaintiff which caused the trial judge to conclude that he was "reluctant"? It was the following evidence in chief:

> "What happened when the hose was handed back towards you? --- My arm was caught in it, in the end, opening of it, whatever you want to call it.
>
> If you could just describe in your own words to the court, how was the hose passed back towards you? --- Passed direct ---
>
> What was the physical action? --- Just passed directly back to me. I moved it a bit to the side to grab it as it was the only way to do it and the next thing my arm was gone.

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46 *Kuhl v Zurich Financial Services Australia Ltd* [2009] WADC 4 at [30]-[31].

Which arm? --- Left, sucked in."

The plaintiff was not asked further questions in chief on that subject. He was not asked any questions in cross-examination about it either. The judge asked no questions about it.

62 *The significance of the trial judge's finding.* The conclusion of the trial judge that the plaintiff was "reluctant to say precisely what happened" is an important one. If that conclusion were soundly arrived at, it would be a significant factor against the plaintiff's success. So, at least, the trial judge, the Court of Appeal majority and the first respondent thought. It would be significant because of the following considerations. Witnesses are supposed to answer questions put by counsel responsively: they are supposed to give a full answer, but no more. It is one thing to say that a witness was not asked the right questions. It is another thing to say that a witness did not answer the questions that were asked. And it is an even more serious thing to say that a witness was "reluctant" to answer. The duty of a witness is to tell the truth, the whole truth, and nothing but the truth so far as the questions asked seek it. The duty of a witness to answer questions responsively involves not only a negative duty (not to volunteer material for which the question does not call), but also a positive duty (to proffer all material within the witness's knowledge for which the question does call). To conclude that a party-witness is reluctant to say what happened is to conclude that the party-witness is deliberately failing to comply with the duty to tell the whole truth. That is a serious conclusion to reach, for the following reasons.

63 The rule in *Jones v Dunkel*[47] is that the unexplained failure by a party to call a witness may in appropriate circumstances support an inference that the uncalled evidence would not have assisted the party's case. That is particularly so where it is the party which is the uncalled witness[48]. The failure to call a witness may also permit the court to draw, with greater confidence, any inference unfavourable to the party that failed to call the witness, if that uncalled witness appears to be in a position to cast light on whether the inference should be drawn[49]. These principles have been extended from instances where a witness has not been called at all to instances where a witness has been called but not questioned on particular topics. Where counsel for a party has refrained from

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47 (1959) 101 CLR 298 at 308, 312 and 320-321; [1959] HCA 8.

48 *Dilosa v Latec Finance Pty Ltd* (1966) 84 WN (Pt 1) (NSW) 557 at 582.

49 *Australian Securities and Investments Commission v Fortescue Metals Group Ltd (No 5)* (2009) 264 ALR 201 at 225 [102].

asking a witness whom that party has called particular questions on an issue, the court will be less likely to draw inferences favourable to that party from other evidence in relation to that issue[50]. That problem did not arise here. The plaintiff's counsel did ask the plaintiff relevant questions.

64 The rule in *Jones v Dunkel* permits an inference, not that evidence not called by a party would have been adverse to the party, but that it would not have assisted the party[51]. But the conclusion by the trial judge that the plaintiff – a party-witness – deliberately withheld evidence reflected a stronger reaction. It operated as a finding that there had been an admission. It could be inferred that the evidence was withheld, in breach of the witness's duty to tell the whole truth in answer to the question, because the plaintiff was conscious that success in the litigation would be rendered impossible or less likely if the material withheld were revealed. Depending on the circumstances, when a party lies, or destroys or conceals evidence, or attempts to destroy or conceal evidence, or suborns witnesses, or calls testimony known to be false, or fails to comply with court orders for the production of evidence (like subpoenas or orders to answer interrogatories), or misleads persons in authority about who the party is, or flees, the conduct can be variously described as an implied admission or circumstantial evidence permitting an adverse inference. The position must be the same where there is a failure of a party-witness to comply with the duty of a witness to tell the whole truth. There is a reason why failure to call a witness or failure to ask a particular question of a witness supports the possible inference that the witness's evidence would not have assisted the party, while failure of a party-witness to tell the whole truth may support an inference that the party suppressed evidence which would have been damaging to the party-witness. A litigant has no duty to call particular witnesses or to procure that any witnesses called by that litigant are asked particular questions. A litigant who enters the witness box, on the other hand, is under a positive duty to tell the whole truth in answer to the questions asked.

65 The trial judge certainly appears to have perceived the plaintiff's answers to have operated as a kind of admission. The trial judge held that WOMA had "a duty to provide a vacuum facility suitable for the purpose, which did not constitute risk of injury to those exercising proper care in its use."[52] It follows

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50 *Commercial Union Assurance Co of Australia Ltd v Ferrcom Pty Ltd* (1991) 22 NSWLR 389 at 418-419. Handley JA stated some stronger propositions in those passages, but what he said is at least authority for what is stated above.

51 *Dilosa v Latec Finance Pty Ltd* (1966) 84 WN (Pt 1) (NSW) 557 at 582.

52 *Kuhl v Zurich Financial Services Australia Ltd* [2009] WADC 4 at [40].

that if the trial judge thought the plaintiff had not exercised proper care, he would fail. The trial judge inferred that "some subsequent action by the plaintiff caused his arm to be drawn in by the suction force."[53] Now a subsequent action of that kind could be compatible or incompatible with the exercise of proper care. If one were ignorant of the dangers of the suction pipe, allowing one's arm to get close to it might not be careless. But the trial judge pointed out that the plaintiff was acutely aware of the dangers. The trial judge plainly assumed that the plaintiff had not exercised proper care, and had deliberately or carelessly placed his arm too near the hose. In the trial judge's apparent view, it was this which he was "reluctant" to reveal in his "less than expansive" description of what happened.

66 It is true that at the end of his reasons for judgment the trial judge took a different stand. He said[54]:

> "the plaintiff having failed to satisfy me as to how and why his arm was drawn into the suction inlet, it is not … possible to identify a relevant breach, and causally relate the incident to it."

Whether the plaintiff has demonstrated that the trial judge was right or wrong about that will be examined below. But it is one thing to say that a plaintiff's evidence is inadequate to make out a claim; it is another thing to say that a plaintiff's evidence is not only inadequate, but that it has been tailored by deliberate non-responsive suppression.

67 It is not sound judicial technique to criticise a party-witness for deliberately withholding the truth in a fashion crucial to a dismissal of that party's claim unless two conditions are satisfied. First, reasons must be given for concluding that the truth has been deliberately withheld. Secondly, the party-witness must have been given an opportunity to deal with the criticism.

68 *The lack of reasons.* It is not necessary to cite authority for the existence of the first condition. It was certainly not satisfied. The trial judge gave no reasons at all for the view he formed. Nothing on the face of the evidence indicates reluctance. The trial judge's conclusion could have been based on the demeanour of the plaintiff in answering the questions, or perhaps on the plaintiff's demeanour at other times during his testimony, or perhaps on his demeanour during the trial while not in the witness box. In this Court the first respondent repeatedly called the trial judge's finding "demeanour based". But the

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53 *Kuhl v Zurich Financial Services Australia Ltd* [2009] WADC 4 at [30].

54 *Kuhl v Zurich Financial Services Australia Ltd* [2009] WADC 4 at [40].

trial judge did not refer to demeanour as a justification for his conclusion. The absence of reasoning is the more serious in the following circumstances. The plaintiff had left school at 15. He was apprenticed as a panel beater and spray painter, and worked in that and other trades in the 34 years before the accident. On one occasion during his testimony he went "blank" and could not think. For him the witness box must have been a more than usually uncomfortable place. His supposed "reluctance" may have resulted from the shock and pain of a terrifying, indeed life-changing, incident. It may have been momentary forgetfulness or inarticulateness. The problem may have been capable of resolution if counsel had paused, or returned to the subject later. To attribute the paucity of his evidence to deliberate suppression without giving reasons for this course excluding all relevant innocent possibilities was an unjustified course.

69 *The lack of warning.* The second condition is more controversial. Judges are not entitled to inform themselves before taking judicial notice without giving the parties an opportunity to comment on the material referred to[55]. Judges are not entitled to criticise expert witnesses by reference to expert material not in evidence without those witnesses having an opportunity to respond[56]. Judges are entitled to take into account the demeanour of party-witnesses, not only in the witness box, but while they enter and leave it, and also while they are sitting in court before and after giving evidence; but observations by the judge of conduct outside the witness box which the representatives of the parties may not have observed, should, if they are influential in the result, be drawn to the attention of the parties so that they may have an opportunity of dealing with the problem[57]. There is thus no general duty on a judge to advise the representatives of the parties of what they can see for themselves, namely the demeanour of the party-witness in the witness box. Nor, a fortiori, is there a duty on a judge to advise the parties that the party-witness's evidence is not adequate to make out the case of that party-witness. But there was held to be a breach of the duty of procedural fairness where a party claiming compensation for injury was held to have feigned or exaggerated her symptoms although this had not been suggested in cross-examination and the respondent disavowed that possibility[58].

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55 *Gordon M Jenkins & Associates Pty Ltd v Coleman* (1989) 23 FCR 38 at 47-48.

56 *Australian and Overseas Telecommunications Corporation Ltd v McAuslan* (1993) 47 FCR 492 at 495-496, 508-510 and 517-519.

57 *Government Insurance Office of New South Wales v Bailey* (1992) 27 NSWLR 304 at 313-314.

58 *Marelic v Comcare* (1993) 47 FCR 437 at 443-444.

70 If, in the present case, the first respondent had submitted in final address that the plaintiff had answered his own counsel's questions in chief about how his arm had been drawn into the vacuum hose by deliberately concealing material adverse to his case and favourable to the first respondent's – an allegation not of inadequacy in evidence but of suppression of evidence supporting an inference that the plaintiff knew his case was bad – a breach of the rule in *Browne v Dunn*[59] would have taken place.

71 In *Browne v Dunn* Lord Herschell LC said[60]:

> "it seems to me to be absolutely essential to the proper conduct of a cause, where it is intended to suggest that a witness is *not speaking the truth* on a particular point, to direct his attention to the fact by some questions put in cross-examination showing that that imputation is intended to be made, and not to take his evidence and pass it by as a matter altogether unchallenged, and then, when it is impossible for him to explain, as perhaps he might have been able to do if such questions had been put to him, the circumstances which it is suggested indicate that *the story he tells ought not to be believed*, to argue that he is a witness unworthy of credit. My Lords, I have always understood that if you intend *to impeach a witness* you are bound, whilst he is in the box, to give him an opportunity of making any explanation which is open to him; and, as it seems to me, that is not only a rule of professional practice in the conduct of a case, but is essential to fair play and fair dealing with witnesses." (emphasis added)

An allegation in final address that the plaintiff suppressed evidence would be in substance a suggestion that he was not speaking the truth and ought not to be believed: for he had been asked in effect to describe the whole of what he observed and remembered about what happened when the hose was handed back towards him, and the allegation would be that he had failed to speak the truth by deliberately not describing the whole of what he remembered, but suppressing unfavourable parts of it. So to allege would have been to "impeach" the plaintiff as a witness. The remedies might have included a refusal by the judge to accept or entertain the submission, and a recall of the plaintiff to the witness box to deal with the allegation.

72 Now if it was not open to counsel for the first respondent to make the postulated allegation, how can it have been open to the trial judge, without

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59 (1893) 6 R 67.

60 (1893) 6 R 67 at 70-71.

warning, to incorporate into his reasons for judgment a finding to the same effect as the allegation?

73 For those reasons the second condition referred to ought to have been satisfied before the trial judge made the criticism he did.

74 The second condition was not satisfied. The plaintiff had no opportunity to deal with the criticism. Normally cross-examining counsel will prefigure and lay the ground work for any criticism a judge may feel minded to make of a witness's evidence in chief. But here there was no cross-examination on the plaintiff's evidence in chief about what happened in the moments before he sustained his injuries. This created a difficulty for the trial judge. The tactical decision of defence counsel not to cross-examine on that topic may well have been shrewd. When Wigmore enunciated his celebrated but controversial proposition to the effect that cross-examination was "beyond any doubt the greatest legal engine ever invented for the discovery of truth", he immediately stated another much less controversial proposition by way of caveat: "A lawyer can do anything with a cross-examination – if he is skillful enough not to impale his own cause upon it."[61] The truth of the second proposition lies in the fact that when a cross-examiner seeks to extract from a witness testimony which is more favourable to the cross-examiner's client than that which the witness gave in chief, the new testimony often turns out to be adverse to the client. If evidence in chief is thought to be too feeble to serve its purpose, cross-examiners often think it best to leave it alone, for to cross-examine will do no more than strengthen it: the repeated questions may cause the witness to think harder, may cause the witness to become more determined, may trigger better recollection and may result in the witness giving the more detailed evidence which was not given in chief. But decisions by cross-examiners of that kind are gambles, and the gambles can be lost. Whether the cross-examiner lost the gamble in this case is discussed below.

75 There was no point in the trial judge mentioning his conclusion that the plaintiff's evidence was not frank and complete unless it played a role in his decision adverse to the plaintiff. In the absence of any challenge from the cross-examiner to the frankness and completeness of the plaintiff's evidence, it was incumbent on the trial judge, if his conclusion that the plaintiff had not been frank and complete was to play a role in his decision adverse to the plaintiff, to make the challenge himself. Perhaps the criticism in the judgment did not occur to the trial judge until after the plaintiff had left the box, or until after the hearing

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61 Wigmore, *Evidence in Trials at Common Law*, Chadbourn rev (1974), vol 5 at 32 [1367].

had concluded and before the judge's reserved judgment was given. It remained necessary either to recall the plaintiff or to have no regard to that aspect of the plaintiff's evidence.

76 The first respondent repeatedly stressed the trial judge's finding under discussion, and sought to render it immune from appellate examination by calling it "demeanour based". But when the above difficulties were raised with counsel for the first respondent in this Court, he raised no strong defence of what happened, and fell back on the different point that the plaintiff's evidence was so scant and meagre as to leave, fatally, an unfilled gap. He described the plaintiff's case as having exhibited a "failure of proof", and he said there was "a lacuna in his evidence", as distinct from the plaintiff being the victim of "an inference adverse to him, drawn by the trial judge or by the Court of Appeal". It must be accepted that the trial judge put the matter in the alternative, but the primary conclusion reached is the adverse inference described above.

77 The difficulties just discussed would justify an order for a new trial – an unpalatable prospect nearly three years after the first trial and almost 12 years after the accident. But the plaintiff does not seek a new trial. He seeks judgment. In the circumstances, although findings of the kind criticised above tend invisibly and inseverably to permeate the whole of a judge's reasoning, the desirable course is to proceed as though the trial judge's reasoning which has been criticised did not exist, with a view to seeing whether it was otherwise defensible.

Duty

78 *A procedural problem.* The Court of Appeal majority overturned the trial judge's conclusion that WOMA owed the plaintiff a duty of care. It did so of its own motion, in the absence of any notice of contention, and despite a concession by counsel for the first respondent that there was a duty of care. This does not seem to have been open to it, although it was open to it to reject the plaintiff's contentions that the duty of care was broader than that found by the trial judge.

79 *The nature of the duty.* It was reasonably foreseeable to WOMA that the vacuum facility it provided to Transfield, and particularly the hose, would be used by Transfield employees to clean out the reactors. It was also reasonably foreseeable that from time to time the hose would get blocked and have to be unblocked. And it was reasonably foreseeable that different workers, whether employed by Transfield, WOMA or Hydrosweep, might work on the task of unblocking the hose, and hand it back and forth while the suction-creating power unit was in operation. Thus there was a duty on WOMA to provide a hose, truck and vacuuming facility that would not subject foreseeable users of the hose (including those who might be inadvertent at times) to an unreasonable risk of

injury in relation to the uses to which it was reasonably foreseeable that it might be put. On that basis WOMA's duty of care extended to risks in relation to the passing of the hose, whether those risks arose from the way the hose was designed (for example, without a break box), or the way it was to be used (for example, without the protection of instruction to turn the power off while it was being handed back and forth between workers).

80 In the Court of Appeal counsel for the first respondent (who was not leading counsel in this Court) was asked the following question by Martin CJ:

> "If passing the vacuum under load created a foreseeable risk of injury … that could have been easily avoided by turning the truck off before you passed the equipment under load … why wouldn't [WOMA] have owed a duty to the plaintiff to instruct Kelleher accordingly?"

He answered in the affirmative. In this Court the first respondent attempted to withdraw that concession on various grounds. It should not be allowed to do so, for the simple reason that the concession was correct.

81 Counsel for the first respondent submitted:

> "The co-existence of knowledge of a risk of harm and power to avert or to minimise that harm does not, without more, give rise to a duty of care at common law …
>
> The mere provision of plant and equipment to someone who intends to integrate it into their enterprise, and upon whom there is a common law duty to devise, institute and maintain a safe system of work, and to provide safe plant and equipment, cannot give rise to a common law duty of care to users of the equipment within the enterprise: something more must be needed. If it were otherwise, the burden on commerce would be intolerable, and areas of responsibility would overlap such as to potentiate conflicts in systems of work, creating rather than abrogating risks of harm.
>
> The supplier of plant and equipment may not know, and may have no means of knowing, the manner in which the plant and equipment will be integrated into its [customer's] enterprise; or how work systems might be adapted to deal with contingencies encountered; it would lead to indeterminate liability; it would make tortious that which was otherwise lawful; it would hinder the efficient operation of commerce."

He submitted that the contract between WOMA and Transfield was relevant; that the equipment had been used for months without incident, and that Transfield had every opportunity to inspect, analyse and systemise the equipment within its system of work.

82 However sound these submissions may be when applied to other circumstances, they are not sound here. WOMA knew, and had the means of knowing, how the fruits of Transfield's work in integrating the equipment within its system of work had developed, for it supplied not only equipment but also workers. However relevant the contract between WOMA and Transfield was, the Court of Appeal majority said it was never clearly explained in the evidence. Hence it has not been established that it restricted WOMA's duty. The incident-free history of the equipment is not irrelevant, but it is not determinative. The submission amounts to the proposition that, if an employer like Transfield owes a duty to its workers to maintain a safe system of work, there can never be a possibility of others owing the workers duties of care. The existence of a duty of care depends on the circumstances of each case; in this case the circumstances were sufficient to create the duty in WOMA which was stated above, which includes the duty that was conceded in the Court of Appeal. That was because of WOMA's special role in supplying the equipment, setting up the hose, clearing blockages and directing and supervising the two operators[62].

83 *The dependence of duty on increased risk.* But, contrary to what has just been said and contrary to the terms of the concession, let it be assumed that the Court of Appeal majority was correct to find that no relevant duty of care could exist in the absence of "evidence of a greater risk that a person's body would come into closer proximity to the suction end inherent in passing it under pressure from one worker to another than in the ordinary operation of the hose, even if it was dropped."[63] The Court of Appeal majority said[64]:

> "There was … no evidence that the hose under pressure … was prone to significant or sudden movement caused by the pressure which would have made the handing over of the hose more hazardous, nor was there evidence of any other characteristics that were likely to lead to an increased risk of injury."

And it said that had the hose had any characteristics likely to lead to an increased risk of injury in these circumstances, "it would have been a simple matter for [the plaintiff] to have led evidence of them."[65] It said there was no such evidence.

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62 See above at [57]-[58].

63 *Kuhl v Zurich Financial Services Australia Ltd* (2010) 194 IR 74 at 87 [75].

64 *Kuhl v Zurich Financial Services Australia Ltd* (2010) 194 IR 74 at 87 [75].

65 *Kuhl v Zurich Financial Services Australia Ltd* (2010) 194 IR 74 at 87 [75].

84 The view that the passing of the hose under pressure from one worker to another did increase the risk of injury is correct for the following reasons.

85 First, there was evidence of the characteristics of the hose. It was approximately six inches in diameter. It was "so flexible". It was "quite hard to hang on to and use". It was "very awkward" to handle. It was heavy. The suction, at 1500 pounds per square inch, was very powerful. It was powerful enough to suck up briquettes, rocks and iron lumps and convey them through the hose for 60 metres. It was fifty times more powerful than a normal vacuum cleaner. It was powerful enough to pick up big boulders incapable of passing through the six inch outlet. It was so powerful that when the plaintiff's arm was sucked in, he could not pull it out, either alone or with Mr Kelleher's help. A hose with these characteristics – in particular the fact that it was very awkward to handle – was dangerous.

86 Secondly, in *Neill v NSW Fresh Food & Ice Pty Ltd* Taylor and Owen JJ said[66]:

> "in many cases no more than common knowledge, or perhaps common sense, is necessary to enable one to perceive the existence of a real risk of injury and to permit one to say what reasonable and appropriate precautions might appropriately be taken to avoid it."

Their Honours said that *Hamilton v Nuroof (WA) Pty Ltd*[67] was such a case. In that case the plaintiff was injured when a bucket of bitumen, which he was lifting onto a roof, spilled over him. The trial judge said that on the evidence he was unable to find precisely how the accident occurred. Dixon CJ and Kitto J said[68]:

> "when a vessel containing forty pounds weight of molten material is raised by hand in front of the body high enough for a handle to be seized by a man above, there must be a greatly increased risk of its spilling whether through mishandling or mistake or mischance and the prospect of serious injury if that happens must be much greater also."

They concluded that the danger was real and evident. The present case is not dissimilar. It was reasonably foreseeable that the danger would increase if the

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66 (1963) 108 CLR 362 at 368; [1963] HCA 4.

67 (1956) 96 CLR 18; [1956] HCA 42.

68 *Hamilton v Nuroof (WA) Pty Ltd* (1956) 96 CLR 18 at 24.

hose were handed from one workman to another while the equipment was operating, particularly since the plaintiff had been on duty for 10 and a half hours at the time of the accident, as part of a 12 hour shift worked seven days a week, who, although he could have taken off one week in three, in fact took no weeks off, and particularly since the plaintiff was operating in conditions which were not only hot and dusty but noisy. As Wheeler JA (dissenting) said[69]:

> "The risks of a slip or clumsy movement are increased because there are more people involved in the movement and, of course, there are risks of 'miscommunication' about the way the manoeuvre is to be performed."

87 The trial judge appeared to infer from his conclusion that the plaintiff was "reluctant" to say what happened that "some subsequent action by the plaintiff caused his arm to be drawn in by the suction force."[70] Wheeler JA pointed out that the trial judge made no positive finding, and there was no evidence, that the plaintiff had deliberately or carelessly injured himself; hence the available inferences were that one of the following happened – that he misunderstood how Mr Kelleher expected him to take the hose, being reliant only on sign language due to the noise; that he took the hose clumsily; that he slipped; or that he misjudged how far away from the end of the hose his arm should be in order to avoid getting caught[71]. That they were the realistically available inferences is supported by the shortness of time between when Mr Kelleher passed the hose and when the plaintiff's arm was caught. Each of those four possible inferences is compatible with the plaintiff exercising proper care. That is because they are illustrations, in the words of Windeyer J, of "some temporary inadvertence to danger, some lapse of attention, some taking of a risk or other departure from the highest degree of circumspection" which may be, and in this case – a case involving the operation of heavy, awkward, noisy machinery – are, "excusable in the circumstances because not incompatible with the conduct of a prudent and reasonable man."[72] The first respondent in this Court contended that the line of authority to which Windeyer J referred did not apply in this case because of the trial judge's finding that the plaintiff was saying less than he knew about how the accident happened. But for the reasons given above that finding cannot stand.

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69 *Kuhl v Zurich Financial Services Australia Ltd* (2010) 194 IR 74 at 77 [14].

70 *Kuhl v Zurich Financial Services Australia Ltd* [2009] WADC 4 at [30].

71 *Kuhl v Zurich Financial Services Australia Ltd* (2010) 194 IR 74 at 77 [10]-[12].

72 *Sungravure Pty Ltd v Meani* (1964) 110 CLR 24 at 37; [1964] HCA 16.

88 The conclusion that the hose was more dangerous when being passed from one workman to another than it was when being used by one workman alone follows from the fact that a workman operating by himself can steady himself and adjust his positioning in relation to the end of the hose, heavy and awkward to handle as it was, more easily than a workman receiving the hose from another workman. To put it crudely, a workman operating by himself is in a static position and in a position to be in full control of the hose; the process of one workman handing the hose to another is dynamic, and neither is in a position to be in full control, because each must depend on the reactions, and his perception of the possible reactions, of the other.

89 The first respondent submitted that by the time the plaintiff suffered his injury the act of passing the hose was complete and the plaintiff was in a static position, in full control of the hose; the accident happened after the hose was passed because Mr Kelleher did not see it. But both Mr Kelleher and the plaintiff were silent as to how precisely the plaintiff's arm became caught in the hose: plainly it happened very quickly and unexpectedly. It cannot be inferred that the plaintiff had regained full and stable control of the hose after receiving it from Mr Kelleher before his arm was sucked in.

90 Hence there was a duty of care on WOMA in relation to the passing of the hose, as the plaintiff submitted.

Breach

91 The plaintiff submitted that it had made out two pleaded breaches of WOMA's duty of care.

92 The first lay in a failure to issue instructions not to pass the hose under pressure; ie, to ensure that the power was turned off before attempts were made to clear the hose by handing it back and forth between workers. Had those instructions been given, compliance with them would have precluded any risk of injury for the plaintiff on the night in question. These instructions were recommended after the accident by Mr Collins, who before the accident had had substantial experience as a safety representative and had received substantial safety training, and thereafter had safety responsibilities at the BHP HBI plant at Port Hedland. It is not clear whether the instructions were actually given after the accident. Had the instructions been given before the accident, they could not have been carried out on the night in question. Although WOMA was responsible for supplying two persons – one to operate the truck and the other to deal with blockages – on that night Mr Kelleher had to perform both roles, and he could not both be unblocking the hose and turning off the pressure 60 metres away down some flights of stairs. That circumstance in itself would have placed WOMA in breach of duty.

93 The second breach lay in failing to install a break box 10 or 15 metres from the head of the hose which could be employed to break the vacuum pressure at the hose end by letting air in. Mr Collins thought that this was "a really good safety device … when … we had to move the hoses around, if they were under load". This idea was implemented soon after the accident. Wheeler JA concluded that a hose reasonably fit for the intended purpose would have included the break box, and that the breach lay in not including it.

94 Plainly the mere fact that one change was recommended after the accident and the other introduced after the accident does not support a conclusion of breach of duty. The significance of these events is only to show what could have been done, not what should have been done. Whether what was done later should have been done earlier depends, inter alia, on whether "it was inordinately expensive or in any other way disadvantageous"[73]. No evidence of inordinate expense or other disadvantage in either technique was called by the first respondent or pointed to in argument. The first respondent put no other significant argument in relation to breach of duty, as distinct from causation.

95 It is not possible to infer from the behaviour of the workers before the accident, at a time when no instruction not to pass the hose under pressure had been given, that they would have disobeyed the instruction if it had been given. It may be inferred from the giving of the instruction that it would probably have been obeyed, unless there is evidence making that inference unavailable: there is no such evidence. Nor can it be inferred from the fact that blockages were frequent and, before the accident, were often dealt with without turning the power off that it was not practicable to turn it off after the accident.

96 The first respondent stressed that, apart from the break box, these and other changes were not made by WOMA, but were made in response to the recommendations of an accident investigation committee chaired by Mr McGillivray, the shutdown superintendent of BHP Billiton HBI. But the authorship of the changes is immaterial. The changes are not admissions of liability; they go only to show what could have been done before the accident.

97 The plaintiff was correct to submit that WOMA was in breach of duty by not adopting the latter technique, which would have greatly reduced at least the extent of injury. The plaintiff was also correct to submit that WOMA was in

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73 *Nelson v John Lysaght (Australia) Ltd* (1975) 132 CLR 201 at 214 per Gibbs J; [1975] HCA 9.

breach of duty by not adopting the former technique, which would have prevented any risk of injury at all.

Causation

98 The first respondent put no submission that the failure to adopt the technique of shutting down the power was not causative of the plaintiff's injuries. Hence if that were a breach of duty, as has been found to be the case, there would be no causation problem.

99 But the first respondent submitted that the absence of the break box was not causative of the plaintiff's injuries. It pointed out that the break box would have been 10-15 metres from the end of the hose; it would not have been possible for either the plaintiff or Mr Kelleher to have moved speedily to slide the aperture in the break box open; it was not self-evident that Mr Kelleher could have done so since there had been industrial disputation because non-Transfield people had done work in the reactor or reactors; there was no evidence of whether the plaintiff's injuries were caused when his arm first entered the hose, or caused before the break box could have been operated, or caused by attempts to remove the arm from the hose. Had the trial been by jury these submissions would have been inflammatory and profoundly counter-productive. It is sufficient now to say only that they are not convincing. There was no inhibition flowing from industrial disputation: the incident did not take place in the reactor; Mr Kelleher was responsible for and had not been inhibited from taking up the task of trying to clear the hose; whatever industrial disputation background there was did not prevent Mr Kelleher from responding to the instincts of common humanity in trying to pull the plaintiff's arm out of the hose, and it would not have prevented him from activating the break box. If the injuries had been caused by the efforts of the plaintiff and Mr Kelleher to pull his arm out, the first respondent would remain liable for them, because Mr Kelleher would simply have operated the break box, had there been one, rendering it unnecessary to pull the plaintiff's arm out. The hose was flexible and, had there been a break box, the plaintiff could have concentrated his energies on activating it rather than struggling on the floor trying to use his legs to free himself from the hose. In any event, according to the evidence of Mr Rogosic, the change actually implemented in relation to the break box involved having one worker operating the hose and another worker sitting beside the break box so that the former could signal to the latter whenever it was necessary to take vacuum pressure off the end of the hose. It would take no more than a couple of seconds for the shouts of the first worker whose arm was sucked into the hose to cause the second to activate the break box.

100 To conclude that the plaintiff's injuries were all caused at the moment his arm was sucked in and not thereafter is unwarranted. The plaintiff's left arm was

exposed to powerful vacuum forces for about 30 seconds. For most of that time the arm was exposed not only to the forces sucking it towards the truck, but to the reverse forces of the plaintiff and Mr Kelleher trying to pull it out. The possible causes of the plaintiff's injuries are divisible into three groups: those derived from the vacuum forces generated by the pump operating at the moment the arm was sucked in, those operating from the vacuum forces generated by the pump from that time until the arm was pulled out, and those operating from the forces applied by the plaintiff, with the aid of Mr Kelleher, in the course of his frenzied struggles to extract his arm from the hose. The reverse force which Mr Kelleher, using two arms, employed would not have been applied if there had been a break box in accordance with the change actually implemented, for the worker next to that break box would have responded almost instantaneously to the accident. Even if the change actually implemented had not been fully implemented, but implemented only to the extent of inserting a break box, the worker in the position of Mr Kelleher would not have taken much longer to respond by operating the break box rather than by trying to pull the plaintiff's arm out. And the plaintiff would not have been applying reverse force for the whole period either: while his instinctive reaction may have been to pull his arm out, he would also have been ensuring that the worker next to the break box (or alternatively the worker in the position of Mr Kelleher) activated it quickly.

101 The first respondent submitted that, without medical evidence, it is not possible to say how much damage to the plaintiff's arm was done at particular stages. This is not a realistic approach. One can say, even without medical evidence, that the longer the arm stayed in the hose, and the more the plaintiff and Mr Kelleher tried to pull it out, the more probable it was that additional damage was being caused. It is a matter of ordinary human experience that trauma to muscles and nerves resulting in lesions, tearing and haematomas caused by force will worsen the longer the force is applied and the more powerfully it is applied.

102 The first respondent's argument thus reduces itself to this: assuming that, even if there were a break box, some damage would have been done in the first couple of seconds after the arm entered the hose, it would not matter how little that damage was nor how much damage was done thereafter: the plaintiff is disabled from recovering any damages at all. It would not reflect well on the law if that submission were sound. To insist, as the first respondent did, on the need for expert medical evidence was to insist on something which would have wasted the time of the medical expert or experts, wasted the time of the court, and wasted the parties' money.

103 The probabilities are that a not insignificant amount of the plaintiff's injuries would have occurred after the initial few seconds in which his arm was sucked into the hose. In the circumstances there is no bar to the conclusion that

the plaintiff's damage was caused by the breach of duty alleged. That is particularly so in view of the fact that the parties had agreed on the quantum of damages. Had this not been so, the trial judge could have reduced the quantum of damages awarded to allow for injuries caused before the break box became operative, were that the only breach of duty involved. To use the plaintiff's sensible limitation of the dispute by agreeing on the damages as an indirect means of completely denying him recovery would not be satisfactory.

104 In any event, the first respondent's submissions operate on an erroneous assumption about the test for causation. The question is whether the taking of a particular step which the defendant did not take "more probably than not … would have prevented or *minimized* the injury which was in fact received."[74] Unless all the damage to the plaintiff was caused when and immediately after his arm was sucked into the hose, the sliding open of the aperture in the break box would have minimized the damage by avoiding some of it – that which would have occurred after that time. That is so whether the aperture was slid open after a very short time by a worker placed behind it, or whether it was slid open a little later by a worker standing in the position of Mr Kelleher. It is less probable than not that all the damage was caused at the moment when, and immediately after, the plaintiff's arm entered the hose. Doubts about what damage was caused when would go the question of quantum: but the parties' agreement on quantum eliminated debate about it.

Relief

105 It follows that the plaintiff's arguments for recovery succeed and the appeal must be allowed.

106 The parties agreed on the quantum of damages. The following additional orders sought by the appellant were not opposed by the first respondent. The first respondent should be ordered to pay the appellant's costs of the appeal. The judgments and orders of the Court of Appeal and the District Court in favour of the first respondent should be set aside. In lieu thereof there should be judgment in the action for the appellant against the first respondent in the sum of $265,000 (that is, in addition to workers' compensation payments). The first respondent should pay the appellant's costs in the courts below. Those orders should be made.

107 What of the second respondent, QBE Insurance (Australia) Limited? It was named as second respondent to the special leave application and to the

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74 *Victoria v Bryar* (1970) 44 ALJR 174 at 175 per Barwick CJ (emphasis added).

appeal. On the special leave application it was represented by the counsel who represented the first respondent. On the appeal it was represented by the same senior counsel as the senior counsel who represented the first respondent. Its brief written submissions in the appeal signed by another counsel and filed by solicitors who were different from those for the first respondent pointed out that the application for special leave did not refer to the second respondent, that the appellant's written submissions did not refer to it, and that the appellant did not seek any orders against it. The second respondent sought an order that the appellant pay its costs of the appeal. The points it made in support of its position could have been made in a letter to the appellant's solicitors, and an agreement could have been arrived at at an early stage without the incurring of significant expense. In the circumstances, as between the appellant and the second respondent, there should be no order as to the costs of the appeal. The orders in favour of the second respondent in the courts below should and will stand.