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Case No: TLQ/14/0468

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Royal Courts of Justice
Rolls Building,
Fetter Lane, London, EC4A 1NL

Date: 31 March 2015

Before :

THE HONOURABLE MR. JUSTICE COULSON

- -

Between :

(1) Hong Cassley	**Claimants**
(2) Mona Cassley	
(3) Hector Cassley	
- and -	
GMP Securities Europe LLP	**1st Defendant**
- and -	
Sundance Resources Limited	**2nd Defendant**

- -
- -

Mr Matthew Reeve (instructed by **Stewarts Law LLP**) for the **Claimants**
Mr John Ross QC and Mr Kiril Waite
(instructed by **Berrymans Lace Mawer LLP**) for the **1st Defendant**
Mr A. John Williams (instructed by **Norton Rose Fulbright**) for the **2nd Defendant**

Hearing dates: 3, 4, 5, 9, 10, 11, 12, 18, and 19 February 2015

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Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

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THE HONOURABLE MR. JUSTICE COULSON

The Hon. Mr Justice Coulson:

1. INTRODUCTION

1. At about 9:14 on the morning of Saturday 19 June 2010, a CASA C-212-100 Aviocar aircraft crashed into a hillside in a remote area of dense jungle in the northwest corner of the Republic of Congo. All 11 people on board were killed. They included 6 members of the Board of Directors of the second defendant, Sundance Resources Limited ("Sundance"), who had chartered the plane from Aero-Service, a Congolese charter flight company. Also killed was Mr James Cassley, a corporate financier employed by GMP Securities Europe LLP ("GMP"), together with Mr Talbot's PA; Mr Jeff Duff of Dynamiq, Sundance's logistics contractors; and the two pilots.

2. Sundance is an Australian mining company which had acquired the rights to mine a number of iron ore deposits in the area, including large, linked deposits at Mbalam in Cameroon and Nabeba in the Congo. Mr Cassley was there to inspect that site because GMP hoped to win the instruction to act as Sundance's representatives in the raising of finance for this major mining project.

3. The aircraft was flying from Yaoundé in Cameroon to an airstrip at Yangadou, over the border in the Congo, and the closest landing strip to the Mbalam/Nabeba site. It appears that the day before the flight, the Sundance directors decided that they would take the opportunity of making a relatively small detour so that they could fly over another large mine in the area near Avima, operated by a rival company (Core Mining), the rights to which Sundance were interested in acquiring. The Avima mine was in the northeast corner of Gabon. The maps and charts show that the Core Mining mine was located just beyond the Avima ridge, a continuous line of hills rising about 250 metres from the floor of the jungle and running west/east. On the morning of 19 June 2010, the area of the Avima ridge was covered in low cloud. The pilots were apparently descending and endeavouring to find the bottom of the cloud base when they flew straight into the ridge itself. This is known as a Controlled Flight Into Terrain ("CFIT").

4. The claimants are Mr Cassley's dependants: his widow, Hong Cassley, and his parents, Mona and Hector. Originally, they made a claim against Aero-Service, whose insurers have now paid out to them about 600,000 Euros. They also brought proceedings in the USA against the manufacturers of the GPS system on board the accident flight, although it appears that that claim has now been abandoned.

5. This claim is brought against Mr Cassley's employers, GMP, for breach of the duty of care owed to him. Although, as noted below, GMP admit the existence of a duty, they deny liability and, in their original defence (and as they maintained at trial) they argue that they were entitled to rely entirely on Sundance, who made all the detailed arrangements in respect of the trip as a whole, and the flight to Yaoundé in particular[1]. The claimants say that, because of GMP's case that they were entitled to rely on Sundance, and that it was Sundance who assumed any relevant responsibilities to Mr Cassley, they had no option but to join Sundance as second defendant. Sundance

[1] Although paragraph 13(d) of GMP's Amended Defence may be slightly more nuanced than this summary, that was essentially what it said.

deny the existence of any duty of care and, if they are wrong about that, deny any breach. In addition, both defendants raise a variety of points on causation.

6. Pursuant to the order of Master Eastman dated 17.3.14, this trial, and therefore this Judgment, is concerned only with issues of liability (including causation). It should also be noted that, although there were contribution proceedings between GMP and Sundance, those proceedings have been resolved and I am not required to rule on them.

7. The Judgment is structured in this way. In **Section 2** I summarise the evidence relating to Mr Cassley. In **Section 3** I deal with Sundance and the Mbalam/Nabeba project. This includes a summary of the evidence relating to the earlier chartered flights that Sundance arranged in this region of Africa, and their previous attempts to exclude their liability if things went wrong. In **Section 4** I deal with GMP, and in **Section 5** I set out the arrangements for the visit to Mbalam/Nabeba in June 2010. This also considers the evidence relating to GMP's reaction to Sundance's attempts to exclude their liability for Mr Cassley in the event of an accident, and the late changes to the original flight arrangements. **Section 6** of the Judgment is concerned with the flight on 19 June 2010. **Section 7** is concerned with Aero-Service, the owners and operators of the aircraft that crashed, and goes on to address the causes of that crash.

8. At **Section** 8 I address standards and statistics. At **Section 9** I summarise the issues between the parties. At **Section 10** I outline some of the difficulties with the expert evidence. Thereafter, at **Sections 11** and **12** below I deal, respectively, with the case against GMP and the case against Sundance, by reference to the conventional sub-headings of Law, Duty, Breach and Causation. Before embarking on any of that, I ought to express my thanks to counsel for the efficient way with which they dealt with this trial, notwithstanding the practical difficulties created by the unwieldy bundling arrangements, and to the claimants, whose dignity and fortitude throughout a distressing trial was of the highest order.

2. JAMES CASSLEY

9. James was the only child of Mona and Hector Cassley, the second and third claimants. He was 30 when he died. He took a BSc in Geology from Queen's University Belfast and then moved to London to pursue a career in finance. He worked first as a corporate finance executive and then in the resources sector, specifically mining. He was certified as a corporate financier by the Securities and Investment Institute. From 21 April 2009 he was employed by GMP as a corporate finance executive. He successfully completed his probationary period on 20 January 2010.

10. James met Hong in 2005 in the ticket queue at Wimbledon. The relationship blossomed and they married in 2007. At the time of his death they were trying for children.

11. Although by June 2010 he had only just completed his probationary period, it was clear that James was doing very well at GMP. The finance officer indicated that, had he continued as he was doing, he would have been offered a junior partnership with GMP within 2 to 3 years. GMP marked James death in their 2010 Accounts in this way:

> "James was a very intelligent pleasant person and a joy to be around – one of a kind. He loved to travel and always did so extensively both in his personal life and for work. With an amiable personality and disposition, James was always approachable and always had time for people willing to help in any way. His infectious humour and energetic spirit will be greatly missed but not forgotten."

12. Mr Cassley always knew that travelling was an integral part of his work for GMP. That was because GMP were primarily involved in raising finance for mining and related start-up projects. A site visit would almost always be required as part of the necessary 'due diligence' process. It is therefore unsurprising that his widow, Hong, said at paragraph 10 of her statement that, as the most senior person in GMP's mining team in London, he travelled a lot. In the year of his death he had already travelled several times to Africa. Furthermore, he knew that these charter flights were somewhat different to routine air travel. At paragraph 11 of her statement, Hong recalls him telling her about one charter flight that he had taken in Africa on an old World War 2 Russian aircraft which "shook like it was coming apart".

13. Hong expressed her concerns to Mr Cassley about this and asked whether it was safe to fly in "a little aircraft like that". Mr Cassley had said that the aircraft had landed, 'so it was fine'. It is therefore clear that he knew that there were some risks attached to his job and the flying that it entailed to remote locations. On the other hand, there is nothing to suggest that he ever knew of, let alone accepted, any unnecessary risks when undertaking these flights.

3. SUNDANCE AND THE MBALAM/NABEBA PROJECT

3.1 Caveat re Sundance Documents/Evidence

14. This Section (and the next Sections of this Judgment) are taken primarily from the documents, principally emails which passed between the relevant parties in the first six months of 2010. I consider that these contemporaneous documents are the best source of information as to how the relevant events unfolded, particularly given the sad fact that so many of the major players (not just Mr Cassley, but Mr Lewis and Mr Carr-Gregg of Sundance and Mr Duff of Dynamiq) lost their lives in the accident.

15. In his closing submissions, Mr Williams issued the court with a polite warning, to the effect that, because of the difficulties created for Sundance by the accident, and the loss of so many key personnel, the court should not necessarily assume that the available documentation was 100% complete. In relation to one or two potentially important factual matters, he asked the court to infer some things that were not necessarily borne out by the documentation.

16. I deal in these narrative Sections with any particular inferences which Mr Williams asked me to make. It seems to me that the contemporaneous documents – particularly the emails – do appear to be broadly complete. In general, I do not draw any inferences or make any assumptions, if they are contrary to the contents of the contemporaneous documents.

17. On the wider question of evidence, I accept Sundance's difficulties in not being able to call Mr Lewis, Mr Carr-Gregg and Mr Duff. But, again in general terms, such was the quality of the paperwork that they left behind, that I consider that a coherent narrative, with very few gaps or queries, emerges from that documentation. This is not a case where, as a matter of justice and policy, I should avoid making findings of fact on the basis that the evidence adduced was too weak to prove anything to an appropriate standard (see ***Sienkiewicz v Greif (UK)*** [2011] UKSC 10 at paragraph 193). On the contrary, I consider that the contemporaneous material allows for clear findings of fact to be made. Those are set out in the next Sections of this Judgment.

3.2 General History

18. Sundance is a well-known Australian mining company which, in 2006, through its subsidiary Cam Iron, acquired exploration rights in respect of iron ore deposits at Mbalam (sometimes called Mbarga) in Cameroon. In 2008, Sundance acquired similar rights at Nabeba, in the Republic of the Congo, about 70km away from Mbalam. In October 2008, a camp was set up at Nabeba. The following year, close to Nabeba, Sundance found the site of a bush landing strip, known as Yangadou.

19. Drilling started at Nabeba in January 2010. The site was not nearly so advanced and it was not yet clear the extent of iron ore deposits there. However, there can be no doubt that, based on the likely projections of the overall worth of the rights at Mbalam and Nabeba, Sundance considered this to be a major project. By the start of 2010 they had already raised substantial sums by way of investment: AUS $60 million by a share placement in August 2007; AUS $15 million capital in April 2009; and AUS $90 million in December 2009. But these were modest amounts compared to the money that was going to be necessary to mine the entirety of the iron ore at Mbalam and Nabeba. The financing for the project as a whole was estimated at AUS $4-5 billion, and involved building a railway to the coast and a port facility in Cameroon.

20. I find that the Board of Directors of Sundance, many of whom lost their lives in the accident, were well-respected and experienced. In particular, both the CEO, Mr Don Lewis, and the non-executive board member, Mr Ken Talbot, had international reputations within the mining industry. As we shall see, the company secretary, Mr John Carr-Gregg, was a sophisticated lawyer who did not eschew the detail. I find that they were not the sort of men knowingly to expose themselves, or others, to unnecessary risk.

3.3 Travel to the Site

21. Travel to the Nabeba camp was usually undertaken by road. However, in 2008, Sundance undertook a detailed review of this mode of travel in West Africa and the difficulties and dangers encompassed in this mode of transport were highlighted. As early as September 2008, Sundance said that they were looking to reduce the amount of road travel "with the planning of charter flight operations to site". They engaged a logistics company, Dynamiq, to provide advice about every aspect of travel and security in this part of West Africa.

22. It appears that, originally, the alternative plan was to use helicopters, but in an email dated 27 November 2009 from Mr Longley, Sundance's Geology Manager and the man effectively responsible for the site, it was clear that some sort of fixed wing

alternative needed to be explored. In part this was dependant on the upgrading of the Yangadou airstrip. In his response of 28 November 2009, Mr Duff of Dynamiq, Sundance's logistics contractors, gave details of a company called Jetfly, a Cameroonian charter company based in Douala, operating a Dornier 15-person aircraft. The email said that the head pilot appeared to be friendly and competent and possessed the ability and contacts to help with both the Cameroon and Congo operations, "including securing authorisation in using the Yangadou airstrip". The email made clear that all of this was dependant on an immediate reconnaissance of Yangadou itself.

23. The evidence was, and I find, that as charter flights became the best option of travelling to Mbalam/Nabeba:

    a) Each charter flight had to be approved by Mr Don Lewis, the CEO of Sundance;

    b) Both Mr Lewis and Mr Carr-Gregg were aware of the risks of air travel and addressed those risks with the potential carriers, including making enquiries about their insurance, certification and other documentation;

    c) Mr Carr-Gregg arranged insurance for every flight taken.

24. These careful procedures can be seen in respect of the proposal to use Jetfly to undertake the first flight to Yangadou. The documentation obtained by Sundance/Dynamiq (over a period of weeks) in respect of Jetfly included their Air Worthiness Certificate, an insurance certificate, an Air Operator's Certificate ("AOC"), and specifications in respect of both operations and maintenance.

25. The enquiries made of Jetfly were in accordance with Sundance's Travel Policy for charter flights to the effect that:

    a) Any fixed wing aircraft would be twin-engined and carry two pilots;

    b) The operators would confirm they had the necessary AOC;

    c) All flights would be approved by the CEO;

    d) There was evidence of third party liability insurance cover of at least $10 million.

26. The reconnaissance flight to Yangadou using Jetfly was fixed for 22 January 2010. Mr Longley, who was not going to be on the flight, said that its purpose was to see if Yangadou could be used for a medical emergency/evacuation. He said that another purpose was to check out the potential use of Jetfly as charterers. Mr Duff of Dynamiq was going to be on board the flight.

27. On 16 January 2010 Mr Carr-Gregg emailed his insurance brokers seeking insurance cover for the flight. In order to make that request, Sundance reiterated that they had obtained extensive information about Jetfly (as set out in Mr Carr-Gregg's email of 15 January 2010), including the name of company, where they were registered, ownership, and where they were registered to fly; the proposed charter agreement; Jetfly's insurance details and copy policy; and detailed information about the

particular trip. There was a concern as to whether the non-employees of Sundance (such as their consultants, Dynamiq) were covered by the Jetfly insurance, and indeed whether Jetfly (a Cameroonian company) would have insurance to fly into Congo at all.

28. The Jetfly flight was approved by Mr Lewis and took place on 22 January 2010. The flight was from Douala to Yangadou, the first time the airstrip there had been used for a flight like this. Mr Duff was on board. It was regarded as a success.

29. As a result of the flight on 22 January 2010, it was concluded that charter flights were appropriate for medical emergencies/evacuation from Yangadou. It also appears that Sundance were looking to set up a regular air service using Jetfly, possibly involving one or two flights every month.

30. In February 2010, notwithstanding this potential commitment to Jetfly, Mr Carr-Gregg emailed Ralph Kriege, Sundance's Exploration Manager, to indicate that they needed a fall-back charterer and suggesting that they try to source a contact through Marc Lour, a Congo pilot with lots of contacts, who was married to Ms Hilly-Ann Fumey, the Dutch Honorary Consul. Mr Carr-Gregg said that "I understand that Jetfly are great and are on holiday and I am not suggesting we don't continue our relationship (although it would be helpful if they could leave us contacts while they are on holiday)."

31. By February 2010, arrangements were progressing for a visit to the Mbalam/Nabeba site in March 2010, bringing as a guest the Cameroon Minister of Mines. On 16 February 2010 Mr Lewis emailed Mr Carr-Gregg to say this:

> "…preparing for site visit will take some days to organise… Flights will need some work as well. The recent flight undertaken by Jetfly took Jeff weeks to organise and he is on R&R during the prep time for this visit. We need to do HSE reviews on the charterer. Work out flight times and the schedule etc. This really takes a lot of effort."

32. On 22 February 2010, it was reported that Jetfly were unavailable for the proposed trip in March 2010. Ms Fumey suggested a Congo aviation company called Aero-Service, the company who undertook the accident flight. A quotation was obtained from Aero-Service which was cheaper than that offered by Jetfly. However, there was no reference at that point to the basic documentation (such as their AOC) which had been obtained from Jetfly in November 2009.

33. The emails, such as the one from Mr Carr-Gregg to Mr Lewis of 10 March 2010, betray a slight whiff of panic about the forthcoming trip with the Minister of Mines. It was an important occasion for Sundance and there was a continuing debate about Jetfly's availability. Thus it was that Mr Lewis, in his response email at 9:58pm on 10 March 2010, instructed Mr Carr-Gregg to pursue the alternative charter quote from Aero-Service "but we will need copies of their insurance, maintenance records, aircraft certification etc to ensure their safety arrangements are satisfactory."

34. One of the most important documents of that type would have been the AOC, issued by ANAC, (the Congolese Civil Aviation Authority) to Aero-Service. The claimants'

closing submissions raised two issues on the AOC: first, whether Aero-Service had such a document and, if they did, whether Sundance ever saw it. This matters because an AOC is the equivalent of a license, a formal approval of the charter flight company by the relevant aviation authority.

35. As to the first point, I am in no doubt that Aero-Service always had an AOC. The audits, and in particular the most recent audit of February 2010 (referred to at paragraphs 137-141 below) expressly reported that Aero-Service had an AOC. There is no suggestion in the subsequent Air Accident Investigation Report that Aero-Service did not have such a document, which would have been one of the first things that would have been checked following the accident. I consider that it is inevitable that, if Aero-Service had not had an AOC, that omission would have been identified in the Report. On the balance of probabilities, therefore, I find that Aero-Service had an AOC.

36. Further, I consider that, also on the balance of probabilities, it is a fair inference that Sundance saw a copy of the AOC in preparation for the March flight. I do not believe that Mr Lewis would have sanctioned the flight without sight of the AOC. However, it is not possible to say that any of the other documentation that Mr Lewis had indicated in his email of 10 March (paragraph 33 above) was provided by Aero-Service. Indeed, as noted in paragraph 110 below, the inference must be that it was not.

37. On 11 March 2010, Mr Carr-Gregg informed Mr Lewis that Jetfly had now confirmed their availability for the flight the following week, but stressed that the Aero-Service quote was 78% of the Jetfly price. In an apparent response to the earlier request for information about Aero-Service, Mr Carr-Gregg said that he had asked Antonie Vermaak, a pilot employed by Fugro (who were carrying out aerial surveys for Sundance) to check out the Aero-Service CASA C-212-300 Aviocar aircraft. He apparently did so and told Mr Carr-Gregg that "it was a reliable aircraft and in good nick".

38. Mr Carr-Gregg went on as follows:

> "I know Jeff [Duff] wants to develop a relationship with Jetfly because of the concept that it is the only airline that can fly from Douala to Yangadou but:
>
> (a) I am assured that Aero-Service (which seems to have more planes and seems to be more reliable (it is sometimes very difficult to contact Jetfly)) can fly this route with no problems;
>
> (b) Aero-Service is cheaper;
>
> (c) The Aero-Service plane is a Congo registered plane and given the sensitivities here, I don't think it is particularly diplomatic to carry the Congolese Minister on a Cameroon registered aircraft;

> (d) Jetfly think they have a monopoly and are – frankly – ripping us off because of this. I think a bit of competition would be a good idea."

The email appeared to include some internet links to information about Aero-Service, including a Wikipedia entry. The Aero-Service website to which reference was made was apparently said to be "under construction".

39. Also, on 11 March 2010, Mr Carr-Gregg sought (from Ms Fumey), Aero-Service's insurance certificates, plane registration details and so on. Mr Carr-Gregg noted that Sundance had gone through "quite a vetting process" with Jetfly. Aero-Service subsequently provided an insurance certificate for their CASA C-212-300 aircraft which was accepted by Sundance's brokers, and the necessary insurance for the flight was arranged. I therefore find that the arrangements for the March flight with Aero-Service were in accordance with Sundance's Travel Policy (paragraph 25 above).

40. The flight on 19 March 2010 went ahead with the Congolese Minister of Mines. The documents make clear that it was a success. It flew from Douala to Yangadou, using the CASA C-212-300 aircraft. It was flown by Mr Canal and Mr Hollingsworth, the two pilots who were to lose their lives in the June 2010 accident. Also on board that flight were Ms Fumey, and Mr Carr-Gregg. Mr Fumey was accompanied by her husband, the pilot Mark Lour. I therefore accept Sundance's submission (paragraph 74 of their written closing submissions) that this was clear testament to the confidence that everyone had in Aero-Service.

41. However, purely coincidently (as Mr Longley confirmed to me in his evidence) on 19 March 2010 he emailed Mr Duff of Dynamiq to ask him to report on any follow-up work he had done with Aero-Service "as a possible alternative or competitive bidder to the Jetfly option". Mr Duff responded by saying that the quote from Jetfly was "pretty reasonable to be honest", and he said that he had not done any follow up with Aero-Service "except confirm they are a decent operator with a CASA aircraft." There was a reference to Mr Carr-Gregg handling that whole project. Although Mr Longley said at one stage he did not know to what that was a reference (and on another occasion said he thought that was a reference to background checks), it was clear to me that that was a reference to the flight that had actually taken place on 19 March 2010, because it was Mr Carr-Gregg alone who had obtained the quotation from Aero-Service, and the insurance documentation. It was he who had provided all the necessary information to Mr Lewis in order that he could make the decision to fly with them.

42. It is clear that, as a result of this successful flight, Mr Carr-Gregg was very happy with Aero-Service. On 20 March 2010 he sent them an email thanking them for their service the previous day and he also emailed Mr Lewis to describe Aero-Service as "excellent and cheap". He was very positive about the plane (the CASA C-212-300 Aviocar aircraft) and he asked Mr Lewis if he wanted him to book Aero-Service for any of the visitors "coming up". However, Mr Lewis told him "not to worry" about following up with Aero-Service, and the idea was dropped.

43. The third and final flight to Yangadou prior to the accident occurred on 30 March 2010. This was with Jetfly. It flew from Douala. Mr Longley and Mr Duff were aboard. Mr Longley's evidence about this third flight was therefore the only evidence

that the court heard from anyone who had flown a charter flight in this region at this time.

44. Mr Longley explained that although they were flying to Yangadou, they also overflew the Core Iron mine at Avima. Having done that, they then turned east and flew along the west/east Avima ridge before circling Nabeba and landing at Yangadou. He said the weather was fair and there was good visibility. He said that the overfly at Avima was high enough to see buildings and vehicles but not individuals, a height which Captain Gillespie (GMP's expert) later put at about 1,000 feet. He said one of the principal purposes of the flight was to look at how Jetfly operated:

> "I was sort of looking at how Jetfly operated, how professional the pilots were, the condition of the plane, what routines they went through, what maps they hold and what generally their professionality sort of regime was. I didn't have any specific concerns about their ability, No."

45. One other point should be made about the flight on 30 March 2010. The emails make plain that insurance cover was only sought on the day of the flight. Furthermore the Journey Management System ("JMS") identified the details of the risks associated with the journey. One of the hazards was identified as "crash": the mitigation was identified as "pray".

3.4 Waiver of Liability/Exclusions

46. The documents reveal that, notwithstanding the rather flippant approach to risk assessment revealed in the previous paragraph, Sundance in fact operated a much more hard-nosed approach to questions of liability. They had, in essence, sought to obtain personal waivers of liability or exclusions from all those boarding the charter flights which they organised, even if the problem with the flight stemmed from their own negligence. A brief outline of this approach is required, because of its relevance to the flight Mr Cassley was required to undertake in June 2010.

47. On 17 January 2010, Mr Carr-Gregg had emailed Mr Lewis to say that his concern was 'a Dornier load of people crashing' and the subsequent claims that would be made against Sundance in Australia, Cameroon and/or the Congo (where Jetfly was not insured). He was concerned that the insurance cover could be exceeded and that Sundance could face multiple claims involving millions of dollars. He therefore thought it was sensible to consider a release limiting claims to the amount of insurance actually recovered. Later the same day, Mr Carr-Gregg reiterated that Congo was an exclusion in the Jetfly insurance contract (see paragraph 27 above) and that extensions had to be obtained for landing in excluded countries.

48. On 20 January 2010, with the exemption (which would have allowed Jetfly to fly into Congo) still outstanding, Mr Carr-Gregg provided to Mr Lewis a release document which he wanted all passengers to sign. The release document was a personal waiver of liability and assumption of risk. It was in broadly similar terms to the exclusion of liability provision to which Sundance sought GMP's agreement in June 2010, although that was not personal but addressed to GMP generally. This version waived the right of the individual who signed it to make any claims against Sundance and

also agreed to indemnify Sundance from claims as a result of flying on the Sundance organised charter.

49. Mr Lewis agreed to the document, unless it conflicted with the terms of Sundance's contract with Dynamiq. But Mr Longley was appalled and emailed back the same day to say:

> "This would be an extraordinary circumstance and I would not allow any Sundance/Cam Iron employees under my responsibility to agree to such a waiver."

He also pointed out that Mr Moorhouse of Dynamiq would have to agree to such a waiver before considering that option for any Dynamiq employees. But Mr Moorhouse agreed with Mr Longley, saying:

> "He would not ask an employee to sign and neither will I. Imagine if something happened and as a result your family couldn't get suitably compensated."

50. It was not only those involved in this story that reacted with outrage at Sundance's attempts to avoid liability. In May 2010, representatives at Vizag Steel were asked by Sundance to sign similar waivers in respect of travel to the project. Their response was in these terms:

> "…it is understood that there is a risk of travel to the representatives of [Vizag Steel] who will be visiting the site either in connection with data collection or for any other due diligence afterwards. It is not the question of who bears the insurance cover for the representatives of [Vizag Steel], it is a question of safety that is underlying in the reply given by you.
>
> [Vizag Steel] is concerned about the safety of its representatives who may visit the site in connection with the data collection/due diligence of the project. In this connection, from your side, how do you resolve the issue of safety if [Vizag Steel] representatives."

51. The collective reactions of Mr Longley, Mr Moorhouse and the representatives of Vizag Steel (with their emphasis on 'the issue of safety') should be contrasted with the reaction of GMP to Sundance's attempt to get them to sign a similar waiver. That is dealt with in **Section 5.2** below.

4. GMP

52. GMP is a bank providing corporate finance and investment services in the mining, oil and gas sectors. It is the London arm of the GMP Capital Inc based in Toronto. It is a substantial worldwide concern with a net income of USD $43 million and total assets of USD $1.1 billion.

53. It is clear that the London part of the GMP business, which began in 2006, was relatively modest, but has since grown to about 25 people. There are three main

business areas within the firm: corporate finance, independent research and a trading desk. There were the usual 'Chinese walls' as between the corporate finance department and the independent research department.

54. In 2010, the principal partner in London was Mr Simon Catt. Mr Cassley reported to him. He signed a number of the relevant documents. He was not called to give evidence at the trial. Instead, the only senior representative of GMP who gave evidence was Mr Butterworth, whose role in the relevant events was peripheral (although whether or not he should have been so disconnected lies at the heart of the allegations of breach against GMP). He was the only lawyer at GMP and, although not a designated member of the firm, was responsible for legal matters and compliance. In that connection, he was responsible for health and safety.

55. Prior to the accident, Mr Butterworth said that he had not had any health and safety training. He said that GMP did not have a specific health and safety budget. He could not remember if he had seen or was aware of the Management and Health and Safety at Work Regulations 1999 prior to the accident. He said he thought that he was the competent person appointed under Regulation 7, although he did not remember any decision to that effect, and he had not satisfied himself that he was in fact the relevant person. He said that whilst it was a reasonable assumption that he had the "sufficient training and experience or knowledge and other qualities" to enable him to fulfil that role in practice, having had no training, experience or knowledge of these matters, he accepted that he was reliant on outside consultants, Modus, to whom he effectively sub-contracted his health and safety responsibilities.

56. The GMP Health and Safety documentation, and Mr Butterworth's evidence in respect of it, was not, in consequence, very illuminating. There was a Health and Safety Induction document dated 12 November 2008 but Mr Butterworth did not know if that document was in force at the time of the accident. Similarly, the Office Risk Assessment dated 1 November 2008, signed by Mr Slatter from Modus, was not a document that Mr Butterworth could say with certainty was in force at the time of the accident. In addition, there was a document entitled 'Risk, Legal and Compliance Report' which may have been useful but had been almost entirely redacted, so that the surviving version in the court bundle was completely useless. I have said before, and can only now repeat, that the redaction of a document like this, in a claim where serious allegations are made against GMP, does not help to alleviate the court's suspicion that the redactor may have something to hide. This is particularly so when one of the headings in the document (it is the headings, save for one paragraph, which are the only survivors of the redaction process) is 'Overseas Jurisdictions'.

57. There is a document entitled Office Risk Assessment, again dating from November 2008. Under the heading 'Those at Risk' it says this:

> "Individuals or groups at risk due to the hazard will be considered. This will include employees, the self-employed and any other person. If vulnerable persons, such as young people, pregnant women, nursing mothers, those with disabilities, lone staff and those working out-of-hours or at remote locations etc are likely to be exposed, additional consideration will be given."

That last sentence plainly related to Mr Cassley in June 2010, although Mr Butterworth's oral evidence indicated that he did not make that connection at the time.

58. There is a further document dating from February 2009 entitled 'Policy Arrangements'. Mr Butterworth was able to confirm that this was in force at the time of the accident. It referred to the Designated Safety Officer (who was Mr Butterworth) and dealt at the start of the document with his responsibilities. It stated that he was "committed to health and safety, will provide leadership and will ensure that health and safety is taken into account when business decisions are taken."

59. The document included a section dealing with risk assessments. It repeated the same words as in the previous paragraph in respect of those at risk. It also contained the following passages:

> "Arrangements for Securing the Health and Safety of Staff.
>
> Elimination of Hazards.
>
> The firm will ensure all hazards will be eliminated, so far as is reasonably practicable. If this is not possible, the remaining risks will either be avoided or reduced to an acceptable level. The measures introduced to achieve this will follow the principles of prevention and aim to combat risks at source.
>
> Assessment of Risk.
>
> If hazards cannot be eliminated or risks avoided, an assessment of the risks will be carried out by competent persons. The following factors will be considered during the assessment…"

There are then references to likelihood, severity, those at risk and so on.

60. Section 15 of the document is entitled 'Contractors'. It contains these passages:

> "Policy Statement.
>
> The site occupiers, the firm will plan, co-ordinate, control and monitor the activities of contract companies to effectively minimise the risk presented to employees, other persons on-site and the public.
>
> Approved Contractors.
>
> The firm will only use contractors who proved able to discharge their primary responsibilities to safeguard their employees and other persons who may be affected by their undertaking. This will be achieved by a selection and evaluation procedure to ensure that only competent contractors are used by the firm…
>
> Safety Rules and Procedures.

> …the firm will make arrangements for the exchange of all relevant information arising from risk assessments and emergency procedures, particularly steps required to protect contractor's employees from other contractors and their employees, as well as the day-to-day activities of the employee's workplace."

61. There was also a Health and Safety Policy dated 3 February 2009. That began with this paragraph:

> "GMP Securities Europe LLP (the "Firm") considers the health, safety and welfare of its employees and others who may be affected by its activities to be of primary importance to the success of the Firm."

In addition, under paragraph 5.14, entitled Firm Travel, it provides as follows:

> "GMP Securities Europe LLP may require employees to travel extensively. We recognise that the health and safety of staff and contractors is put at risk by travelling and we are concerned to do all that is reasonably practicable to minimise these risks.
>
> We are aware that it is safer, mile for mile, for staff to travel by rail or air rather than road. Therefore where practicable trains can be used for longer journeys or air travel where authorised."

5. THE JUNE VISIT TO MBALAM/NABEBA

5.1 The Preparations

62. On 25 February 2010, Mr Andrew Young, a colleague of Mr Cassley's at GMP, sent Mr Lewis of Sundance an email offering to meet him the next time he was in London. It was a sales pitch. It was not until 16 April 2010 that Mr Lewis responded, by which time he was in London. He had a meeting with Mr Young at this time, although Mr Young did not deal with that meeting in his witness statement. Both Mr Cassley and Mr Fernley, from GMP's research department, were also present. By this stage, as an earlier email that Mr Lewis sent to Mr Duff on 11 March 2010 made plain, the Sundance Board was planning a mid-June board meeting in Cameroon, including a site visit to Mbalam/Nabeba. This proposal was subsequently confirmed in the Sundance board minutes of 29 April 2010.

63. The reason for holding the Board meeting there was that high grade ore had been identified at both Nabeba and Mbalam. The Congolese permits from Nabeba were due for renewal in early August and Sundance were anxious to demonstrate their commitment to the project and, in particular, to secure the renewal of the permits. Linked to that, of course, was the issue of how further investment funds might be raised.

64. Following the meeting between the GMP representatives and Mr Lewis, it became plain that it would be in everyone's interests for a representative of GMP to visit the site at the same time. Originally, Sundance envisaged that Mr Fernley would attend

because of his research papers on iron ore deposits in that area of West Africa. However, Mr Fernley declined to make the trip because, as someone in the research department, he would have had a conflict of interest and would have been unable to sign the usual confidentiality agreement. It was in those circumstances that Mr Cassley – who was going to Canada in June and was not very keen to go to Africa immediately afterwards – was identified as the representative of GMP who would make the trip.

65. All the arrangements for the site visit were made by Sundance. On 5 May 2010, Mr Carr-Gregg emailed Jetfly to see whether the Dornier was available to fly from Yaoundé to Yangadou on Saturday 19 June 2010 and return to Yaoundé on the Sunday. Mr Steele of Sundance indicated that, if there was a problem, he had contact with South African pilots (a company called Solenta, see **Section 5.3** below) who might be able to help. However, by 18 May 2010, it was looking likely that Jetfly were available to undertake the trip.

66. On 18 May, Messrs Cassley, Young and Fernley met with Mr De Nardi of Sundance in London. Thereafter, Mr De Nardi, who was based in Perth, was GMP's point of contact in respect of all the arrangements concerning the trip to Mbalam/Nabeba. On 28 May 2010, Mr De Nardi sent Mr Cassley an overview of the planned trip. The relevant part of the written itinerary was:

> "19 June depart 8:00 charter flight Yaoundé to Nabeba
>
> - Inspect Nabeba mine site/camp
> - Inspect Mbarga mine site/camp
> - Overnight in Mbarga campsite
>
> 20 June depart Mbarga for 9:30 charter flight Nabeba to Yaoundé
>
> Arrive 11:.. Yaoundé"

The itinerary also made plain that Mr Cassley would be flown from Paris to Yaoundé in the private jet belonging to Mr Talbot, a Non-Executive Director of Sundance and a big figure in the mining world. The email said that "all internal Cameroon flights will be booked by Sundance". It also said:

> "You will be able to see part of the rail corridor from the plane and when you're on the ground at Mbarga."

67. On 1 June 2010, Mr De Nardi told Mr Cassley in an email that the flight from Yaoundé to Congo and the return was "on a Jetfly charter flight". That was the only reference to any carrier in any of the information provided to GMP by Sundance. At no time did GMP seek any further information about Jetfly from Sundance, nor did they undertake any researches of their own.

68. Also on 1 June 2010, Mr Cassley sent Ms Champion, GMP's Office Manager in London, details of the trip, because he needed the relevant visas. In respect of the site

visit he said that that was "via chartered plane (company has arranged). Morning will be site visit in Cameroon, afternoon will be Congo (company arranging visa). Overnight at the Congo mine camp."

69. In early June 2010, it became apparent that there might be a problem with Jetfly undertaking the flights to and from Yangadou. ANAC had indicated that Jetfly might not be permitted to land at Yangadou because they were not a Congolese registered carrier. Initially, Mr Carr-Gregg seemed relaxed about that and on 8 June 2010 he emailed Mr Duff at Dynamiq to say:

> "There may be a bit of turbulence in relation to the proposed flight but please press on – we do not need helicopter backup – if the flight can't go for any reason the Board will cancel Yangadou."

At the same time he asked Mr Steele to follow up with ANAC to see if the problem could be resolved. Mr Steele said he had already seen ANAC three times on the same subject.

70. Mr Steele's researches into the potential difficulties with the Jetfly flight to Yangadou make plain that the problems were wider than just a question of the national registration of the carrier. ANAC had given Mr Steel technical reasons why the landing strip may be unsafe; they had raised concerns about the absence there of police, customs and immigration control; they said that Souanke, the nearby strip, was already ratified for international flights (and was therefore a better alternative); and they also claimed that the Jetfly flight in March 2010 had been refused landing.

71. Eventually, these negotiations caused Mr Carr-Gregg to become exasperated with the attitude of ANAC. He pointed out in an email to Mr Steele, copied to Mr Lewis, and dated 10 June 2010, that the Yangadou airstrip had been expressly approved by ANAC for the Minister of Mines to land on it. He denied that the airstrip had been created without authorisation, noting that Sundance had graded and improved an existing airstrip. He said he had never heard of a refusal to provide permission to use the strip but he went on:

> "This now a matter of urgency as we are going to have to cancel the directors visit to site if we do not have approval to land in Yangadou."

72. None of these difficulties were shared with GMP. Instead, during the middle part of June 2010, the correspondence between GMP and Sundance was almost entirely taken up with Sundance's desire to ensure that GMP waived any rights that they might otherwise have in the event of injury or death during the visit. I deal with those exchanges in **Section 5.2** below.

73. On 10 June 2010, Mr Steele emailed Mr Carr-Gregg in connection with the ongoing problems with the proposed use of Yangadou. He said that the Board flight on 19/20 June 2010 would be authorised if Sundance agreed to the Souanke option. He said that if that did not happen, the threat was that any planes which landed at Yangadou would be seized. The following day, on 11 June 2010, Mr Carr-Gregg emailed Mr Duff to tell him to explore the use of Aero-Service for the flight, which he described

as "likely to be more expensive but potentially acceptable to ANAC (as it uses Congolese aircraft)."

74. Mr Steele sought a quotation that day. Aero-Service responded through one of the pilots, Frederick Canal, who was to lose his life in the accident. This set out a proposal for the programme, identifying various hour blocks between Friday and Sunday 18- 20 June 2010. As Mr Steele made plain, there were no difficulties with that programme but the real question was the cost. Aero-Service did not quote for the cost of the flight until 14 June 12010. The quotation was in the sum of 18.5 million CFA Francs. No other information was provided.

75. On the same day, 14 June 2010, Mr Steele emailed Mr Lewis to say that, with 90% certainty, "the only flight authorised to land at Yangadou was the one with the Minister. We face fines for any others that they can prove to have occurred, along with penalties for operating an unauthorised airstrip." The email went on to say that he did not believe that ANAC would ratify the Yangadou airstrip. He proposed a solution which involved upgrading the airport at Souanke; using whenever reasonable a Congolese based carrier; and agreeing to use for the short term Souanke for all but VIP payload and medevac missions.

76. Mr Lewis responded in detail on 14 June 2010 noting that "the preferential use of a Congolese carrier is a big restriction and cost impact. I would accept on this special occasion (subject to cost) but our aim should be to negotiate a regularised arrangement for both alternatives – international flights from Cameroon to either Souanke or Yangadou and internal flights from Congo." He went on to say that:

> "In summary, I only want to negotiate the minimum arrangement at this stage to secure the Board trip. That is, a minor upgrading of the Souanke strip plus possible use of a Congolese air charter. The rest should be there for discussion when I am in Brazzaville with ANAC advised that any such discussions will be much more difficult if I can't get to site next week to analyse the situation first hand."

77. Mr Steele responded later that day in relatively gloomy terms, saying that he did not believe that the ANAC would ratify the airstrip at Yangadou for use. He proposed, amongst other things, using a Congolese-based carrier "whenever reasonable". He also proposed that Souanke be upgraded at Sundance's expense and used in the short term for all but VIP, heavy load and medevac missions. Mr Carr-Gregg pointed out that it would be more embarrassing paying ANAC fines when they arrived at Yangadou than cancelling the trip to site. He said "the Congo is not Cameroon, and it is quite possible that all of this communication leads to a blackmail attempt of some sort in relation to our departure." He proposed cancelling the flight unless a guarantee could be given that everything was fixed. Mr Lewis replied that the Sundance Board "will make a very clear decision if they tried this sort of stunt". There the documentary trail turns cold. However it appears clear that, at some point on 15 June at the latest, authorisation was given to fly to Yangadou. The inescapable inference in that this authorisation was directly linked to the switch from Jetfly to Aero-Service, a Congolese company. That switch is dealt with in greater detail in **section 5.4.1** below.

78. On 15 June 2010, Mr De Nardi sent Anna Roberts at Sundance (with a copy to Ms Champion at GMP in London), a detailed itinerary for the visit. That referred to the charter flight from Yaoundé to Yangadou on 19 June 2010 but did not refer to the name of any particular carrier. Another internal Sundance document of the same day still refers to Jetfly. The evidence is that Mr De Nardi, based in Perth, never knew of the switch from Jetfly to Aero-Service. In consequence, no-one at Sundance ever told GMP about that switch.

5.2 The Exclusion of Liability

79. On Friday 11 June 2010, Mr De Nardi of Sundance, sent to Mr Fernley at GMP, a Confidentiality Agreement for GMP to sign. It was also copied to Mr Cassley and Mr Young. The covering email said that its purpose was to "allow the Board to speak freely with James on site".

80. The document was actually entitled a 'Confidentiality and Waiver of Liability Deed'. Although much of it was indeed concerned with confidentiality, clause 14 was an entirely different type of provision. It provided as follows:

> "**14. EXCLUSION OF LIABILITY**
>
> 14.1 In order to give effect to the Purpose, the Recipient or Representatives of the Recipient and/or and Affiliate of the Recipient may travel to and from Cameroon, Congo and the Project Area.
>
> 14.2 The Recipient acknowledges that:
>
> (a) Any travel to and from Cameroon, Congo and the Project Area and
>
> (b) Being on location Cameroon, Congo and the Project Area,
>
> involves an element of risk and danger and may result in property damage, illness or bodily injury and/or death.
>
> 14.3 The Recipient agrees that it will undertake its own investigations regarding the risks and dangers involved with:
>
> (a) Any travel to and from Cameroon, Congo and the Project Area and
>
> (b) Being on location Cameroon, Congo and the Project Area,
>
> shortly before each time any such travel is planned and will advise all its Representatives travelling to Cameroon, Congo and the Project Area of such risks and dangers.

> 14.4 The Recipient agrees to indemnify and hold harmless the Disclosing party and each of the Disclosing Party's Affiliates and Representatives (together the 'Indemnified Party') from and against all claims, liability, damage, loss, costs and expenses (including attorney fees) arising out of the death or injury to the Recipient, its Affiliates and Representatives ('indemnifier') and the damage to any property of the Indemnifier if the said injury, death or damage results from the acts or omissions, negligent or otherwise, of the Indemnified Party."

81. Clause 17, which dealt with notices, referred to GMP but the details of addresses and individuals were left blank. The execution of the document was proposed to be by GMP 'by authority of its directors'.

82. Mr Young sent the document on to Mr Butterworth, as GMP's Head of Legal and Compliance.

83. On 15 June 2010, Mr De Nardi sent to Mr Cassley a revised deed (version 2). There was no change to clause 14. However, clause 17 had been filled in to refer to GMP Securities Europe LLP, and to include an express reference to Mr Cassley. The execution page also now referred to GMP Securities Europe LLP and the signature of "a duly authorised member". The evidence was that these changes were made by Mr Carr-Gregg.

84. At about midday of 15 June 2010, Mr Butterworth sent to Mr Young and Mr Morgan (a member of the GMP Partnership), with a copy to Mr Cassley, his own amended version of the original deed (version 3). Mr Butterworth had made some amendments. The first was to identify GMP Securities Europe LLP at clause 17(b). Secondly, instead of the notice being for the attention of Mr Cassley, it was now for the attention of 'the Designated Member, Corporate Finance'. Thirdly, he had changed the execution page to GMP Securities Europe LLP (by authority of its members, in accordance with its constitution). Two signature spaces were left, both for what were called "authorised signatories".

85. When sending this document on, Mr Butterworth said that it was for signature by Mr Young and Mr Morgan. He said that the deed "has been reviewed and to execution of which by GMP Europe there is no objection in my view from a legal and compliance perspective." I deal in greater detail with Mr Butterworth's explanation for this advice in paragraphs 88-96 below.

86. Mr Young and Mr Morgan signed this version of the deed (version 4) which was then sent back to Sundance. However, that version was never countersigned by Sundance and so never came into effect. It would appear from the documents that the reason that version 4 was not signed by Sundance was that, when Mr Carr-Gregg came to review the documents, he saw that version 2, with its express reference to Mr Cassley and the need for it to be signed by a GMP Member, had not been followed through. The blank copy of the deed that accompanied his email to Mr Lewis later on 16 June 2010 (the last email he sent on this point) was of version 2. I therefore conclude that

this was the version which Sundance (through Mr Carr-Gregg) wanted GMP to sign, but which they never did sign. Sundance did not execute version 2 of the deed either.

87. Given that the deed was never signed, in any of its versions, and therefore never came into effect, it was originally unclear to me why the document mattered so much at trial. But I was persuaded that it did matter, in part because their reaction to it provided an indication of GMP's attitude to health and safety. As we have already seen, other attempts by Sundance to obtain indemnities from those travelling to this project were met with consternation and downright hostility from the proposed recipients, and those looking after their interests. Mr Longley said at paragraph 37 of his witness statement:

> "I strongly felt I would not allow any Sundance or Cam Iron employees under my responsibility to agree to such a waiver."

And yet Mr Butterworth was more than happy to agree to it on behalf of GMP. How did that come about?

88. Mr Butterworth was cross-examined extensively about this at the trial on the afternoon of 4 February 2015 and the morning of 5 February 2015. He agreed that the clause was unusual and that he had had no previous experience of anyone trying to do this before. He knew that it related to Mr Cassley's trip to Cameroon, but he said he was comfortable with the proposed trip. When asked why, he said that his comfort was based on a conversation that he had had with Andrew Young. However, he could not remember any part of that conversation. He agreed that his evidence amounted to no more than a memory of being satisfied as a result of that conversation, but he could not now remember any particular basis for his satisfaction. Mr Young said that there was no discussion with Mr Butterworth on the practical question of Mr Cassley's safety.

89. In my view, this was unacceptable. At the very least, a short written note or memo should have been made of what the risks were and how and why those risks had been addressed or dealt with to Mr Butterworth's satisfaction. Such an approach is now GMP's standard practice: I can see no reason why it should not have been their standard practice in 2010. I conclude that the conversation between the two men did not extend beyond a general and brief discussion of Sundance's good reputation as a mining company.

90. Mr Butterworth was also very honest as to the perceived purpose behind clause 14. He was asked if the clause told him anything about whether Sundance were prepared to accept responsibility for taking care of Mr Cassley. Mr Butterworth said that the clause told him that they were *not* prepared to accept responsibility for him, and agreed that clause 14 was in fact "a complete shovelling-off of responsibility". He also said that he recognised that at the time, saying that it was 'a very clever' clause, and the sign of a very professional company that was protecting its interests. He said that he recognised that it was an attempt by Sundance to shirk responsibility even in circumstances where they were careless or negligent.

91. Mr Butterworth sought to excuse his lack of concern about Sundance's attempt to escape liability by saying that "there were no material risks identified". It was unclear what this meant. As Mr Reeve pointed out in cross-examination, the material risks

were plainly spelled out in clause 14: a heightened risk of danger, injury and death. It may be that Mr Butterworth was referring back to his conversation with Mr Young, but of course the difficulty with that was that he could not remember what was said. Furthermore Mr Butterworth accepted that this clause made GMP responsible for the risks and for the investigations into those risks. When asked what investigations he understood that he was promising to make pursuant to the clause, all Mr Butterworth could say was that he took comfort from his conversation with Mr Young.

92. There was then this exchange:

> "Q: Mr Butterworth, you should have looked into the risks and dangers of this travel, shouldn't you?
>
> A: In retrospect, now knowing what can be done to do further due diligence on trips, then yes, I would like very much to have had that knowledge at that time. Obviously we now do that, having improved the policy.
>
> Q: So you are clear, I am putting a slightly different point to you, and I want you to have the opportunity to answer it. Forgetting hindsight, having received that clause and having seen the attempt to impose an obligation on you to conduct investigations, and having seen the attempt of Sundance to avoid responsibility for care in making the arrangements, you should, at the very least, have looked into those risks and dangers yourself?
>
> A: I would have liked to, yes."

93. Following some further cross-examination about the circumstances in which clause 14 was sent to Mr Cassley, there were then these exchanges:

> "Q: You were the senior person, you are a lawyer, you are in charge of health and safety. He is a corporate finance associate, six to nine months (after) finishing his probationary period. What on earth was he supposed to make of this?
>
> A: I cannot answer that question.
>
> Q: Do you agree that you and GMP failed in your duty to take reasonable care for James?
>
> A: No.
>
> …
>
> Q: At the time of this email, apart from the contents of clause 14, what information did you have about Sundance's capabilities for organising the trip properly and carefully?
>
> A: Nothing other than their reputation."

94. When Mr Butterworth claimed that Sundance were saying that they were not going to be liable if something went wrong, I asked him if, on the face of clause 14, it was actually saying rather more than that, because it was expressly warning GMP that they had to do their own investigations. Mr Butterworth gave this answer:

> "I can describe it only as a manageable risk, knowing the reputation of Sundance, having my assurances from Andrew Young in a brief conversation that James was a guest of Sundance, I had no concerns, and particularly I had no concerns about signing clause 14, because if I had, it would have been ludicrous to sign clause 14. It was precisely because I had no concerns that I saw no objection to signing clause 14."

95. This answer was taken up by Mr Reeve on the following day (Day 3). He said:

> "Q: I am going to suggest to you that what was critical was your conclusion from your conversation with Mr Young that there were no safety concerns of questions requiring further investigation about the safety of the trip.
>
> A: That's right.
>
> Q: If you had not reached that firm conclusion it would have been ludicrous to proceed as you actually did?
>
> A: Yes.
>
> Q: On your conclusion that there was no cause for concern or further investigation was pivotal, wasn't it?
>
> A: Yes.
>
> …
>
> Q: It follows that if you had had grounds at that point to question the safety or care to be taken in the arrangements by Sundance for James, you would have come to a completely different view of the proposals from Sundance?
>
> A: Yes.
>
> Q: Because the safety of your employee would then be engaged, wouldn't it?
>
> A: Yes.
>
> Q: You would have regarded the waiver as ludicrous in those circumstances?
>
> A: Yes.

> Q: It would have been ludicrous in that event because it would have shown Sundance to be shovelling off a liability for taking care in circumstances where it might be necessary?
>
> A: Yes.
>
> Q: It would have been ludicrous because it would have given rise for doubting that they were a responsible person to whom care of your employees could be entrusted?
>
> A: Yes.
>
> Q: I suggest to you that if that had been your train of thought you would have wanted to have nothing more to do with that deed?
>
> A: Yes. That's right.
>
> Q: You would have been concerned that the clause focused on the wrong investigation, that is investigations by you rather than investigations by Sundance for the purposes of making the trip safe.
>
> A: Yes."

96. I am anxious not to be too critical of Mr Butterworth, who was an honest and thoughtful witness, who was endeavouring to do his best to assist the court. But I have concluded that, although he realised that the wording of the proposed deed was an attempted abdication of responsibility on the part of Sundance, he never thought through the obvious consequences of that for Mr Cassley's health and safety. He was prepared to accept that his email approving clause 14 and notifying Mr Cassley of it was "a pro-forma type act". Unlike Mr Longley, Mr Moorhouse and particularly Vizag Steel (paragraphs 49-51 above), he never considered the deed from a health and safety perspective. I accept Mr Reeve's observation in his closing submissions that this may have been because Mr Butterworth, having sub-contracted responsibility for health and safety matters to Modus, was simply not used to thinking about such matters himself.

5.3 Solenta

97. On Wednesday 9 June 2010, Sundance received an email from Solenta Aviation. It was essentially pitching for the charter flight work that Sundance might have in the future. It was linked back to Mr Steele's email at paragraph 47 above. Parts of the Solenta email read as follows:

> "We have been following your expansion in Congo and would like to offer Aviation services to you, should the need arise.
>
> We have full Approved Maintenance Organisation (Part 145AMO) facilities in Abidjan, Côte d'Ivoire and Accra, Ghana and Line Maintenance Facilities and approval in Dakar, Niger, Lomé.

> We have five B1900D's and three ATR42's presently in the region, we have over USD $1 million worth of spares and tooling situated in Dakar, Abidjan, Accra, Niamey and Lomé.
>
> Our aircraft will be sent up with a dedicated spares pack, as well as a dedicated engineer, and would have access to our extensive spares pool based across West Africa…
>
> Solenta is Safety and Quality Audit approved by VALE, BP, BHP Billiton, Goldfields Gold, Newmont Gold, Total Oil, Anadarko Oil, Tullow Oil, DHL, ICRC, UN, WFP, ENI/AGIP, as well as several Civil Aviation Authorities all over Africa and the Middle East."

It is noteworthy that, alone of all the charter operators involved in this case, Solenta were the only ones to refer expressly to their safety and quality audit.

98. This email found its way to Mr Longley of Sundance, the General Manager at the site. He sent an email on Monday 14 June 2010 to Mr Duff of Dynamiq asking him to make contact with Solenta to see if they could fly in and out of Yangadou and to obtain a "ball-park indicative pricing". In his evidence Mr Longley said that, at least at the time that he sent this email, he was thinking in terms of Sundance's longer term requirements as to charter flights, as opposed to the forthcoming flight on 19 June 2010.

99. However, it is clear that that intention was not shared by Mr Duff. Because of the ongoing difficulties with obtaining authorisation for a flight to land at Yangadou (see **Section 5.1** above) Mr Duff said, in an email to Mr Lewis dated Monday 14 June 2010, that he had contacted Solenta specifically in connection with the forthcoming flight on 19 June 2010. He said:

> "…they will be sending through their capabilities and costs today.
>
> …they have a BEECH 1900 available in Ghana which might be able to be used…they have to look at our airstrip recce provided by MSS first as it is a much bigger craft."

100. The quotation from Solenta, also dated 14 June 2010, was plainly for the flight on 19 June 2010 (what Solenta called "your requested mission"). The quotation was detailed and again expressly referred to airline safety standards, and performance and safety criteria. It stressed that Solenta Aviation was OGP approved: "the very high safety and quality standard set by the Oil and Gas Producers Industry".

101. Although Mr Longley maintained in his evidence that he had thought that enquiries were being pursued by Solenta for general purposes, rather than for the purposes for the June flight, he acknowledged that the quotation for this particular flight from Solenta was expressly emailed on to him later on Monday 14 June 2010. He was asked if he had considered this quotation for the purposes of engaging Solenta to provide the flight on 19 June 2010. He said No, adding that "I didn't join the dots at the time". It was unclear as to whether he had done anything further in relation to this

Solenta quotation. Mr Duff, on the same day, did take the matter forward because he said he liked what he was seeing and asked for a quote for his immediate need, namely the flight on 19 June 2010. Mr Longley said he was unaware of this.

102. The quotation from Solenta came the following day on 15 June 2010. The quote was USD $35,000. The quote made plain that the flight would be done in two rotations (namely, the passengers would be split over two flights), and it made the point that most/all aircraft would need two rotations to achieve these missions. Again the quotation was expressly based on the ways in which to achieve the result of getting the passengers to Yangadou "safely i.e. airline performance standards". Mr Longley could not remember seeing the quotation but did think that he 'remembered the numbers'.

103. It is very unclear what happened to this quotation. Mr Longley had originally said he could not remember any conversations in respect of it and said that Mr Kriege was dealing with the detail. He said he left everything to Mr Kriege and could not remember the specifics. Subsequently he thought that Mr Kriege had mentioned that Solenta might have had difficulty in obtaining authorisation to land at Yangadou.

104. On Wednesday 16 June 2010 Solenta chased Mr Duff for a response to their quotation. They made it plain that "if we don't apply for clearances by today, we may run the risk of not getting them in time to do the flights. Clearances normally take 2-3 working days…"

105. At some point on that Wednesday, a decision was taken by somebody at Sundance (I conclude that it must have been Mr Lewis) to reject the Solenta quotation. When Mr Duff emailed Solenta later on the Wednesday he did not say that the problem was anything to do with permits, although (because they were not a Congolese-registered carrier) Solenta would have had precisely the same difficulties as Jetfly in obtaining authorisation to land at Yangadou. I note that all three experts have subsequently agreed that, for the flight in question, it was necessary to charter a Congo-approved charter. In addition, another reason for the rejection of Solenta's quotation may well have been financial. They themselves acknowledged that their quotation was expensive because it involved two flights, although they had stressed the safety aspects of this.

106. The Solenta story does not quite end there. In their response, Solenta said that they quite understood the rejection, again referring to cost. They then went on to say this:

> "As a service to you, and only if you want, let us know how you are going to do this charter flight (aircraft type, route, payload) so that we can check up for you if it is being offered safely and legally. Many operators operate illegally and unsafely just to win the business. We have the performance software/graphs of most aircraft to analyse. Solenta will not compromise safety to win a flight."

Even endeavouring to put all hindsight to one side, it is a striking feature of the material from Solenta that safety considerations were treated as a matter of paramount importance. The offer to undertake a safety check of the flight eventually organised was not taken up by Sundance.

107. Although there was no pleaded case in respect of Solenta, the suggestion in the claimants' closing submissions was that, in some way, Sundance should have chosen them as alternative carriers to Aero-Service. It is as well to deal with that allegation here. I accept Sundance's case that they had no reason to prefer Solenta, a carrier of whom they had no experience and about whom they knew very little (other than what Solenta itself had told them) over Aero-Service, a carrier they had used successfully before. In addition, I accept the proposition that, realistically, there was insufficient time between Solenta's first pitch for the business, and the date of the proposed trip, in order to allow Sundance to make the necessary enquiries in order for the June flight to go ahead with Solenta. Still further, I find that, on the balance of probabilities, even if Sundance had decided that Solenta should make the flight, because they were registered in Ghana and thus were not authorised to land at Yangadou by the Congolese authorities, Solenta would not have been permitted to make this flight anyway.

108. For all those reasons, therefore, to the extent that it was the claimants' case that Sundance should have used Solenta for the flight on 19 June, I reject that case as unpleaded, unrealistic, and – most importantly – contrary to the evidence. Of course I accept that, if Solenta had made their pitch for the business a month of two before, then the position might have been very different, but that is simply too speculative for the purposes of the claimants' case.

5.4 The Late Changes

5.4.1 The Carrier

109. Although, as I have said, there is no evidence as to precisely how and when the arrangement with Jetfly was cancelled, it appears that, at some point on 15 June 2010, somebody at Sundance (again, I infer that it was Mr Lewis) decided to cancel the order with Jetfly and instead to ask Aero-Service to undertake the flight. This can be seen from the email of that date to Mr Steele from Mr Lewis in which he asked Mr Steele to advise Mr Carr-Gregg and him of the plane details, so that they could advise the Board and Mr Carr-Gregg could arrange insurance. Mr Lewis went on to ask:

> "Can you also check out their maintenance protocols, pilot experience, etc as I am sure that some of the Board will ask this re safety, etc."

110. It seems to me plain this email confirmed that, by then, the switch had been made to Aero-Service. No such request was necessary for Jetfly, as this information had long since been provided. The email also recognised that, even though Sundance had used Aero-Service before, they did not have all the formal documentation which Mr Lewis felt they needed. This request from Mr Lewis echoes his earlier request to Mr Carr-Gregg (paragraphs 33-36 above) and, in my view, makes reasonably clear that that earlier request had *not* been followed up in the interim.

111. There is nothing to suggest that Mr Steele undertook the work that Mr Lewis asked him to do. He replied to say that he thought it was the same plane and same pilot. Everyone assumed that that was a reference to the same plane and the same pilot that had undertaken the trip from Douala on 19 March 2010. On the same day, Mr Carr-

Gregg emailed Mr Lewis to say that they needed to switch insurances from Jetfly "to Congo charterer in country".

112. After that, Mr Duff was asked to provide details about the aircraft, call-signs, flight plan and so on. Captain Gillespie, GMP's expert, agreed that this was 'pure housekeeping' and did not relate to matters of safety. He was of a similar view about the subsequent email from Mr Carr-Gregg which sought the same information and insurance details. Thus, I find that – on the balance of probabilities – the specific request that Mr Lewis made, for Aero-Service's maintenance protocols and the like, was never actioned. However, I also find that, because the evidence was that Mr Lewis had to approve every flight, it is a proper inference to draw that he approved the Aero-Service flight on 19 June 2010, based on the information which he had available at the time. He would therefore have known that he did not have the further information he had asked for, but he considered that he knew enough to sanction the use of Aero-Service for a second flight.

113. In the run-up to the flight, Mr Cassley was never told about the late change of carrier. He was in Canada, where he had trouble picking up or opening documents on his Blackberry. Because of those difficulties, which are clearly documented, I find that, on the balance of probabilities (and to the extent that it matters), Mr Cassley had not read clause 14 of the deed[2]. Although at one point he said that he was prepared to sign the deed himself, I find that this was because he thought that it was concerned with confidentiality. Clause 14, of course, was something very different. When eventually he received the itinerary that he had been chasing, it was no more than a copy of the previous version, which had not referred to Jetfly; the version sent to him on 16 June 2010 did not refer to Aero-Service.

5.4.2 The Aircraft

114. On 15 June 2010, when the switch to Aero-Service was made, Mr Carr-Gregg had expressly asked Mr Steele whether it was the same plane and pilots as the last time. Mr Steele had said that he thought that it was. It does not seem that this belief ever changed. Mr Steele's subsequent emails (in which he admits that he was "starting to fall a bit behind on the program") do not indicate otherwise. Indeed, it appears that this was precisely what Aero-Service were telling him. Their email on 16 June 2010 said that "the aircraft that will carry out the flight is the same one that you have already used recently."

115. But a closer reading of this same email from Aero-Service shows that it referred to the type of plane as a CASA C-212-100. That was *not* the plane that had flown to Yangadou in March 2010. Accordingly it appears that, although Aero-Service seemed to be saying that it was the same plane, they were actually planning to use a different plane. Moreover, the insurance details which they provided to Mr Carr-Gregg were for the CASA C-212-100, the plane that was used for the accident flight, rather than the previous flight in March. Nobody at Sundance appeared to pick up on the potential discrepancy, so it may only have been when they boarded the plane on Saturday 19 June 2010 that the Sundance representatives realised that it was a different plane to the one that had made the landing at Yangadou on 19 March 2010.

[2] I accept that there was some evidence that the text may have been pasted into the text of an email that he was sent, but I remain of the view that Mr Cassley probably did not read the detail of clause 14.

116. In the late afternoon of 15 June, Mr Carr-Gregg told his brokers that the carrier had changed and would now be Aero-Service, "the same carrier that we used on the Minister's flight". He sought an insurance quote and chased it again just after lunch on the following day, 16 June. At 3.46pm his brokers responded setting out the detail of the insurance for the charter flight. The insurance was in respect of the six directors and was said to be a maximum of $10 million "agg limit". The email made plain that the insurer "has confirmed cover for the charter flights in this occasion". It is plain, therefore, following the documentary trail, that there was no difficulty in Sundance obtaining the appropriate insurance for the charter flights to be performed by Aero-Service on 19 and 20 June.

5.4.3 The Flight Plan

117. The original flight plan showed a straightforward flight from Yaoundé to Yangadou at about 11,000 feet. The flight was over relatively flat, dense jungle. The only ridge that it overflew was the eastern end of the Nkout ridge which rose above 250m from the jungle floor. The flight involved Instrument Flight Rules ("IFR") with a change to Visual Flight Rules ("VFR") for the approach and descent at Yangadou. The flight plan indicated that, if the meteorological conditions at Yangadou were unsatisfactory, the flight would divert to Ouessa or, in a worst-case scenario, return to Yaoundé. This option also remained part of the amended flight plan.

118. Mr Longley suggested that the Sundance Board always wanted to overfly the mine at Avima. He said that, although that was owned and operated by Core Mining, Sundance were and had always been interested in acquiring the rights to that site. Be that as it may, I find that the change to the original flight path, to involve the overfly at Avima, was not made until late on 18 June 2010. Indeed, formal confirmation of it was not provided to Mr Longley, who was waiting at Yangadou, until the morning of 19 June 2010. It is not known why this change in the flight plan was made so late.

119. The Journey Management System ("JMS") in respect of the changed flight plan showed a flight to Avima, on a course that was a little southwest of the original flight plan, and then an easterly course to Yangadou (much like the trip that Mr Longley had taken on 30 March 2010). The flight from Yaoundé to Avima would have been very similar to the original flight plan with the plane passing over the western (and slightly lower) edge of the ridge at Nkout, rather than the eastern edge. The Avima ridge itself rose around 200m above the Avima mining site. The only significant change was that the transition from IFR to VFR would have happened earlier in the flight, so as to allow the overfly at Avima, and the flight from there to Yangadou.

120. I also note that a post-accident email dated 20 June indicates that Aero-Service were in contact with Jetfly prior to the accident flight in order to obtain coordinates. It is therefore reasonable to infer that Aero-Service spoke to Jetfly so that they could enquire about the flight that Jetfly had taken in March, with Mr Longley on board, to over-fly the Avima mine. In consequence of this, the Aero-Service crew pre-programmed the Avima way points into the GPS they were using for navigation. That suggests a considerable degree of care being taken by Aero-Service in connection with this late change of route.

121. Captain Gillespie described both the original flight plan and the modified flight plan as a 'low risk, routine flight'. Professor Ball (Sundance's expert) agreed with that

description of the flights as planned. Mr Watson had a separate point to make about the absence of GPWS on the aircraft (which I deal with at paragraphs 254-266 below) but beyond that, it was unclear whether he took a different view, and if so, why? He was much too given to a hindsight analysis to address this question properly: at one point he appeared to suggest that, because the plane crashed, it must have been a high risk flight from the outset. For the avoidance of doubt, I reject that approach. In my view, there were no foreseeable risks in respect of this flight plan (either original or modified). I therefore accept Captain Gillespie's evidence and his summary, to the effect that the risks associated with this flight were very similar to the type of low-level risks faced every day by tourists on safari trips in Africa.

5.4.4 Consequences

122. The last-minute changes meant that:

(a) The flight was being operated by a company who had not been asked for all the documentation which Mr Lewis had indicated that he wanted to see, but which he had approved not once, but twice.

(b) The flight was being undertaken by an aircraft which had not landed at Yangadou before, although there is nothing in the evidence to suggest that the CASA 212-100 was not capable of undertaking the flight and landing there.

(c) The pilots on board had never flown from Yaoundé to Yangadou before, although they had flown from Douala to Yangadou in March, with the Congolese Minister of Mines.

(d) The transition from IFR to VFR would occur earlier in the flight, to allow the overfly at Avima, thereby necessitating a longer period of low-level flying.

I find that none of these changes altered the fact that the flight on which Mr Cassley embarked on 19 June 2010 remained a low risk, routine flight.

123. I also accept that this is one important area of the case where Sundance (and therefore to an extent, GMP) are hampered by the unhappy fact that their representatives on the ground at Yaoundé on 18/19 June 2010 were unable to give evidence at the trial. There would inevitably have been oral exchanges between the members of the Sundance Board about the new carrier and the new route. There would have also been exchanges between them and the pilots. As a matter of inference, based on what I know of the individuals involved, I accept the submissions (set out in paragraph 2.3.3 of Mr Ross QC's closing submissions) that, if Mr Lewis or any of the Sundance Board had any reservations about the carrier or the amended flight path, the flight would not have gone ahead. Although this part of the trip was not unimportant, there were other elements of the trip, including those parts which did not involve Mr Cassley (such as a meeting with the President of the Republic of Congo) which were much more significant. A visit to the Nabeba mine was not of such importance that the Sundance Board would have been prepared to take foreseeable risks in order to undertake it.

6. THE FLIGHT ON 19 JUNE 2010

124. The aircraft was the CASA C-212-100 Aviocar aircraft. The captain was Mr Canal and the co-pilot was Mr Hollingsworth. On board were nine passengers: six members of the Sundance Board including Mr Lewis, Mr Talbot and Mr Carr-Gregg; Mr Talbot's PA; Mr Duff of Dynamiq and Mr Cassley.

125. The flight took off at 8:13am on the morning of 19 June 2010 from Yaoundé. The flight was expected to last just over an hour. At 8:30am, the crew informed Yaoundé that the aircraft was stable at flight level 110 and was in contact with Brazzaville Flight Information centre. The tower controller asked them to maintain flight level 110 and to continue the flight with Brazzaville Flight Information Centre. That was their last contact with Yaoundé. The crew continued in radio contact with Brazzaville until about 8:50am.

126. At about 9:00am the aircraft was approaching the area of the Avima mine. That was on the southern side of the Avima ridge. The area was in cloud. The aircraft began to descend, preparatory to overflying the mine. This involved the transition to VFR.

127. The aircraft flew into cloud but continued to descend. At 9:15am the aircraft flew into the Avima ridge, which the pilots could not see because of the cloud. For whatever reason, the pilots did not know that the ridge was there.

128. At the time of the crash the aircraft was flying at full and stable power. It was in cruise control. It was flying parallel to the ground. The long trail of wreckage confirmed each of those findings.

129. Mr Longley was at Yangadou waiting to receive the flight. He said that there was some early morning mist but that this had cleared away by 9:00am. This contrasts with the Air Accident Report, which suggests that there was "thick fog" at Yangadou. Since Mr Longley was not challenged on his evidence that that was not the case, I find that there was no relevant cloud at Yangadou at the time of the accident, 70km west at Avima.

7. THE CAUSES OF THE CRASH

7.5 Introduction

130. In my view, the twin causes of the crash were pilot error: the decision to fly into the cloud when descending (a breach of VFR), and the failure to identify the proximity of the Avima Ridge. I think that these errors can, in one sense at least, be traced back to some of the details in the audits undertaken on Aero-Service by another company, MPD Congo SA ("MPD"). It is therefore appropriate to summarise those audits first before going on to deal with the Air Accident Report, even though the audits were not seen by Sundance – or any other party to this case – until after the accident.

131. It must also be stressed at the outset that, despite the individual failings identified in these audits, their general conclusions about Aero-Service, and the service that they provided, were extremely positive. Based on them, MPD were happy to use them to supply two flights a week to air bush strips serving their Zanaga project, over an 18 month period.

7.5 The MPD Audits

7.2.1 Wyvern (January 2009)

132. The Wyvern audit was carried out by reference to the Republic of Congo audit requirements. It identifies the following areas as needing improvement:

(a) Protracted and on-going maintenance programmes and delays in the supply of replacement parts;

(b) The flight preparation paperwork and loading procedures were described as 'scruffy' and the format needed to be redesigned;

(c) The quality, experience and training of cabin staff was not addressed and was an outstanding issue;

(d) Matters of health and safety had been given little or no consideration for some time;

(e) No annual or continuation training was provided so there were no records to be maintained; and

(f) There were no written policies in the Operations Manual.

133. The conclusions were:

> "Aero-Service aircraft serviceability rate is poor. Under-funding for day to day needs is apparent and licensed engineering support is barely sufficient. However there are no other operators in competition with this company at present."

Three recommendations were made that were relevant to both Aero-Service and MPD:

> "MPD Development plans will generate a dramatic increase in the headcount and there will be an urgent need to transport these people in and out of camp reliably and on schedule. Three recommendations are made that are relevant to both Aero-Service and to MPD Congo –
>
> - Provision of suitable aircraft, funded, operated and maintained to recognised standards.
>
> - A back-up aircraft availability.
>
> - A contract between the operator and MPD for shared or exclusive use of the aircraft for use on MPD travel schedule."

There was no criticism as such of any particular aspect of their health and safety regime.

7.2.2 FSS Audit: 3 August 2009

134. The conclusions of this audit were very positive:

> "The standard of service provided by Aero-Service using its CASA 212 100/300 and Cessna 402/404 aircraft largely complies with the guidelines laid down in the OGP Aircraft Management Guide (considered industry best practice). Some minor exceptions are noted in the following report, but MPD Congo can be confident of a reliable and proficient service to support the camp at Lefoutou and other established routes…"

MPD were warned that ANAC was undergoing an audit by representatives of the International Civil Aviation Organisation ("ICAO") which included visits to all Congolese aviation companies. As a result few, if any, air operators, had been granted Air Operator's Certificates ("AOC") and most had been granted temporary derogation. It was anticipated that full AOCs would be issued in due course.

135. The audit itself found a number of areas which required improvement. These included:

(a) Aero-Service did not have a Safety Management System;

(b) No Emergency Response Plan had been developed or exercised;

(c) Aero-Service did not have a functioning quality system;

(d) The draft training manual did not specify recurrent training requirements;

(e) Aero-Service had not published a company safety policy;

(f) The draft Operations Manual did not contain guidance on the conduct of instrument approaches and other matters;

(g) Aero-Service did not conduct CFIT training; and

(h) Aero-Service did not hold approval from ANAC in respect of Operations Manual and the Maintenance Management Manual.

136. The audit pro-forma, which was similar to the form used and recommended by the OGP regulations, made plain that the CASA C-212-300 Aviocar aircraft had no ground proximity warning system ("GPWS"). I should add that, although there was no similar checklist done on the plane involved in the accident, it was common ground that that aircraft too did not have GPWS. This was not noted as a particular issue or problem.

7.2.3 FSS Audit: 11 and 12 February 2010

137. This audit (also carried out by reference to the OGP Regulations) is the most relevant audit because it was the closest in time to the accident. The key passages in the 'Conclusions' section were as follows:

> "The core problem is that AS has been operating successfully in an informal and safe fashion for many years, and there has

> been little pressure from ANAC to change. However the international aviation community has developed in this time and become much more formal with a corresponding reduction in accidents. AS needs to formalise its current operating procedures and has begun to do this with a new operations manual. But more needs to be done: Safety Management, Quality assurance, Aircraft Standard Operating Procedures, Emergency response Plan are all key issues that need to be addressed. Communication within the company from management to the staff, pilots and engineers needs to be more formal to ensure vital information is transmitted correctly.
>
> AS is recommended to go through a process of closing the gap between its current practices and those recommended by both ICAO and the OGP guidelines. Although some of these are listed in this report, an audit is only a sampling process and there may be others. These should be easily discovered if both the sound QA system is put in place and an in-depth risk assessment (requirement of a Safety Management System) is carried out. AS can then correct its own deficiencies rather than have them brought to its attention by external auditors.
>
> The findings also indicate that AS is leaving individuals to their own devices in several ways. It should be remembered that the company has a legal responsibility to exercise control over its operations. This can be brought about by standardisation in every respect – Standard Operating Procedures for the aircraft, reliable communication to all personnel and other procedures are all ways of ensuring that the way personnel work is according to the company standard. This may have serious safety implications as standardisation reduces the chance of an error in flight, because the crew are following the same procedures and each knows what the other should be doing.
>
> Particular areas of concern in flight operations are: the lack of an SMS, a QA system and an Emergency Response Plan…
>
> These points aside, Aero-Service provides a good and reliable service to MPD."

138. Within the audit report itself, it was noted that the corrective actions required by the findings in the audit of August 2009 were still outstanding. These included the absence of a Safety Management System. Although a manual had been drafted, the safety officer had not been trained and only had a limited knowledge of what to do. In addition, there was no Aviation Safety Policy, no Emergency Response Plan, no Quality System for Flight Operations and no training for CFIT. The position was, therefore, broadly the same before. This time, the audit expressly referred to the existence of an AOC.

139. The audit also said that CFIT avoidance was important due to the number of accidents from that cause. The aircraft was not equipped with GPWS which was not identified

as a problem itself, but the audit noted that it made this training even more important. No such training had yet been done.

140. The audit went on to note that the pilots had no facility for flight planning or operations. This was noted as a failing. The pilots did their planning in their own homes, but that was not subject to Aero-Service standardisation. The audit also referred to various other non-compliances. There was reference to a new flight operations manual, although the pilots had not seen it. It recommended the provision of a library, a computer and company organisation for the pilots. The aircraft checklist was again done on the CASA C-212-300 Aviocar aircraft and the same matters as before were noted.

141. The man who undertook the February 2010 audit was Mr Colin Sole. He produced a witness statement which explained and amplified the audit. His conclusion was at paragraph 22 of his witness statement:

> "Taking all of the factors identified in my audit of Aero-Service in the round, while the operator did not meet the AMG guidelines in some respects, it was my view, in the context of factors such as the competence and experience of the pilots in bush flying, and the condition and maintenance of the aircraft, that these were not high risk factors, and that the CASA planes operated by Aero-Service were safe and suitable for use."

Mr Sole was not cross-examined on his audit or this summary.

7.2.4 The View of MPD

142. Each of the three audits referred to above were seen by Mr Colin Harris who was closely involved in the Zanaga project on behalf of MPD, and which explained their need for a reliable charter flight company. Mr Harris' witness statement (on which he was not challenged) makes plain that the audits were carefully studied and that, on the basis of the detailed findings, MPD were quite content to use Aero-Service twice a week and sometimes up to four times a week. His statement refers repeatedly to the good service provided by Aero-Service, and the experience and competence of their pilots. Mr Harris makes plain at paragraph 18 of his statement that, if MPD had not been satisfied with Aero-Service's performance as described in the audits and/or had Aero-Service failed an audit, MPD would not have used them to travel to the Zanaga project.

143. Mr Harris was aware that Aero-Service was on the EU blacklist, but he explained that it was his understanding that all Congolese operators were blacklisted because of difficulties with ANAC. He thought many African air charters were on the EU blacklist for the same reasons. He concluded paragraph 19 of his statement by saying:

> "The fact that Aero-Service was on the EU blacklist did not, to me, (or, as far as I am aware, the auditors we instructed) indicate that Aero-Service was an unsafe operator."

144. It should be noted that one of the allegations against GMP and Sundance (in particular) is that, if they had undertaken proper investigations, they would have

discovered that Aero-Service 'would not have passed an audit'. As is apparent from the forgoing, this allegation is wholly unfounded. Not only would Aero-Service have passed an audit, but they did in fact pass these three audits. Indeed, there is no evidence that Aero-Service ever failed an audit. What is more, it seems plain that, if Sundance had made more detailed enquiries of Aero-Service, these three audits and/or the response to these audits by MPD would have become known to Sundance. On the face of it, therefore it appears that, if Sundance had found out more information, it would have confirmed their view that Aero-Service were an appropriate company, capable of flying safely to and from the bush strip at Yangadou.

7.3 The Allegations About Aero-Service's Poor Accident Record

145. The claimants' pleaded case alleges that Aero-Service had a poor accident/incident record and that this should have been known to GMP and/or Sundance. It was said that the information should have been obtained via a particular web-site (www.aviation-safety.net).

146. There was no evidence adduced at all about these alleged accidents/incidents. Neither was there any evidence that either GMP or Sundance should have made the enquiries alleged, or discovered this purported history. In short, the claimants adduced no evidence in support of this part of their pleaded case. It was the subject of neither the written opening nor the written closing submissions. Paragraphs 11(6) and 15(1) of Mr Williams' closing submissions on behalf of Sundance said expressly that Sundance had assumed that this part of the claimants' case had been abandoned. Mr Reeve did not suggest to the contrary. I therefore dismiss this part of the claimant's pleaded case.

7.4 The Air Accident Report: February 2012

147. The Air Accident Report was dated February 2012. It made plain that it was not conducted in order to establish fault or to evaluate individual or collective responsibilities. It was produced with the assistance of an independent French organisation.

148. From the 'Basic Information' section of the Report I note the following observations:

> "1.7 Meteorological Conditions
>
> The crew carrying out the journey N'Simalen/Yangadou on 19 June 2010 which took off at 08:13, had not requested the weather forecast from the Bureau Meteo Principal of Yaoundé N'Simalen the day before when preparing for the flight. The airline Aero-Service indicates that its crew sometimes use meteorological information issued on the internet."

Identifying the daily weather forecast from Yaoundé airport, the report stated that "the cloud ceiling was low between 0700 and 1030."

149. Also in this section of the Report there was a section dealing with navigation aids. This said:

> "There are no electrical radio aids for navigation in the zone where the accident happened. The aeroplane was equipped with two VOR, two ADF and one GPS. The aeroplane was not equipped with an Enhanced Ground Proximity Warning System ("EGPWS"), the crew had no aeronautical charts enabling Visual Flight Rules. In order to navigate in this zone, the crew used the MAP 496 GPS on board…no path was recorded during the occurrence of the flight. An examination of the configuration pages enable the confirmation that the saving function was not activated. The memory space dedicated to GPS points is empty."

150. The Report indicated that, although no aeronautical charts were found in the crashed aircraft, other documents were found, including a Google image showing a flight path and the destination and the turning point situated to the west of Avima.

151. The 'Analysis' section of the Report is divided between the preparation for the flight and the flight itself. In the 'Preparation' section, the following were noted:

> "The Preparation of the Route:
>
> The documents found on the aeroplane and the turning points entered in the GPS show that the aeroplane did not follow the route as written on the initial flight plan filed the day before.
>
> Aeronautical Documentation:
>
> There was no evidence that the crew filed aeronautical documentation showing the ground relief and peak altitudes.
>
> The crew did not request the weather forecast.
>
> The documents found in the aeroplane and the points on the GPS that were introduced show that the crew changed flight paths."

152. In the part of the Report dealing with the flight, it noted the change in the path and said:

> "The proposed flight of the client found at the accident site shows that the pilot had to change his initial route in order to go through a point situated to the west of Avima and then to fly over Avima where there are mines, and then to go directly towards Yangadou situated 30nm further east…the pilots had decided to descend to overfly the mining site which is at an altitude of 3,200 feet. It is likely that during the descent, the crew was not aware of the relief [the Avima ridge] on its flight path, peaking at 3,900 feet in an area where there was dense cloud cover. On site, the analysis carried out on the wreckage as well as the spectral analyses of the cockpit voice recorder showed that the aeroplane was flying at a consistent speed."

153. The causes of the accident were noted as follows:

> "The accident was a result of the collision of the aircraft with ground during an improvised phase of flight at a low height.
>
> Contributions to this accident:
>
> — The late change in the route on request by the client to overfly a mining site at a low height;
>
> — The descent of the aeroplane to a low height without precise knowledge of the region's topography;
>
> — The meteorological conditions on the day which prevented the crew from being able to identify obstacles in time."

154. In relation to the recommendations, the following reminders were made in the Report:

> "— Flights at a low altitude must be prepared with appropriate navigation maps in the zone that is being flown over;
>
> — Any change to the flight plan in the air must be as a result of information given my [by? to?] air traffic organisations."

As to security, the following were recommended:

> "— Crews must make themselves aware of metrological conditions according to the meteorological centre at the departure aerodrome by going on site…
>
> — Commercial transport aeroplanes must all be equipped with an Enhanced Ground Proximity Warning System (EGPWS)."

155. Finally, as I have already noted, the Report can only sensibly be read as confirming the existence of both a current AOC and a current Airworthiness Certificate for the plane that was destroyed in the accident. That is also consistent with other documentation. If these documents had not existed, the Report would have said so. In addition, because the Report made no mention of any failure to comply with existing ANAC Regulations, it is reasonable to infer that the investigators did not consider that any aspect of the accident demonstrated a breach of ANAC's Regulations in force at the time. That would, of course, include the absence of a GPWS system. I revert to this topic at paragraphs 254-266 below.

7.5 Conclusions

156. In my judgment, the accident happened for a number of reasons.

157. First, there was a lack of any formal safety procedures at Aero-Service. They did not have a Safety Policy, nor an Emergency Response Plan, nor a Quality Assurance System. They had a safety officer who had not been trained and a draft manual which the pilots had not seen. There was, to use the cliché, no formal culture of safety. I should however say that I am not persuaded that the absence of an SMS was of any great significance: the evidence was that, in the UK, there are plenty of operators without a CAA approved SMS. The USA only adopted SMS as a regulatory requirement at the start of 2015.

158. This background had a number of links to the subsequent accident. One was the failure on the part of Aero-Service to carry out any training for the avoidance of CFIT. This accident was a Controlled Flight Into Terrain, something which the auditors had identified as being a matter in respect of which no avoidance training had been carried out. The impression given is that the pilots at Aero-Service had no particular understanding of this problem. This was not insignificant because none of the Aero-Service planes had been fitted with GPWS.

159. Secondly, as the audits pointed out, there was no facility for flight planning. Captain Gillespie, GMP's expert, was dismissive about this and said that this was not a problem, and that he had often planned commercial flights in hotel lobbies. With respect, I think that misses the point. If there was no facility for flight planning, it was not clear whether any proper flight planning was actually being done at all or, if it was, how it was being done. This absence of a planning facility was important for the reason noted below.

160. I find as a fact that there were no aeronautical charts on board the plane. No such charts were found at the crash site. Because it is clear from the Air Accident Investigation Report that other documents did survive the accident, it is not a realistic possibility that the charts were burnt or otherwise lost. Moreover, the evidence was that aeronautical charts are substantial and, if they had been on board, would have been in books in the door pockets in the cabin. The absence of such charts, and the absence of a facility for flight planning, point inexorably to the conclusion that this flight was not properly planned and that, in particular, even though they knew that they were going to overfly the Avima mine, the pilots were unaware of the precise location and dimensions of the Avima ridge. What makes this failure surprising is that, as noted in paragraph 120 above, the evidence suggests that the Aero-Service pilots had contacted their counterparts at Jetfly to obtain more information about the flight which Jetfly had undertaken in March to overfly the Avima mine.

161. The failure to plan the flight properly was not limited to an ignorance of the physical topography. The air accident report makes clear that the pilots had not asked for any meteorological data. Although Aero-Service say that the pilots often obtained their own information from the internet, the lack of a planning facility was again another obstacle to the pilots obtaining all relevant meteorological information. Accordingly, the pilots did not know and did not find out what the weather was going to be like at Avima.

162. Although the failings which I have noted came together as the flight began to descend to overfly the Avima mine, the primary cause of the accident remained pilot error. The pilots were faced with cloud which they did not expect, but they ought not to have flown into or through that cloud cover. They should have instead abandoned the

overfly of the Avima ridge, and they should have continued onto Yangadou where, as I have noted, there was no cloud cover and they could have landed safely. Instead, they entered the transition to VFR, which meant that they flew into the cloud and could not see where they were going. That was a basic error. Ultimately, they struck a ridge because they did not know that it was there. That was a second basic error. The errors made were both one-off mistakes, even if they could be linked back (at least indirectly) to the inadequate culture of safety at Aero-Service. One of the central issues in this case is whether that background should have been reasonably known to either Sundance or GMP and, if so, what difference (if any) that would have made.

8. STANDARDS AND STATISTICS

8.1 General

163. In this case, the Amended Particulars of Claim does not put the claimants' case by reference to any published standards or written guidance concerning the assessment of travel risks for those in the position of GMP and Sundance. The experts agree that there were no standards or standard practice for the assessment of travel risks or aviation charters (see paragraphs 9-12 of their Joint Statement). Accordingly, in many ways, the standards to which reference is made below, which were identified during the evidence, are of marginal relevance to the issues in the case. However, given that they were the subject of extensive cross-examination it is necessary at least to identify them.

8.2 ICAO Annex 6

164. The requirements in ICAO Annex 6 are designed to make mandatory various parts of the Chicago Convention. These are standards which should be applied by State regulatory authorities. However, operators have no specific obligation to ICAO to abide by these standards and every signatory State has the right to opt out of, or modify, any individual requirement.

165. One of the requirements of Annex 6 was that every aircraft should have a GPWS. However, all over the world, there are plenty of aircraft in service that were manufactured without a GPWS, and where the installation of a GPWS system into an existing aircraft would be prohibitively expensive. Accordingly, some State regulators do not require GPWS and/or permit a 'difference' from the ICAO.

166. In the present case, the relevant regulatory body is ANAC. They have not provided a copy of their Regulations that were in operation at the time of the accident flight. It is therefore not known whether or not they required GPWS on every aircraft. However, as already explained, I find that the inference must be that they did not. I have found as a fact that Aero-Service had an AOC and I have also found as a fact that neither of their CASA aeroplanes had GPWS. The only appropriate inference to draw is that ANAC had expressly approved this 'difference', a view supported by the absence of any reference to the lack of GPWS as a breach of Regulations in the Air Accident Report.

167. It is important not to confuse GPWS with the Enhanced Ground Proximity Warning System ("EGPWS"), to which reference is made in the Report. That is a new and improved system of GPWS which is not mandatory under Annex 6. The Report

recommended that such a system be fitted into aircraft of this type which, in its own way, is a telling point: EGPWS, because it gives greater warning of the terrain in front, as well as below, might have prevented this accident. That explains the recommendation. A standard GPWS was not recommended, presumably because the investigators concluded that it would not have prevented the accident.

168. The experts did not suggest that either defendant should have been aware of ICAO or Annex 6. Mr Watson expressly conceded that he did not expect Sundance to know about them. There is no reason, therefore, why GMP would have known about ICAO or Annex 6.

8.3 The ANAC Regulations

169. For the avoidance of doubt, I accept the defendants' submissions that it is a fair inference that Aero-Service were not in breach of any part of the ANAC Regulations at the time of the accident. That inference is based on the fact that the Air Accident Report, does not suggest, anywhere in its pages, that Aero-Service were in breach of the applicable Regulations. I accept the suggestion that it would be an extraordinary omission from the Report if some failing on the part of Aero-Service, relevant to the causes of the accident, was not identified fairly and squarely as a breach of the ANAC Regulations.

8.4 The OGP 'Aircraft Management Guidelines' ("AMG")

170. These guidelines were produced by oil and gas producers, who are extensive users of chartered aircraft. The AMG guidelines were therefore relevant to oil and gas producers, but were not relevant to GMP (a bank) and Sundance (a mining company). Mr Watson accepted in cross-examination that he did not consider that Sundance should have been aware of these guidelines and none of the experts expressed the view that GMP (or Sundance) should be judged by the standard of OGP members.

8.5 The Flight Safety Foundation Basic Risk Standard

171. This standard (known as BARS), is referred to in a number of the pleadings. However, it seems to me plain that BARS could not possibly apply to either GMP or Sundance. First, they were not produced until either December 2009 or early 2010. By June 2010 the BARS scheme could only fairly be described as being in its infancy. Secondly, they were produced by the Flight Safety Foundation and there is no evidence that either GMP or Sundance were (or should have been) aware of the Foundation or the guidelines that they have had produced. Thirdly, the BARS scheme was concerned with audits of aircraft operators and, by 2013, it became apparent that there were very few companies who either had audited or had been audited by reference of the BARS standard.

172. Despite his introduction of and reliance on this document, neither Mr Watson, nor any of the other experts expressed the view that either GMP or Sundance should be judged by the BARS standard.

8.6 Statistics

173. Although it was not a topic which featured in Mr Watson's expert report, Mr Reeve on behalf of the claimants made much, both in the cross-examination of Captain Gillespie and in his closing submissions, of the IATA statistics of 2013. It was the claimants' case that these statistics demonstrated that the accident which occurred here was one which was more likely to happen than other kinds of air accident. On the other side, the defendants argued that the statistics demonstrated that the risk of this type of accident was "very, very low". As is often the way with statistics, the IATA statistics could be said to support both propositions.

174. It is certainly right that the statistics demonstrated a correlation between fatal accidents and a lack of proper regulatory oversight, an absence of safety management procedures, deficiencies in the operator's training procedures, and the absence of safety equipment such as GPWS. They showed that Africa was the biggest source of IATA accidents in the world and that 74% of cases involved inadequate regulatory oversight. There was also a strong correlation between CFIT and the failure to fit GPWS.

175. Equally, the statistics, as explained by Captain Gillespie, demonstrated how low, in real terms, any of these risks actually were. For example, there was a risk of 0.2 CFITS accidents for every one million flights.

176. It was difficult to see where, ultimately, any of this went. It was not suggested by Mr Watson that the IATA safety report was one that either GMP or Sundance should have been aware of or acted upon. It was not suggested that they should have known anything of these statistics. It might have been interesting to know whether Mr Sole (the auditor who audited Aero-Service) was aware of the statistics and to have his views on whether or not it made any difference to his conclusions about Aero-Service, but he was not cross-examined at all. Ultimately it seems to me that these statistics and the evidence surrounding it demonstrated no more than the obvious: that the absence of a GPWS system gave rise to an increased risk of CFIT, compared with a baseline risk, but that both the baseline risk and the enhanced risk remained very low.

9. THE ISSUES

177. There is no agreed list of issues. However, broadly speaking, they break down in this way.

9.1 The Case Against GMP

178. As to the duty owed by GMP to Mr Cassley, what was the nature, scope and extent of that duty? To what extent, if at all, could GMP rely, without more, on Sundance's arrangements?

179. As to breach, what did GMP do in discharge of its duty towards Mr Cassley? Was that sufficient? If not, why not? If not, what other things should GMP have done?

180. Assuming that GMP were in breach of their duty, and should have made further enquiries, what further information would have become available as a result of those enquiries? What difference (if any) would that information have made? Specifically, would that further information have meant that, on the balance of probabilities, Mr

Cassley would not have been on board the accident flight on the morning of 19 June 2010?

9.2 The Case Against Sundance

181. As to the existence or otherwise of a duty of care, did Sundance assume a responsibility to Mr Cassley or did they owe him a duty by reference to the usual touchstones of proximity, the reasonable foreseeability of damage, and the imposition of a duty being fair, just and reasonable.

182. If Sundance did owe Mr Cassley a duty of care, what was its nature, scope and extent? Specifically, was it a duty to take reasonable care in the appointment of Aero-Service, or was it some more onerous, non-delegable duty that made Sundance liable for the poor performance of Aero-Service's duties?

183. Assuming a duty of care, was there a breach? What did Sundance do in discharge of its duty towards Mr Cassley? Was that sufficient? If not, why not? If not, what other things should Sundance have done?

184. Assuming that Sundance were in breach of their duty, and should have made further enquiries, what further information would have become available as a result of those enquiries? What difference (if any) would that information have made? Specifically, would that further information have meant that, on the balance of probabilities, Mr Cassley would not have been on board the accident flight on the morning of 19 June 2010?

10. THE EXPERT EVIDENCE

10.1 The Directions

185. At the CMC before Master Eastman on 17 March 2014, there was a dispute between the parties as to the particular expertise required of the expert witnesses in this case. Some wanted aviation experts; others risk management experts. The Master resolved the debate by something of a 'fudge', by which he allowed each party could call one expert in "corporate travel risk assessment and management". That has led to a mismatch in the background and expertise of the three experts in this case, and is one of the reasons why the expert evidence has been of less help then it might have been.

186. There are other reasons too. In some parts of the Queen's Bench Division (notably in the Commercial Court and the Technology and Construction Court) orders in respect of expert evidence follow a particular sequence. The requirement is for the experts to meet first and to produce a Joint Statement identifying those matters on which they are agreed and those matters on which they disagree (with a short note identifying the disagreements). The experts' reports are served after that, and they are limited to those matters on which the experts disagree. Experience has shown that this is an efficient way of getting the experts to focus on the real issues between them. It also allows the court a degree of control as to the scope and extent of expert evidence.

187. That did not happen here. In consequence the reports are voluminous (Mr Watson, the claimant's expert, filed a report which fills two lever arch files) but each deals

with different questions framed by different solicitors. There is therefore little overlap between the questions that each expert has endeavoured to answer.

188. These difficulties were compounded rather than resolved by the Joint Statement. That is a long and rambling document which is difficult to follow and even more difficult to analyse. It is internally contradictory. It fails to set out crisp propositions or identify which experts agree or disagree with such propositions. None of this has made the court's task any easier.

10.2 Particular Observations on the Expert Witnesses

10.2.1 Mr Watson

189. Mr Watson is a very experienced aviation consultant. His principal expertise is in aviation auditing. He possessed knowledge and technical expertise that neither GMP nor Sundance had, or could reasonably have been expected to have. On the other hand, he had no expertise in assessing health and safety risks. In consequence of this, there were times when I concluded that what he was suggesting GMP or Sundance should have done about Aero-Service was wholly unrealistic. He continued to focus on highly technical points arising out of the audits of Aero-Service which, in my view, had very little connection with what GMP or Sundance could reasonably have been expected to do prior to the June flight.

190. It is that issue which, so it seems to me, lies at the heart of this case. Assuming duty and assuming breach, what was it that Sundance and GMP should have done, and would have meant that, on the balance of probabilities, Mr Cassley would not have been on that Saturday morning flight. Despite the centrality of those issues in this case, Mr Watson's report dealt very sketchily with that topic. Moreover, I find that his approach to them was tainted by hindsight, working back from the accident rather than forward from the information available, pre-accident, to GMP and Sundance.

10.2.2 Captain Gillespie

191. By his own admission, Captain Gillespie, although an aviation expert, was not a consumer: he was not somebody who regularly arranged charter flights. It was therefore sometimes difficult for him to say what somebody in that position would or should have done. He did, however, have extensive expertise of undertaking flights very similar to the accident flight in this case.

192. Captain Gillespie was in many ways an impressive witness, and I have been persuaded by the commonsense of much of what he said. But I considered that at times he was too willing to minimise the evidence about the potential failings of ANAC and of Aero-Service, in a way that sometimes seemed strangely partisan.

10.2.3 Professor Ball

193. Professor Ball was not an aviation safety expert and much of his report was concerned with rather academic nit-picking over the technicalities of risk assessment. I did not derive any real assistance from that material. Moreover, many of Professor Ball's opinions as stated in his report were based on his version of the facts as he understood them. Some of those factual assumptions were in fact incorrect, which raised

concerns as to the reliability of his conclusions (although in that he was not very different to Mr Watson).

194. That said, because of his risk assessment expertise, Professor Ball was well placed to give evidence about what measures and steps were reasonably required to be taken by both GMP and Sundance in the discharge of their respective duties of care. Thus his evidence about the relatively limited nature of any risk assessment required here, because of what he considered to be the absence of any significant risks identified as attaching to this trip, was of particular resonance. In addition he emphasised that not only did air travel carry the lowest level of travel risk, but that this flight was a low risk exercise because the flight was taking off from a recognised airport, going to a landing strip that had been examined by the Congolese authorities, and being piloted by qualified pilots.

10.3 Summary

195. For these reasons, although I found some parts of the expert evidence useful, I found other parts of it unhelpful. Furthermore, I consider that too much of the material covered by the experts in their reports and in their oral evidence actually went to questions which were matters for me, rather than for them. I make plain therefore that my analyses of breach and causation, recorded in the next two sections of this Judgment, are based largely on my own conclusions based on my findings of fact, as opposed to my reliance on any one expert view over another.

11. THE CASE AGAINST GMP

11.1 The Law

11.1.1 Statutory Duty

196. GMP owed Mr Cassley no relevant statutory duty. Although three were identified in the pleadings, by the close of the case, the claimants were not putting their claim by reference to these alleged statutory duties. I therefore deal with them briefly for completeness only.

197. Section 2 of the Health and Safety at Work Act 1974 provides an obligation on the part of every employer to ensure, so far as is reasonably practicable, the 'health and safety and welfare at work of all of his employees'. Section 47 of the same Act, however, excluded the imposition of civil liability for breach of section 2.

198. The second statutory requirement referred to was the Management of Health and Safety at Work Regulations 1999. Regulation 3 provided for a risk assessment. That only applies were there is a specific statutory duty relied on by the claimants in respect of which there is a 'need'/requirement for a risk assessment so as to ensure compliance. Again, that is not this case.

199. Thirdly, there is a reference to Framework Directive 89/391 (wrongly referred to as Regulation 89/391). This does not give rise to any free standing statutory duty: see ***Cross v Highlands and Islands Enterprise*** [2001] IRLR 336, OH.

200. Thus the claimants' case against GMP depends on the common law.

11.1.2 Common Law Duty

(a) General

201. An employer owes a duty to its employees:

a) to provide a safe place of work;

b) to take care in selecting proper and competent fellow workers and supervisors;

c) to take care to provide proper machinery and materials; and

d) to provide and maintain a safe system of work.

This is the long-accepted summary of the decision in ***Wilsons and Clyde Coal Co v English*** [1938] AC 57. It has been expressed as a duty to carry on operations in such a way "as not to subject those employed by him to unnecessary risk" (see ***Smith v Baker*** [1891] AC 325 at 362). ***Harris v Bright Ash Felt Contractors Limited*** [1953] 1 WLR 341 defined an unnecessary risk as "any risk that the employer could reasonably foresee and which he can guard against by any measures, the convenience and expense of which are not entirely disproportionate to the risk involved". In consequence of the modern obsession with acronyms, this is now referred to as ALARP: reducing risks to a level As Low As Reasonably Practicable.

202. This is a personal and non-delegable duty. In ***Cook v Square D Limited*** [1992] ICR 262, Farquharson LJ said that it was the employer's duty to take all reasonable steps to ensure the safety of his employees in the course of their employment, and that such a duty could not be delegated.

(b) Third Party Premises

203. In ***Smith v Austin Lifts Ltd*** [1959] 1 WLR 100, Lord Denning said:

> "…employers who send their workmen to work on the premises of others cannot renounce all responsibility for their safety. The employers still have an overriding duty to take reasonable care not to expose their men to unnecessary risk. They must, for instance, take reasonable care to devise a safe system of work, see ***General Cleaning Contractors Ltd. v. Christmas*** [1953] AC 180; and if they know or ought to know of a danger on the premises to which they send their men, they ought to take reasonable care to safeguard them from it."

204. ***Cook***, referred to above, is also authority for the proposition that the duty noted at paragraph 201 applies to those occasions when an employee is engaged on third party premises, although the nature and extent of the duty will always depend on what is reasonable in all of the circumstances. Farquharson LJ said at pages 8H-9B:

> "It is clear that in determining an employer's responsibility one has to look at all the circumstances of the case, including the place where the work is to be done, the nature of the building concerned (if there is a building), the experience of the

> employee who is so dispatched to work at such a site, the nature of the work he is required to carry out, the degree of control the employer can reasonably exercise in the circumstances, and the employer's own knowledge of the defective state of the premises."

205. In ***Cook***, an employee of a UK company was injured when he slipped on the floor of a site 8,000 miles away. Although a duty was found, there was no breach because the employer had been reasonably satisfied that the occupiers of and the general contractors working at the site in Uthmaniyah, Saudi Arabia, were reliable companies and aware of their responsibilities to those working there. The court noted that "the suggestion that the home-based employer has any responsibility for the daily events of a site in Saudi Arabia has an air of unreality".

206. The result in ***Cook*** is to be contrasted with that in ***McDermid v Nash Dredging and Reclamation Co Limited*** [1987] ICR 917. There the claimant was employed by the defendant as a deck hand when he was injured by mooring ropes. Although, at the time of the accident, he was working on board a tug owned by a Dutch company, and under the control of a Dutch captain employed by them, it was found that the captain and the claimant were working together in a small team of three to perform a contract which the defendant and the Dutch company were carrying out together. Accordingly, both duty and breach were found in that case. Farquharson LJ in ***Cook*** described it as a case where the duty of the employers was "much more direct" than it was in ***Cook***. The employers could not escape responsibility because at the time of the accident it was an employee of the tug owners rather than their own employee who was actually conducting the operation. The approach in ***Cook*** was also followed by the Court of Appeal in the interim payment case of ***Berry v Ashtead Plant Hire Co Limited*** [2012] PIQR P6.

(c) Travel to and from Third Party Premises

207. I note that GMP admits that they owed Mr Cassley a duty "to take reasonable steps not to expose James to foreseeable unnecessary risks in the course of travel in the course of his employment". For the reasons set out below. I consider that that admission is properly made.

208. In ***Palfrey v Ark Offshore Limited*** (23.2.01, QBD, Deputy Judge HHJ Graham Jones – unreported) the claimant was the widow of the defendant's employee who had died from malaria after travelling twice to West Africa in order to work on an oil rig operated by Atwood, the third party. He had been bitten during an overnight stay on an island before being ferried out to the oil rig. The defendant had told the deceased that he did not need any medical protection for the trip because he would be based offshore. The judge upheld the claim against the defendant, holding that they ought to have had, but did not have, an effective policy for the provision of advice as to health precautions to be taken by an employee sent to Cameroon in the course of his employment. Because they had no such policy, they failed to give the deceased any or any appropriate advice as to such precautions and thereby endangered his safety.

209. In ***Durnford v Western Atlas International Inc*** [2003] EWCA Civ 306, the employee of an oil exploration company successfully claimed damages against his employer when he suffered an acute prolapse of an inter-vertebral disc due to the inadequate

minibus that had been supplied for a long journey to the third party premises where he was to work. The judge found that there was a foreseeable risk of injury to a person of ordinary physical robustness as a result of the minibus journey and there was no evidence of any enquiries made regarding alternative transport. That decision was upheld by the Court of Appeal. It is an illustration of the liability of an employer for breach of its duty of care in relation to transport abroad.

210. The outcome in ***Durnford*** is to be contrasted with that in ***Hopps v Mott McDonald Limited and the Ministry of Defence*** [2009] EWHC 1881 (QB). In that case the claimant was injured by a roadside bomb. Christopher Clarke J (as he then was) found that a duty of care was owed by the defendant to the claimant in connection with his travelling in Basra but, for the claim to succeed, the claimant needed to demonstrate that Mott McDonald should only have allowed him to travel in an armoured vehicle, and not in any other form of transport. On the evidence, it was held that it was not unreasonable for the claimant to have been carried around Basra at the relevant time in an un-armoured vehicle.

211. Finally, there is a very recent decision concerned with travelling to foreign destinations in the course of employment, with some similarities to the present case. In ***Dusek v Stormharbour Securities LLP*** [2015] EWHC 37 (QB) Hamblen J upheld the claim of the dependants of Mr Dusek, who was killed when the helicopter taking him away from Cusco, in the Andes, which he had visited in the course of his employment, crashed, killing everybody on board. At paragraph 134 of his judgment, citing ***Palfrey***, Hamblen J found that his employer, Stormharbour, owed Mr Dusek a duty "to take reasonable care to see that he was reasonably safe while travelling to and from and at his place of work abroad where he was required to go in the course of his employment". In my judgment, GMP owed a precisely similar obligation to Mr Cassley in the present case, which is why I consider the admission at paragraph 6 of the first defendant's amended defence to be appropriate.

(d) Risk Assessments

212. Whether or not an employer owes an obligation to perform a risk assessment in the circumstances of the case, and the nature, scope and extent of any such risk assessment will always be a matter of fact. In ***Hopps***, and the subsequent Court of Appeal decision in ***Uren v Corporate Leisure (UK) Limited v Ministry of Defence*** [2011] EWCA Civ 66, some form of risk assessment was found to be required. As Smith LJ J put it in ***Uren***:

> "72. I do accept that what amounts to 'a suitable and sufficient' risk assessment may well vary according to circumstances. For example I can see that if an employer uses a contractor for some activity and satisfies himself that a contractor has carried out a thorough risk assessment in relation to that activity, that might well lead to the conclusion that the risk assessment carried out by the employer is suitable and sufficient even though it is not as detailed as would otherwise be required. That would be a question of fact in each individual case and it is impossible to generalise as to the standard of risk assessment which will be required of an employer. Here on the facts, it is clear that CL did not carry out a suitable or sufficient risk

> assessment and it could not sensibly be argued that the MOD could properly rely on it. The two defendants did not even confer about risk assessments."

That passage was cited by Hamblen J in ***Dusek***.

(e) Actions of Third Parties

213. A point that was raised with some force before me, but which did not arise on the facts in ***Dusek***, concerned an employer's liability for the actions of third parties. This arises in the present case because Mr Ross QC maintains that, because the accident that killed Mr Cassley was the result of pilot error, it was an onerous task in law for the claimants to establish that GMP was liable for the negligent acts of a third party.

214. He relied on two cases in particular. The first was ***Smith v Littlewoods Organisation Limited*** [1987] 1 AC 241. That was a case where an empty cinema owned by Littlewoods was set on fire by vandals and the fire spread to other buildings and caused damage. The owners of the adjoining buildings claimed damages in negligence against Littlewoods. The House of Lords rejected the claims. Lord Mackay said this:

> "In approaching these rival submissions it has to be borne in mind that the damage to the neighbouring properties, upon which the claims against Littlewoods are founded, is damage by fire or otherwise resulting from vandalism in Littlewoods' premises. A duty of care to prevent this damage is the only duty incumbent upon Littlewoods relevant to this case. From this it follows that unless Littlewoods were bound reasonably to anticipate and guard against this danger, they had no duty of care, relevant to this case, requiring them to inspect their premises. Unless, therefore, Littlewoods, on taking control of these premises without any knowledge of the subsequent history of the property after they assumed control, ought reasonably to have anticipated that they would be set on fire and thus or otherwise create a substantial risk of damage to neighbouring properties if they did not take precautions, the claims must fail."

The claimants were unable to meet that high test and the appeal failed.

215. Similarly, in ***Longworth v Coppas International (UK) Limited*** [1985] SC 42, the widow of a petro-chemical worker who was killed following the Iranian bombing of Basra in 1980 failed in her claim because she had not set out the facts required to show that the danger from the activities from an independent third party "was very likely to happen". Lord Davidson said:

> "In certain instances a pursuer had been found entitled to a remedy when, but for the act of an independent third party, the assumed fault of the defender would not have done the pursuer any harm. But in such cases, it was essential for the court to be satisfied that the intervention of the independent third party was

> very likely to occur. If it was not very likely to occur, then the defendant's fault was not the effective cause of the accident."

Lord Davidson went on to note the basic duty of the employer to take reasonable care that the employee is not exposed to unnecessary risks and said that, if an employer learnt that his employee's place of work had become part of a warzone and that the employee's safety was imminently threatened by the activities of the combatants, nothing would excuse the employer from the duty of assessing the risk and in appropriate circumstances of advising, exhausting, or even of enjoining his employee to quit the danger area. But he went on:

> "In my opinion, the decisions and *dicta* in the cases cited by the defenders' counsel justify the conclusion that where the danger to be guarded against is one caused by the activities of independent third parties over whom the defenders have no control, the court should examine the pursuer's averments of fact and fault with more than usual care and caution…On considering the pursuer's averments I do not see how a court could reasonably reach the conclusion that a missile attack upon Petrochemical Complex No. 1 was not merely a possibility but was an event very likely to occur…
>
> In my opinion for purposes of relevancy the pursuer's case of fault must be tested by reference to facts which, considered objectively, should have prompted the defenders to take one or more of the steps desiderated by the pursuer."

11.2 Duty of Care

216. For the reasons set out above, I find that, as Mr Cassley's employers, GMP owed him, not only the general duties identified in subsection 11.1.2(a) above, but also the duty in respect of remote third party premises referred to in subsection 11.1.2(b) and the duty in respect of the travel to those premises, as noted at subsection 11.1.2(c) above. Those duties were non-delegable. The extent to which those duties were satisfied is considered in greater detail in the next sections of this Judgment.

11.3 Breach of Duty

217. I find that GMP took no steps *at all* to satisfy their duty of care to Mr Cassley. They undertook no enquiries of any sort about the proposed trip. Although they were entitled to rely to a large extent on Sundance, they needed to satisfy themselves that the trip was reasonably safe. That was, after all, what they had undertaken to do by reference to their own health and safety policies (see paragraphs 56-61 above). Instead, they did not ask Sundance any questions about any aspect of the trip. Specifically, they did not ask any questions about the internal flights within West Africa, or about Jetfly, or about Sundance's experiences of Jetfly. I find therefore that they were in breach of their duty to Mr Cassley.

218. Mr Butterworth accepted that no enquiries had been made (see paragraphs 92-93 above). Although he could not remember the detail of his conversation with Mr Young, I have found that this did not extend beyond a reference by Mr Young to

Sundance's good reputation as a mining company. That could not, on its own, begin to equate to any sort of proper enquiry on the part of GMP for the purposes of ensuring the health and safety of Mr Cassley: see my findings at paragraphs 88-96 above. On the contrary, such widespread omissions failed to meet GMP's own health and safety policy. And although Mr Butterworth said on a number of occasions that he did not believe that the flight presented any material risk, I find that he was only able to say this because he had not given any consideration at all to what the potential risks of the flight might be. He thought there was no material risk because he had not considered the possibility of such a risk in any meaningful way.

219. It is I think, unnecessary to spell out each and every way in which GMP's failure to take any action at all constituted a breach of their own health and safety policies, set out at paragraphs 56-61 above. But I find in particular:

a) They failed to ensure that all hazards would be eliminated so far as reasonably practicable or to ensure that the remaining risks would either be avoided or reduced to an acceptable level;

b) They failed to give any consideration at all, let alone additional consideration, to the risk to Mr Cassley, a vulnerable person at a remote location:

c) They failed to show any leadership or effective action in respect of health and safety;

d) They failed to conduct risk assessments as a central strand of the safety management system (a criticism with which Professor Ball expressly agreed);

e) They failed to subject contractors, whose activities might affect the health and safety of employees, to selection processes requiring them to prove their safety standards. Mr Butterworth accepted this; and

f) They failed to place Mr Cassley's health and safety at the top of all priorities.

In addition, they redacted a potentially important health and safety document (paragraph 56 above) without proper explanation.

220. Furthermore, if there was any remaining doubt that GMP ought to have made some enquiries of Sundance and wholly failed to do so, there are the clear words of the deed (paragraph 80 above). Even if (which I do not accept) GMP were entitled in some way to rely (without more) on Sundance, the words of clause 14, and clause 14.3 in particular, would have jolted any reader of the document out of such complacency. Clause 14 made it clear to GMP that, not only were Sundance not accepting responsibility in law for what might happen on the trip, but they were expressly telling GMP that they needed to undertake their own investigations. I do not read that as preventing GMP from making enquiries of Sundance themselves; far from it, it seems to me that Sundance were the obvious first port of call. But this was a clear warning to GMP that they needed to undertake their own investigations. To fail in those circumstances to undertake any investigations at all amounted to a clear breach to their duty to Mr Cassley.

221. I note that Professor Ball, the best-qualified expert to give evidence about risk assessments in these circumstances, concluded that GMP should have carried out a risk assessment, albeit on the limited material available. In his cross-examination by Mr Reeve, he agreed that the employer had to think about his own lack of expertise in these matters, and to consider seeking assistance. He too thought the obvious source of such assistance was Sundance.

11.4 What Should GMP Have Done?

(a) Employ an Aviation Consultant or Auditor?

222. The claimants' primary case is that GMP (and/or Sundance) should have employed an aviation consultant or auditor to consider the proposed trip to and within West Africa. The only one of the three experts who advocated this as a possibility was Mr Watson. Neither Captain Gillespie nor Professor Ball thought that this was reasonable or required.

223. When he was cross-examined, Mr Watson gave the surprising evidence that GMP and Sundance were not obliged to take account of a wide variety of circumstances when reaching a view as to whether they needed to engage an aviation specialist. I do not accept that, particularly since Mr Watson then went on to identify a much more limited range of matters which he took into account in reaching his conclusion that such help was required. He identified the problem associated with the permission to land at Yangadou and the previous use of both Jetfly and Aero-Service. He referred to Solenta. He referred to the fact that the Board of Sundance were very experienced and were concerned with safety. Following this ragbag of factual observations, he then went on to suggest that, because the flight was going to a bush strip, "this is all crying out, absolutely screaming, in my opinion, for an expert aviator to come and assist". The high watermark of Mr Watson's evidence in cross-examination concluded as follows:

> "Q: I suggest to you that is a gross overstatement.
>
> A: I don't believe so.
>
> Q: So although this was screaming out for an aviation consultant, and although on your report Sundance possessed an aviation expertise above and beyond what you might have otherwise expected of a company, it seems that none of the individuals concerned who tragically died in this accident heard the scream: is that your position?
>
> A: Yes it is. It is related to Mr Duff, responsible for the risk assessment and the chartering of the aircraft. His background is military and logistics and no doubt a very capable man, but is limited to no aviation knowledge and experience, to attempt, in my view, gaining some form of assurance but I haven't seen any conclusions of those assurances, and neither have I seen any evidence, in my view, that the people doing that assurance were in fact qualified or even doing the right things."

224. I consider that the sustained criticisms of these answers made by Mr Williams at paragraph 108 of his closing submissions are measured and correct. Mr Watson's denial that somebody in the position of GMP or Sundance would have had to have taken into account a wide variety of facts and circumstances was unjustified, and seemed designed to allow him to argue from a much narrower factual baseline. The individual circumstances which he identified as giving rise to the "screaming" necessity for an aviation consultant were only some of the factors relevant to GMP and Sundance. Some of those he identified (such as the experience of the Sundance Board) could only have been in favour of not getting outside help. In addition, he completely ignored many of the other factors which were relevant, such as the various personal recommendations of Aero-Service by others, and the successful flight the previous March. His singling out of Mr Duff, as opposed to Mr Lewis, who personally approved every flight, was inexplicable. I regard his overall approach to this issue as partisan and unconvincing.

225. In my view, the majority view of Captain Gillespie and Professor Ball on this topic is to be preferred. Their evidence made it plain that employing such a third party consultant was not common practice or was, at the very least, one on which a reasonable range of opinion existed. In ***R(Juntann Oy) v Bristol Magistrates Court*** [2003] ICR 1475, Lord Hobhouse said:

> "Safety is a question of opinion. There is no such thing as absolute safety. All safety is relative. Two men can legitimately hold different opinions [as to] whether a machine is safe or unsafe. Different assessments can be and are made of the safety of a particular machine by the authorities in different countries."

The same is true in the present case as to whether or not it was necessary for health and safety purposes for an independent aviation consultant to be employed by GMP and/or Sundance. It is a matter of opinion; there is no basis for saying one view is right and the other wrong.

226. There was no evidence that an employer like GMP (or a user like Sundance) would, in 2010, routinely have employed such a consultant to advise on such a trip. The experts were agreed that there was no guidance or any other kind of documentation which, had they looked at it, would have led GMP to adopt such a course. There was nowhere near sufficient evidence to persuade me that such a consultant was required to advise on this particular trip, and that the failure to engage him was a breach of duty.

227. Furthermore, I note that there was nothing in the BARS standard – on which Mr Watson relied for other purposes – to suggest that it was normal or appropriate for an employer in the position of GMP, or a user in the position of Sundance, to obtain the advice of an aviation consultant and effectively go straight to an audit of the carrier (or even the aircraft) concerned. I agree with Mr Williams' submission that that was an unreasonable and extreme position. I reject it.

228. Finally, I respectfully agree with Hamblen J in ***Dusek***, when he said that an employer was not required from the start to instruct an aviation consultant to conduct a desktop

audit of the flight in question, even in circumstances (which was not this case) where the proposed journey carries with it obvious and inherent risks of danger.

229. Accordingly, on the evidence before me, I reject the suggestion that the failure to hire an aviation consultant was a breach of the duty owed by GMP to Mr Cassley.

(b) Enquiries to Sundance

230. As foreshadowed in paragraph 220 above, I consider that Sundance were the first and logical port of call for the enquiries which GMP (probably Mr Butterworth) should have made about the trip generally, and the charter flight in particular. They were the obvious source of the assistance referred to by Professor Ball, because they were the organisers of the trip. Whilst I consider GMP could not simply rely on Sundance to do everything without making their own enquiries, it was appropriate for those enquiries, at least in the first instance, to be aimed at Sundance. GMP were remote, whilst Sundance were 'on the ground' in West Africa.

231. In my view, GMP should have asked Sundance about the individual elements of the trip, including in particular the chartered flight to and from Yangadou since that was, on the face of it, the most unknown element of the visit, involving as it did a charter flight with a local company and a landing (and take-off) at a bush strip. I consider that my conclusion that, on the facts of this case, GMP ought to have made enquiries of Sundance as to the flight operator, the route, and how Sundance had satisfied itself that the proposed flight was safe, to be consistent with the approach of Hamblen J in ***Dusek*** at paragraph 192.

232. What should GMP have asked Sundance in order to perform a proper risk assessment? They should have asked for information about the carrier. Did it have an AOC? What was its insurance position? Had they been recommended and, if so, by whom and in what terms? Had Sundance used them before? Were Sundance happy with them? Was the strip at Yangadou safe? Had it been used for similar flights before?

(c) Enquiries of Others

233. I consider that the only independent enquiries that GMP ought to have made should have been to the Foreign and Commonwealth Office website. I note that Professor Ball was of the same view. The FCO provides guidance to those travelling to all foreign countries; it is a basic tool for those arranging such foreign travel, whether they are gap year students or those employing city financiers. It is a resource which GMP should have used.

234. GMP should have made those enquiries in relation to Cameroon and Congo, the two countries that Mr Cassley was visiting. As to Cameroon, it is not suggested that there would have been any relevant warning or other information. As to Congo, the warning at the time would have been in relation to two areas of the country which were not relevant to this trip. GMP would also have noticed that the FCO was saying that there was a low threat from terrorism. They would also have seen that the EU had published a list of Congolese air carriers that were subject to an operating ban or restrictions within the community, and noted the link to that material "to see whether this would affect your travel".

235. In my view, no other independent enquiries needed to have been made by GMP.

11.5 Causation

(a) Introduction

236. The principal difficulty for the claimants in their claim against GMP involves getting from what GMP should have asked, and the information which those enquiries would have revealed, to a finding by this court that the answers would have prohibited Mr Cassley from getting on board the charter flight at Yaoundé Airport on that Saturday morning. In my view, for the reasons noted below, there is a significant gap between, on the one hand, what GMP would reasonably have done based on the information they should have discovered and, on the other, a decision by GMP prohibiting Mr Cassley from getting on the accident flight with the Sundance Board. It is a causation gap which I consider to be unbridgeable.

(b) The claimants' late primary case

237. It may be that, in recognition of these causation difficulties, Mr Reeve chose, in his closing submissions, to advance for the first time a new and overarching case on causation by reference to clause 14 of the deed. He argued that because it was such a blatant attempt to pass responsibility onto GMP, Mr Butterworth should have realised what was going on and should have immediately said that, in consequence of the attempt alone, Mr Cassley was not to get on board the accident flight. As Mr Reeve put it at paragraph 98 of his closing submissions, if Mr Butterworth had understood the deed for what it was, "he would have had nothing more to do with the deed or the second defendant and he would not have allowed James to take the trip." Mr Reeve said that, given that Mr Butterworth's admissions (noted in full in paragraphs 92-95 above) arguably supported this case on causation, it was open to him. Both Mr Ross QC and Mr Williams complained about the unpleaded and unheralded nature of this new case on causation.

238. I do not consider that this new case emerges with any clarity from the claimants' pleadings. But I would be very reluctant to decide this important element of what is, on any view, a very sad case, on a pleading point. And it is unnecessary, given that, in my view, this argument must fail as a matter of principle. Of course Mr Butterworth should have been alerted to what Sundance were trying to do through the agency of clause 14 (indeed, some of his answers indicated that he was); of course Mr Butterworth ought to have realised that Mr Cassley was going to be exposed to certain risks, and should then have embarked on a proper consideration of those risks himself. But it is a complete *non-sequitor* to say that, in truth, his only proper response was to refuse Mr Cassley permission to get on board the Aero-Service flight.

239. The mere fact that Sundance were adopting a hard-nosed approach to potential injury or fatal accidents claims does not mean to say that they were not properly having regard to all issues of safety. It is perfectly possible to do both: to take every reasonable step to ensure the safety of a particular trip, but at the same time, to endeavour to avoid legal liability if something goes wrong. The attempted exclusion in law gives no indication of the steps which Sundance were taking to ensure that no accident occurred in the first place.

240. Furthermore, this argument must logically attach to every aspect of the trip to Cameroon. If it is right then, taken to its logical conclusion, Mr Cassley should not have been allowed on board Mr Talbot's private jet in Paris to fly to Cameroon on the first leg of the trip. That part of the trip was also covered by clause 14. But no-one suggests for a moment that it was negligent for GMP to allow Mr Cassley to fly to Cameroon in Mr Talbot's jet.

241. Accordingly, I reject the suggestion that, merely because Sundance wanted to exclude their legal liability for anything that might happen to Mr Cassley, GMP should automatically have refused Mr Cassley permission to make the trip. The second proposition simply does not follow from the first. Moreover, it is wholly contrary to the claimants' basic case, as advanced during the hearing, which focussed on all those things which they said GMP should have done in order to obtain further information about the visit and in particular about the carrier to Yangadou. It is therefore necessary now to turn to that aspect of the claim.

(c) Information about the Carrier

242. It is here that we come to the central problem for the claimants in their case against GMP. As I have said, GMP should have made the enquiries noted at paragraph 222 above (to Sundance) and the enquiries at paragraph 234 (to the FCO). And they would all have been about the Cameroonian-registered carrier, Jetfly. That is because, from the end of May until the day of the accident, GMP were always told that the carrier for this flight was going to be Jetfly. The enquiries would not have been aimed at anyone else because no other carrier was ever mentioned to them.

243. And if GMP had made these enquiries, Sundance would have answered them in full. They would have told GMP that Jetfly had all of the relevant documentation, including the AOC referred to at paragraph 24 above; that Sundance had used Jetfly on at least two occasions; that Jetfly had flown twice to the Yangadou airstrip (in January and again in March); and that Jetfly had appropriate insurance.

244. There is no evidence that Jetfly were anything other than a reliable and appropriate carrier. There is no claim that GMP would have been in breach of their duty to Mr Cassley if they had allowed him on board a Jetfly flight to Yangadou. Mr Watson confirmed that at no time had he considered or analysed the circumstances and flight safety of Jetfly. Jetfly was registered in Cameroon and there was no evidence that air transport was not properly policed and regulated by the Cameroonian authorities. Had Jetfly remained the carrier, there are no grounds for concluding that it would have been anything other than an entirely appropriate and safe carrier to convey Mr Cassley and the Sundance Board to Yangadou and back to Yaoundé. Similarly, there would have been nothing in the information from the Foreign and Commonwealth Office to cause GMP any doubt about the proposal: Jetfly were not a banned carrier and there was no EU blacklist of Cameroonian carriers.

245. Accordingly, but for the late switch to Aero-Service, the claimants' case against GMP would have been completely unarguable.

246. I accept the suggestion made by Mr Reeve that, because GMP ought to have been more pro-active, they should have conveyed to Sundance that they required detailed information about the actual carrier, even if the identity of the carrier changed, and

even if that change occurred at the last minute. But let us assume that they made that clear to their point of contact at Sundance, Mr De Nardi in Perth, at the end of May, when they were first given the details of the itinerary, and that they reiterated it on a number of occasions subsequently. That would still have made no difference, because Mr De Nardi himself never knew about the change of carrier from Jetfly to Aero-Service until after the accident had occurred. Thus, even if GMP had asked Mr De Nardi to keep them informed of any change, he would not have told them because he did not know. GMP cannot be blamed for an internal communication failure within Sundance. It was a matter over which GMP had no control, and could not have reasonably achieved any control.

247. Accordingly, it seems to me that the claimants' case against GMP fails on causation. Although GMP were in breach of their duty, because they failed to make any enquiries of Sundance about the carrier, the enquiries that they should have made would have all been about Jetfly, and would have been the subject of satisfactory answers.

248. I regarded this as the 'elephant in the room' throughout the trial. It was repeatedly assumed that GMP knew (or should have known) that it was Aero-Service who would be undertaking this flight. The claimants' case against GMP, and Mr Watson's expert's report in particular, was predicated on the basis that Aero-Service was a Congolese carrier, banned by the EU, and inherently unsafe, and that GMP should have sought the necessary information so as to make themselves aware of these facts. Indeed, this can be demonstrated by paragraphs 1-3 of the claimants' closing submissions, which states that "the nub of this case" was the failure to make any enquiries into Aero-Service. I find as a fact that GMP did not know and had no reasonable way of knowing that this flight was even being undertaken by Aero-Service. Accordingly, the entire factual basis of the claimants' case on causation falls away.

(d) Enquiries in respect of Aero-Service

249. Now let us assume that I am wrong to conclude that GMP did not know about Aero-Service or that, in some way, GMP should have asked questions which would, before the accident flight, have identified Aero-Service as the carrier. On the balance of probabilities, would the information provided by Sundance, in answer to the questions about Aero-Service which should have been asked, have put GMP on a train of enquiry so as to lead them reasonably to conclude that Mr Cassley should not have got on that flight?

250. In my judgment, the answer to that question is No. In many ways, GMP would have got the same answers about Aero-Service as they would have got if they had asked about Jetfly. They would have been told that Aero-Service had been recommended to Sundance by other pilots; that there was an AOC; and that there were relevant insurance documents. Most significantly of all, they would have been told that Aero-Service had already flown Sundance to Yangadou, in the company of the Congolese Minister of Mines. GMP would have also been told that, for these reasons, the Sundance Board were themselves happy to fly with Aero-Service. There would have been nothing in any of that to put GMP on any kind of alert. On that alternative basis, therefore, the claimants' case fails on causation.

251. Now let us assume that that conclusion, too, is wrong and that GMP's questions should have gone deeper into Aero-Service's fitness to undertake the flight. It seems to me that such further questions would have raised, directly or indirectly, the information within the audits into Aero-Service. On this hypothesis, Sundance (prompted by GMP) would have themselves enquired of Aero-Service as to whether or not there were any recent audits which they could see. I deal with that case at paragraphs 320-327 below. I conclude that, if the question of audits had been raised (directly or indirectly) with Aero-Service, Sundance (and, on this assumption, GMP) would have discovered either the factual findings within the three audits carried out for MPD Congo or, more likely, they would have been provided with copies of those audits themselves. Those audits and their positive recommendations would have been more than sufficient to persuade Sundance, and therefore GMP, that there was no reason not to allow Aero-Service to undertake this flight. More widely, as Mr Williams pointed out at paragraph 173 of his closing submissions, there was no evidence that Aero-Service had failed any audit or that any company had ever been advised not to use Aero-Service.

252. In all those circumstances, it seems to me that, even if further enquiries (beyond those identified at paragraph 232 above) should have been made by GMP of Sundance about Aero-Service, the information from Sundance would have been reassuring. Any reply from the organiser of the flight would have been to the effect that the proposed carrier was established; carried an AOC; had been recently successfully audited; had been previously used by the organiser to fly the proposed destination; and that it was reasonably satisfied as to its safety. That would reasonably have been sufficient for GMP to discharge its duty to Mr Cassley and they would have concluded that the flight was safe. My analysis of the similar claim against Sundance is also relevant to this conclusion (paragraphs 312-327 below). I consider that it is consistent with paragraph 193 of the judgment of Hamblen J in ***Dusek***.

253. It is impossible not to factor in additional, more prosaic considerations. GMP and Mr Cassley would have realised the commercial imperative of undertaking this flight. Visits like this were common but important. GMP would not have wanted to cancel Mr Cassley's participation any more that he would have wanted not to go to Nabeba, unless some good reason to fear for his safety had been identified. In my view, there was no such reason.

(e) GPWS

254. During the course of the trial, one of a number of shifts in the claimants' case involved a new emphasis, through the evidence of Mr Watson, on the alleged importance of the GPWS system, and the fact that the aircraft which undertook the accident flight did not have such a system on board. This went from a matter which was referred to in Mr Watson's expert report but not identified as amounting to a regulatory breach, on one view, to the lynch pin of the claimants' case on the facts. By the end of the trial three (linked) propositions were being advanced by the claimants:

a) GPWS was required under ICAO standards;

b) Sundance, and therefore GMP, should have discovered that the aircraft in question did not have GPWS; and

c) The absence of GPWS was the cause of the crash.

On a proper analysis of the evidence, none of these three propositions can be sustained. My reasons are set out below.

255. First, I note that Mr Watson's evidence in support of this new case was only advanced in his oral evidence in chief when he said that, when auditing an operator, the first relevant bar was the regulatory bar, which he described as 'the absolute minimum standard'. He said that the absence of GPWS meant that this aircraft fell below that minimum standard, a point he had not made in his written report. That suggests to me that the whole question of GPWS was something of an afterthought, alighted on by Mr Watson some time after both his report and the experts' meeting.

256. Secondly, whilst GPWS was required by the ICAO standards, that requirement could be waived by ANAC, as the relevant regulatory body: see paragraphs 166-168 above. I have found that, on the balance of probabilities, Aero-Service were not required by ANAC to install a GPWS in this aircraft. If they had been so required, they would not have been granted an AOC.

257. Thirdly, even Mr Watson conceded that he did not expect Sundance to know of ICAO and Annex 6. There could be no possible basis on which it could have been suggested that GMP should have known about ICAO and Annex 6.

258. The next issue is whether or not Sundance or GMP should have known about the absence of GPWS. In his oral evidence, Mr Watson said that "GPWS is so important, as a regulatory requirement, it would be unprofessional to recommend the use of that aircraft to Sundance or GMP or any other client that was asking for your professional opinion." That evidence was predicated on the assumption that an aviation consultant/auditor had been appointed to do a detailed equipment check on the aircraft, and had spotted the omission. I have already set out my reasons why I do not accept that assumption in this case. It is a further example, in my judgment, of Mr Watson answering a question from an incorrect and inappropriate starting- point.

259. Then there were the contents of the three audits. Although, as I have noted, the audits note that a GPWS system was not fitted to the Aero-Service aircraft, they make nothing of this. None of the audits say that the absence of a GPWS system was of any significance. They certainly do not suggest that this omission somehow made the aircraft dangerous or that Aero-Service should not be used as a carrier. On the contrary, as we have seen, the audits were very favourable to Aero-Service. In those circumstances, it is simply not possible for the court to conclude that Sundance or GMP should either have known that there was no GPWS or, even if they had noted that omission, that it was a matter of any significance or seriousness at all.

260. There is also the Air Accident Report. That too makes no reference to the absence of a GPWS system as being of any relevance at all.

261. Finally, as I have said, there is the issue of the GPWS in practice. Prior to the trial there was no suggestion from any of the experts that the absence of a GPWS had any relevance to the crash. However, in a supplementary report produced at the start of the trial, Mr Watson suggested that, if a GPWS had been fitted, the crash would not have happened. Despite the objections of Mr Ross QC, I allowed that report in,

because it was quite clear that Captain Gillespie was in a position to deal with the detail of it.

262. Captain Gillespie demonstrated in his evidence that there were simply too many variables for any aviation expert to come to a concluded view as to whether or not the absence of a GPWS made any difference in this case at all. Those are set out at paragraphs 3.4.26-3.4.34 of Mr Ross QC's closing submissions. These included the track the aircraft was flying at the time of impact (which meant that each of Mr Watson's three hypothetical tracks could each have been incorrect); the precise GPWS unit that might have been fitted; the expected GPWS detection and warning performance; and the nature of the radio frequency reflective characteristics that would have been required for flying over this kind of terrain. I note the warning on charts published in the user's manual (which are described as merely illustrative) and that the actual behaviour of the system is highly dependable on a number of dynamic factors unique to the particular event. To be fair, Mr Watson did not seek to deny any of this, saying in cross-examination that his supplementary report was 'conjecture', for the reasons given by Captain Gillespie.

263. For himself, Captain Gillespie thought that GPWS probably would not have supplied a sufficiently early warning in this case to enable effective avoidance measures, given that the pilots were in breach of the standard flight rules and were descending through cloud cover. Mr Watson was unable to give a cogent contrary view. On the expert evidence, therefore, it is quite impossible for the court to conclude that the absence of the GPWS had any role at all in this accident.

264. I should add that I accept the point made at paragraphs 2.5.11 and 3.2.6 of the closing submissions of Mr Ross QC that, on the evidence, a GPWS system would only have engaged when the aircraft flew below a height of less than 2,500 feet above the terrain. On that basis it would only have operated when the plane arrived at the Yangadou landing strip, and it would have been automatically disconnected when the landing gear locked into position.

265. I also note and accept Captain Gillespie's evidence that although GPWS has had some effect in preventing accidents in the cruise phase of flight, this was very small compared to its effect on approach and landing accidents. Again that suggests that, in the present case, when the aircraft was in the cruise phase of the flight, a GPWS would have had no effect.

266. For all these reasons, therefore, notwithstanding its late appearance in this case, I have concluded that the absence of a GPWS on this plane was of no relevance to the accident and was of no relevance to the case against GMP or Sundance.

(f) Enquiries of Others

267. True it is that, if (contrary to my findings) GMP had been obliged to undertake their own separate investigations into Aero-Service by reference to the FCO, they may well have found out about the EU banned list. That would have been a negative factor (which obviously did not apply to Jetfly) against all the other positive factors to which I have already referred. For the reasons set out below, it is idle to suggest that, in those circumstances, the EU banned list would have made any meaningful difference to GMP's decision on the balance of risk.

268. If we assume that GMP knew, or should have known, that the carrier had been changed to Aero-Service, then they should also have been aware from the FCO information that the EU had published a list of carriers that were subject to an operating ban "within the community". Let us also assume for this purpose that they would have realised that Aero-Service was on that banned list. What difference would that have made?

269. In my view, it would have made none. It might have spurred GMP on to make the enquiries of Sundance to which I have referred above, but it would not have altered their reaction to the information about Aero-Service which Sundance would have provided. If Sundance were happy with Aero-Service, for the reasons which Sundance would have set out to GMP, then it is entirely unrealistic now to say that GMP would not have been satisfied with those answers just because of an EU list.

270. It is also right to say, as Mr Ross QC does in his closing submissions at paragraph 8.2, that the FCO advice does *not* caution against the use of any internal carrier in the Congo or advise against flying in the Congo. There is nothing to say that the prospective traveller should not use a carrier on the banned list. The only advice given is that their inclusion on a banned list might affect the prospective travel, but that is as high as it is put. Again it is unrealistic to think that, even if GMP had reached this point in their enquiries, they would have prevented Mr Cassley from getting on board the accident flight.

271. At paragraphs 31-32 of his closing submissions, Mr Reeve argued on behalf of the claimants that the fact that Aero-Service was on the banned list would have lead GMP and/or Sundance to conclude that the AOC was of no comfort to them; that it was, somehow, a worthless document. I am bound to say that I consider this argument to be nonsensical. It was not suggested to Captain Gillespie or Professor Ball during cross examination. It does not follow that, merely because Aero-Service were on the banned list, that their AOC was of no worth. There was no link made, either in the FCO documentation, or in the EU banning order, between any concerns about the Congolese regulatory authority, on the one hand, and the AOC of individual airlines on the other. It was another *non-sequitor*.

272. Finally, for completeness, I refer back to paragraph 143 above. Mr Harris of MPD Congo did know about the blacklist, and it made no difference to him. I find it would have made no difference to GMP either.

(g) The Alleged 'Unravelling'

273. At paragraphs 47 and 48 of his closing submissions, Mr Reeve suggested that, as the enquiries were (or should have been) made, GMP (and Sundance) would have uncovered ever-increasing grounds to be concerned about Aero-Service "as each layer of information unfurled". He made the same point at paragraph 109 where there is a reference to Mr Butterworth "lifting the stone" by initiating enquiries and that "he would never have been fully satisfied by the result".

274. For the reasons that I have set out, I consider that this significantly over-states the evidence. I have accepted that GMP should have made further enquiries. But it seems to me plain that the answers that they would have received to those further enquires would have been more than enough to satisfy them that Mr Cassley could

safely take his place on board the accident flight. In one of the numerous authorities to which my attention was drawn, the judge observed that the claimants' case bore a striking similarity to the story of a kingdom lost for want of a nail, because of the incessant layering of individually plausible events giving rise to a wholly improbable result. I consider that the same criticism can be made of the claimants' submissions on causation in the present case.

*(h) Contrast with **Dusek***

275. It is worth comparing my conclusion, that any risk assessment performed by GMP, even if it had been focussed on Aero-Service and not Jetfly, would not have led to Mr Cassley's removal from the flight, with the end result in ***Dusek***. That is because, so it seems to me, the facts in the present case were of a completely different order to the facts there. In ***Dusek,*** Hamblen J found that the helicopter flight in question was high risk. It was an inherently dangerous flight because the planned route meant that the helicopter was working at or beyond its AOC and its density altitude limit. There was also a serious risk of operational limits being exceeded because of the cloud cover (helicopters cannot fly in cloud). Moreover, there was evidence that the proposed route was so dangerous for helicopters that there had been express warnings about that danger. Thus at paragraph 176, the judge said:

> "The proposed flight raised obvious and foreseeable safety risks. The essential nature of the risk was unsafe operation or performance of the helicopter flight. Further there was a real prospect of that risk eventuating given the challenging nature of the flight."

276. All of that has to be contrasted with the present case. Here, both the original planned journey and the modified journey were low risk flights. There were no foreseeable risks beyond those which affect every flight over the African jungle to a bush landing strip. There were no prior warnings about this flight because there was no perceived danger. In ***Dusek***, on the facts found by the judge, there was an accident waiting to happen; here the accident was due to pilot error, even if those errors may have indirectly had their roots in cultural failings at Aero-Service. What happened here was manifestly not the 'highly likely' consequence of the actions of an independent third party.

(i) Actions of a Third Party

277. For the reasons I have given, I conclude that, although GMP failed in their duty to Mr Cassley, if they had done what they should have done, he would still have been on the flight that crashed at Avima on the morning of 19 June 2010. The accident, and the causes of the accident, was not reasonably foreseeable and/or too remote in law. The claimants seek to make GMP liable for the selection of Aero-Service as the carrier for the flight, and the manner in which that flight was executed when, as Mr Ross QC rightly points out at paragraph 6.1.25 of his closing submissions, GMP was two steps removed from that decision. The manner in which the charter was executed was the responsibility of the pilots.

278. The above point seems to me to bring this case full square into the line of authorities concerned with damage caused by actions of a third party (paragraphs 213-215

above). There is no general liability on a defendant for the action of a third party unless what happened was a "highly likely" consequence of the actions of that third party. That is not this case: the actions of the pilots that caused the accident were not 'highly likely'. In those circumstances, the duty owed by GMP did not extend to the performance of the carrier once the flight had started: again that is consistent with the judgment of Hamblen J in ***Dusek***. Or to put the same proposition in another way, no risk assessment performed by GMP would have identified the risk of pilot error, which was the primary cause of the accident.

279. For all those reasons, the claim against GMP must fail.

12. THE CLAIM AGAINST SUNDANCE

12.1 Law

280. The claim against Sundance is put primarily on the basis that they assumed responsibility to Mr Cassley for the making of the arrangements of the accident flight. The relevant responsibility can be assumed in the work place by a third party: see ***McGarthy v Eve NCI Limited*** [2002] EWCA Civ 374. In ***Lynch v Ceva Logistics Limited*** [2011] ICR 746 the claimant was an electrician employed by D2 and was sent to carry out an inspection at D1's warehouse, where he was injured by a forklift truck driven by one of D1's employees. The control exercisable by D1 justified a finding that D1 owed a duty of care to the claimant. Moore-Bick LJ said:

> "I also agree with Jackson LJ that the first defendant owed a duty of care to the claimant at common law to take reasonable steps to ensure that he did not suffer personal injury whilst working in the warehouse. The claimant was employed by the second defendant, who might reasonably have been expected to draw the first defendant's safety requirements to his attention, if he had been made aware of them. In fact, however, the Judge's finding show that it was the practice of the first defendant to give safety briefings when contractors arrived for work and that a job of this kind it would normally require the contractor to provide a method statement describing how it proposed to carry out the work and also risk assessment. The Judge found, however, that neither was obtained in this case and that a proper safety briefing was not given either to the second defendant or to the claimant. The result was not simply that the first defendant failed to live up to its own high standards, but that the claimant was not made aware of the precautions he needed to take in order to avoid injury. In those circumstances I agree that the first defendant failed to discharge its duty of care to him. The fact that the second defendant was a reputable contractor does not affect the matter, because the first defendant failed to put him in a position to give the claimant as his employee the necessary safety instructions himself."

281. In any case where it is alleged that there has been an assumption of responsibility, the claimant needs to demonstrate reliance by the claimant: see most recently the

judgment of Jay J in ***Risk v Rose Bruthard College*** [2013] EWHC 3869 (QB). Furthermore, the Supreme Court has recently restated the general principle that, even where there may have been a general assumption of responsibility, English law does not impose liability on a defendant for injury or damage to the person or property of a claimant caused by the conduct of a third party: see ***Michael v The Chief Constable of South Wales Police and another*** [2015] UKSC 2.

282. The other way in which a duty might arise is by reference to the three-pronged test in ***Caparo Industries PLC v Dickman*** [1990] 2 AC 605: loss must be reasonably foreseeable; there must be a relationship of proximity between the claimant and the defendant; and the imposition of liability must be just and reasonable.

283. In ***Perrett v Collins*** [1999] PNLR 77, the claim was against the defendant who negligently certified an aircraft as being in an airworthy condition. Hobhouse LJ (as he then was) considered that, as the case fell within the recognised category of liability for personal injury, the only question was whether there was sufficient foreseeability and proximity. In his view, the fact that the injury in question was caused indirectly was irrelevant to the imposition of a duty of care. However, in other cases involving indirect personal injury, the Court of Appeal has applied the full three stage test. Thus in ***Watson v British Board of Control Limited*** [2001] QB 1134, the necessary proximity requirement was satisfied because the defendant had complete control over the source of the danger and the claimant would, or would be expected to, rely on the defendant. By contrast, in ***Sutradhar v Natural Environment Research Council*** [2006] UKHL 33, such complete control was missing and the House of Lords concluded that no duty of care existed.

284. It is the claimants' pleaded case that Sundance owned a personal non-delegable duty to Mr Cassley to procure that reasonable care was taken in the performance of the duty by whomever the duty-holder holder might get to perform the particular obligation (in this case Aero-Service). Sundance submit that if (which it denies) it owed any duty of care at all, it was a duty to take reasonable care in the selection of Aero-Service, rather than a more onerous duty to procure the careful performance of their work. Outside of the employment relationship, a non-delegable duty only arises in certain exceptional cases: see ***Woodland v Swimming Teachers Association*** [2014] AC 537. Exceptions are those situations where the function being performed was either inherently hazardous or where there was a protective duty of care (usually involving a child, hospital patient or someone vulnerable).

285. A duty of care in selecting independent contractors can also be linked to the particular activities being carried out by that contractor. Thus, in ***Bottomley v Todmorden Cricket Club*** [2003] EWCA Civ 1575, the defendant had hired a two man stunt team to conduct a pyrotechnic display. The judge found that the whole operation was highly dangerous and that the stunt team was "an amateurish organisation operating in a field which required the highest degree of professionalism if danger was to be avoided". The judge ruled the defendant liable because they failed to exercise reasonable care in selecting the stunt team. The extra-hazardous nature of the activity in ***Bottomley*** can be contrasted with the tree-felling in ***Yates v National Trust*** [2014] EWHC 222 (QB) where it was held that the activity was not extra-hazardous. The claim in that case was a little unusual because the claimant was employed by the very contractors whom, it was said, the National Trust should not have appointed. The claim failed.

12.2 Duty of Care

286. In my view, Sundance assumed a responsibility to Mr Cassley in respect of the trip as a whole, and in particular in relation to the flight to and from Yangadou. They were the organisers of the trip, over which arrangements they had complete control. He was their guest. They assumed a responsibility to take reasonable care of him and he plainly relied upon them to take reasonable care in making the appropriate arrangements. I note that (although ultimately it is a matter for me) Professor Ball, Sundance's risk expert, assumed that they owed Mr Cassley this type of duty of care.

287. Absent the wording of the deed (an issue to which I revert below) I had understood that Sundance accepted the existence of a duty of care because they had complete control over the arrangements for the flight. In the course of his closing submissions, Mr Williams indicated that he did not necessarily accept the existence of the duty because Sundance did not have control over the aircraft. I have to say that I do not follow that argument. Sundance owed a duty in respect of the arrangements for the flight. That included, in particular, making proper investigations into the safety and security of Aero-Service. It patently did not extend to any control over the flight itself which is a separate point, and dealt with under the heading of 'Causation' below.

288. For completeness, and should it be relevant, I consider that Sundance also owed a duty of care to Mr Cassley because the three elements of ***Caparo*** were present: there was proximity; the loss if Sundance failed to take reasonable care in the selection of Aero-Service was reasonably foreseeable; and the imposition of liability on Sundance would, in all the circumstances, be just and reasonable.

289. It follows from this that I find that the duty owed by Sundance was a duty to take reasonable care when selecting the aviation carrier, Aero-Service. To the extent that it was suggested that Sundance owed him a more onerous, non-delegable duty, namely some sort of obligation to procure the proper performance by the carrier, then I reject such a case. This was not one of the exceptions identified in ***Woodland.*** Indeed, it seems to me that the situation in this case is precisely caught by paragraph 25(3) of the judgment of Lord Sumption:

> "In the absence of negligence of their own, for example in the selection of contractors, they will not be liable for the negligence of independent contractors where on analysis their own duty is not to perform the relevant function but only to arrange for its performance."

In my view, for the reasons that I have given, Sundance owed a duty of care in connection with the selection of Aero-Service, but they were not liable for the negligence of those independent contractors.

290. Mr Williams argued that the existence of clause 14 of the deed demonstrated that Sundance had not assumed responsibility to Mr Cassley and/or negated the duty of care referred to above. I do not accept that submission for a number of reasons.

291. First, the deed was never signed. It was therefore of no legal effect. It would be a curious result if a deed that was not signed by either party somehow regulated their legal relationship.

292. Secondly, even if the deed had been signed, I am satisfied that Mr Ross QC is right and that it would have offended against section 2 of the Unfair Contract Terms Act 1977. It would have been an illegitimate attempt to exclude liability for personal injury or death. It would therefore have been of no effect. Again, therefore, it is difficult to see how it could at the same time be utilised to negate any liability otherwise arising on the part of Sundance.

293. Thirdly, clause 14 related to the relationship between Sundance and GMP. It was not and was never made personal to Mr Cassley himself. It was therefore different to the personal waiver that Sundance had endeavoured to utilise in the past (paragraphs 46-51 above). Accordingly, even if the deed had been signed, it would not have affected the duty which Sundance owed to Mr Cassley personally.

294. Fourthly, I reject the suggestion advanced by Mr Williams that, as a result of the words of the deed, GMP and Mr Cassley were not entitled to rely on Sundance as far as risk assessment/investigations were concerned. I accept of course that the deed made plain that GMP should undertake their own investigations but that does not of itself mean that GMP and Mr Cassley could not make enquiries of Sundance, nor rely upon their answers. In other words, the wording of the deed did not, in my view, negate Sundance's assumption of responsibility and duty of care. Mr Butterworth's evidence about the reputation of Sundance also demonstrated reliance.

295. Fifthly, I accept Mr Reeve's submission that the indemnity sought was predicated on the basis that a liability was otherwise owed by Sundance at least to GMP, if not Mr Cassley. That liability also reflected GMP's/Mr Cassley's reliance on Sundance, so it can fairly be said that the deed assumed their reliance rather than negating it.

296. Finally, I do not believe that the words of the deed could, as a matter of fact, negate the clear assumption of responsibility which Sundance, as the organisers of the trip, assumed to Mr Cassley. As a matter of fact, they were organising the trip and inviting Mr Cassley as their guest. They may have sought (ultimately unsuccessfully) to exclude their legal liability to GMP through the vehicle of clause 14, but that did not mean, as a matter of fact, that Sundance had not assumed responsibility to Mr Cassley in a way that allowed the duty of care (of the type referred to in paragraph 289 above) to arise.

12.3 Breach

297. The scope of the duty owed by Sundance was to take reasonable care in selecting the carrier; of undertaking an effective risk assessment of Aero-Service. What should have happened is perhaps best identified by Christopher Clarke J (as he then was) in ***Hopps v Mott McDonald Limited*** [2009] EWHC 1881 as follows:

> "I accept the submission of the MOD that that involves considering: (a) the nature of the risks; (b) the likelihood of it eventuating; and (c) the likelihood of harm being sustained (and the extent of that harm) if it does. In deciding what steps had to be taken in order to deal with these risks it is relevant tot take into consideration (i) the nature and purpose of the work that the claimant was employed to perform; (ii) the priority of the risks i.e. which were the principle and which were the

> secondary risks; (iii) the effectiveness of various protective measures that could be taken; and (iv) the consequences of taking them."

298. In the present case, I find that every form of transport involves some degree of risk. The nature of the risk here was the risk of a catastrophic accident. The real issue was the likelihood of that eventuating. The appropriate protective measure was to take reasonable care in selecting a charter flight company that would discharge its obligations properly. This was a low risk routine flight. The only remaining issue was whether it was reasonable to appoint this carrier to undertake the accident flight.

299. Sundance had, of course, originally engaged Jetfly to carry out the flight to Yangadou. As noted already, there is no suggestion that Sundance were in breach of any duty towards James in respect of the plan to use Jetfly. Accordingly, the focus of the case against Sundance can only be in relation to the late change of carrier to Aero-Service.

300. Did Sundance switch to Aero-Service without having undertaken reasonable checks or given any consideration to the wisdom of using them for this flight? In my view, the answer to that question is No; on the contrary, Sundance had amassed a good deal of information about Aero-Service over the preceding months. In particular:

a) They were aware that Aero-Service were a long-established business in the Congo whose planes had undertaken numerous flights into bush strips.

b) They had originally been recommended by the Dutch Honorary Consult, Ms Fumey, whose husband Marc was himself a pilot.

c) They had had a check on Aero-Service undertaken by another pilot whom they knew and trusted, Antonie Vermaark. His report was positive (paragraph 37 above);

d) They had sufficient basic documentation (which I find must have included the AOC) to allow them to use Aero-Service for the flight in March (paragraphs 33-38 above);

e) They had eventually been able to insure the March flight by reference to Aero-Service's own insurance documentation (paragraph 39 above); and

f) They had entrusted the Congolese Minister of Mines to Aero-Service when they flew to Yangadou in March, and the trip had been such a success that Mr Carr-Gregg had wanted to use Aero-Service permanently after that (see paragraphs 40-42 above).

301. When they decided to change from Jetfly to Aero-Service on 15 June 2010, Sundance had all that accumulated knowledge. They were changing from one carrier which they had used successfully before to another carrier which they had used successfully before. In addition, they knew that the pilots were going to be the same experienced pilots as before, another obvious source of reassurance. Mr Lewis had to approve every flight. He was aware of safety matters: he was also aware – because he said so – that the Board might ask him about such safety matters. I find that he reasonably

decided that in all the circumstances, the flight to Yangadou on 19th June 2010 could go ahead.

302. I accept that there were some things which Sundance had not done by the time of the flight. In particular, it does not appear that they had obtained the manuals and other information requested by Mr Lewis (paragraphs 33 and 109). Furthermore, they had not themselves undertaken detailed audits or seen detailed audits prepared by others. And they had not discovered that Aero-Service were on the EU banned list.

303. The first issue for me is whether, having obtained a good deal of information about and experience of Aero-Service, but not having obtained other information about them which could have been obtained, Sundance were in breach of their duty to Mr Cassley. I have concluded that, on balance, they were not.

304. Theirs was a duty to take reasonable care in selecting the charter flight company Aero-Service; it was not a more onerous duty. The fact that there was other information that Sundance might have obtained, but did not, does not mean that the information which they had in fact obtained was insufficient for them to discharge their duty to Mr Cassley.

305. In particular, it seems to me that the fact that Aero-Service had provided such a good service for the flight in March, when they had an extremely important guest on board, was the most important element in Sundance's conclusion that this flight could be entrusted again to Aero-Service. The information that they had obtained by June, and the steps that they took to satisfy themselves that Aero-Service were an appropriate carrier, were reasonable. They were therefore not in breach of their duty of care to Mr Cassley.

306. I reach the same conclusion by reference to the claimants' pleaded case that Sundance failed properly to recognise, assess and avoid the risks to Mr Cassley when undertaking this trip. The documents demonstrate that Sundance recognised the risks associated with all modes of travel in the region, including air travel. They concluded, rightly, that it was safer to fly than to travel by road. In addition, although they recognised the comparative safety of air travel, they made careful enquiries before each charter flight. The email exchanges in January, March and again in June 2010 before each of the relevant flights to Yangadou, make that only too clear.

307. As to the assessment of risks, Sundance assessed the risks of flying with Aero-Service locally through Ms Fumey and her husband, and then Mr Vermaak. Then came their careful appraisal of the flight in March. And whilst they could not avoid all risks associated with taking a chartered flight to an African bush strip, there was nothing to suggest that there was anything about the proposed trip that was particularly risky or dangerous. Far from it: the charter flight to and from Yangadou was a low risk enterprise.

308. In summary, I conclude that a company in the position of Sundance, who was selecting a specialist service provider for a one-off charter flight, was obliged to undertake reasonable enquiries as to that carrier. But it was under no duty or obligation to investigate the minutiae of matters such as the equipment fitted on the plane, the charts on board, the manner in which the pilots intended to execute the flight, and the extent to which the pilots might be able to deal with particular weather

conditions. Sundance were obliged to identify and evaluate any particular risks associated with the proposed flight plan and to select a reputable carrier. There were no risks in relation to this flight and Aero-Service were a reputable carrier whom they had used before.

309. For all these reasons, I find that there was no breach of duty on the part of Sundance and the claimants' claim against them must fail.

12.4 What Should Sundance Have Done?

310. Now let us assume that I am wrong in concluding that the duty owed by Sundance was limited, and/or wrong in finding that, on balance, there was nothing more that Sundance ought reasonably to have done in connection with Aero-Service. In doing so, I acknowledge that each of the experts, in rather different ways and in different terms, suggested that more might have been done by Sundance. In that event, what further actions should they have taken, and what (if any) difference would those actions have made?

311. First, it follows from paragraphs 222-229 above that I do not consider that Sundance should have engaged an independent aviation consultant. The evidence did not support Mr Watson's exposition of this possibility. In my view, Mr Watson was essentially saying that anyone chartering a flight in the Congo was obliged to instruct an aviation consultant to undertake a full audit of the charter company, even if it was only a one-off flight, and even if the duty-holder had obtained its own information as to the reliability of the carrier. I consider that to be unrealistic.

312. Putting the point another way, I conclude that an aviation consultant would only have been required if Sundance should have realised, from the information available to them, that this was a high risk flight (see ***Dusek***). However, as I have found (paragraph 121 above) this was not a high risk flight. It was a low risk flight to the African bush and there was nothing about it which should have alerted Sundance to any particular or specific risks of any kind.

313. In my view, the most that can be said against Sundance is that they should have followed up Mr Lewis' original (and then repeated) attempt to obtain safety manuals and the like. I think it likely that, if they had pursued this line of enquiry, Aero-Service would not only have provided the information on these issues which is apparent from the three audits, but they would have been more likely than not to provide copies of those three audits themselves. It would have been much quicker and easier for Aero-Service to provide that documentation, in one go, if they had been asked further questions about safety. In the alternative, Sundance might have asked Aero-Service whether they had been the subject of any audits and the likelihood is that the audits set out above would then have been provided to Sundance.

314. Accordingly, if Sundance ought to have done more, they ought to have followed up Mr Lewis' enquiries and/or asked Aero-Service directly about audits, and, if they had done so, I find that they would have received the information set out in the three audits (and in all probability the documentation too). The remaining question is what, if any, difference it would have made if that information had been provided to Sundance. I deal with that in the next section of this Judgment.

315. It is important here for me to say that, although there are other enquiries which it is alleged Sundance should have made, and other things they should have put in place, I reject those as being unrealistic or unreasonable. First, Sundance did not know of the EU ban: there was no evidence on which any contrary finding could be based. Moreover, I do not think that Sundance would have had any reason to make any further enquiries so as to discover the EU ban. They were an Australian company chartering a flight in West Africa. They could not readily have found out about the EU ban, but even if they had done so, they would have hardly been likely to accord it any importance (especially not compared with the local information which they had obtained). They could just have easily have noted that no Congolese carriers were banned by the US authorities. I note that both Mr Harris and Mr Sole (who undertook the February 2010 audit of Aero-Service) were aware of the ban but did not believe that this indicated that Aero-Service was an unsafe carrier.

316. It is also said that Sundance should have employed someone to supervise the flight has not been made out. There was no evidence that somebody in the position of Sundance should have engaged an independent flight supervisor (i.e. someone actually on board the aircraft). In any event, given the circumstances of the accident, it is impossible to see what difference any such flight supervisor would have made. He could not have been in the cockpit (the evidence was that only pilots were allowed there) so he could not have prevented the errors that caused the accident.

317. Finally there is the issue of the equipment fitted to the plane. Below the surface of the claimants' claim was the suggestion that the absence of a GPWS on this aircraft was a significant factor which, in some way, Sundance should have known about. But Mr Watson accepted in cross-examination that Sundance could not have been expected to consult the ICAO Annex 6, in which international standards for equipment are set out. Furthermore, this type of plane was not manufactured with GPWS and the cost of installing such a system in the plane would have been prohibitive. It was therefore unrealistic to suggest that in some ways Sundance could be linked to the absence of a GPWS on this particular aircraft. All of the conclusions about GPWS in connection with the case against GMP (at paragraphs 254-266 above) apply again in respect of the case against Sundance.

318. The debate about GPWS is part of a wider debate about a variety of factors, such as whether, charts, air traffic control and the like, on which the claimants rely in support of their case against Sundance. They are a mixture of risk factors and suggested control measures. As to these, I accept paragraphs 153-156 of Mr Williams' closing submissions, that these were matters which were wholly outside and beyond the capability of duty-holders such as Sundance to investigate and assess. That reality may explain why the claimants' needed a case that an independent aviation consultant was required to consider all of these factors, but that would lead, as the defendants submit, to a situation where an independent consultant was required to consider every proposed flight, which I consider to be a wholly unrealistic stance.

319. I also accept the submission that there is nothing in any standard or official guidance to suggest that these risk factors/control measures were matters that a duty-holder such as Sundance (or GMP for that matter) were required to investigate. They are concerned with the detail of aviation. To argue that they were matters that should have been considered sets the standard far too high for a company in the position of Sundance. They amount to a case that Sundance ought to have micro-managed every

aspect of the accident flight. I again consider that to be unrealistic. In addition, it would mean, as a matter of logic, that Sundance were not entitled to rely on any information produced by third parties (such as the AOC). I accept Mr Williams' submission that the claimants' case sets the bar far too high. It is not the standard set out in ***Dusek***.

12.5 Causation

320. This only arises if my conclusion in **Section 12.3** above is wrong, and that Sundance ought to have undertaken the further enquiries set out in **Section 12.4** above. As noted there, those further enquiries would have led to Sundance knowing what we now know, courtesy of the three audits. Would those have made any difference to Sundance's decision to fly with Aero-Service?

321. In my view, if the information in the audits had been made available to Sundance, it would simply have confirmed their positive views of Aero-Service: see paragraph 144 above. They would have seen that all three audits were generally positive and that, although there were things that needed to be improved, none of those things were regarded as significant or important, and none of them affected (or were recommended as affecting) the use of Aero-Service by MPD Congo. I find that Sundance would have concluded that, if Aero-Service were recommended to MPD Congo for two flights a week for 18 months, then they would have been good enough for Sundance to undertake this one off trip to Yangadou and back.

322. Mr Watson obviously appreciated that, on the face of it, the three audit documents did not provide the sort of damning critique of Aero-Service which was required to sustain the claimants' case. Accordingly, he gave evidence to the effect that if he, as an experienced aviation consultant, had looked at these audits, he would have disagreed with the positive views expressed by the auditors themselves, and would instead have looked between the lines and found evidence of the major failings which he said existed. He made plain in his oral evidence that he did not accept the findings of the auditors, saying at one point: "let's be blunt. I think they got it wrong." At another point in his evidence, he describes their findings as "typical audit errors".

323. This evidence neatly demonstrated the difficulty inherent in the claimants' case on the audits, as advanced by Mr Watson. In essence, he was advocating a contradictory case; that although Sundance (if they had seen them) would have been entitled to take the audits at face value, they would in fact have been wrong to do so, and they should instead have engaged an aviation expert, who might have given a potentially different view.

324. There are all kinds of difficulties with such a proposition. First, for the reasons already explained, I have found that neither GMP nor Sundance were obliged to engage an independent aviation consultant. Secondly, even if they had done, the experts were not agreed that such an expert would necessarily have taken a different view to that of the auditors. On the contrary, Captain Gillespie said that the audits were very positive and would have led him to conclude that Aero-Service were an appropriate company to undertake this flight. I conclude that this was therefore a matter on which, at the very least, different experts might reach different views.

325. Finally, there was Mr Watson's own admission in cross-examination that the three auditors who audited Aero-Service in 2009 and 2010 were far better placed than he was to make an informed judgment about whether or not it was safe to use Aero-Service for charter flights. That admission was clear and unqualified. It seemed to me that it negated all of Mr Watson's criticisms of those audits.

326. For these reasons, I conclude that Mr Watson's need to go behind these audits and to say that, if they had seen them, Sundance should have reached the opposite conclusion to that of the auditors themselves, demonstrated the insurmountable difficulties which the audits created for the claimants' case on causation. Even if Sundance should have asked for them, there was nothing on the face of these audits which should have alerted Sundance to the existence of any meaningful difficulties at Aero-Service. Mr Watson's evidence to the contrary was, in my view, unrealistic and tainted with significant amounts of hindsight.

327. Accordingly, even if (which I do not accept) Sundance ought to have carried out further enquiries, I find that those further enquiries would have resulted in their being provided with the information (and probably the documentation) surrounding the three audits. Armed with that information, I am in no doubt that Sundance would have confirmed the flights with Aero-Service. Accordingly, even if (which I do not accept) there had been a breach of duty on the part of Sundance, that breach was irrelevant; it was not causative of Mr Cassley being on the plane on that Saturday morning. Again, I find that the accident, and the causes of the accident, was not reasonably foreseeable and are too remote in law.

328. I should add for completeness that it is no part of the claimants' case that either an alternative means of transport should have been used or that, alternatively, a different carrier should have been used. Although Solenta was referred to in the evidence, it was not pleaded that the flight should have been arranged with them. That would not have got round the permit problem in any event. Although there was a suggestion in Mr Reeve's closing submissions that the flight should simply have been cancelled, I am dubious as to whether this could properly be said to have been pleaded. In any event, for the reasons that I have explained, there was nothing (and would have been nothing if further investigation had been undertaken) that would have warranted the cancellation of the flight in any event.

329. Although it is a point I have already made, it is again worth comparing the facts of the case against Sundance (when taken at their highest) with the decision of Hamblen J in ***Dusek***. In that case, there was an inherently dangerous and high-risk flight which should have been the subject of a careful risk assessment and was not. Here, there was a low risk flight which did not give rise to any reasonable concerns, and a carrier had been the subject of reasonable scrutiny. The stark differences in the facts explain, in my view, the different outcomes in these two cases.

330. Another way of arriving at the same conclusion as to causation is to consider the twin causes of the accident: the failure to plot the route properly (and to be aware of the Avima ridge); and the failure properly to assess the weather conditions before and during the flight. These were plainly matters which were the responsibility of the pilots. Mr Watson conceded that in cross-examination. Those were not matters which Sundance could have identified or done anything about prior to the accident.

331. It is possible for this analysis to be presented in one final way. I have referred at paragraph 281 above to the recently re-stated principle that English law does not impose liability on a defendant for injury or damage to the personal property of a claimant caused by the conduct of a third party. Ultimately, for the reasons set out above, I have concluded that this accident occurred due to pilot error. Sundance were not liable for the errors made by the Aero-Service pilots, who were third parties. There was nothing that they could reasonably have done to have avoided those errors.

332. For all the reasons set out above, the claimants' claims against Sundance are also rejected.