JUDICIARY OF
ENGLAND AND WALES

IN THE CROWN COURT AT SHREWSBURY AND STAFFORD

REGINA
(On prosecution by the Health and Safety Executive)

-v-

SHREWSBURY AND TELFORD NHS TRUST

SENTENCING REMARKS OF THE HON. MR JUSTICE HADDON-CAVE AT STAFFORD CROWN COURT, 28th NOVEMBER 2017

INTRODUCTION

Plea

1. On 23rd June 2016, Shrewsbury and Telford NHS Trust ("the Trust") pleaded guilty to breach of section 3(1) of the Health and Safety at Work etc Act 1974, in failing to conduct its undertaking, namely the provision of medical support, in such a way as to ensure, so far as was reasonably practicable, that persons not in its employment who might be affected thereby, including Mohan Singh (74), Eileen Thomson (81), Edna Evans (92), Ada Clarke (91) and Gerald Morris (72), were not exposed to risk to their health and safety, namely risk associated with falls. The Prosecution followed investigations by the HSE into the deaths of these five patients at the Princess Royal Hospital and Royal Shrewsbury Hospital between June 2011 and October 2012. Both hospitals are managed by the Trust.

2. The Trust has pleaded guilty on the following basis of plea:

> "(a) that it is accepted that each of the named patients was exposed to the risk arising from a failure to mitigate, so far as was reasonably practicable the risks arising from elderly and vulnerable patients suffering falls whilst in hospital,
>
> (b) that the basis that the mitigation of falls risk of vulnerable patients (particularly those without capacity) in acute care settings is and has been the subject of rapid continuous evolving learning by healthcare professionals,
>
> (c) that, in this regard, whilst significant efforts were made to address the risks through the implementation of systems

that met recognised standards in the NHS, it is accepted that in the period to which the charges pertain there were matters that could reasonably practicably have been more effectively implemented to have better mitigated the risk posed by falls to elderly and vulnerable patients.

(d) The root cause analyses identify how the Trust reacted to each incident, the system in place to remediate matters and how problems were identified variously in regard to adherence to and completion of falls risk assessment material and with "handovers'. It is accepted that there were incidents where systems were not sufficiently adhered to relating to both falls risk assessment and the quality of handovers."

3. The Prosecution accepts the Basis of Plea. However, Mr Thorogood, Counsel for the Prosecution, makes two observations. First, in relation to (c), he submits that the Prosecution accept that the Trust's system as regards falls risks was one which met the standards prevalent at the time, but whether "significant" efforts were made to address the problems which were evident from these five case is a matter for the Court. Second, in relation to (d), he submits that this is matter of mitigation not plea, but he accepts that the Trust has shown marked improvements since these cases.

4. I will now sentence the Trust for this offence.

THE FACTS

5. I set out below a summary of the facts and medical evidence in relation to each of the deceased patients as I find them on the materials before me. A detailed initial investigation of each case was carried out by David Kivlin of the HSE, which led to the instruction of individual experts.

(1) MOHAN SINGH

6. Mohan Singh was admitted, aged 74, to the Princess Royal Hospital Medical Assessment Unit ("MAU") via Accident and Emergency on 15th June 2011. He fell in the early hours of 17th June 2011 and died on 21st July 2011.

History

7. Mohan Singh had reduced mobility, confusion, increased falls in recent times, and complex medical problems including high blood pressure, heart disease and postural hypotension leading to dizziness. He was noted in the MAU to be confused and disorientated. He was at very high risk of falling and from falls when in the Trust's care.

8. However, his Falls Risk Assessment ("FRASE") "score" was only 12, indicating a medium risk and his "Falls Care Bundle" was not followed. There was no plan for observations or checks for injuries and other actions. When Mohan Singh

was transferred to bay C on Ward 7 he demonstrated a hesitant gait, but staff did not conduct a FRASE at that stage. The transfer information when Mohan Singh was moved from the MAU to Ward 7 was poor. When, after Mohan Singh fell (see above), staff did carry out another FRASE, the "score" only reached 15. This was subsequently increased to a more realistic figure of 23.

9. Staff on Ward 7 wanted to give Mohan Singh "enhanced" care, *i.e.* one-to-one attention, from a nurse or HCA (a "bed watcher"). The Trust's own guidance provided that enhanced care meant that a patient should not be left alone. However, the staff on Ward 7 were unable to watch Mohan Singh continuously because they were sometimes attending to other patients. It was on one such occasion, when staff were attending to another patient with acute needs, that Mohan Singh fell at bay C and suffered brain injuries which led to bronchopneumonia, and death. The fall and its consequences are given as causes of death in the Post Mortem.

10. When his family visited him at about 11am the next morning, they found him incoherent. They were concerned that they had not been told earlier about the fall. Contrary to the requirements of the Falls Care Bundle, only minimal neurological observations had been carried out. These should have taken place hourly for at least 4 hours following the fall.

HSE investigation

11. An HSE investigation followed with the assistance of an expert, Jennifer Hannay. Major failings by the Trust in Mohan Singh's case included:

    (1) poor risk assessment;
    (2) inadequate record keeping;
    (3) poor passing of information; and
    (4) a failure to provide enhanced care.

12. The Trust should have an effective system available to deal with demands in the night for enhanced patient care. There was no suggestion that the period 15th-17th June was one of exceptional demand for enhanced patient care *i.e.* which the Trust could not reasonably meet.

13. The Trust has since developed an improved and better resourced/structured system for the provision of enhanced patient care.

Significant cause of actual harm

14. The law is clear: for the Court to find that there was a causal connection between one or more aspects of the breach, and the fall, it is only necessary to conclude that one or more aspects of the breach was a cause of the fall and therefore the loss of life, and only in the sense that it made a more than a *de minimis* or trivial contribution to the death.

15. This approach to causation was helpfully summarised by Lord Hughes in *R v Hughes* [2013] UKSC 56; [2014] 1 Cr. App. R. 6 at paragraph 22. He continued in paragraph 23:

> "23. The law has frequently to confront the distinction between "cause" in the sense of a sine qua non without which the consequence would not have occurred, and "cause" in the sense of something which was a legally effective cause of that consequence. The former, which is often conveniently referred to as a "but for" event, is not necessarily enough to be a legally effective cause. If it were, the woman who asked her neighbour to go to the station in his car to collect her husband would be held to have caused her husband's death if he perished in a fatal road accident on the way home. In the case law there is a well recognised distinction between conduct which sets the stage for an occurrence and conduct which on a common sense view is regarded as instrumental in bringing about the occurrence. There is a helpful review of this topic in the judgment of Glidewell L.J. in *Galoo Ltd v Bright Grahame Murray [1994] 1 W.L.R. 1360*. Amongst a number of English and Commonwealth cases of high authority, he cited, at 1373–1374, the judgment of the High Court of Australia in *57 *March v E & MH Stramare Pty Ltd* (1991) 171 C.L.R. 506 at 515, in which Mason C.J. emphasised that it is wrong to place too much weight on the "but for" test to the exclusion of the "common sense" approach which the common law has always favoured, and that ultimately the common law approach is not susceptible to a formula."

16. As Lord Hughes states, there is a well-recognised distinction between conduct which (merely) sets the stage for an occurrence (*i.e.* 'but for') and conduct which, on a common sense, view is regarded as instrumental in bringing about the occurrence.

17. The Prosecution submits there was a clear common sense connection between the lack of enhanced or one-to-one care for Mohan Singh and the fall. I agree. I am satisfied that if Mohan Singh had been given enhanced or one-to-one care the risk of falling would have been very significantly reduced, and that Mohan Singh would not have fallen. This is demonstrated by the fact that he did not fall when he had one-to-one care, but did fall in the very few minutes when he was left alone. I am also satisfied that his fall in hospital was a cause of his death.

18. The Defence argued that the risk of falling in elderly patients cannot be entirely eliminated and provided evidence in the form of national statistics as to the incidence of falls nationally. In my view, however, this is not to point. Whatever the national statistics may be, the point which the Court has to determine is whether in the instant case(s), failures of care or management on the part of the Trust can be said as a matter of common sense to have been a significant cause or contributory factor to this patient's death. In this context, significant means more than *de minimis* or trivial (see Lord Hughes in *R v. Hughes*, *supra*, at paragraph 22). In my view, it is clear that the heightened risks to which Mohan Singh was exposed were a more than trivial cause of the fall and his death.

19. Note: In the defence note of 21st June 2016 it was said that the plea did not encompass acceptance that the breaches were "demonstrably a substantial cause of death" – this approach to the question seems to be reflected in the defence expert's report. However a breach only needs to be more than a minimal or trivial cause, for it to count as "significant".

(2) EILEEN THOMSON

20. ET was admitted, aged 81, to the Princess Royal Hospital MAU on 3rd May 2012. She fell on 5th May, 12th May and again on 15th May and died on 16th May 2012.

History

21. Eileen Thomson needed a Zimmer frame and had reduced mobility due to leg, knee and back problems. She also suffered from cataract, heart and disc problems and chronic Myelomonocylic leukaemia and renal failure and had fallen at home. She was admitted to the MAU with worsening leg swelling. She was at very high risk of falling with the associated risk of uncontrolled bleeding associated with her leukaemia.

22. Eileen Thomson was placed in a bed in bay A in Ward 9 where she was not visible from the nurses' station unless she walked about. On 3rd May a FRASE was carried out which gave her a "score" of 11 (medium risk). As a result, Eileen Thomson's "handling strategy" was marked "I/S", meaning "Independent/ Supervise". On 6th May, she was moved to Apley Ward in ignorance of the fall the previous day. On 6th May, in Apley, Eileen Thomson's FRASE was scored at 14. Apley Ward consisted entirely of side rooms which could not be viewed from the nurses' station. It was unsuitable for Eileen Thomson. On 9th May her FRASE score was reduced to 9. The FRASE risk assessments were again inadequate (for the same reasons as given above). There was an evident lack of sufficient training in FRASE.

23. On 12th May, Eileen Thomson fell for a second time but the staff simply entered "1" on the FRASE form and failed to increase her score above 10 and she continued to be assessed as only at medium risk of falling. Some "shared care" and one-to-one care arrangements were then put in place, but these ceased at 1pm on 13th May.

24. On 15th May Eileen Thomson was found having fallen again by her bed. She suffered a skull fracture and brain swelling and died at 2.15am on 15th May she died. The Post Mortem Report found the fall as a cause of her death.

25. The Trust's Root Cause Analysis (i) acknowledged that the FRASE "did not accurately reflect the patient's needs on initial admission", (ii) noted the increased bleeding risk, (iii) found poor communication between Ward 9 and Apley Ward "contribute[d] to the adverse event", and (iv) concluded: "The handover of the patient appears to have not been clear…".

HSE investigation

26. An HSE investigation was conducted with the assistance of an expert, Jennifer Hannay, which concluded that:

    (1) Eileen Thomson was at serious risk of falling;
    (2) the FRASE assessments were inadequate;
    (3) there was overreliance on FRASE "scores";
    (4) handovers were inadequate; and
    (5) the Trust failed to ensure Eileen Thomson's health and safety, including failing to position her visibly on the ward or provide enhanced care.

Significant cause of actual harm

27. I repeat the guidance as to the question of causation given by Lord Hughes in *R v Hughes* [2013] UKSC 56; [2014] 1 Cr. App. R. 6, para 23 (see above).

28. This was a frail and elderly woman with obvious needs. I am satisfied that had the requisite care been provided, not only would Eileen Thomson's risk of falling have been significantly reduced, but that she would not have fallen and her fall in hospital was a cause of her death.

Victim impact

29. I have read the helpful victim impact statements of from members of Eileen Thomson's family – her daughters, Helen, Janice and Wendy who have struggled to come to terms with their mother's death. She is described, movingly, as "a loving mother and very caring person and loving mother who helped soldiers returning from Dunkirk during the war."

(3) EDNA EVANS

30. Edna Evans was admitted, aged 94, to the Princess Royal Hospital AMU via Accident and Emergency on 2nd October 2012. She had fallen from her bed at about 3am on 3rd October, sustaining fractured head of right humerus. She was discharged on 24th October and died on 30th October. The prolonged immobility made necessary by the fall, along with the fracture, were identified in the Post-Mortem report as causes of her death.

History

31. Edna Evans used a Zimmer frame, had high blood pressure, heart disease, osteoporosis, diabetes, dizziness, a UTI, was confused and had a history of falls at home. She was at high risk of falling. She should have been on a high/low bed or on a mattress on the floor and not a normal height bed, especially ones with rails (see the Root Cause analysis and expert report of Lucia Holmes).

32. She was placed in bay A in an ordinary hospital bed, with bed rails fitted at her family's request. The nursing station had their backs to bay A and visibility was "extremely restricted" during the day and poor at night.

33. She was given a FRASE score of 14, but should have been well over 20. Her confused state meant that she should not have had bed rails fitted, lest she try and climb over them. The Agency nurse who completed the FRASE failed to justify the use of bed rails.

34. The Root Cause Report pointed out that (i) the need to position Edna Evans on the ward was not done or picked up on by any supervisor, (ii) Edna Evans should have been in a high/low bed or on a mattress, (iii) there was no clear information about the use of the bell, and (iv) Edna Evans required enhanced care.

35. After her fall on 3rd October, Edna Evans' FRASE score was initially raised to 17 and then 28, enhanced care given and a high/low bed was arranged for her.

HSE investigation

36. The HSE investigation by expert Lucia Holmes concluded that:

    (1) Edna Evans should not have been in a normal height bed with rails;
    (2) should not have placed effectively out of sight; and
    (3) should have had enhanced care from the outset, in a high/low height bed.

Significant cause of harm

37. I repeat the guidance as to the question of causation given by Lord Hughes in *R v Hughes* [2013] UKSC 56; [2014] 1 Cr. App. R. 6, para 23 (see above).

38. Edna Evans was in a confused state and from the moment she arrived at the hospital was at high risk of falling and at serious risk if she did. I am satisfied that had the requisite care been provided, not only would her risk of falling have been significantly reduced, but that she would not have fallen and her falls in hospital were a cause of her death.

Victim impact

39. I have read the helpful victim impact statement of Edna Evans's great niece, Lucy Anderson-Edwards who speaks eloquently of the great loss to the family that her great aunt's death has caused. She explained what a remarkable lady she was and how her great aunt had brought up her mother and uncle as her own.

(4) ADA CLARKE

40. Ada Clarke (known as "Sadie") was admitted, aged 91, to the Princess Royal Hospital AMU on 22nd October 2012 by her GP, following a fall at home. She fell on 29th October after overcoming the fitted bed rails on her normal height bed, and died that day. The post-mortem report indicates that a contributory cause to her death was the fall, fractured right humerus and associated severe trauma and blood loss.

History

41. Ada Clarke suffered from a variety of medical conditions including heart disease, Parkinson's, a UTI, kidney disease, osteoporosis, an unsteady gait, macular degeneration, biliary sepsis. She had a history of falls at home and poor mobility and used a Zimmer frame. She was at a very high risk of falling when she arrived at the AMU.

42. The FRASE on the AMU reached a score of 22, well into "high risk", but no assessment was carried out which would have indicated that bed rails were not appropriate. No FRASE or bed rails review was carried out on her transfer to ward 10. The Inquest jury found the fall could have been prevented. As the Coroner put it:

> "The danger of bed rails was that it increases the height from which a patient may fall if the patient was agitated and trying to climb out of bed.
>
> This was precisely what happened……."

43. During the night of 28rd October Ada Clarke became more confused and agitated. The night staff nurse asked the day team to procure a high/low bed, however none was located before Ada Clarke fell that morning at 10.30 fracturing her right humerus. Her agitated activities in bed were also found to have caused 5 skin tears to her lower legs.

44. The Trust's Root Cause Analysis accepted that the "trigger factors" identified as the root causes of the accident included:

    (1) The failure to reassess the FRASE and bed rail assessments;
    (2) Delay in availability of high/low bed when the risk identified.

HSE investigation

45. An HSE investigation was carried out with the assistance of an expert, Mary Mason, which identified key failings by the Trust as including:

    (1) lack of suitable risk assessment(s) leading to the identification of appropriate control measures for Ada Clarke;
    (2) no high/low bed provided when recommended and requested;
    (3) no effective monitoring system, to identify the inadequacies in Ada Clarke's care planning.

Significant cause of actual harm

46. I repeat the guidance as to the question of causation given by Lord Hughes in *R v Hughes* [2013] UKSC 56; [2014] 1 Cr. App. R. 6, para 23 (see above).

47. Ada Clarke clearly should not have been placed in a normal height bed with bed rails. In her confused state she was at serious risk of climbing over the bed rails and falling. I am satisfied that there is a clear, common sense causal connection between these failings in care by the Trust, the fall and Ada Clarke's death.

Victim impact

48. I have read the helpful victim impact statements of Ada Clarke's family – her son and daughter-in-law, Alan and Margaret Clarke and her grand-daughter, Elspeth Clarke. They explain what a loved mother and grandmother she was and the guilt that they feel for arranging for Sadie to be admitted to hospital where they expected her conditions to be properly treated.

(5) GERALD MORRIS

49. Gerald Morris was admitted, aged 72, to the Royal Shrewsbury Hospital following a fall at home, via Accident and Emergency, on 6th October 2012. He fell in the early hours of 12th October. He died on 18th November but the fractured femur which was given as a cause of his death was already present when he arrived at hospital. The Prosecution does not suggest in his case that the evidence shows a sufficient causative link, to the criminal standard.

History

50. Gerald Morris had a history of falls, blackouts, postural hypotension, pulmonary disease, vascular disease and diffuse atherosclerosis. He was also taking medication which made him dizzy. He was noted to have confusion and disorientation on arrival in Ward 23N at AMU on 11th October. Gerald Morris was clearly at very high risk of falling and at risk from the effects of a fall.

51. His FRASE assessment "score" was just 9 (the lowest score) and clearly wrong. There was no FRASE review until he went to Ward 23N on 11th October when his condition had deteriorated and a "high" risk score of 15. He was put in a bed in bay 2 next to the nurses' station but the nurses in fact face away from that bay when seated at the station.

52. He fell shortly after midnight (so just into 12th October) as he walked past the nurses' station. It was not until 15th October that an X-Ray was taken and the fractured neck of the left femur was revealed. Gerald Morris' condition deteriorated thereafter until his death on 18th November.

HSE Investigation

53. The HSE conducted an investigation with the assistance of an expert, Jennifer Hannay, which concluded:

    (1) Gerald Morris required enhanced care but was not given it;
    (2) The passing of information on handover was inadequate, in particular, nothing was said about hypotension on transfer; and
    (3) The Trust failed to ensure health and safety in relation to the risk of falling.

Significant cause of actual harm

54. Gerald Morris was at significant risk of falling and he was not given the enhanced care which was required in his case, or otherwise protected from the risk of falls to the required standard. As stated above, however, the Prosecution does not suggest that the fall can be shown to be connected to Gerald Morris later death.

Victim impact

55. I have read the helpful victim impact statements of Gerald Morris' son, Ian Morris, who explains poignantly how the whole family have been deeply affected by the death of his father.

THE LAW

Health & Safety at Work Act

56. The Trust owed duties under the Health and Safety at Work etc Act 1974 ("the Act"), to conduct its undertaking in such a way as to protect patients from exposure to risk. By section 3(1) of the Act every employer has a duty to conduct its undertaking in such a way as to ensure, so far as is reasonably practicable, that persons not in its employment who may be affected by the conduct of its undertaking, are not as a result exposed to risks to their health or safety.

57. An employer fails to ensure the health and safety of such persons if there can be shown to exist "a risk to safety". This bears its ordinary meaning, *i.e.* denoting the possibility of danger rather than actual danger. The section imposes a strict liability, subject only to the qualification of "reasonable practicability", *i.e.* requiring an employer to do all that is reasonably practicable to prevent or minimise material risk.

58. Elderly patients at The Princess Royal Hospital were clearly exposed to risks to their health and safety arising from inadequate falls risk and handover procedures. The Trust accept that it failed to take every reasonably practicable step to minimise or reduce that risk.

Sentencing - general principles

59. Lord Thomas of Cwmgiedd LCJ (sitting in the Court of Appeal Criminal Division with Mitting and Thirlwall JJ) gave definitive guidance as to the correct approach when sentencing large organisations for breach of health and safety legislation in the conjoined appeals *R v. Sellafield* and *R v. Network Rail Infrastructure Limited* [2014] EWCA Crim 49.

60. I have set out that guidance in full in my Sentencing Remarks in *R v. Mid-Staffordshire NHS Foundation Trust* (16th December 2014) at paragraph 31ff. and the other criteria relevance to sentencing and the relevant approach to the fines. I direct myself in accordance with that guidance and the general guidance as set out in my 2014 sentencing remarks, which it is not necessary to repeat again here.

61. I do, however, repeat the remarks of Scott Baker J. in *R v F. Howe and Son (Engineers) Limited* [1999] 2 Cr. App. R. (S.) 37 at 44:

> "The objective of prosecutions for health and safety offences in the work place is to achieve a safe environment for those who work there and for other members of the public who may be affected. A fine needs to be large enough to bring that message home where the defendant is a company not only to those who manage it but also to its shareholders."

62. I also direct myself in accordance with Section 142 and 164 of the Criminal Justice Act 2003 as regards sentencing.

Sentencing Guidelines

63. I have regard to the Sentencing Guidelines on Health and Safety Offences Causing Death published in February 2016.

THE ISSUES

64. The following issues require determination:

A. **Culpability**: was the culpability of the Trust high or medium, within the meaning of those terms in the guideline?

B. **Harm**: which harm category does the offending fall into: *i.e.* what was the risk of harm arising from the offence and what was the risk created by the offence?

C. **Significant cause of harm**: Was the offence a significant cause of actual harm, and if so, whether, when coupled with a consideration of the extent of persons exposed to the risk, what final harm category should be assigned under the guidelines?

D. **Aggravating and mitigating features**: What were the aggravating and mitigating features?

E. **Financial consequences**: How great should be the substantial reduction in the fine to mitigate what would otherwise be the significant impact of the Trust's ability to provide services?

ANALYSIS

A. Culpability

65. The Prosecution contend that culpability in this case should be characterised as high under the Sentencing Guidelines because (i) the breaches subsisted over a significant period, (ii) they were systemic in nature, (iii) there was a failure to respond effectively to earlier incidents (across the 5 falls which the case focuses on), (iv) the Defendant fell well short of the appropriate standard in relation to the risks concerned, and (v) management had not ensured that sufficiently robust measures were in position, or appropriately supervised and monitored staff and systems.

66. The Defence contend that culpability should be characterised as medium because significant efforts were made to address the continuing falls risk in elderly patients, albeit there were lapses and problems at times.

The FRASE tool

67. I have been assisted by the evidence of Professor Simon Conroy, Honorary Professor at the University of Leicester and consultant geriatrician at the Leicester Royal Infirmary who leads the Acute Frailty Network, a national improvement collaborative focussing on urgent care for frail older people. As Professor Conway explains, the FRASE tool is one of many in-hospital falls risk assessment tools; it has been evaluated in acute medical and surgical ward settings in controlled, pre-post evaluations. The evaluation found that risk assessment and intervention (*e.g.* hazard card over bed and/or use of mobility monitors, patient education, bell at hand, low bed position, frequent checks) was associated with a 15% reduction in falls. In his experience, the FRASE tool is not widely used, but it is a validated tool. Moreover, recent guidance from the Royal College of Physicians steers hospitals away from using risk stratification tools for falls prevention, and focussing more upon individualised assessments. The Prosecution accepts that the aim is that standards and techniques are constantly developing and improving.

68. In my judgement, the following points are pertinent.

69. First, it is clear and accepted by the Trust, that the Trust fell short of the appropriate standard in relation to (a) its mitigation of the falls risk for the elderly in its care, (b) the quality of handovers and (c) the provision of control measures (such as Enhanced Patient Support and high/low beds). The Trust was also at fault in failing properly to address the causes of the serious falls and incidents it was experiencing and to make timely and appropriate changes to its systems and training.

70. Second, the Trust's failures were undoubtedly significant in each case, but its failures were individual and unfortunate instances which should not, in my view, be characterised as indicative of 'systemic' problems or a systemic failure.

71. Third, the Trust did have a falls risk system in place which it believed (and the HSE accept) represented adherence to recognised standards in the NHS as regards falls risk mitigation in the elderly. Indeed, as Mr Matthews QC submitted, the Trust rightly felt that it was somewhat more advanced than other Trusts in having already begun to implement a 'multi-factorial' approach to falls risk assessment, *i.e.* one which was not simply based on FRASE. There was background, as Professor Conway explains, of (a) developing awareness of the limited effectiveness of FRASE and (b) a recognition that the system of falls risk mitigation in the elderly was evolving and posed practical challenges in terms of training, competing hazards and resource demands. It should be noted that FRASE was first introduced by NICE (the National Institute for Clinical Excellence) in 2004; but in a paper published in December 2011, NICE explained that its 2004 guidance was not intended to be germane to falls in hospitals and further guidance would be needed. In April 2012, the Royal College of Physicians published its guidance called "Falls Safe" which was then adopted by NICE in 2013. Accordingly, it is apparent that, during the period in which the instant five cases took place, namely June 2011 to October 2012, the thinking on the management of falls risks for hospital patients was in a phase of transition. The Trust began piloting "Falls Safe" in March 2013.

72. Fourth, the Trust carried out a 'benchmarking' exercise which it carried out in 2011 which demonstrated that its falls risk systems complied with NHS current standards. The Trust also deserves credit for a positive culture of incident reporting and of also attempting to learn lessons of failures and mistakes by a robust Root Cause Analysis.

73. Fifth, the Prosecution accepts that the Trust had and has a sincere interest in safe systems.

74. For these reasons, in my view, the culpability in this case can properly be characterised as Medium Culpability under the Sentencing Guidelines.

B. Harm

75. The Defence contend that a real likelihood of an elderly person suffering a fall in a hospital does not equate to the likelihood of harm that was created by the offence: in the present case, the gap in the systems increased the risk in a small way. A hospital environment is by definition the location of a panoply of risks – many of them high risks (*i.e.* real likelihoods of serious adverse consequences). The risk created by the offence (rather than the pre-existing risk) was of a medium likelihood of level C harm: Category 3 and a low likelihood of level A harm: Category 3.

76. Mr Thorogood contended on behalf of the Prosecution that falls for the elderly or frail involved a high risk of serious harm, including life-changing injuries or death (as the instant cases demonstrate); and accordingly, the likelihood of relevant harm was high and the risk created by the offence should be placed in Category 1, Level A, i.e. Harm Category 1. He subsequently modified his position.

Analysis

77. The NHS published a paper in July 2017, The incidents and costs of in-patient falls in hospitals, which gave a breakdown of reported falls within age groups by severity 2015/16 for all hospital settings in England (Table 1). This table demonstrates very clearly that the incidence of harm arising from the 190,000 falls in the over 65 year old patient category was as follows:

(1)	No harm:	71.1%
(2)	Low harm:	26.0%
(3)	Moderate harm:	2.2%
(4)	Severe harm:	0.6%
(5)	Death:	0.1%

78. Thus, in only 0.7% of cases can it be said that a fall by an elderly patient results in death or serious harm (even allowing for the slightly higher incidents in medical hospitals rather than mental or community hospitals). In these circumstances, as Mr Thorogood was bound to accept, it was difficult for the Prosecution to argue that the risk of Level A harm (*i.e.* death or serious impairment) on page 5 of the Sentencing Guidelines was anything other than in the "low likelihood" category.

79. I find that there was a Level A harm (*i.e.* death or serious impairment) under the Sentencing Guidelines but it was, as the above NHS national statistics show, a "low likelihood" and therefore the relevant starting category is Category 3.

C. Significant cause of harm

80. The Defence contend that none of the five falls can be proved to the requisite standard to have arisen because of systemic failing in regard to falls risk management, *i.e.* that the fall would not have occurred but for the offence. Research to support the change in falls risk management of the elderly in hospital settings establishes that the rate of falls in people receiving gold standard treatment can only be reduced by one-third. The Defence also rely upon a number of detailed points made by Professor Conway in relation to each of the four patients in respect of whom the Prosecution contend the Trust's failures were a cause of death.

81. I have considered Professor Conways' evidence carefully. However, as presaged above, the test of causation in law (*selon R v. Hughes*, *supra*) is merely that breaches have to be shown to be breaches to be a "significant" cause of death in question in the sense of being more than trivial or *de minimis*; not that they have to be the cause or a very substantial cause."

82. I am satisfied to the requisite standard that the Trust's breaches were a significant cause of, and/or contributory fact to, the deaths of four out of the five patients which are the subject of the charge, namely, (1) Mohan Singh, (2) Eileen Thomson, (3) Edna Evans and (4) Ada Clarke. Significantly, therefore case, therefore, involves the deaths of four people in the Trust's care.

83. For this reason, in my view, the categorisation of this offence should be moved from Category 3 to Category 2 (see p. 5 of the Sentencing Guidelines).

D. Aggravating and mitigating features

84. There are a number of aggravating factors put forward by Mr Thorogood on behalf of the Prosecution to which I have had regard:

(1) Vulnerable individuals were put at risk, over and above the five patients in this case;

(2) The Trust had a previous relevant conviction in 2010: this related to an elderly patient who suffered a fall in 2007 as a result of a failure to place a second bedrail.

85. I have read and considered carefully everything that Mr Matthews QC has said by way of mitigation on Trust's behalf. In particular, I have regard to the following mitigating factors:

(1) The Trust's self-reporting and early plea of guilty and acceptance of responsibility;

(2) The high level of co-operation shown by all Trust staff with all investigations (which has been fully acknowledged and appreciated by the HSE);

(3) The steps taken voluntarily by the Trust to learn from and improve its systems (and the marked improvements which the HSE has acknowledge); and to put effective Health and Safety systems in place.

E. Financial consequences

Accountability of public bodies

86. I referred in my 2014 sentencing remarks to the philosophical conundrum: What is the point of fines when they are paid out of public funds? I said this:

> "34. The answer lies in accountability. All organisations, public or private, are accountable under the criminal law following Parliament's removal of Crown immunity. This means that Health and Safety at Work etc Act 1974 and the Criminal Justice Act 2003 apply to all responsible public bodies, just as they do to private organisations. Accordingly, public bodies are to be held equally accountable under the criminal law for acts and omissions in breach of Health and Safety legislation and punished accordingly. Accountability is the reciprocal of responsibility."

Sentencing Guidelines

87. The SG provide that there should normally be reduction in the level of fine to take account of the fact that a defendant is a public body. The level of reduction is at the discretion of the sentencing judge in the light of all the circumstances (see Elias LJ in *R v. Havering Borough Council* [2017] EWCA Crim 242). The 2006 Sentencing Guidelines also provide:

> "Where the fine will fall on public or charitable bodies, the fine should normally be substantially reduced if the offending organisation is able to demonstrate the proposed fine would have a significant impact on the provision of its services."

Analysis

88. I have received and considered detailed evidence regarding the Trust's finances. The Defendant is a well-established Trust, with a significant level of revenue, providing NHS services to the public. It is a 'large' organisation under the Guidelines (p. 7). The 2016 indicated revenues of £325m. However, the Trust is running at a deficit. There was a deficit in 2015-16 of £31m (including accountancy losses). The net deficit for the year end 1st March 2016 is a deficit of £14.6m.

89. In addition, I bear in mind that the Trust is currently set up in two locations, both in relatively rural surroundings with two separate A&E departments. It has real difficulties in recruiting and retaining staff. 25% of its staff are bank or temporary staff. Mr Matthews QC has told me that the Trust hopes to consolidate onto one site. It requires a £310 million capital development fund to do this. In order to be eligible for and secure this fund, the Trusts needs to demonstrate it can control its recurrent deficit.

Decision on level of fine

90. I start by considering the level of fine which would have been appropriate if the defendant had been a private company.

91. This case, is as I have said, a Medium Culpability, Category 2 case, *i.e.* with a starting point of £600,000 and a range of £300,000 to £1,500,000. Taking all the significant harm factors and the above aggravating and mitigating factors into account, the proper starting level of fine in this case if the defendant had been a private commercial organisation would have been £1 million.

92. The Trust is entitled to a reduction of 1/3rd for its early plea of guilty and co-operation taking this figure down to £666,666.

Financial impact on public body

93. I further reduce this figure by 50% to reflect the Trust's financial circumstances and that it is public health care body. Accordingly, the net fine which I impose is £333,333. In my judgment, the imposition of a fine of this level is the minimum which would achieve the aims of Parliament encapsulated in section 164 of the Criminal Justice Act 2003 and the Health and Safety legislation.

Costs

94. The Guideline provides (in paragraph 29):

> "29. The defendant ought ordinarily (subject to means) to be ordered to pay the properly incurred costs of the prosecution"

95. The HSE have put forward a costs estimate of £132,540.80 which is accepted reasonable by the Defence.

96. Mr Matthews QC sought to persuade me that the fact that the Trust had already paid £70,000 by way of FFI (HSE Fees for Intervention) meant that the Court should award a lower costs figure in respect of the subsequent proceedings. I disagree. They are separate matters. I will, however, round the HSE's costs down.

97. Accordingly, I order the Trust to pay prosecution costs in the sum of £130,000 in addition to the £333,333 fine which I have imposed (to be paid within 18 months in view of the Trust's cash flow position).

Postscript

98. Finally, it must be remembered that this case involves the death of a much-loved family members. I wish to add my condolences to all the family and friends to those that have already been expressed and pay tribute to the quiet dignity of those in the public gallery. No financial penalty can adequately equilibrate to loss of life. What the Court is required to do is sentence the organisation responsible in accordance with the relevant Legislation and Sentencing Guidelines and in order to ensure accountability under the law as I have described.

The Honourable Mr Justice Haddon-Cave
28th November 2017