IN THE CROWN COURT

AT STAFFORD

REGINA

[HEALTH AND SAFETY EXECUTIVE]

- v -

MID STAFFORDSHIRE NHS FOUNDATION TRUST

SENTENCING REMARKS

OF THE HON. MR JUSTICE HADDON-CAVE

THE BACKGROUND

1. On 1st April 2007, Mrs Gillian Astbury, aged 66, was admitted to the Accident & Emergency Department of Stafford Hospital having suffered a fall at home. She had sustained fractures to her arm and pelvis. She was a Type 1 diabetic and suffered from mild *dementia*. She required daily insulin to control her condition. On admission, Mrs Astbury's friend and carer, Mr Ronald Street, made it clear that she suffered from 'brittle' diabetes which required regular monitoring.

2. People with diabetes have been said to occupy 16% of hospital beds in the UK and diabetes-related treatment to consume 9% of hospital costs.[1] Accordingly, the admission of a patient with an underlying diabetic condition was not an unusual scenario.

3. The doctor who admitted Mrs Astbury directed that if her blood sugar rose above 18mmols blood sugar at any of the four blood tests to be conducted daily, she was to receive a fast acting insulin called *Actrapid*. A daily dose of slow acting insulin was also to be given. He entered her prescriptions on her drug chart. He also required Mrs Astbury to be seen by a dietician, to ensure she received appropriate nourishment whilst in hospital.

4. Ten days later, on the evening of 10th April 2007, Mrs Astbury was found in a collapsed state in her bed on the Trauma and Orthopaedic Ward. A blood test showed a blood sugar reading of 27.8mmols. She died in the early hours of 11th April due to diabetic *ketoacidosis* (insulin deficiency).

5. This was a wholly avoidable and tragic death of a vulnerable patient who was admitted to hospital for care, but who died because of the lack of it. This fatality was not simply due to error and omissions by an individual nurse or nurses. The underlying causes were far more fundamental. As repeated investigations have

[1] Audit Commission 2000

revealed, there was a systemic failure at Stafford Hospital in relation to two of the most basic (and simple) tenets of patient care: proper handovers between nursing shifts and proper record-keeping. The hospital management failed to prescribe, monitor and enforce a proper, structured and rigorous system of work for handovers between nursing shifts and to devise and ensure the proper marshalling, updating and checking of medical records and notes.

6. These failures of organisation and management, meant that nursing and medical staff were working within a lax and poorly run system from the start. There was an absence of effective management, oversight or control. There was little or no accountability. There was a chronic shortage of nurses throughout the hospital. It was a system that was set to fail. It is precisely when individuals are expected to work within such a system that professional standards drop, mistakes multiply and a general lassitude takes over. Some of some the nursing staff at Stafford Hospital charged with nursing Mrs Astbury habitually ignored basic nursing standards and principles. This was because of an underlying unsafe system of work. As the Trust have openly acknowledged from the start, responsibility for the poor state of affairs at Stafford Hospital in 2007 lay firmly at the door of management at the highest level.

7. These failures put legions of patients at Stafford Hospital at serious risk. Proper systems of handovers and record-keeping in hospitals are obviously vital to ensure the correct and timely marshalling and passing on of patient information to enable the continuous delivery of appropriate medical care to patients and the carrying out of patient care plans. In Mrs Astbury's case, this included the need to administer a basic diabetes care plan.

8. There is no doubt that these failures were directly causative of Mrs Astbury's death. The simple fact is that Mrs Astbury died in Stafford Hospital because she was not given the insulin that she needed. The disturbing fact is that there was a systemic failure to implement her care plan, despite the involvement of numerous medical staff in the days leading up to her death. A proper system of handover between shifts and record-keeping is axiomatic for proper patient care. It is especially important if patients are not able to speak for themselves. It was vital for Mrs Astbury in view of her 'brittle' diabetes. The absence of a proper system meant that there were numerous failures properly to record and communicate critical information regarding her condition. The system of patient care at Stafford Hospital in 2007 was effectively broken.

THE FACTS

9. Following her admission to Stafford Hospital on 1st April 2007 as aforesaid, Mrs Asbury was allocated to a vascular ward, Ward 7. A Senior Staff Nurse on Ward 7 noted during the night shift that Mrs Astbury appeared to be eating very little. However, no referral to a Dietician was made.

10. On the 4th, 6th and 7th April, Mrs Astbury's blood sugar levels exceeded the 18mmols threshold and *Actrapid* was duly administered. However, there is no evidence, however, of the Diabetes Nurse having being contacted at any stage.

11. In the early evening of 8th April, Mrs Astbury was transferred from Ward 7 to the Trauma and Orthopaedic Ward, which was housed in temporary premises and shared facilities and space with other wards. She was placed in a relatively isolated bay, with two beds. It was not possible to observe her directly from the main ward. The Ward Manager stated that this created difficulties in operating the ward, exacerbated by staff shortages and no extra nursing cover. The Ward Manager Ward 7 and the Trauma and Orthopaedic Ward used different documentation for patient notes, and the Ward 7 notes would not have been continued or updated after the transfer. The fact that Mrs Astbury suffered from 'brittle' diabetes was not passed on from one ward to the next. Mrs Astbury was in the care of the 'Blue' team of nurses on the Trauma and Orthopaedic Ward. The Staff Nurse in charge of the shift did not perform the shift handover because she went off duty prior to the next shift start time.

12. On 9th April, a Staff Nurse conducted the lunchtime and teatime blood sugar tests, but was concerned that Mrs Astbury had not been given a Diabetic Menu for her meal. It is not clear, however, whether she informed the Ward Manager of this. At 15:00 hours on 9th April, she handed over to another Staff Nurse from the in-coming shift. There was a dispute as to whether the fact of Mrs Astbury's diabetes was communicated. There was no written record of the passing on of information. At 23:00 hours on 9th April, the Ward patients were handed over to another Staff Nurse and an "Adaptation Nurse" (a nurse from abroad in familiarisation training), who stayed on shift until 07:15 hours on 10th April.

13. Blood sugar tests were carried out on Mrs Astbury on 9th and 10th April, showing results of 14.6mmols and 19.7mmols respectively. A Staff Nurse stated, however, that he misheard the second of these results as *"9.7"*, and so he had no concerns, as the threshold point for administering fast acting insulin was 18mmols blood sugar.

14. At 07:15 hours on 10th April, a Staff Nurse handed over to a Senior Staff Nurse but, again, there is a dispute as to whether the fact of Mrs Astbury's diabetes was communicated. At 8:00 hours, a Staff Nurse arrived on duty but confusion arose as to whether the incoming or outgoing Staff Nurse would carry out the medicines round. The incoming Staff Nurse stated that she was unaware of the diabetes issue. At lunchtime, a Healthcare Support Worker who was aware of the diabetes issue, noted that Mrs Astbury did not have a diabetic menu. A lunchtime blood sugar test was not conducted. Nor did the drugs round reach Mrs Astbury. Consequently, she went without her 08:00am slow release insulin. At 13:45 hours, a further handover took place during which the diabetes issue was not mentioned. It is also clear that the patient notes were not read at this time. At 15:00 hours, Mrs Astbury was given her evening medication but the nurse in question failed to notice that she had not been given her morning medication. At teatime, on 10th April, no blood sugar test was undertaken. Mrs Astbury was given an ordinary menu.

15. At 21:15 hours on 10th April, a further shift handover took place at which time Mrs Astbury was found in a collapsed state. A blood test showed a blood sugar reading of 27.8mmols. She died at 01:20 hours on 11th April due to insulin deficiency as aforesaid. I repeat, this was a wholly avoidable death.

THE REPORTS

The Trust's internal Report

16. The Defendant, the Mid Staffordshire NHS Foundation Trust ("the Trust") conducted its own internal investigation into Mrs Astbury's death. The Trust's Report characterised the system of the handover between nursing staff as *"inconsistent and sometimes non existent"*. It found that the nursing records for Mrs Astbury were *"almost non existent"*.

The HSE Wood/ Halliday-Bell Report

17. The Health & Safety Executive ("HSE")'s Report[2] found that the various aspects of Mrs Astbury's nursing care and communication of her care *"fell significantly short of what would be expected, not just over one shift but eight shifts, possibly eleven drug rounds by a series of nurses."*

The Nicholls Report

18. A Report by a nursing expert, Ms Lorraine Nicholls, comprising a helpful 'Plain English' analysis of Mrs Astbury's medical records, revealed numerous failures. There was a *plethora* of different, overlapping forms in use at the Trust, some outdated, many incomplete. The basic *Multi-Disciplinary Care Pathway for Emergency Admission (Adult)* Form was hardly filled in. Between 5th and 7th April, there was an absence of any medical notes being made at all. There were no entries in the *Diabetes Care Plan* after 7th April. There was a failure to record any observations of Mrs Astbury after 9th April. There were failures to notice Mrs Astbury's blood sugar level rising above the threshold of 18mmols and to administer *Actrapid* when needed. There was a failure to move Mrs Astbury even when she was at risk from *C Difficile.* There was a failure to call a doctor even when Mrs Asbury was displaying signs of distress.

The Francis Report

19. The death of Mrs Astbury case must be also viewed against the background of the detailed and damning findings of the *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* chaired by Robert Francis QC which was published to Parliament on 6th February 2013. Mr Francis QC's magisterial Report spoke of *"…an engrained culture of tolerance of poor standards, a focus on finance and targets, denial of concerns, and an isolation from practice elsewhere."* The Trust's culture was characterised as one of *"self promotion"* rather than critical analysis and openness. The Trust management ignored numerous warning signs. The Trust lacked a sufficient sense of collective responsibility or engagement for ensuring that quality care was delivered at every level. The Trust management had no culture of listening to patients and inadequate processes for dealing with complaints or serious untoward incidents. The Board had failed *"to get a grip"* on its accountability and governance structure despite these being issues that were apparent to the incoming Chair and

[2] Prepared by the HSE's two in-house specialists, Ms Julie Wood, (Principal Specialist Inspector Occupational Health) and Dr J. Halliday-Bell (Medical Inspector, Corporate Medical Unit) dated 13th February 2009.

Chief Executive in 2004 and 2005. The evidence fully supported the description of the Trust's clinical governance process as *"vestigal"*. There was a focus on financial issues at the expense of the quality of service delivered. The economies imposed by the Board, year after year, had a *"profound"* effect on the organisation's ability to deliver a safe and effective service. There was an *"unacceptable delay"* in addressing the issue of shortage of skilled nursing staff. The system as a whole paid *"lip service"* to the need not to compromise services and their quality, and it was *"remarkable"* how little attention was paid to the potential impact of proposed savings on quality and service. As a result of poor leadership and staffing policies, a *"completely inadequate"* standard of nursing was offered in some wards in Stafford. The Trust prioritised its finances and its Foundation Trust status application over its quality of care and *"failed to put patients at the centre of its work"*. The Board at the time must bear collective responsibility for allowing the *"mismatch"* between resources and needs to persist, without protest or warning of the consequences. (See generally, the Executive Summary to the Report, especially paragraphs 1-1.16)

20. Staff shortages also compromised time available for handovers. The Public Inquiry Report[3] described *"a chronic staffing deficiency exacerbated by the need to meet financial targets"* in 2006. An internal review in 2007 showed that the Trust was some 120 WTE nurses short of what was required, nearly 13% of the total nursing establishment.[4] The Trust Board was made aware of this at its meeting July 2007 meeting.[5] Band 7 nurses were expected to be responsible simultaneously for three wards, *i.e.* 74 beds.

21. Whilst the Francis Report addressed wider issues than those raised in this prosecution, there is a clear relationship between lack of proper governance, leadership, management and supervision, laid bare in the Francis Report, and the poor care, record-keeping and handover regimes which led to Mrs Astbury's death.

THE PROSECUTION

22. The Trust were prosecuted by the HSE under the Health and Safety at Work etc Act 1974 ("the Act") in respect of the death of Mrs Astbury.

Trust's admission - 2010

23. In 2010, the Trust made a formal admission accepting responsibility for the death of Mrs Astbury as a result of inappropriate treatment during her admission to the Trauma and Orthopaedic Ward in 2007.

HSE prosecution - 2013

24. On 19th April 2013, Mr Stephen Flanagan, Her Majesty's Principal Inspector of Factories, wrote on behalf of the HSE inviting the Trust to put forward a representative for interview under caution. The Trust nominated Ms Julie Hendy, the Trust's new Director of Quality and Patient Experience, to appear at interview.

[3] *Mid Staffordshire NHS Foundation Trust Public Inquiry Final Report* (Volume 1, page 211)
[4] *Mid Staffordshire NHS Foundation Trust Public Inquiry Final Report* (Volume 1, para 2.284)
[5] *Mid Staffordshire NHS Foundation Trust Public Inquiry Final Report* (Volume 1 Para 2.283)

At interview, Ms Hendy read a statement making full and frank admissions as to the Trust's responsibility for the death of Mrs Astbury:

(1) The Trust accepted the HSE's factual summary was a broadly accurate account of the events leading to the hospitalisation of Mrs Astbury.

(2) The Trust accepted the findings of its own internal investigation into the death of Mrs Astbury and its failures.

(3) The Trust accepted that it had failed to deliver the diabetes treatment regime which it had determined was necessary for Mrs Astbury, which the led to her death.

25. On 4th September 2013, a Summons was issued, returnable on 9th September 2013. When the matter came before the Stafford Magistrates on 9th September 2013, the Trust formally entered a plea of guilty. The Magistrates committed the matter to the Crown Court because they considered their sentencing powers insufficient.

26. The Trust, therefore, pleaded guilty at the earliest possible opportunity, having previously volunteered a formal admission of responsibility for the death of Mrs Astbury.

THE LAW

Health & Safety at Work Act

27. 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.

28. 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.

29. Patients at Stafford Hospital were clearly exposed to risks to their health and safety arising from inadequate handover and record-keeping procedures. The Trust clearly failed to take every reasonably practicable step to minimise or reduce that risk.

Sentencing - general principles

30. The Lord Chief Justice, Lord Thomas of Cwmgiedd (sitting in the Court of Appeal Criminal Division with Mitting and Thirlwall JJ) has recently given 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.

31. Given the importance of this guidance to the present case, it is appropriate to cite paragraphs 3-7 in full:

> "3. It is important at the outset to recall the provisions which Parliament has enacted in the Criminal Justice Act 2003 (CJA 2003) in relation to the duty of the courts in sentencing, as these principles are applicable to all offenders, including companies:
>
> i) The courts must have regard in dealing with offenders to the purposes of sentencing which Parliament specified as (a) the punishment of offenders (b) the reduction of crime (including its reduction by deterrence), (c) the reform and rehabilitation of offenders, (d) the protection of the public, and (e) the making of reparation by offenders to persons affected by their offences (s.142 of the CJA 2003).
>
> ii) In considering the seriousness of the offence the court must have regard to the culpability of the offender and the harm caused or which might foreseeably be caused (s.143 of the CJA 2003).
>
> iii) If a court decides on a fine it must approach the fixing of fines having regard not only to the purposes of sentencing and the seriousness of the offence, but must also take into account the criteria set out in s.164 of the CJA 2003:[6]
>
> (1) Before fixing the amount of any fine to be imposed on an offender who is an individual, a court must inquire into his financial circumstances.
>
> (2) The amount of any fine fixed by a court must be such as, in the opinion of the court, reflects the seriousness of the offence.
>
> (3) In fixing the amount of any fine to be imposed on an offender (whether an individual or other person), a court must take into account the circumstances of the case including, among other things, the financial circumstances of the offender so far as they are known, or appear, to the court.
>
> (4) Subsection (3) applies whether taking into account the financial circumstances of the offender has the effect of increasing or reducing the amount of the fine.
>
> 4. There can be no doubt as to the objective in applying these principles when sentencing a company for offences against health and safety and environmental legislation. As Scott Baker J stated in giving the judgment of this court *R v F Howe & Son (Engineers) Ltd* [1999] 2 All ER 249 at 255, [1999] 2 Cr App R (S) 37 at 44:

[6] Section 164 of the Criminal Justice Act 2003 was in force in 2007.

> "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."
>
> 5. Where a fine is to be imposed a court will therefore first consider the seriousness of the offence and then the financial circumstances of the offender. The fact that the defendant to a criminal charge is a company with a turnover in excess of £1 billion makes no difference to that basic approach.
>
> 6. The fine must be fixed to meet the statutory purposes with the objective of ensuring that the message is brought home to the directors and members of the company (usually the shareholders). The importance of the application of s.164 in relation to corporate defendants was reinforced in the Definitive Guideline of the Sentencing Guidelines Council *Corporate Manslaughter & Health and Safety Offences Causing Death,* published in 2010. It has been reflected in more recent decisions of this court: see for example: *R v Tufnells Park Express Ltd* [2012] EWCA Crim 222 at para 43 (the fine after trial on a company with a turnover of £100m and profitability of £7.7m was £225,000; this represented, as the court noted, 2.9% of its operating profit).
>
> 7. It will therefore always be necessary in the case of companies with a turnover in excess of £1 billion to examine with great care and in some detail the structure of the company, its turnover and profitability as well as the remuneration of the directors. …".

32. The Court of Appeal upheld fines of £700,000 against Sellafield Ltd for offences arising out of the disposal of radioactive waste and £500,000 against Network Rail for an offence arising out of a collision at an unmanned level crossing, causing very serious injuries to a child.

Accountability of public bodies

33. HSE prosecutions of public bodies involve a philosophical conundrum: What is the point of fines when they are paid out of public funds?

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.

35. The fact that a fine will have to be met from public funds or in a reduction in investment by a public body is, however, a factor which a court must take into account when assessing the level of fine (*R v Milford Haven Port Authority* [2002]

2 Cr App R 423*; R v Network Rail* [2011] Cr App R (S) 44, [2010] EWCA Crim 1225 at para 24).

36. The Court of Appeal in *R v. Sellafield* (supra) pointed out that a fine will, nonetheless, serve three other purpose of sentencing if (a) it reduces criminal offences of the kind committed, (b) reforms and rehabilitates the defendant as an offender and (c) protects the public. The Court of Appeal went on to say that, to ensure that a fine will achieve these statutory purposes of sentencing, *"the fine must be such that it will bring home to the directors and members of [the organisation] these three purposes of sentencing"* (paragraph 70).

Further sentencing authorities

37. Mr Climie, Counsel for the Defence, cited *R v. Southampton University Hospital NHS Trust* [2006] EWCA Crim 2971 which he submitted was a useful comparable. In that case, the Court of Appeal Criminal Division quashed a fine of £100,000 imposed on Southampton University Hospital NHS Trust for failures to supervise doctors, and substituted a fine of £40,000. In my judgment, however, this case is clearly distinguishable for three reasons: (a) the Trust failures were held to be non-causative of the patient's death, (b) two Senior House Officers were prosecuted and found guilty of manslaughter and (c) the case was a pre-Sentencing Guideline case.

38. Mr Thorogood, Counsel for the Prosecution, cited a number of recent cases involving deaths where the following fines had been imposed following Health & Safety Executive prosecutions: a fine of £100,000 imposed by HHJ Eccles QC in *R v. Lifeways Community Care Ltd* (22nd January 2010 at Oxford Crown Court); a fine of £150,000 imposed by HHJ Jukes QC in *R v. BUPA* (19th January 2011 at Birmingham Crown Court); a fine of £80,000 imposed by HHJ Davies QC in *R v. Midland Heart Ltd* (5th October 2011 at Birmingham Crown Court); and a fine of £125,000 imposed by HHJ Milmo QC in *R v. UK Coal Mining Ltd* (15th April 2013, Nottingham Crown Court). However, none are comparable in seriousness to the present case.

THE SENTENCING GUIDELINES

39. In 2010, the Sentencing Guidelines Council published is *Definitive Guideline* on *Corporate Manslaughter & Health & Safety Offences Causing Death.* The guideline applies in cases, such as the present, where it is proved that the offence was a significant cause of death, not simply that death occurred (paragraph 4(c)).

40. As the Court of Appeal Criminal Division noted in *R v Marble City Ltd* [2010] EWCA Crim 1872, no starting point is provided in the guidelines themselves and no specific bracket or figures are given. The guidelines simply provide that fines must be punitive and sufficient to have an impact on the defendant, having regard to its means. General guidance is, however, given in paragraph 25, where it is said that where the Health and Safety Offences are shown to have caused death, *"the appropriate fine will seldom be less than £100,000 and may be measured in hundreds of thousands of pounds or more"*.

41. I direct myself in accordance with paragraph 37 of the Sentencing Guidelines.

Factors likely to affect seriousness

42. I take full account of all the guidance as to the *"Factors likely to affect seriousness"* in Section B of the Definitive Guidance. In summary: death or serious injury was plainly foreseeable in this case; the Trust fell far short of appropriate standards of care, handover and record-keeping; these failures were serious and systemic; responsibility for the breaches went to the very top of the organisation; there was a failure to heed warnings; the victim in this case was particularly vulnerable; there was, however, a prompt acceptance of responsibility, a high level of co-operation with the investigation, beyond that which will always be expected and a genuine effort to rectify the defects (See futher below).

Aggravating factors

43. There are five striking features of this case which distinguish it from other cases and render it far more serious than any of the cases cited:

    (1) It involved serious systemic breaches which were directly causative of the death of Mrs Astbury.

    (2) The breaches related to core skills and functions of any hospital operation, namely basic handover procedures and medical record keeping.

    (3) The breaches were symptomatic of a general malaise as to culture, standards and priorities which existed between 2004 and 2007 at Stafford Hospital.

    (4) The underlying causes of the breaches and the malaise were fundamental organisational and managerial failures, which can be traced to the very top of the organisation.

    (5) These failures included ignoring warning signs that there was serious systemic issues at the Trust which required urgent and effective action.

Mitigating factors

44. This is also case which a number of powerful mitigating factors.

45. First, the Trust made an early voluntary admission of culpability for the death of Mrs Astbury and entered a plea of guilty at the first opportunity. Further, at all material times, the Trust has shown a high degree of co-operation with the authorities, and has been entirely candid about its failures and accepted full responsibility for the death of Mrs Astbury.

46. Second, the events in question and the death of Mrs Astbury took place over seven years ago. The lengthy delay in bringing the prosecution has been for entirely understandable reasons: the HSE sensibly wished to allow the various other processes (*i.e.* the inquest, internal inquiry and public inquiry) to take their course before reaching a final conclusion on whether a prosecution under the Act was justified. But lengthy delay there has been; and in the intervening years, radical change has taken place in relation to (a) the senior managerial staff at the Trust, (b) the clinical and managerial practices and standards at the Trust, and (c) the financial health and structure of the Trust (see further below).

47. Third, the entire senior management layer of the Trust in post at the time of Mrs Astbury's death has been replaced and the majority of the individuals whose shortcomings may have had some bearing upon the unfortunate events leading to Mrs Astbury's death are no longer with the Trust. There were also disciplinary proceedings against several of the staff.

48. Fourth, the Trust has been the subject of the most rigorous and thorough public inquiries ever to have been conducted in relation to a hospital (chaired by Robert Francis QC) and has been the subject of intense public and press scrutiny, which has taken its toll.

49. Fifth, since 2009 standards of care at the Trust have steadily improved, year-on-year. In 2012 and 2013, the Trust was the subject of 14 separate Care Quality Commission reports which signalled very significant improvements in the provision of care and standards at the Trust and progress in the restoration of public confidence. Three Improvement Notices served in November 2013 have been complied with.

50. Sixth, the pressures engendered by the well-publicised difficulties of the Trust, has had an adverse effect on morale, particularly amongst the front-line staff, and recruitment, making staffing levels impossible to maintain. In December, the special administrators appointed by Monitor declared the Trust no longer financially or clinically viable and recommended the Trust be wound up as soon as practicable. Whilst 30% of NHS Trusts were expected to find themselves in deficit in the financial year 2013/2014, the Mid-Staffordshire NHS Trust is the only NHS Trust to have been placed in administration.

51. Seventh, on 26th February 2014, the Secretary of State for Health, the Rt Hon. Mr Jeremy Hunt MP, accepted Monitor's recommendation and announced that the Mid-Staffordshire NHS Trust would be dissolved, some services removed and the remainder divided between the neighbouring health authorities, the Royal Wolverhampton Trust and the University Hospitals of North Stafford Trust. I understand that the dissolution will be effected in September or October 2014.

The Trust's Financial situation

52. I have considered the helpful statement of Ms Sarah Preston, the Trust's Director of Finance. The Trust has made a financial deficit in the last four accounting years and is forecast to make a deficit in the current financial year:

2009-2010:	£ 4,478,000 deficit
2010-2011:	£13,967,000 deficit
2011-2012:	£19,911,000 deficit
2012-2013:	£14,739,000 deficit
2013-2014:	£21,200,000 deficit (forecast)

53. Ms Preston explains that the Trust has only been able to continue to provide healthcare services to the people of Stafford and Cannock by receiving additional funding directly from the Department of Health. She summarises the stark financial position of the Trust as follows:

"The Trust is not currently, or in the near future, going to be in a financial position to be able to pay a fine as we have no ability to earn any money that could cover our deficit and go towards the payment of the fine nor do we have any reserves which could be called upon."

54. I accept Ms Preston's evidence in its entirely.

Consequences of the fine

55. Mr Climie submitted that that the Trust had already learned its lessons and been punished enough in the past seven years; and given the Trust's financial situation the results of the prosecution would be primarily visited on innocent employees of the Trust who had nothing to do with the events in question and the public who used the hospital. He did not, however, give any details of how this might be the case. He further submitted that whilst there was a need for a punitive element to sentencing under the legislation and the need to mark loss of life in many cases, in the unique circumstances of the present case there was no need to send out a 'message'. He accepted, however, that the imposition of a mere nominal fine would not be justified; but somewhat bravely suggested that a fine in the region of the magistrates' limit of £20,000 would be appropriate. In my judgment, a fine at that level would be nominal in the context of this case.

Decision on level of fine

56. I start by considering the level of fine which would have been appropriate if the defendant had been a private company. Given the gravity of the situation which existed at the Trust between 2004 and 2007, and in particular the systemic nature of the serious failures which gave rise to the death of Mrs Astbury, if the defendant had been a profitable commercial organisation, I would have imposed a fine in the region of £1 million. The failures here lay at the very heart of hospital work; responsibility for them went to the very top of the organisation; and, as elucidated in the Francis Report, amounted to a fundamental breakdown of the care system at Stafford Hospital.

57. The Trust is, however, a public body. It is in serious financial difficulty. It is, moreover, due to be broken up in the near future. Even Mr Climie did not suggest, however, that in the circumstances, a nil or nominal fine should be imposed. This would not give effect to the will of Parliament or punish the organisation in question. In my judgment, a significant fine is called for to reflect the gravity of the offence, the loss of a life and in order to send out a strong message to all organisations, public or private, responsible for the care and welfare of members of the public. There is a wider public interest at stake here, beyond that of the instant case, namely ensuring that public and private bodies are held properly accountable in respect of their responsibilities to the public under the Health and Safety Legislation.

Starting point

58. Taking all the above circumstances above fully into account, in my judgment, the proper starting level of fine for the Trust in this case would be £400,000.

Plea of guilty

59. There must be a substantial reduction, however, for the early plea of guilty, for the early admission of responsibility and for the unprecedented level of co-operation by the Trust with the various inquiries. The reduction should be greater than the normal. In my judgment, a reduction of 50% is called for in all the circumstances of this case.

60. Accordingly, the net fine which I impose is £200,000.

61. In my judgment, the imposition of a fine of £200,000 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, If, as Mr Climie intimated, the fine has ultimately to be paid by the Department of Health itself, then sobeit. That is a matter for the authorities.

Costs

62. 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"*

63. The HSE have put forward a costs estimate of £27, 049.74. This seems to me to be a moderate amount and well within the range of costs for this type of work. Accordingly, I order the Trust to pay prosecution costs in the sum of £27, 049.74, in addition to the £200,000 fine which I have imposed.

Postscript

64. Finally, it must be remembered that this case involves the death of a much-love person, Mrs Gillian Astbury. I wish to add my condolences to her family and friends to those that have already been expressed. No financial penalty can adequately equilibrate loss of life. What the Court seeks to do is simply to punish the organisation responsible in accordance with the relevant Legislation and Sentencing Guidelines.

65. As Mr Street observed, this prosecution affords "a small measure of justice to Gillian [Astbury]".

66. I am grateful to both Mr Thorogood and Mr Climie and their legal teams for their able assistance in this case.