**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**
**(16th DECEMBER 2015)**

---

## INTRODUCTION

1. On 4th November 2015, Mid Staffordshire NHS Foundation Trust ("the Trust") pleaded guilty to breaches of section 3(1) of the Health and Safety at Work etc Act 1974, following investigations into the deaths of four patients at Cannock and Stafford Hospitals between 2005 and 2014, namely Jean Tucker (aged 77), Ivy Bunn (aged 90), Joy Bourne (aged 83) and Patrick Daly (aged 89). The Trust managed these two hospitals.

2. It is important to state at the outset that the Trust has fully co-operated with the Health and Safety Executive ("HSE") inquiry to a very high level. The Trust does not dispute the facts or the failures which form the background to the tragic death of these four elderly and vulnerable patients. The Trust has fully accepted the findings of its own internal investigations into each of these four deaths. This has obviated the need for the HSE to conduct a separate investigation at public expense. The Trust indicated its pleas at the earliest possible stage. This has save public expense and the need for family members to give further statements.

3. It is also important to note that the Trust was dissolved on 31st October 2014 and now exists in name only for the purpose of ensuring appropriate finality of its obligations to the families. The adjoining Hospital Trusts took over the running of the services provided from Stafford and Cannock hospitals on 1st November 2014.

*My 2014 Sentencing Remarks*

4. I sentenced the Trust on 28th April 2014 in this Court, following a plea by the Trust to breaches of s.3(1) of 1974 Act which led to the death of Mrs Gillian Astbury. In that case, I fined the Trust £200,000 and ordered it to pay £27,049.74 in costs. Many of the observations in my sentencing remarks in that case are directly relevant and apposite to the present cases. I will not repeat all that is contained in my 2014 Sentencing Remarks but they should be treated as fully pertinent and incorporated into these sentencing remarks.

5. It is accepted by Counsel that following passages in my 2014 sentencing remarks in Mrs Astbury's case encapsulate the fundamental failures of the Trust in the present cases (https://www.judiciary.gov.uk/judgments/regina-v-mid-staffordshire-nhs-foundation-trust/):

> "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 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."

6. The current prosecutions must be viewed in the wake of the Sir Robert Francis QC inquiries which are summarised in my 2014 Sentencing remarks. The inquiries were followed a multi-agency review of 214 deaths at Stafford and Cannock hospitals. The HSE considered the available evidence surrounding the deaths of Jean Tucker (in 2005), Ivy Bunn (in 2008), of Joy Bourne (in 2013) and Patrick Daly (in 2014) merited prosecution.

## THE FACTS

### (1) JEAN TUCKER

7. Jean Tucker died at Stafford Hospital on the 21st October 2005, aged 77 years. She was admitted to the Accident and Emergency Unit ("A&E") at Stafford Hospital on 8th October 2005, following a fall at home the previous day. Jean Tucker was allergic to penicillin. The hospital were made fully aware of this. However, poor record keeping and internal practices led to Mrs Tucker being prescribed intravenous *Augmentin* (a penicillin-based anti-biotic) which resulted in her suffering cardiac arrest and serious brain damage which led to her death two weeks later.

*Internal investigation*

8. The internal report of the Strategic Health Authority and Deputy Director of Clinical Standards, reached the following conclusions:

(1) Mrs Tucker's allergy status was not established by the nursing staff in A&E nor on the Emergency Assessment Unit ("EAU").

(2) A green wristband was (erroneously) placed on Mrs Tucker's wrist, giving the impression that she did not have any allergies.

(3) A doctor identified his proposed treatment plan sometime after the initial assessment during a telephone conversation with the RMO.

(4) The doctor wrote the prescription onto the treatment sheet without access to the medical records and his initial assessment.

(5) The nurse administering the *Augmentin* did not verbally check the patient's allergy status before beginning to administer the drug (albeit there was no policy which required such verbal confirmation).

(6) The administering nurse and the checking nurse assumed that the patient did not have allergies, as she was not wearing a red wristband and the allergy section on the treatment sheet was not completed.

*HM Specialist Inspector*

9. HM Specialist Inspector (Occupational Health), Lorraine Nicholls, said that poor written communication and record-keeping was the major contributor to the events which led to Mrs Tucker's death. She concluded that there was a lack of robust management systems to safeguard patients. In particular, a robust system for picking out and treating patients with allergies, together with poor recording and passing on of information.

*Victim Impact Statements*

10. In his helpful statement, Mrs Tucker's son, David Tucker, describes a fit and active lady who adored her family, who loved cooking (particularly traditional Welsh food) and whose death has devastated her grandchildren. As he put it *"My Mum had a family and a life and that should not have ended when it did.*

## (2) IVY BUNN

11. Ivy Bunn died on the 6th November 2008 at Stafford Hospital, aged 90 years.

12. Mrs Bunn was admitted to Stafford Hospital on the 31st October 2008, following a fall at home. She suffered from diabetes, but was very active and independent. Having been admitted to hospital because of a fall at home, her vulnerability in respect of falls was obvious. However, no "FRASE" assessment (a 'falls risk assessment for older people') was carried out. Unfortunately, Mrs Bunn suffered three further falls in the space of four days in hospital. The first two falls were from her bed; the final fall at 23.30 hours on 4th November, probably from her chair, proved to be fatal. A CT scan showed left acute subdural haematoma and she deteriorated rapidly.

*Internal investigation*

13. An independent case review undertaken by the Acting Matron for Neurosciences and a specialist in cardiology and intensive care, concluded as follows:

    (1) The major issue with regard to Mrs Bunn's care management was that no falls assessment was carried out on an elderly lady, notwithstanding that she had been admitted with a fall, and had suffered a further fall in hospital which had been witnessed.

    (2) After the first hospital fall, two-hourly neurological observations were requested by the doctors. On average these were completed every 3 hours by the nursing staff although none were done between 20:00 on 2nd November and 12:00 on 3rd November – a period of 16 hours.

    (3) No falls assessment was completed after this fall (as it clearly should have been).

    (4) Following the second fall in hospital a falls risk assessment was undertaken at the request of the medical staff, when in fact this was a nursing responsibility. The FRASE assessed Mrs Bunn at high risk. However no plan was put in place to prevent a third fall, which occurred a matter of hours after the second.

    (5) A second CT scan showed a marked deterioration which must have happened following the third fall. This fall proved fatal.

    (6) The nursing documentation on Ward 10 was of poor quality.

    (7) It is likely that this reflects a lack of clarity in managing this patient's needs.

    (8) Much more could and should have been done to manage the risk of falls.

    (9) The causal connection was accepted. This is a death that should not have happened and, if proper precautions had been taken, it would not have happened.

*HM Specialist Inspector*

14. HM Specialist Inspector (Occupational Health), Lorraine Nicholls, said there had been a systemic failure by staff in recognising the pre-disposing factors laid out in the NICE (National Institute of Clinical Excellence) guidance on falls. Obvious warning signs were there to be seen, from admission into A&E, in AMU and in Ward 10. Yet staff on these three wards or units appeared not to heed them and consequently failed to undertake a falls risk assessment, or devise appropriate control measures. In her opinion, had the required falls risk assessment been undertaken, to the proper standard, and the required controls put in place, accompanied by suitable and sufficient notes and handovers, Mrs Bunn's risk of falls would have been greatly reduced. All of this would have been reasonably practicable to put in place.

*Victim Impact Statements*

15. In his helpful statement, Mrs Bunn's son, Graham Bunn, describes how his mother doted on her family and three grandchildren and took great pride in her house and garden. He describes the devastating impact that the manner of her death has had upon him. He describes how fit and active Mrs Bunn was and there was no reason why she should not have gone on to live a similarly long life as Mrs Bunn's sister who is 104 years old.

**(3) JOY BOURNE**

16. Mrs Bourne died on the 22nd July 2013 at Stafford Hospital, aged 83 years.

17. She was admitted on 9th July 2013 to New Cross Hospital, Wolverhampton following a stroke. She was transferred to Fairoak Ward, Cannock Hospital on the 11th July, for rehabilitation. On admission, a "FRASE" falls risk assessment was carried out and she was assessed as 'medium' risk of falls and given bedrails. The Prosecution submitted that she should have been assessed as a high risk of falling since had had a stroke, was 83 and had come to hospital with double vision. Bed rails were not suitable for patients who were confused or agitated and in some ways added to the risk. Mrs Bourne suffered falls whilst in the care of the Trust. There was insufficient pathological evidence, however, to link her falls to the particular head injury which was the main cause of death (a ruptured dissecting aneurysm of the aorta). Nevertheless, the Trust's failures put Mrs Bourne at increased risk of falling.

*Internal investigation*

18. An investigation conducted into the circumstances of Mrs Bourne's care and death by the Deputy Director of Nursing and a Consultant was critical of the Trust in a number of areas:

    (1) The Trust Falls Policy was not followed for the falls on Fairoak Ward, the FRASE was not reviewed after each fall, the care plan was not updated and guidance on post-fall care was not applied.

    (2) There were poor nursing records relating to Mrs Bourne's falls and attempted self-harm at Cannock.

    (3) There was no clear written (or established) process for the transfer of patients from Cannock to Stafford, including medical and nursing handover of patient care.

    (4) There was no clear handover of care between the A and E department and the AMU, leading to incomplete knowledge in the AMU. If the AMU had known about the suicide risk, 1:1 supervision would have been arranged and maintained. The AMU used bed rails even thought the assessment concluded they were not recommended.

(5) There was no 1:1 supervision organised, to provide the required level of observation at Cannock or Stafford, despite Mrs Bourne's confusion and falls history (and the professed intent to self-harm).

(6) Information on falls risk and the need for a CT scan was not effectively communicated between wards, so as to enable suitable and sufficient risk assessments to be undertaken in order to identify appropriate safety measures and carry out required CT investigations.

(7) There was a failure to implement and properly manage effective communication systems for recording and sharing patient information, including in relation to transfers between wards and shift handovers.

*HM Specialist Inspector*

19. HM Specialist Inspector (Occupational Health), Lorraine Nicholls, said there was a failure to review Mrs Bourne's falls risk assessment after any of her falls or changes in her condition, as guidance, the Trust's policy (and commonsense) required. She concluded that Mrs Bourne was exposed to risks to her health and safety through multiple failings of the management systems in place at the Trust. Had the Trust ensured that its policies and procedures were in place and adhered to by all staff, the risks to Mrs Bourne would have been significantly reduced.

*Victim Impact Statements*

20. In their helpful statements, Mrs Bourne's brother, Philip Stimpson, and sister, Jennifer Lee, describe Joy Bourne as a very busy and cheerful lady, who loved gardening, watching cricket and Wimbledon. She was also a volunteer at Cannock hospital for 28 years. She will be sorely missed.

## (4) PATRICK DALY

21. Patrick Daly died on the 13th May 2014 at Stafford hospital, aged 89 years.

22. Mr Daly was admitted to Stafford hospital on the 3rd April 2014 with a hypoglycaemic episode. He was diabetic and suffered from progressive kidney disease. On admission, he reported no recent falls history but said that when his blood sugars were low, he become weak. There is no record of a proper "FRASE" assessment being carried out at that stage. He suffered a backwards fall whilst trying to go to the toilet in a bathroom on 9th April which he attributed his fall to not wearing his glasses. No "FRASE" review was carried out at that stage. On 12th April, Mr Daley suffered a further fall when he was being escorted to shower by a Health Care Support Worker ("HCSW"). The HCSW turned the shower on but the shower head fell off and a jet of water hit Mr Daly, causing him to fall backwards and hit his head on the floor, from a standing position. A CT scan showed a haematoma and subarachnoid haemorrhage and a fracture to his right occipital bone. Mr Daly steadily deteriorated, and became generally unwell and died on the 13th May 2014.

*Internal investigation*

23. The Trust's Serious Incident Investigation Report identified failings including the following:

    (1) No evidence of falls assessment documentation was provided to the investigation.

    (2) No assessments were performed for shower use but as Mr Daly had already fallen "use of a shower chair may have been pertinent as it is possible that he would not have fallen when hit by the water if he had been sitting in a chair". Documentation and assessments were inconsistent.

    (3) Nursing records show that some aspect of the Trust's falls policy were followed but the documentation did not always evidence this.

    (4) Entries on Mr Daly's admission show references by the Critical Care Outreach Team to inadequate information and information is missing.

    (5) No incident form was completed after the first fall.

    (6) There was no evidence of reassessment of falls risk after the first fall.

    (7) There was a lack of training for HCSWs regarding appropriate methods to assist patient whilst using shower.

*HM Specialist Inspector*

24. HM Specialist Inspector (Occupational Health), Lorraine Nicholls, said that had the Trust carried out a falls risk assessment on Mr Daly's admission to the ward (as required by virtue of his age, without more) and considered Mr Daly's age and his visual impairment, his falls may have been prevented. The falls risk assessment identifies that if glasses are needed they should be worn. The Trust's policy contained clear instructions for staff in relation to falls risk assessments on admission, when the patient changed wards or if there was a change in the patient's condition. Staff did not adhere to the policy. There was no falls risk assessment even after the first fall. In her view, staff and management lost touch with the basic fundamentals of nursing care, and management systems broke down - policies and procedures in place were not implemented and adhered to.

*Victim Impact Statements*

25. I their helpful statements, Mr Daley's widow, Catherine Daley, and daughters, Una and Patsy, explain the family's huge sense of loss of a husband of 57 years - Mr and Mrs Daley were childhood sweethearts – and a devoted father. They describe a fine man who had a wonderful sense of humour, even when in hospital.

**Summary**

26. HM Specialist Inspector (Occupational Health), Lorraine Nicholls, concluded that the basic failings in each case were similar. In the three falls cases – the Trust had a falls policy and written procedures in place but due to a combination of factors stemming from poor management of the Trust, these policies and procedures were not implemented and followed. There appeared to have been no checks in place that these procedures were followed and no accountability for actions taken or not taken. It appears that due to the poor management and lack of accountability within the Trust, standards slipped, with management not checking or controlling the situation. In HM Inspector's view, risk assessment, controls, monitoring and auditing, *"the fundamentals of health and safety and a good management system"* were missing from the Trust when these patients died.

**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 and Cannock Hospitals were clearly exposed to risks to their health and safety arising from inadequate handover and record-keeping procedures. The Trust accept that it failed to take every reasonably practicable step to minimise or reduce that risk.

*Trust's statement*

30. I have read the helpful statement of Mr Tim Rideout, the Trust Special Administrator, who explains the Trust's acceptance of the prosecution and firm position not to mount any defence on the merits of the case. The Prosecution readily acknowledges the full cooperation of the Trust at all stages.

*Sentencing - general principles*

31. The Lord Chief Justice, Lord Thomas of Cwmgiedd (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.

32. I have set out that guidance in full in my 2014 Sentencing Remarks in the case concerning Mrs Astbury (see paragraph 31) and the other criteria relevance to sentencing. I direct myself in accordance with that guidance and the general guidance as set out in my 2014 sentencing remarks, which I do not repeat again here.

33. 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."

34. The need for fines to be large enough to have *"a real economic impact"* has been echoed in the current Definitive Guideline (see futher below). In the context of public bodies, fines are still expected to reflect the sentencing aims, and be punitive and of substance, but public accountability may take precedence over issues of economic impact.

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

*Sentencing Guidelines*

36. I have regard to the Sentencing Guidelines on Heath and Safety Offences Causing Death published in 2010 (see below). New Guidelines are due to come into force in February 2016, with substantially increased levels fines, but it is common ground between Mr Thorogood who appears for the Prosecution and Miss Judge who appears for the Defence that I should simply have regard to the current Guidelines and I do so.

## ANALYSIS

*The Trust's Financial situation*

37. The unusual situation now is that the Trust having been wound up, as Miss Judge has explained, and it has no funds whatsoever; and accordingly any fine will have to be paid ultimately by the Department for Health. The imposition of a fine, will therefore, be very much a financial 'revolving door' as described by HHJ Baker in *R v. NHS Litigation Authority* (Preston Crown Court on 8th September 2015).

*Accountability of public bodies*

38. 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.

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] 9 2 Cr App R 423*; R v Network Rail* [2011] Cr App R (S) 44, [2010] EWCA Crim 1225 at para 24).

39. As I have explained before , it is necessary for the court:
    (a) To mark the gravity of the case;
    (b) To mark the public's disquiet at the needless loss of life; and
    (c) To demonstrate the financial consequences of poor health and safety practices to other employers: the message should go out to other employers, whether public or private.

40. But the Court must, of course, strike a balance.

**Sentencing Guidelines**

41. I take full account of the *"Factors likely to affect seriousness"* in section B of the Definitive Guidance. In summary: It was easy to foresee if the risk of falls of these elderly and frail individuals was not properly dealt it could result in serious injury or death; falls are a common cause of serious injury and death in healthcare settings; there were no robust systems for the recording or passage of information, or managing falls risks effectively, and no sufficient supervisory or management "grip"; the breaches were widespread and had become the norm; there was a lack of effective management at all levels; the failings have produced several fatalities; there was a corporate failure to heed the lessons the earlier cases presented; these were vulnerable patients; there was a prompt, indeed very early, acceptance of responsibility; from the earliest point the Trust has made its intent clear, to the extent that the prosecution could refrain from an extensive investigation, which might otherwise have been necessary to prove the matters which have been admitted; there was a high level of co-operation with the investigation in all cases, beyond that which will always be expected; however, since the Francis Report and the internal investigation into Gillian Astbury's death, the Trust was aware of failures in record keeping and the passage of information yet these problems surfaced again in the case of Mrs Bourne and Mr Daly.

42. I emphasise, however, as Miss Judge did in her able submissions, that this was not a case of 'cost-cutting at the expense of safety' or deliberate failures. She submitted that there were many hardworking, dedicated healthcare professional at both hospitals throughout this time who were doing their best for patients. There were procedures in place to improve patient care and safety. However, what happened in these cases was that the implementation of these procedures was insufficiently rigorous and insufficiently monitored

**Aggravating Features**

43. The following aggravating features distinguished the present cases from some other cases, namely:

(1) The systemic breaches were directly causative of at least three of these deaths;

(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.

**Additional aggravating features**

44. I take into account also the following additional aggravating features:

(a) The vulnerable nature of all four victims;
(b) Multiple fatalities, linked to similar management failings; and
(c) The failings were of a systemic nature.

**Mitigating features**

45. This is a case in which there are also a number of powerful mitigating factors.

(1) First, the Trust made an early voluntary admission of culpability as I have said.

(2) Second, there has been substantial change in (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).

(3) Third, the Trust has been the subject of the rigorous and thorough public inquiries chaired by Sir Robert Francis QC and has been the subject of intense public and press scrutiny.

(4) Fourth, standards of care at the hospitals have markedly improved (see further below).

(5) Fifth, the pressures engendered by the well-publicised difficulties of the Trust, has had an effect on morale and recruitment.

(6) Sixth, the Trust has effectively been wound up save for dealing with *sequelae.*

**Further factors to take into account**

46. There are a number of futher important factors that I take into account.

47. First, *overlap.* As Mr Thorogood accepted, there is a significant degree of overlap between the first two cases and the sentence I passed in 2014 in relation to Mrs Astbury's case. The level of fine my reflect this overlap. However, it is right also to bear in mind the lengthy period over which all five of these deaths occurred, 2005 to 20154 shows the longevity of the problem and how difficult it is to change culture.

48. Second, *totality.* As Miss Judge, emphasised, it is important to have regard to totality, which I do. Sentencing in cases such as this is not simply a mathematical exercise.

49. Third, *the overall context and the future.* I acknowledge and pay tribute to, as the HSE do, the huge strides that have been taken to put Stafford and Cannock hospitals back on their feet, the large amount of work by many dedicated staff and healthcare professional to rebuild the systems, culture and reputations of both hospitals, the substantial financial investment that has been made of £250,000, and the significant support from the local community. There is, as Miss Judge elegantly put it, there is unequivocal evidence of real change. In his statement to the Court, the University Hospitals of the North Midlands Medical Director, Mr Robert Courtney-Harris said this:

> "County Hospital's culture, clinical services and facilities are immeasurably changed since it integrated with Royal Stoke University Hospital in November 2014. The major clinical services successfully transferred to Stoke Hospital in 2015 as part of the £250m transaction. This has allowed the Trust to start a large planned regeneration of the hospital, which includes a £15m ward refurbishment, a new £3.1m Renal Dialysis Unit and a £1m MRI Unit. These developments are transforming the inpatient environment into high quality, modern facilities for patients.
>
> Patients will benefit from the trebling of single rooms available with full en-suit facilities, improving privacy and dignity, appropriate facilities for disabled patients and creating more space on the ward. These changes will help County Hospital staff to improve infection prevention and control and make wards 'dementia friendly' with improved signage, better layouts and visibility. In addition, the Trust has recruited more than 800 nurses over the past year.
>
> All of these changes have seen a positive impact on patient safety at County Hospital. Complaints have fallen since last summer, the Trust has a falls ratio far below the national average and the mortality is lower than expected, with plans to reduce this further. These changes led to County Hospital receiving 23 Good assessments and only one inadequate assessment from a CQC visit in July 2015. There is still much to do over the second and third years of the

integration, but I'm confidant that the recent past of the hospital has now been left behind and has been replaced by a modern local hospital that meets the needs of its patients and the wider community."

## DECISION ON LEVEL OF FINE

50. As before, in my view, there should be a similar substantial reduction for the early plea of guilty, for the early admission of responsibility and for the continued unprecedented level of co-operation by the Trust in these cases as with the previous 2014 case. In my judgment, a reduction of 50% is called for in all the circumstances .

51. Taking all the above circumstances above into account, in my judgment, the proper starting overall figure by way of penalty for the Trust, *i.e.* covering these four conjoined cases together, would be £1,000,000.

52. Accordingly, applying the discount which I have mentioned, **the net overall fine which I impose is a total figure of £500,000 covering these four conjoined cases together.**

53. In my judgment, this level of fine would achieve the aims of Parliament encapsulated in the Criminal Justice Act 2003 and the Health and Safety legislation. The fact that the fine will ultimately have to be paid by the Department of Health itself does not detract from the necessity to impose the fine in the first place.

## Costs

54. The Guideline provides (in paragraph 29):

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

55. The HSE have put forward a costs estimate of £35, 517.34. In my view, this is a reasonable amount and within the range of costs for this type of work. Accordingly, I order the Trust to pay prosecution costs in the sum of £35,517.34 in addition to the fine which I have imposed.

## Surcharge

56. In addition, I order that such surcharge as is applicable shall be levied.

*Postscript*

57. Finally, it must be remembered that this case involves the deaths of four much-loved elderly relatives. I wish to express my condolences to their families and praise the quiet dignity of those present today. As I said in 2014, no financial penalty can adequately equilibrate loss of life. What the Court seeks to do is simply to signify and mark that serious offending has taken place by imposing a fine in accordance with the relevant Legislation and Sentencing Guidelines.

58. I hope that today brings some closure to the families and finally draws a line under the past for all those involved - and that Stafford and Cannock Hospitals can open a new and bright chapter and become hospitals that their dedicated staff and local communities can, once again, be proud of.

59. I am grateful to both Mr Thorogood and Miss Judge and their legal teams for their able assistance in this case