JUDICIARY OF ENGLAND AND WALES

SENTENCING REMARKS OF DISTRICT JUDGE WILKINSON

IN MATTER OF REGINA V DUDLEY NHS TRUST

18th and 19th NOVEMBER 2021

WOLVERHAMPTON MAGISTRATES' COURT

At the outset of these sentencing remarks I wish to say that the Magistrates' Court is not a Court of record in the sense that transcripts are not usually available as our proceedings are not recorded. I was asked yesterday by Mr Bridge on behalf of the CQC as to whether I would produce a written judgment. I had already determined, in fact, that it was the right thing to do in this particular case. The families will undoubtedly wish to consider in detail how I reach my sentence as may members of the press and public and given the importance of this process when dealing with such a tragic case it is important that there is an accurate record for all who wish to view it. I can only apologise for any grammatical or spelling mistakes that exist. A copy of these remarks will therefore be available through this Court and published on the judiciary.uk website.

This prosecution is brought by the Care Quality Commission (CQC) against the Dudley Group NHS Trust (The Trust). The CQC has been represented throughout by counsel Mr Ian Bridge and the Trust by counsel Mr Paul Spencer.

The two charges before the Court are contrary to Regulations 12 and 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (The Act)

The charges are summary only and can only be dealt with in a Magistrates' Court by a duly authorised District Judge. They are punishable by way of an unlimited fine.

Each charge concerns a tragic death resulting from breaches of the Act at Russell's Hall Hospital in Dudley.

Natalie Billingham was only 33 years of age when she died on the 2nd March 2018.

Kaysie- Jane Bland was just 14 years old when she died on 10th March 2018.

I am grateful to the families who have kindly allowed me to refer to their two loved ones by their first names throughout my sentencing remarks.

The Trust has entered guilty pleas to both offences.

In the case of Natalie, they accept that the level of care provided was not sufficient to discharge its duties under the Act. A basis of plea was presented to the Court after expert consideration of the circumstances leading to Natalie's death by Dr Ebrahim on behalf of the Trust and Professor Nutbeam on behalf of the CQC. That basis accepted that whilst there

were significant care and treatment failings that the trust had not caused the death of Natalie. The CQC did not seek to challenge this basis as they concluded that they could not prove that death had been caused to the requisite standard of proof in the criminal courts, the CQC concluded that there was nothing that could be gained by exploring this issue during any Newton hearing. The Trust will therefore be sentenced in respect of Natalie on that basis. I know that the CQC have been diligent in explaining this decision to Natalie's family.

In the case of Kaysie-Jane the trust entered their guilty plea accepting that their unsafe treatment and care caused her death.

The Trust entered their guilty pleas at the first practical opportunity before this Court and will therefore be entitled to full credit.

I do not intend to fully rehearse the facts of each case or the chronology leading to the deaths of the two victims at this point as they were fully opened by the prosecution yesterday and I do not wish to cause further pain and distress to their families by repeating those details. For completeness however the facts will be repeated in my written sentencing remarks.

Natalie Billingham

5. Natalie Billingham (NB) was born on 24 May 1984. She was a 33 year old mother of 6 children. On 28 February 2018, NB called 999 and she was brought into the Emergency Department (ED) at RHH by Ambulance. She died without leaving RHH on 2 March 2018 at 22:51. The cause of death is recorded as being 1a) multiple organ failure. 1b) beta haemolytic streptococci group A. NB had been suffering from necrotising fasciitis, a time critical infection.

6. NB presented with a 1-day history of numbness to her right foot, which had worsened with warm swelling to calf and increased pain. She had attended the Sandwell Hospital on the 27th February with severe pain in her ankle.

28th February 2018

16:08 NB called 999 for an ambulance

17:18 Arrival at RHH

17-30 Handover to a Triage Nurse. The Triage process lasted 3 minutes. It failed to identify disordered clinical observations.

17:34 Bloods were taken. There was no cubicle available in the ED due to overcrowding. Observations were not completed by staff. NB remained in the ambulance assessment bay area out of sight of the main department, this area was used for longer than it was intended to be (until 21-48), due to overcrowding.

19:25 Blood tests indicated that NB had an acute kidney injury. A call from pathology to ED giving results re. the kidney injury was apparently not acted on. It is not clear if the message was passed on.

19:59 Dr Day, an ED registrar who arrived on the ED post NB's admission, gave a working diagnosis of DVT. NB was still in the ambulance assessment bay she was crying out and in substantial pain. Anticoagulant therapy indicated for DVT, was not commenced. Blood

pressure, pain levels and kidney failure were known at this stage and should have flagged sepsis.

20:10 The blood results were available on the Soarian system, but unfortunately despite being communicated to a staff member on ward, they were not acted upon. Soarian is an electronic healthcare system used in the Trust to electronically request clinical orders for investigations and test and to report and review results uploaded from the laboratory and radiology teams.

21:21 Dr Day administered morphine noting that NB was very anxious. Dr Day did not access the blood results on Soarian

21:48 NB moved to a majors and a cubicle became available – 4 hours and 30 minutes post admission.

22:41 NB had become agitated and distressed. She was screaming in pain. NB's pain should have prompted a second clinical review and reconsideration of the initial working diagnosis of DVT (which was incorrect). No review was undertaken. The blood results were not reviewed. If they had been they would have triggered a treatment review.

01:17 The ED staff nurse noted the condition of NB's foot. NB's condition had deteriorated significantly. She was looking paler and was rocking backwards and forwards.

01:38 A prescription for flucloxacillin by Registrar Sajid Mohammed was made out but not administered.

02:30 Face to face review. Escalation to ITU.

02:45 Intensive care review. Junior Anaesthetist (Dr. Kozman) noted that NB had acute kidney injury. NB had significantly deteriorated. NB's right leg was swollen and tender, there was an evolving necrotic area on the medial aspect of the right heel with black lesions. NB was taken to theatre initially for debridement of tissue to the right ankle within one hour of transfer to ITU.

03:22 3 x Antibiotics prescribed

03:49 Antibiotic administered

04:00 Transfer to theatre for surgery

04:01 & 02 Antibiotics prescribed and administered

7. Since NB's arrival at RHH at 17-07 there had been multiple reasons and opportunities to review and reconsider the initial diagnosis of DVT. The opportunities for review were missed or ignored. Any one of these opportunities should have led to reconsideration of the diagnosis. A diagnosis of sepsis and the commencement of appropriate treatment and care would have slowed the progress of NB's time critical infection.

8. In summary, NB was admitted to RHH, where there was a delay in the application of the sepsis pathway designed to fast track time critical sepsis patients. Despite deranged blood results identifying infection and multi organ failure no review occurred in the ED and no action was taken in a timely manner.

9. On the day when she arrived at RHH treatment was compromised by inter alia the following issues

i) The ED resuscitation facility was full,

ii) There was a three-and-a-half-hour delay for treatment in the ED,

iii) There were staff shortages - Dr Day's shift start was delayed due to planned training and adverse weather

iv) There were medical staff shortages with major admissions waiting time at 1 hour.

v) The Trust had not done all that was reasonably practicable to ensure that NB received timely care appropriate to her condition.

10. Over the course of the 12 hours following her admission Natalie Billingham exhibited symptoms and signs consistent with severe infection which should have prompted the delivery of time critical treatments and interventions. The failure to act on available clinical findings and information resulted in avoidable treatment delays.

11. Professor Nutbeam who is an expert in emergency medicine and a specialist in sepsis treatment has reported on the care and treatment afforded to NB. In his opinion earlier treatment and intervention in the ED would likely have saved NB's life.

12. An analysis of the notes reveals the following specific breaches of Regulation 12 failing to provide care and treatment in a safe way.

i) There was a failure to review and consider the disordered physiology demonstrated whilst NB was with the ambulance team.

ii) NB should have been re-triaged when her pain did not settle, and her condition worsened.

iii) The patient should have been triaged into category 2 on the emergency severity index due to her presentation with extreme pain requiring morphine, a pain score of 8 and abnormal vital signs. She was instead placed into the less urgent category 3.

iv) There was a failure to act on a "Red Flag" high risk marker for sepsis at 20:30 and then begin treatment for sepsis in a timely manner.

v) There was a failure to start Sepsis 6 Pathway due to a miscalculation of NEWS (national early warning score) and despite deranged blood results a failure to diagnose infection.

vi) There was a failure to reassess NB following a request by a health care professional.

vii) There was a failure to calculate NEWS correctly and poor documentation and infrequent observations.

viii) There was a failure by the ED senior doctor to adequately assess the patient and record findings.

ix) There was failure of nursing and medical staff to recognise the deteriorating septic patient and to recognise that increased agitation was due to clinical deterioration.

x) There were staffing shortfalls & reduced capacity in ED. Due to these shortfalls the allocated role of the sepsis trained nurse was not filled.

xi) There was overcrowding & exit block in the ED.

xii) There was a failure to escalate, check and act on NB's blood test results.

xiii) The patient was not prescribed antibiotics and treatment for serious infection in a timely manner.

13. The systemic failures which were attributable to the Trust exposed NB to a significant risk of avoidable harm by actions taken, or not taken, in her care at the RHH. NB should have been escalated at multiple points during her care between 28th February and 1st March. NB's mother, Marina Tranter presents a different factual picture to that given by staff. She has provided a witness statement detailing the treatment she saw afforded to her daughter.

Kaysie Jane Bland

16. Kaysie Jane Bland (KB) was 14 years old when she was admitted to the RHH on the 4th March 2018. She had complex medical needs, with a history of cerebral palsy, quadriplegia, epilepsy, scoliosis of the spine (with restrictive lung movement) and was fed via a Percutaneous Endoscopic Gastrostomy (PEG) tube. KB was transferred from RHH on Birmingham Children's Hospital (BCH) on 5th March. She died, without going home, at BCH on the 10th March 2018. The cause of death is recorded as 1a) cerebral tonsillar shock 1b) septic shock and sepsis of unknown origin

17. KB had not slept for 48 hours prior to her admission to RHH. She presented with a 2 - 3 day history of diarrhoea and vomiting and worsening agitation and distress. .

4 March 2018

11:35 KB arrived at the ED as a priority in an ambulance at RHH. KB was taken to the ED paediatric area for assessment, as the ED resuscitation room was full. A triage assessment was carried out and KB was triaged as level 2 ESI (emergency severity index) priority.

11:43 First observations were taken, giving a PEWS (paediatric early warning score) of 3. No blood pressure was taken at this point due to patient distress and contraction of limbs. The PEWS assessment was inaccurate and did not follow RHH guidance. The correct PEWS was 6. The recorded PEWS of 3 did not trigger the commencement of the sepsis screening tool.

18. KB was noted to be pale, sweaty, clammy, and tachypneic (breathing fast). The ED doctor documented that impression was gastroenteritis or aspiration pneumonia. No documented suggestion of sepsis diagnosis was made despite the blood gas results becoming available. There was no documented review in light of arterial blood gas readings.

19. KB was transferred, in the absence of staff, by her mother at 14-45 to ward C2 from the Emergency Department. There was no review by a paediatric team. On the ward, monitoring and observations recommenced. No blood pressure was taken with no reasons recorded for the failure to measure blood pressure. A screening tool was commenced on C2 but the sepsis section was not completed. The patient had by this stage received antibiotics and intravenous fluids. According to C2 staff the form was completed on the ward as the form from the ED was missing. The PEWS Standard Operating Procedure (SOP) states a blood pressure should be taken.

20. At 15:06 the laboratory phoned blood results through as abnormalities were detected, the sample showing evidence of acute kidney injury, stage 2. There was no documentation of blood test review or escalation following the results being recorded in the notes.

21. The nursing staff on the ward noted that KB's temperature had increased to 41 degrees Celsius and her breathing had become worse. The associate specialist recognised that KB had deteriorated since admission and a paediatric consultant review was requested.

22. At 21:15 observations including a blood pressure reading were taken for the first time. This was the first patient review conducted by the consultant paediatrician in the over 9 hours since KB's admission to RHH.

5 March 2018

23. At 00:50 the paediatric consultant noted the severity of KB's illness and escalated her treatment. KB was then transferred to theatre for further stabilisation and intubation. At 04:05 KB was transferred across from theatre to ITU for ongoing critical care whilst awaiting transfer out to a specialist paediatric unit. A bed became available at Birmingham Children's Hospital (BCH) and KB was transferred. She remained in BCH from the 5th March to the 10th March on which date she died when life support was ended.

24. The CQC obtained an expert report from Dr Gayle Hann, a consultant paediatrician in the paediatric emergency department at North Middlesex University Hospital. Dr Hann has provided a comprehensive report in which she opined that the care provided to KB in RHH's A&E and by its general paediatric team was inadequate and fell below expected standards of care. Dr Hann details numerous failings. There is a very detailed chronology appended to her report. Dr Hann opines that had KB's serious illness been identified and treated earlier she could have survived this episode of illness, despite her life limiting complex medical needs. In addition Dr Hann refers to the CQC inspections in December 2017 and January 2018 and confirming that it is also her opinion that there were multiple systemic failings at the RHH (conclusion line 719 of her report). The failures of the Trust are listed below:

i) Failure to treat promptly as per priority status.

ii) PEWS was incorrectly calculated and clinical observations were not completed in line with national guidance.

iii) Under-resuscitation with fluids - KB weighed 35 kg and so should have been given a 700 ml bolus rather than 500 ml given.

iv) There was a lack of a senior review in A&E from a doctor with paediatric competence.

v) Blood pressure was not measured in A&E - blood pressure was a part of the Sepsis 6 pathway that the Trust had adopted. There is evidence in the medical records that the policy/pathway was not understood. The pathway was not complied with on this occasion.

vi) A potentially unsafe transfer was completed to the paediatric ward.

vii) There was a failure to recognise sepsis on admission to the paediatric inpatient ward - The sepsis 6 pathway sheet is not completed and had apparently been lost in the ED.

viii) There was a failure in the system for relaying and recording abnormal results in the ED.

ix) There was poor medical record keeping and audits of the application of the sepsis 6 pathway.

25. In the case of KB there is uncontradicted evidence that the failure to provide safe treatment and care contrary to Regulation 12 caused her death and that her death was avoidable but for the breaches of Regulation 12.

We have all now heard and been deeply moved by the victim personal statements from Natalie's mother Mrs Marina Tranter and Natalie's brother Trevor Rawlins and from Kaysie Jane's mother Miss Jane Robinson, who also read the statement from Kaysie Jane's grandmother Mrs Susan Robinson. To hear direct from the mothers of both victims and to witness first hand both their distress and bravery is something that I doubt any present will ever forget.

They have given some insight into the personalities of the two victims and the joy that they brought to those closest to them. They have illustrated how deeply their absence is felt and how these two families will be traumatised by their loss forever. They also serve to illustrate how pervasive the loss continues to be in every aspect of family life.

It is important that the Court pays tribute to the fortitude and patience of the families in this case. These proceedings could not have been easy for them and there have been delays, albeit purposeful ones, in getting to the point of sentence. I know that they have waited too long for this chapter in their lives to conclude. I hope that at the end of the hearing today that they will feel that their loss has been reflected, as far as is legally possible, in the sentence passed. And that some small measure of justice, within the criminal jurisdiction, has been done for Natalie, Kaysie Jane and their families.

There are no offence specific sentencing guidelines for these offences. My understanding is that this may be only the second prosecution of its kind after the specific offences were introduced.

I have been informed that it is the first prosecution ever of any Trust for failings within an Emergency Department. Previous prosecutions of NHS Trusts were brought under different legislation by the Health and Safety Executive and concerned failings within different departments. There are only a handful of reported cases of prosecutions of the NHS which offer this Court some limited assistance in respect of the approach that the Court should take when sentencing the NHS and I shall refer to those cases as I turn to the approach the Court must take to sentence.

Whilst there are no specific sentencing guidelines the Court is required to consider the overarching principles that are published by the Sentencing Council. Those principles require the Court to have regard to the statutory maximum sentence, in this case an unlimited fine; any sentencing judgments by the Criminal Division of the Court of Appeal; and definitive sentencing guidelines for analogous offences.

At all times the guidelines stress that any approach to sentence must never be a simple arithmetical procedure.

When considering sentence the Courts are required to consider the culpability of the defendant and the harm caused (or risked).

In addition the Court is required to have regard to the "five purposes of sentencing"

- The punishment of offenders
- The reduction of crime (including its reduction by deterrence)
- The reform and rehabilitation of offenders
- The protection of the public
- The making of reparation by offenders to persons affected by their offences

Of course in the almost unique circumstances of this case it is impossible to achieve most of those purposes save for the protection of the public by way of the imposition of a financial penalty that ensures, as far as possible , that members of the public are protected from future harm by reinforcing that where such failures are proved against an NHS Trust that the Courts will impose appropriate financial sanction.

This may be even more important when it relates to an Emergency Department. Such Departments throughout the NHS are the principle point of entry into the hospital system for most of us. Patients present with a wealth of symptoms and ailments. Some very serious. Every patient that attends has the right to expect that the care that they will receive will be safe, and that well established best practices will be followed. Whilst sadly it is inevitable that genuine mistakes will occur, as is the nature of medicine, it will be rare in the extreme that failures of care will lead to criminal liability. It is a sad indictment of this case that Natalie and Kaysie-Jane entered a department in February and March 2018 that would fail them so badly as to lead to criminal liability.

Mr Justice Haddon-Cave said, in the case of R V Shrewsbury and Telford NHS Trust that the purpose of sentencing in such cases "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 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."

Before I move to my approach to sentence and my conclusions in this case it is important that I make clear what the remit of this Court is in relation to this prosecution.

It is solely to sentence the Trust as an organisation. I said in Court yesterday that I recognised that the failures to treat Natalie and Kaysie -Jane appropriately in 2018 were reflective of an organisation that had been in crisis since it was identified as part of the Mid-Staffordshire Inquiry which identified it as one of ten Trusts with high levels of mortality. This led it to be included in Sir Bruce Keogh's national programme which reported in July 2013 on 14 Trusts and which made recommendations for change. It is just another tragic

aspect of this case that those recommendations had not led to any sustained change at the time that Natalie and Kaysie-Jane entered the Emergency Department.

It is NOT the purpose or remit of this Court to apportion blame to any individual or group of individuals be they doctors, nurses or management. Neither is it the purpose to absolve any individual or group of individuals within the Trust of blame.

It is NOT the remit of this Court to attempt to put a "price" or "value" on the lives of Natalie and Kaysie-Jane when calculating the fine. Or to reflect, in monetary terms, the continuing pain and distress caused to their families and loved ones which is so palpably real and ongoing. Although the harm risked, and indeed caused, by the Trust will form part of my sentencing conclusions.

It is NOT the remit of this Court to award compensation in this case.

Having said what I am not empowered to do I make it very clear that I am entitled to take into account, when reaching my sentence, the powerful victim impact statements in this case. But I am acutely aware that nothing that I can do or say, and no sentence that I can impose can ever truly reflect what these two families have gone through and will continue to deal with for the rest of their lives.

As I have said I am required to consider the closest analogous definitive sentencing guideline. In this case, in my view, agreed by both prosecution and defence counsel and used in previous prosecutions by the Health and Safety Executive, the closest guideline available is that for Organisations breaching health and safety regulations. Sadly, such cases also often involve exposure to risk of death and actual fatality. As such the guideline will offer me assistance and form the framework for my approach in this case.

The guideline provides for a stepped approach to sentencing which is required to be followed by each Court sentencing such cases and both prosecution and defence submissions have been made concerning the approach that I should take at each step. I apologise to all that the process may seem methodical and laborious, but it is essential that a Court explains its route to sentence in any case. That is even more important in a case of this magnitude where the lives of so many have been affected and will continue to be affected.

The first thing I must do is to determine the offence category by reference to culpability, harm risked and the likelihood of that harm arising.

The Trust accepts that this case is one of high culpability which is also the submission of the CQC. I have reached the same conclusion as one of the most significant features of the case when considering culpability was that the Trust had been inspected by the CQC in a series of unannounced visits during the months preceding this tragedy.

What was found on each occasion clearly shocked the inspecting team of health care professionals. Effectively they discovered an Emergency Department in crisis with poor standards of care and treatment seen. The statements of Katherine Williams and Jenny Mills bring into sharp focus the state of affairs they found.

The first relevant inspection took place on 5th and 6th December 2017. In (very) brief summary their observations included that ;-

The team in the Emergency Department were "unclear on the triage system in use". Trust staff were "unable to identify the system in use or explain how it worked". It became clear to

CQC staff that the Trust had moved away from any recognised triage system which can obviously put patient safety at risk.

The team felt that the department appeared “chaotic” and in their opinion patient “health and medical conditions were not being monitored effectively “. “The frequency in which staff took patient clinical observations was not sufficient to detect deterioration”.

There was a particular issue regarding the approach taken to detecting potential sepsis in patients. CQC staff were informed that a “conscious decision” had been taken not to include oxygen saturation levels in a sepsis “scorecard” system. This resulted in patients who in other hospitals would be placed on the sepsis “pathway” being kept off that route by having their sepsis “scores” artificially lowered.

Record keeping on the unit was found to be poor with an inconsistent approach being taken which meant that signs that should trigger escalations in care were not being actioned. There was a particular problem identified in relation to sepsis screening, and the process was identified as absent or delayed in many cases.

Katherine Williams (a registered nurse herself) in her statement gives a particularly poignant account of encountering an elderly patient in a cubicle within the department who presented as seriously unwell. Despite attempts to alert staff to the situation and seek assistance for the patient it was only when she deteriorated further and Katherine Williams sought out senior health care professionals on the unit that action was taken. This account drives home the chaotic presentation at the unit on the first inspection dates.

Detailed feedback was provided by the CQC team to the Trust during a meeting with members of the Trust executive team at the end of the inspection and in follow up correspondence. The CQC were assured during that meeting that “ they understood the gravity and seriousness of everything … explained”. They also further assured the CQC team that action would be taken to “ensure the safety of other patients”.

The CQC issued a letter on 11th December which highlighted 13 areas of “immediate concern”. This was followed by a letter of intent on 22nd December 2017 warning the Trust that possible urgent enforcement action would be taken against it unless immediate improvement was seen.

The Trust responded on 2nd January 2018 “providing confirmation from the trust of the measures being implemented immediately to ensure the health, safety and welfare of people who use their services.”

The CQC concluded that they were not satisfied with the response and the safeguarding measures being taken and resolved to inspect again.

They returned on 11th January 2018 at 6pm for a further inspection. What they found can only be described as further chaos. The team reports that they found limited staff and no one could identify who was in charge in the recently opened Immediate Medical Assessment Unit. Patients were calling out for help, doors were propped open and medication observed lying about unattended.

Of critical importance there remained confusion over sepsis and the proper approach to be taken, whilst there had been improvements in some aspects there were still significant failings in some of the areas of concern highlighted in the earlier inspection. Potential life-threatening failures were observed during the inspection in the way in which the Trust reacted to and safeguarded those actually diagnosed with or suspected of having sepsis on the unit.

Again, at the end of the inspection, detailed feedback was provided to the Trust executive.

As a result of the second inspection the CQC took action utilising their powers under section 31 (1) (2)(a) of the Health and Social Care Act 2008 and imposed two conditions on the Trust. These two operating conditions were designed to safeguard patients within the Emergency Department at the hospital.

The CQC team again attended over three days commencing 16th January 2018 to conduct an inspection of the leadership at the Trust. Further concerns were highlighted during this inspection.

Further conditions were imposed by the CQC on the Trust on 5th February again using their emergency powers.

Throughout the period leading up to the two tragic deaths at the centre of this case the CQC continued to communicate with the Trust by letter, telephone and in meetings highlighting their ongoing concerns regarding patient safety.

It was against this backdrop that Natalie and Kaysie Jane were failed by the Trust. It is clear that had the Trust reacted to the concerns of the CQC in a timely fashion then this double tragedy may not have unfolded. The warnings were clear and unambiguous from the CQC and the failure to take immediate robust action to protect the public is clearly relevant to the determination of culpability. Whilst the Trust submits that efforts were made and that change can effectively take time the catastrophic consequences of the failure to deal with the issues flagged up more than once by the CQC are plain. Where lives are clearly at risk, and where sepsis is concerned minutes and hours matter, the Trust had a duty to ensure that immediate permanent improvement took place. Nearly three months had passed since the first inspection and yet Natalie and Kaysie – Jane fell victim to the self-same failures identified during the inspection of early December 2017. It is clear to me that this is a case of high culpability as the Trust fell far short of the required standards of care as it;

Failed to have in place health service recognised measures in relation to the detection/treatment of sepsis;

It failed to act swiftly and decisively to the concerns raised by the CQC, those concerns themselves warned that lives and patient safety were at risk;

And the Trust allowed those breaches to subsist over a relatively long period of time as, in my judgment, 3 months (at least) in an Emergency Department must be viewed as a long period. Particularly when one factors in the Trust's own figures for the number of patients treated in that department per year. Put bluntly in a three month period about 25,000 patients would potentially be exposed to the risk of harm discovered by the CQC.

As the Trust already recognises this case falls within harm category A of the most analogous guidelines as the harm risked was clearly death. The Trust submits that the likelihood of that harm arising was in the medium category and prays in aid that "only" these two patients were harmed in a unit that deals with 100,000 patients annually. The prosecution submits that the likelihood of this type of harm arising was high, suggesting that any failure to properly identify and treat sepsis could very swiftly lead to the most serious of harm. I have balanced the two arguments and consulted the test identified in the guideline which requires me to assess the likelihood of harm level A arising. Given everything I now know having read the volumes of case material, and particularly the expert medical evidence, I must conclude that any failure to correctly identify potential sepsis and react swiftly must lead to a high likelihood of level A harm occurring.

Having reached that conclusion this places the case for sentencing purposes in Harm category 1, the very highest category for such cases.

However there is a secondary step when considering harm which requires the Court to consider two further factors;

1- Whether the offence exposed a number of members of the public to the risk of harm. The greater the number of people, the greater the risk. Clearly, as I have already mentioned in the three month period between the initial inspection and the arrival of Natalie and Kaysie -Jane at the hospital as many as 25,000 patients would have been treated. I accept that many of those would not have a risk of sepsis developing but a substantial number would which is why so much attention has to be paid to diagnosis and swift treatment. Clearly this Trust exposed significant numbers of the public to the risk of harm.
2- Whether the offence was a significant cause of actual harm. Sadly it was the cause of at least Kaysie- Jane's death as accepted by the Trust in its basis of plea.

Where one or both of these factors apply ,and in the case of Kaysie-Jane it is both, then the Court must consider, in harm category 1 cases, whether it should move up in value at the starting point when calculating the fine at step 2 of the sentencing approach within the guidelines.

I have thought long and hard as to whether there should any distinction between the starting point for the fine in relation to these two victims as clearly the Trust have entered their guilty pleas on a different factual basis for each victim. In addition the two factors above are only both present in the case of Kaysie-Jane. I am grateful to the Trust, and it may be of some comfort to Natalie's family, as in their sentencing submissions they state that the Court should not treat the two offences differently in the approach to sentence. However as a matter of law I must consider whether there should be any disparity between the two fine starting points. I remind myself that whilst I am obliged to follow the guidelines they are not "tramlines" and discretion is permitted. It strikes me that in a case of this importance which has caused so much harm and trauma to both families. Where the harm will be lifelong and has been life changing for so many including, in the case of Natalie, six children. That it would not be correct to approach the two fines from a different starting point.

Step 2 of the process involves identifying the starting point for a fine and the category range. When dealing with a organisation then the approach is to take annual turnover, or equivalent, as a starting point. An NHS Trust does not have an annual turnover in the normal sense but it's average income over the last three years is in excess of £400 million per annum. The Trust has urged me to consider other aspects of its unique position when considering the starting point. However, in my view, those factors are relevant to later stages of the sentencing approach and the proper approach in fixing a starting point is to equate income with turnover. As a result that places the Trust in at least the Large Organisation category. I say "at least" as the guidelines make it clear that a Large organisation has a turnover or equivalent of £50 million and over but where that figure is "greatly" exceeded the organisation may need to be categorised as a Very Large organisation which might permit a Court to move outside even the upper limits of the suggested range for the starting point of the fine. I am grateful to the CQC for directing me to the conclusions of Mr Justice Stuart-Smith in the case of R v Southern Health Foundation Trust who did not feel it necessary to move outside the range for an NHS Trust with a "turnover" of over £300 million. I shall adopt the same approach to this Trust albeit their "turnover" is higher.

Next I consider whether any of the statutory or other aggravating features are present which would result in upward pressure on the starting point. None of the aggravating features exist. I then look to the factors that might reduce seriousness or reflect mitigation which can justify a downward adjustment of a starting point for fine. One of the principal factors is a lack of previous convictions and good health and safety record which this Trust possessed prior to the tragic events which have led to this prosecution. The Trust has also accepted responsibility in this case which is a further factor listed in the guidelines as reflecting mitigation.

The guidelines give a starting point for a fine for a harm category 1 case with high culpability for a large organisation of £2.4 million with a range of between £1.5million and £6million as the start point.

I have already indicated and given reasons as to why I will not differentiate between the two cases when fixing my starting point and as result the fine will be the same for both offences.

Given what I have already outlined concerning the size of the organisation and its income and the extra aggravating factors concerning the numbers of members of the public exposed to the risk and the fact that the risk led to, at the very least, the death of Kaysie-Jane then in my judgment the starting point must be said to be higher than the suggested starting point of £2.4 million. Even with the lack of aggravating features and the presence of the mitigating factors identified the starting point must be a high one. Were this anything other than a public body then I would place the starting point on these facts at £4.8 million per offence. In the absence of the mitigating factors identified it is likely that the starting point would have exceeded the upper end of the suggested range in this particular case.

At steps three and four the specific features of this Trust and specific mitigation on behalf of the Trust become central to my considerations and I shall, prior to moving onto those steps, outline some of the principle points.

The Trust itself is a leading hospital group with 40 sites and employs in the region of 5,500 staff. It serves a large population and annually treats 500,000 outpatients and treats 100,000 people in the Emergency Departments.

The Trust have apologised through senior management statements to the families of Natalie and Kaysie-Jane. These were read by Mr Spencer directly to the families in Court yesterday. Of course no apology can ever repair the harm that has been done but from a legal perspective it does demonstrate remorse.

It is clear that following these two deaths the Trust have taken significant steps to make long lasting improvements particularly in their Emergency Department. Extra staff and resources are now in place. Spending on the department has increased by 47% since these two tragedies whilst staffing levels have increased by 56%. There has been a particular emphasis on sepsis management and the Trust has just secured further funding to expand its Emergency Department capacity.

As a direct result of these two deaths the Trust commissioned an independent expert report from Professor Bewick to examine what had gone wrong and what could be done to improve and prevent future tragedy as well as conducting their own internal reviews.

It is clear that the Trust have taken very significant steps to learn from the events of 2018 and this is evidenced as I have now seen the latest CQC report which is dated April 2021 but arose out of an inspection in February of this year. Whilst the overall rating is “requires

improvement" it is clear that the Trust has improved since the dark days of 2018 and continues to improve. In his submissions Mr Spencer asked me to consider the effect on possible recruitment of staff if the Trust was portrayed as a failing organisation. Whilst that may have described the Trust historically it is clear that that is no longer an appropriate description of this Trust and I certainly would not wish to say anything in this context that might dissuade anyone from joining the Trust and to help it to continue to improve.

At step three of the guideline I am required to take into account whether the proposed fine based on turnover, or equivalent, is proportionate to the overall means of the organisation. This step involves the Court considering the overall financial circumstances of the organisation and the economic realities in which the organisation operates. The Trust have provided detailed financial information as part of their mitigation bundle and I have had regard to that information. The fact that I am sentencing the NHS will be factored in at a later stage of the process however at this point I note that whilst the "turnover" figure is high the Trust is actually operating at break even point with a slight net deficit over the last four years. The Trust highlights that any substantial penalty will inevitably impact on its ability to deliver care. These factors do require the Court to adjust the starting point of the fine downwards and I have reduced the starting point to £3.8 million accordingly.

Step four requires me to "consider other factors that may warrant adjustment of the proposed fine". The guidance makes it clear that at this stage that should the "fine fall on a public body then the fine should normally be substantially reduced if the offending organisation is able to demonstrate that the proposed fine would have a significant impact on the provision of services".

In this case that public body is our most revered of institutions the NHS. Each of us have benefitted from its existence at various stages of our lives and even before the pandemic it's place in our society was assured, now we recognise it's worth and the phenomenal work done by its staff with even greater admiration. However, whatever I may feel on a personal level I am required as a Judge to apply the law dispassionately and without favour or prejudice. In that sense I am grateful to those who have gone before me and dealt with sentencing the NHS, particularly when considering the appropriate level of "substantial reduction."

In his judgment in Regina v Shrewsbury and Telford NHS Trust Mr Justice Haddon-Cave put the reduction at 50% recognising that any fine that impacted significantly on the ability of an NHS Trust to discharge it's duties to the public would be counter- productive and used the term "philosophical conundrum" when describing sentencing a public body in earlier sentencing remarks. Others have applied a less substantial reduction.

In the simplest of terms when does a fine grow so large that it defeats the objects of just sentencing by denying an NHS Trust the ability to hire doctors and nurses or purchase new life saving equipment. Whilst the fines in such a terrible and tragic case must be significant and meaningful they must also not produce such a dramatic effect on the defendant Trust that they potentially put future patients at risk of very serious harm and I am sure that neither of these families would want a fine to result in future devastation to other families. A "philosophical conundrum" perhaps does not do the dilemma full justice. Again, I emphasise at this point that no fine a criminal court imposes is ever an attempt to quantify, in monetary terms, the devastating effect of the death of any individual.

For my part I have chosen to adopt the "NHS reduction" of the, now, Senior Presiding Judge and reduce the fine starting point by 50% to £1.9 million for each offence.

The final two steps in this case involve reflecting the early guilty plea by the Trust and consideration of the totality principle.

The Trust entered its guilty pleas at the earliest realistic opportunity and are entitled to maximum credit and a reduction of one third in relation to each fine. This gives a figure of marginally more than £1,266,666.

I must then consider totality. The guidelines in this respect require me to consider that where the fines arise from two separate incidents, as in this case, whether "they are just and proportionate. If the aggregate amount is not just and proportionate the court should consider whether all of the fines can be proportionately reduced. Separate fines should then be passed."

Having considered, at length and in detail, every aspect of my approach to this sentence and recognising that there are two distinct offences which have had such terrible consequences for so many people I can find no reason to further reduce my sentence.

The Trust shall pay a fine of £1,266,666 for each offence. A total of £2,533,332.

In addition, they shall pay a contribution towards the costs of the CQC of £ 38,000 which was agreed prior to hearing between parties.

Finally, they shall pay the appropriate surcharge which was £170 at the time of the two offences.

Before we end today I would like to thank the Court staff who have been involved in organising matters and looking after the participants, particularly the families. Our Court is not well equipped to deal with such large numbers and I hope that all feel that they have been as well looked after as was possible in such an old building with very limited facilities. I am grateful to my two ushers Miss Sansom and Miss Boot, and to my Court Associate Miss Derrick all of whom, I know, have been greatly moved when listening to the case and have been invaluable in assisting me. I would also like to thank our security staff who have helped deal sympathetically and sensitively with the visiting families. I owe a specific debt to the Legal Team Manager Mrs Hayward who has worked tirelessly behind the scenes to ensure that this case could be accommodated appropriately and has been involved as liaison between the parties since the matter first entered the Criminal Justice system. Finally, I thank HHJ Michael Chambers QC the Resident Judge at Wolverhampton Crown Court who allowed us to occupy Court 9 for these proceedings. It is the largest Court and the most well equipped as it was converted many years ago into a Crown Court. It has allowed me to hear the case in a single room and accommodate the families as comfortably as is possible. It has also allowed me to conduct the case in surroundings that befit the gravity of this terribly tragic case.

Finally, I would like to again pay tribute to the two families. They have carried themselves with dignity throughout and continue to live with the pain and loss caused by these offences. It has been impossible not to be moved by their words and particularly by the bravery of the two mothers in reading their victim personal statements to the Court themselves. No fine can ever replace their lost loved ones, no words can do more, at most, than ease their pain briefly. I hope that they can be a little more at peace now that this chapter is finally at an end and they can be assured that none of us present will ever forget Natalie, Kaysie-Jane and these two families.