JUDICIARY OF
ENGLAND AND WALES

REGINA (HEALTH AND SAFETY EXECUTIVE)

-v-

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

SENTENCING REMARKS OF

THE HON. MR JUSTICE CAVANAGH

CHELMSFORD CROWN COURT

16 JUNE 2021

INTRODUCTION

1. On 20th November 2020, at Chelmsford Magistrates Court, the Defendant, Essex Partnership University NHS Foundation Trust ("the Trust") pleaded guilty to a charge that, during the period from 1 October 2004 to 31 March 2015, it had failed, so far as was reasonably practicable, to manage the environmental risks from fixed ligature points within its inpatient mental health wards across various sites under its control in Essex, thereby exposing vulnerable patients in its care to the risk of harm by ligature. The risk of harm was that patients would kill themselves, or would attempt to kill themselves, by hanging, using such ligature points as were available to them in the inpatient wards. During this period, 11 inpatients hanged themselves using ligature points, and at least one other, and probably more, tried unsuccessfully to do so.

2. A ligature point is anything which could be used to attach a cord, rope, or other material for the purpose of hanging or strangulation. This can include tying to, wedging around, or behind, or held in place by any means, something capable of bearing the weight, wholly or partially, of a person. In a ward environment, ligature points can include shower rails, coat hooks, pipes and radiators, bedsteads, window and door frames, ceiling fittings, handles, hinges, and closures. They do not have to be attached to a ceiling or high up: often such ligature points are low-lying.

3. During the relevant period, the inpatient wards to which these proceedings relate were under the control of the Trust's predecessor, North Essex Partnership University NHS Trust, which was previously known, at various times, as North Essex NHS Foundation Trust, North Essex Mental Health Partnership NHS Trust, and North Essex Mental Health Foundation Trust. The Defendant Trust was created, and assumed responsibility for these sites, on 1 April 2017. The Trust is the result of a merger between North Essex Partnership University NHS Trust and South Essex Partnership University NHS Foundation Trust. It is accepted that the Trust is legally liable for its predecessor's actions, and, for convenience, I will refer to "the Trust" whether I am referring to events before or after 1 April 2017.

4. The Trust provides community health care, mental health care, and learning disability services for patients across a number of sites. The inpatient units that were operated by the Trust at the relevant time for adult mental health patients included the following:

    - The Linden Centre, Chelmsford. This contained Galleywood and Finchingfield Wards, which housed a mixture of patients who were either under section or were otherwise vulnerable as a result of being in an acute phase of mental illness.
    - The Lakes Mental Health Hospital, Colchester. This contained Gosfield and Ardleigh Wards, which were also acute adult mental health inpatient wards.
    - Clacton Hospital. This contained the Peter Bruff Ward, which was another acute adult mental health inpatient ward (since moved to Colchester General Hospital).
    - Shannon House and the Derwent Centre, Harlow, which contained Chelmer and Stort Mental Health Wards, each of which provided acute in-patient care for adults with a primary diagnosis of mental health.
    - The Christopher Unit, Chelmsford, which is a Psychiatric Intensive Care Unit (P.I.C.U).
    - The Severalls House Complex in Colchester, which focused on long-term rehabilitation and which contained Maple Ward, part of a low-secure unit at Willow House on the site.
    - The Crystal Centre, Chelmsford, which included Ruby Ward, an older persons' mental health inpatient ward.

5. The offence to which the Trust has pleaded guilty is an offence under s.3(1) and section 33(1)(a) of the Health and Safety at Work etc. Act 1974. Section 3(1) imposes a duty upon every employer to conduct his undertaking in such a way as to ensure, so far as is reasonably practicable, that persons not in his employment who may be affected thereby are not thereby exposed to risks to their health or safety. The prosecution was brought by the Health and Safety Executive (HSE).

6. At the heart of this case are a number of interconnected failures by the Trust. In summary, these are that there was a consistent failure to comply with national standards and guidance involving ligature risks (these are sometimes referred to as "environmental" risks); failure to act in a timely manner when environmental risks were brought to the Trust's attention, and failure to act in a timely manner on recommendations made by the Trust's own internal Audits; and failure to act appropriately after serious incidents had occurred, by failing to make appropriate environmental changes to reduce suicide risks, so as to remove the environmental risks from the same or similar locations. These failings often persisted for a number of years, and meant that dangers resulting from ligature points on wards, such as, for example, door hinges or wardrobe handles, were not identified and dealt with.

7. There is no significant disagreement of fact between the parties in relation to the offence, though they each emphasise different points and disagree about how the Court should approach the sentencing exercise. Each of the parties has obtained expert reports from Consultant Psychiatrists. The Prosecution has provided me with reports from Dr Jayanth Srinivas dated 17 January 2020 and 29 March 2021, and the Defendant has provided me with reports from Dr T A Clark dated 8 February 2021 and 4 May 2021. The two experts have also prepared a Joint Experts' Report dated 19 May 2021. There is a great deal of agreement between them, though they disagree about the way in which the offence should be categorised for the purposes of the relevant Sentencing Guideline, whilst recognising that this is ultimately a matter for the

sentencing judge. They agree that the Trust fell significantly below the appropriate standard.

8. I have also been provided with a witness statement dated 27 May 2021 from Mr Trevor Smith, the Trust's CFO, to explain the Trust financial position. This is supplemented by the Trust's Final Annual Accounts for the years 2017-18, 2018-19, and 2019-20, and by other financial information.

9. Victim Impact Statements have been read to the court on behalf of family members of several of those who died by hanging in the Trust's mental health wards during, or very shortly after, the relevant period. Where I refer to a person who has died, I will refer to him or her either by their full name, or by their initials, or without identifying them at all, according to the family's wishes, where known. Victim Impact Statements have been provided by Robert King and Kathleen King, the father and mother of David King, who died, aged 41, on Peter Bruff Ward on 20 December 2009; by Melanie Leahy, whose only son, Matthew James Leahy, died, aged 20, in the Galleywood Ward at the Linden Centre, on 15 November 2012; by Alan Oxton, the son of Steve Oxton, who died in Ardleigh Ward at The Lakes on 1 April 2012; by Robert and Linda Wade, whose son, Richard, died aged about 30, in the Linden Centre on 17 May 2015; and by Lisa Anne Morris, the mother of Ben Morris who died, again aged 20, in the Linden Centre on 28 December 2008. I have also read a Victim Impact Statement from a family member who did not want to be identified.

10. Each of the Victim Impact Statements was moving, often heartbreakingly so, and dignified. They were delivered with great courage. In each case the personality and positive qualities of the loved one shone out, and the pain and anguish suffered by the family left behind was starkly revealed. There is no doubt that each of the persons who died was greatly loved and valued by their family. They brought a lot of joy to those around them and they should not be defined or remembered entirely by the way they died. I have no doubt that the same applies to the others who lost their lives, some of whose next of kin could not be traced for the purposes of this sentencing hearing, and so who have not been able to provide Victim Impact Statements.

11. There are two points that need to be emphasised at this stage. The first is that each of the 11 people to whom I will refer in greater detail in a moment died by their own hand by hanging in one of the Trust's mental health wards, but it does not follow that they really intended to commit suicide. It is often the case that such attempts are made as a cry for help without the desire actually to die. The second is that the penalty that the law lays down for this offence, where the Defendant is a body corporate, is a fine. There is a Sentencing Guideline which I must apply when deciding upon the amount of the fine, but it is not the purpose or the intention of this sentencing exercise to put a price on a human life. Nothing I can say or do can eradicate the pain caused by the loss of a loved one.

12. On behalf of the Trust, Mr Thorogood, the Trust's barrister, proffered a profound apology and expressions of remorse and sympathy for the failings which had taken place.

13. I have also been provided with a statement, dated 24 May 2021, from Mr Paul Scott, the Trust's Chief Executive. He was not in post at the time of the events with which this sentencing hearing is concerned, and bears no personal responsibility for them. He said,

"As the Chief Executive of Essex Partnership University NHS Foundation Trust, I would like to take this opportunity to publicly express my profound apologies to the families and friends of those who tragically lost their lives and for the pain and distress they continue to experience. I have met with some of the families and will carry their experiences with me in all my future work."

and

"I should like to provide the court with my personal assurance that I am fully committed to learning from these tragedies. This learning must be translated to an improved environment, an improved culture and improved outcomes for the patients we serve."

14. On 21 January 2021, Nadine Dorries MP, Minister of State at the Department of Health and Social Care, announced that there will be a Non-Statutory Independent Inquiry into the circumstances of mental health inpatient deaths at the current Trust and its two predecessor Trusts, over the period from 1 January 2000 to 31 December 2020. However, that Inquiry will not reopen the investigation of fixed ligature points which has given rise to this prosecution, and this sentencing hearing has no connection with that Inquiry.

15. I will first summarise the relevant facts, and I will then go through the steps that the court is required to go through by the Definitive Sentencing Guideline for Health and Safety Offences, in order to determine the amount of the fine that I will impose upon the Trust.

THE FACTS

The risk of suicide attempts using ligature points in mental health wards was foreseeable

16. It is well known that mental health conditions commonly precipitating admission to psychiatric hospital, including depression, schizophrenia, and personality disorder, are associated with an increased risk of self-harm and suicide. It is also well-known, and was set out in literature and national guidance before 2004, that the most likely means that inpatients will use to attempt to commit suicide is hanging. Three-quarters of people who kill themselves whilst on a psychiatric ward do so by hanging or strangulation.

17. A ligature point must normally be used if a person is to hang themselves.

Preventative measures

18. There are two types of measures that can be used to minimise the risk of death by hanging in mental health wards. The first is by medical care, such as the use of treatment and counselling. This is not the subject of these proceedings. The other is by reducing opportunity, and this involves ensuring that patients do not have access to ligature points or to items or materials, such as belts or cords, which could be used by a patient to hang themselves.

19. However, as the Defence pointed out, it not realistically possible completely to eradicate the risk of suicide attempts by hanging. Patients who are very determined can be ingenious in finding ways of hanging themselves, and may use unlikely objects as ligature points. Also, as again the Defence pointed out, not everyone who is admitted to a mental health ward is necessarily a suicide risk, and a balance must be struck between reducing suicide risks and providing patients with appropriate living

conditions. As the Defence expert pointed out, the provision of inpatient mental health services is both clinically and operationally complex.

20. Nonetheless, it is well recognised that the identification, and removal, of ligature points is a key step in the reduction of suicide risks (like the parties, I use the phrase "suicide risks" to refer to the risk of a patient hanging themselves, although, as I have said, some patients may not actually intend to kill themselves).

The Trust was aware of the importance of removing ligature points and other risks

21. In 2002, the Department of Health launched a "National Suicide Prevention Strategy" which referred to reducing deaths by hanging and strangulation as this was both the most common method of suicide for men and women overall, and the most common mechanism of death among mental health inpatients.

22. The Strategy introduced the "Twelve points to a safer service" – Action 1 was to reduce the risk of deaths in high-risk groups, including "people in the care of mental health services, including inpatients". The strategy identified the need for "regular assessments of ward areas to identify and remove potential risks, i.e. ligatures and ligature points, access to medications, access to windows and high-risk areas (gardens, bathrooms and balconies). The most common ligature points are doors and windows; the most common ligatures are belts, shoelaces, sheets, and towels. Inpatient suicide using non-collapsible shower rails is a 'Never Event' [i.e. something that should never happen]. New kinds of ligatures and ligature points are always being found, so ward staff need to be constantly vigilant".

23. The strategy also said that, "One of the most effective ways to prevent suicide is to reduce access to high-lethality means of suicide. This is because people sometimes attempt suicide on impulse, and if the means are not easily available, or if they attempt suicide and survive, the suicidal impulse may pass."

24. Throughout the period covered by the HSE investigation, numerous alerts were issued drawing the attention of NHS organisations, including the Defendant Trust, to the risks from ligatures within mental health settings and the need to take action to remove them.

25. It is clear, therefore, that, during the period from 2004-2015, the Trust was well aware of the importance of checking for and removing ligature points on wards. This is also shown by the fact that the Trust did take a number of steps during this period.

26. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness published a 20-year review in 2016. This said that the number of suicides by mental health in-patients in England had decreased in the period from 2004-2014. Between 2004-2013, the number of deaths by hanging of such patients fell by 56%. However, in 2014, there were still approximately 20-30 deaths by hanging each year in in-patient mental health wards in England.

The Trust took steps during the period from 2004-2015 to reduce ligature points, but the steps were inadequate

27. During this period, the Trust carried out anti-ligature work, but there was no real sense of urgency and there was much that could have been done that was not done.

28. The Trust had a number of risk management policies and strategies in place, including policies for the assessment and management of service users who self harm, and for the management of suicidal service users and, from 2012 onwards, a Suicide Prevention Strategy. It also had a number of committees which were focused on risk management, such as the Risk and Governance Executive.

29. The Trust employed a person as Risk Manager (the job title changed from time to time) who conducted annual health and safety audits on the wards, as required by the National Suicide Prevention Strategy. These were known as Patient Safety Environmental Audits (PSE Audits). Their purpose was to identify risks on wards, including risks from fixed points of ligature. The audits were conducted by members of the Risk Manager's team, sometimes with assistance from the Trust's estates team and/or ward staff. From 2006 onwards, the Trust used a set of Environmental Standards, which included photographs to help staff identify potential ligature points. These standards were reviewed and approved by the Risk and Governance Executive before they were published. The Patient Safety Environmental Audit on each ward would be reviewed by the charge nurse and signed off by an operational director.

30. Each year, the Risk Manager's team would produce an annual report containing all of the PSE Audits across the Trust, known as the Patient Safety Audit Report. The Trust's director of finance would then decide on what money was available to undertake remedial work.

31. The way in which the PSE Audit process was conducted by the Trust was flawed. The HSE Investigation examined reports from 2011-2014. Each year, the vast majority of the risks identified on the various wards related to risks from ligature points, but the same risks were recorded on an annual basis with no identified action being taken to reduce the risk, even where the action would have been relatively simple. This happened on many occasions. The same risk appeared in multiple locations, but no co-ordinated action was taken to address it. Also, there were numerous occasions on which a risk was not assigned a risk level, despite the audit calling for one to be assigned. Often, the same risks would be assigned different risk levels at different locations. Sometimes, actions would not be taken to address risks which had previously played a part in patient deaths. The risk level assessment for particular units did not decrease over time. As a result of all of this, there were numerous failures to complete recommended actions to reduce risks which were being highlighted on a repeated basis. The audits were ineffectual, both in terms of identifying ligature risks and ensuring action was taken to remove them.

32. There was a failure to act with sufficient speed, or to put sufficient resources into resolving the issues. Though the PSE audits said that a great deal of anti-ligature work had been undertaken, the same action points appeared year after year, such as the installation of anti-ligature door furniture, piano hinges on doors, the fixing of wardrobes to walls, and the installation of window restrictors (which would require window replacement).

33. Members of the Risk Manager's team who were conducting the ward audits were provided with no formal training to assist them in identifying ligature points (even though a 2007 action plan had recommended specialist outside training). There was also a lack of training for the checking that shower rails were collapsible.

34. There are many examples of these failings in the documents with which the court has been provided. Two will suffice for present purposes.

35. The PSE annual summary reports for Galleywood and Finchingfield Wards at the Linden Centre in 2011, 2012, 2013 and 2014 identified a risk from the type of bedroom door hinges that were being used, and recommended their replacement with a type of hinge known as a "perko" hinge. The Department of Health had given national guidance in an alert, warning of the risks of the hinges that were being used, as far back as 2006. In November 2012, Matthew Leahy died after using a bedroom door hinge as a ligature point in a bedroom on Galleywood Ward. This was a type of hinge that had been identified as being "high risk" in the 2011 PSE report for the ward, and which had been identified in the Department of Health alert in 2006. Even after the Trust's internal investigation after Matthew's death recommended that the risk relating to door hinges should be thoroughly reviewed to prevent recurrence of an incident such as this, it was only in July 2015 that suitable alarmed replacement doors were installed in the rooms. The Risk Manager's explanation for this was that, after Matthew's death, the Trust had been looking at replacing the doors altogether and it would have been a waste to replace the hinges and then to replace the whole door. The effect of this is that remedial action was taken some 9 years after the Department of Health recommended that action be taken because of the risk from the door hinges, 4 years after the risk had been identified in a PSE audit, and nearly 3 years after a patient had died after using a door hinge as a ligature point.

36. The second example is concerned with bed and shower rails. It has been well-understood for many years that these rails were a serious ligature risk, which could be mitigated by ensuring that the rails were collapsible. In 2000, a report by the Chief Medical Officer had said that hanging from non-collapsible bed and shower curtain rails was the commonest method of suicide on mental health inpatient wards, and recommended that they should all be removed by 2002. In January 2002, the NHS issued an Estates Safety Notice, i.e. an alert, stating that Trusts should replace all non-collapsible rails with collapsible ones, and advising that thereafter there should be annual load-testing to ensure that non-collapsible rails functioned correctly. Despite this, problems with rails continued at the Trust for many years. From 2009 onwards, the Trust used an outside company to audit the installation of their safety rails. There was no planned regular schedule for these audits. The first audit was carried out in February 2009 and identified a number of rails which failed the checks. The company noticed other problems, including an unsafe roller blind which had been bought with petty cash from Argos and installed in a bathroom. The company conducted a further audit in 2011 and found that a number of rails needed replacing or needed work so that they would operate as designed. For example, there were a number of rooms in Finchingfield Ward in which wall fittings had failed, and the rails had been taped to the brackets. In between the audits, it was left to Trust staff to check the rails on the wards, even though they had no training, or inadequate training, to do so. They would look at the rails and give them a pull to see if they fell down. In 2013, there was a serious near-miss incident in which a patient tried to use a shower rail to commit suicide, and the rail did not collapse. Fortunately, the patient was discovered by staff and revived. The external company conducted its next audit in 2015 and found again that a number of rails failed the test.

37. The amounts that were spent by the Trust on anti-ligature work during the relevant period were relatively modest. An overall sum in excess of £100,000 was allocated each year, but this was for all patient safety equipment, not just anti-ligature work. The Risk Manager would decide what the priorities were, and the Risk Manager's team would liaise with the estates department for the work to be completed, working down the prioritised list until the allocated sum ran out. This annual budget would sometimes be reduced by having funds "clawed back" by the Trust. In 2011, the annual spend from this budget was £0. In 2012 it was £29,800. In each of 2013 and 2014, it was just under £70,000, and in 2015 it increased to £208,487.

38. From 2013 onwards, the Care Quality Commission (CQC) conducted a number of inspections of the Trust which commented upon problems with ligature management. The CQC identified a lack of urgency on the part of senior management to address risks, even where deaths had occurred, and a lack of robust governance processes and systems to learn lessons.

The deaths by hanging during the relevant period, and the Trust's investigations

39. After each death or near-miss involving a ligature, the Trust would commission a panel including a clinician who had not been involved in the incident to investigate it and prepare a Serious Untoward Incident Report (SUI). An action plan was created to identify the actions that were required to prevent repetition, and to set timescales for actions to be completed. The SUIs during the relevant period did not follow a set pattern, were inconsistent, and did not always contain reference to previous audits or environmental issues. As a result, opportunities to learn and to put preventative measures in place were lost. The sheer number of incidents that took place during this period should have triggered greater concern at the Trust and a more proactive response.

40. Some of the SUIs also highlighted that more preventative work could have been done before the incident took place, and drew attention to defects in the anti-ligature work that was being done at the Trust. Notwithstanding these SUIs, the problems continued, and many of the recommendations were not acted on.

41. During the relevant period, or shortly after it, there were 12 deaths and there was also at least one SUI following one near-miss. In chronological order, these were:

(1) DG, 25 October 2004

42. DG died on 24 October 2004 at the Linden Centre, after she attached a ligature to a door closure. The SUI report, dated 13 June 2005, said that the patient had made a number of previous attempts to attach ligatures to doors and said that the way in which DG was able to wedge or loop the ligature flex over the door was a regular feature which with hindsight may have benefited from risk assessment, and that the door closures were subsequently removed. Despite the SUI report saying that risk assessment would be beneficial, no environmental actions were raised as a result of this SUI.

(2) FP, 4 December 2004

43. FP died on 4 December 2004 on Gosfield Ward, The Lakes, from a ligature using an exposed pipe bracket in a bathroom. This was in a private unobserved area. The SUI dated 1 December 2005 recorded that a previous audit had identified this ligature point which led to an action plan to address it, but it had not been removed prior to the incident and staff were unaware that the remedial work had failed to address it. The report recommended that once ligature risks are identified, work to address them should be given completion dates, and there should be a cycle of re-audit to check that the work has been done correctly and that changes or modifications do not themselves create ligature risks.

(3) EJ, 31 December 2007

44. EJ died on 31 December 2007 from a ligature suspended from a curtain pelmet on Maple Ward, Willow House. The SUI noted that the patient had made previous attempts with a ligature tied to bedroom door and raised concerns about the confusing and contradictory evidence they received about risks and audits and a lack of records regarding concerns which were raised other than the audits, despite various members of staff giving evidence that they had raised concerns about the pelmets presenting a risk. The SUI recommended that the Trust should address the issue of outside specialist training for those employees undertaking the task of environmental risk assessment to enhance knowledge and skills in this area. The SUI recommended that the ward environment should be assessed for risk on a regular basis specifically for ligatures, including actions to ensure robust reporting and the keeping of written records.

(4) Ben Morris, 28 December 2008

45. Ben Morris died on 28 December 2008, from a ligature through a wardrobe door handle on Galleywood Ward, Linden Centre. The SUI, dated 14 July 2009, said that the risk from handles had been identified in the audit of September 2007 but was categorised as "low". The wardrobes at that time were free-standing. An action had been raised to replace the handles, but this had not been carried out, and the wardrobes had subsequently been secured to walls which meant they no longer toppled if used as a ligature point (and therefore were more dangerous). No re-assessment of risk was completed following this change even though this had increased the risk. The report recommended that the Trust implement a system to re-assess risk where modifications were made to items identified as a risk. The report further recommended that there be monthly environmental meetings with the Risk Management Department and feedback on audit findings. The report also noted that the ward had multiple ligature points (notably round windows) and hidden areas at the far end of the corridor.

46. I heard a Victim Impact Statement from Ben's mother, Lisa Anne Morris. She spoke of the distress and agony that she felt when she heard what had happened. She said that she howled like an injured animal. She said that a massive part of her died with Ben. He had a brother and sister and a 2 and ½ year old daughter. The whole family has been suffering since. The pain continues. Ben's mother says that every day is like a torture, a nightmare you can never wake up from, that she is broken and shattered. Her mental health has been very seriously impacted.

(5) David King, 20 December 2009

47. David King died on 20 December 2009, on Peter Bruff Ward, from a ligature tied on the handle of his bedroom wardrobe, which he had tipped against a wall and wedged with a slipper. The SUI report recommended that a review of the potential use of bedroom wardrobes as ligature points be undertaken to ensure that future risk was minimised. In fact, there had been a national alert on this type of risk some time previously.

48. The problem of wardrobe handles was not fully addressed by the Trust until 2014, some six years after the death of Ben Morris, and five years after the death of David King.

49. David King's parents have provided the court with a Victim Impact Statement. They told of the terrible anguish they felt when they were told of their son's death, and of the pain that was caused to his son, who was then six years old. They said that the memory of that day never goes away, and that the ongoing impact of has lived with the family ever since. They said that on the day of his death David had tried to ring them, and had left a message on their answerphone saying that he loved them both and would try to call again. They point out that his name means "beloved".

(6) SM, 16 September 2010

50. SM died on 16 September 2010, on Ardleigh Ward, The Lakes, using a ligature from an open window. The SUI, dated 8 February 2011, said that the Panel were satisfied that the design of the window and the layout of the room did not in themselves present a specific or significant ligature risk, although it may be necessary to revisit the unit risk assessment with Risk Management for clarification. The SUI recommended that the risk assessment of ligature points at The Lakes be updated and fed into the yearly ligature audit.

(7) Steve Oxton, 1 April 2012

51. Steve Oxton died on 1 April 2012, on Ardleigh Ward, The Lakes, again using a ligature from an open window. He died on the same ward and in the same manner as SM, just over 18 months after SM's death. The SUI report noted that annual ligature audits were being conducted and should continue. It is a matter of concern that the SUI does not appear to have focused on the parallels with SM's death, despite the obvious similarities, and did not consider whether the audits should already have identified the risk associated with open windows.

52. The court has been provided with a Victim Impact Statement from Mr Oxton's son, Alan. He emphasised the very vulnerable and suicidal state his father had been in when he was admitted to Ardleigh ward on 31 March 2012, and the very severe impact that his father's death has had on his own life, and on his own mental health. Mr Alan Oxton had been his father's primary carer for a number of years before his death.

(8) Matthew Leahy, 15 November 2012

53. Matthew Leahy died on 15 November 2012 on the Galleywood Ward at the Linden Centre, from a ligature made from a pillowcase suspended from the hinge of his bedroom door. I have already noted that the Trust had been alerted some years previously to the risk arising from the type of hinge that was involved. It had also been identified as being a "high risk" in the previous year's PSE Audit. The SUI report dated 19 December 2012 recommended that risk relating to door hinges should be "thoroughly reviewed" to prevent recurrence of a serious incident such as this. In fact, it was to be several more years, in 2015, before the Trust properly addressed this problem.

54. Matthew Leahy's mother, Melanie Leahy, has provided the court with a Victim Impact Statement. She vividly described the distress and devastation she suffered when she heard of his death, and how her grief and suffering, and that of her family, has continued ever since, especially on his birthday. She said that her world stopped when he died. She said that her life is consumed by the manner of Matthew's death, and how she can make sense of it. She said that the pain of losing a child cannot be fully expressed and those who have this pain must find a way to walk with it every single day of their lives. He has lost the opportunity to be a father and she has lost the opportunity to be a grandparent. She describes Matthew as someone who was a source of fun and jokes at family events.

(9) Near-miss incident, 18 April 2013

55. There was a "near-miss" incident on 18th April 2013 in which a patient was found hanging from a collapsible shower curtain rail which had failed to collapse in the

bathroom on Ardleigh Ward, The Lakes. Fortunately, the patient was found in time and cut down and survived the incident. A SUI report was produced which noted that there had been a similar incident involving the same patient a few days earlier, but it did not appear to have led to a formal report being completed and it was not known whether the rail had failed to collapse on that occasion. It also recorded that testing following the incident identified problems with other rails which would not collapse – particularly in relation to curved shower rails. This was against the background that the Chief Medical Officer had recommended the removal of all non-collapsible shower rails by 2002.

(10) Iris Scott, 1 March 2014

56. Iris Scott died on 1 March 2014 from a ligature tied to the outside of the bathroom door in her bedroom on Ruby Ward in the Crystal Centre. The SUI report dated 8 June 2014 recommended that "Consideration should be given to improve the anti-ligature design of the door within the bedrooms to make this act more unlikely, such as curved top edge, a panel above the door which would "pop out" under pressure or a load release mechanism on the latch." The report also observed that there was a lack of staff awareness of risk assessment and risk management in relation to environmental factors demonstrated in interviews.

(11) Unnamed Patient, 12 February 2015

57. This patient died on 12 February 2015 from a ligature tied to the bathroom door in his bedroom in the Linden Centre. The cause of death was similar to that of Iris Scott less than a year before. The SUI report recommended that all the equipment provided within the shower and bathrooms across the Trust be thoroughly reviewed, such as shower curtains and bins, to see if any possible alternatives can be sourced that would reduce the risks of an Incident occurring again. This was acted upon and an action plan was instituted with a view to fitting doors on units with alarmed anti-ligature doors with a target completion date of 2015. However, the Trust had received an NHS Estates alert over 8 years previously, in 2006, which was concerned with doors being used as ligature risks and which suggested that such risks were reduced or removed as a matter of priority.

(12) DK, 23 March 2015

58. On 23 March 2015, patient DK died on Gosfield Ward, The Lakes, from a ligature which had been tied to an unsecured loft hatch in the toilet ceiling. The SUI report, dated 15 July 2015, recommended that the Trust should ensure more efficient distribution and actions from PSE Audits, and that steps should be taken by the estates department to manage the risk of loft hatches across the Trust. The existence of an unsecured loft hatch in a private area was contrary to national guidance. Staff had been unaware of this environmental risk, and there had been a failure to communicate risks properly.

(13) Richard Wade, 17 May 2015

59. Richard Wade died on 17 May 2015, by hanging, whilst an inpatient in the Linden Centre. This was very shortly after the period to which the offence relates. As a result, it was not investigated as part of the HSE investigation and is not formally part of these proceedings. Nevertheless, I agreed to read a Victim Impact Statement from Richard's father, Robert Wade, and Richard's mother, Linda Wade and I think that it is appropriate to refer to it in these Sentencing Remarks.

60. Mr and Mrs Wade's statements refer graphically to the pain and anguish that the family suffered at the time of Richard's death and have continued to suffer since, as Mr Wade put it, the chest-crushing anxiety. Their life plans were altered irretrievably. Their health has suffered. As Mr Wade said, things can never be as they once were. They describe Richard as a huge character with a warm deep laugh, a great sense of humour, good values and interests in many things. He was very family minded, and the family was very close. Richard was academically gifted, and had already obtained a PhD and published an academic book before he died.

The Joint Experts' report dated 19 May 2021

61. The key points of the Joint Experts' report can be summarised as follows:

(i) The extent of available guidance and documentation concerning ligature points within inpatient settings is comprehensive and inclusive.
(ii) Ligature risks are an important environmental risk that all inpatient mental health services should be aware of and should manage.
(iii) Effective management of ligature risks involves a combination of environmental, clinical, and local risk management.
(iv) There were systems in place to identify the risks posed by fixed ligature points, but these risks were not always addressed promptly enough.
(v) It is difficult to define normal parameters for untoward incidents, including ligature incidents, due to the lack of relevant local and national benchmarking data and also due to the complexity of clinical and service delivery issues.
(vi) Earlier CQC reports are critical of the Trust, while more recent CQC reports seem to identify areas of improvement.
(vii) The Trust fell significantly below the appropriate standard.

The actions of the Trust since 1 March 2015

62. Inspections by the CQC in 2015 placed the spotlight on management of ligature risks at the Trust. In 2015, for the first time, the Trust implemented a policy for "Trust management of ligature risks in mental health inpatient units". In addition, the Trust's annual expenditure on anti-ligature work more than tripled to over £200,000, and funding for such work became readily available. Directors began accompanying the risk management team on ligature audits.

63. In 2017, when the current Trust took over, the Trust commenced a structured and comprehensive review project on ligature risks, managed at Board level. The Trust has strengthened its governance structure and this has been acknowledged by the CQC. Staff training has been improved. The Trust is conducting a peer review with the East London NHS Foundation Trust, which is rated outstanding by the CQC, directed at ligature management policies and procedures. In the financial years from 2017/18 to 2020/21, the Trust spent a total of £1.826 million on its environmental ligature work investment programme. The Trust spent a further £1.9 million on window replacement in 2019-21. Ligature risk assessments are now conducted every year on every ward, and potential ligature risks are dealt with at the earliest opportunity. Each ward has been given a red tabbed ligature wallet, containing key information.

64. However, in a CQC focused inspection of multiple locations at the Trust in September 2016, including The Lakes, The Linden Centre, Chelmer & Stort Wards, The Christopher Unit, Peter Bruff Ward and Shannon House, the CQC identified multiple ongoing issues and determined that improvement was still required in relation to the trust's assessment and management of fixed ligature points on wards. Further problems were identified in a report in 2017. The Trust produced a further action plan,

but a further CQC inspection report in January 2018 into certain mental health wards identified ongoing problems with ligature risk management at the merged Trust. These included that the Trust did not ensure that staff had easy access to accurate ward ligature assessments, and the Trust had not taken sufficient action to reduce the number of ligature points on wards. A further inspection report in October 2019 noted an improvement. It said that some improvements had been made and praised the leadership and governance structure at the Trust. The report also commented that staff knowledge and management of ligature risks had improved since the previous inspection. However, some problems with ligature risks remained, and the Trust had not ensured that staff, leadership, and governance processes addressed all risks, in their entirety, identified in the two previous investigations in 2018 and April 2019. The 2019 CQC inspection gave the Trust an overall rating of "Good" and for Caring, the rating was "Outstanding." The rating for "Safe", however, was "Requires Improvement".

65. There is now a new Chief Executive in place, and patient safety is being given the highest priority. I am satisfied that matters have improved since 2019, and that things are moving in the right direction.

THE SENTENCE

General principles

66. The purposes of sentencing are set out in the Criminal Justice Act 2003 (CJA), section 142 as follows: (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. 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 (section 143).

67. 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. The relevant criteria are in subsections (2) to (4) of s. 164. These provide that:

"(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."

68. The objective in applying these principles when sentencing a company for offences against health and safety legislation were identified by Scott Baker J in **R v F Howe & Son (Engineers) Ltd** [1999] 2 All ER 249 at 255, [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."

69. The Defendant in the present case is not a commercial company: it is a health Trust. This gives rise to the philosophical conundrum that was considered by Haddon-Cave J in his sentencing remarks in **R (Health and Safety Executive) v Mid-Staffordshire NHS Foundation Trust** (2014), namely, what is the point of fines when they are paid out of public funds? The answer was given by Haddon-Cave J in his sentencing remarks:

"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.
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)."

70. Later in the same judgment, in an observation that applies equally to the present case, Haddon-Cave J said:

"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."

71. In a second sentencing exercise involving Mid-Staffordshire NHS Foundation Trust in 2015, arising out of similar facts to the first one, Haddon-Cave J said:

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

72. Once again, in my judgment, this is the approach that I should follow in this case.

The Definitive Sentencing Guideline

73. The Guideline provides a structure within which to sentence for health and safety offences. However, as has been emphasised many times, there is inherent flexibility in the Guideline (see, for example, **Whirlpool UK Appliances Limited v R (on the prosecution of Her Majesty's Inspectors of Health and Safety)** [2017] EWCA Crim 2186, at paragraph 12, per Lord Burnett of Maldon CJ). It is not a straightjacket, and it is not a mathematical exercise.

Step 1: Determining the harm category

74. The first step in the process is to determine the offence category. This involves assessing (a) culpability and (b) harm. The court must then consider two further factors in the round. These are (c) whether the offence exposed a number of workers or members of the public to a risk of harm and (d) whether the offence was a significant

cause of actual harm. If one or both of (c) and (d) applies, the court must consider either moving up a harm category or substantially moving up the category range at Step Two. The court should not move up a harm category if actual harm was caused but to a lesser degree than the harm that was risked.

(a) Culpability

75. The Guideline sets out four categories for culpability. These are Very High Culpability, High Culpability, Medium Culpability, and Low Culpability. The Prosecution submits that this case falls within High Culpability and the Defence submits that it falls within Medium Culpability.

76. In my judgment, this case clearly falls within the High Culpability Category. Very High Culpability is for cases of deliberate breach of or flagrant disregard for the law. That was not the case here.

77. However, in the present case, all but one of the factors that are set out in the Guideline as being present in a High Culpability case are present in this case. The factors that are present are (1) failing to put in place measures that are recognised standards in the industry; (2) failing to make appropriate changes following prior incidents exposing risks to health and safety; (3) allowing breaches to subsist over a long period of time; and (4) serious and/or systemic failure within the organisation to address risks to health and safety.

78. It is true, as the Defence points out, that systems were in place within the Trust to address environmental risks consisting of ligature points, but the summary of the facts that I have set out demonstrates that they were woefully inadequate. Time and again there was an incident, resulting in loss of life, that should have alerted the Trust to the urgent need to review and address problems with ligature points in inpatient mental health wards, but time and again the response was too little, too late. The PHE Audit process was patchy at best, and the Trust frequently failed to act in a timely fashion on recommendations that were made in Audits or in SUIs. As a result, the breaches subsisted over nearly 11 years. The same environmental risks recurred again, for example in relation to door hinges, wardrobe handles, and windows. In my view, this amounts to a systemic failure. The Trust fell far short of recognised standards for health Trusts.

79. The factors for Medium Culpability include "systems were in place but these were not sufficiently adhered to or implemented." In my judgment, this does not adequately describe what went on. The problem went further: the systems themselves were not robust enough. The fact that there were a large number of patients who did not try to commit suicide by hanging themselves from ligature points on wards does not mean that adequate systems were in place.

(b) Harm

80. The other consideration that determines the offence category is the categorisation of harm. This breaks down into two elements, (a) the seriousness of the harm risks, which can be at Level A, Level B, or Level C, and (b) the likelihood of that harm arising, high, medium or low.

81. The Guideline emphasises that health and safety offences are concerned with failure to manage risks to health and safety and do not require proof that the offence caused any harm. The offence is in creating the risk of harm.

82. The parties agree that the seriousness of the harm was in Level A, the highest level, as the harm that was risked was death. I agree.

83. The parties disagree about the likelihood of that harm arising, however. The Prosecution says that the likelihood was high, and the Defence says that the likelihood was medium.

84. In **R v Squibb Group** [2019] EWCA Crim 227, a case that was concerned about the likelihood of harm arising from exposure to asbestos, Leggatt LJ said that the likelihood was not something that was rationally capable of being assessed simply on the basis of supposition, impression or imagination. It is a scientific question which should be answered, if possible, with the assistance of scientific evidence. In the present case, the two medical experts each express a different view as to whether the likelihood of harm was high, although they recognise that this is ultimately a decision for the judge.

85. The question in the present case is not a scientific question in quite the same way as in the asbestos case. However, the objective factual evidence to which I have already referred provides, in my view, a clear answer to the question about likelihood of harm.

86. In my judgment, the likelihood of the harm arising was high. I agree with the Prosecution that where numerous patients with mental health problems were exposed to the risk from multiple fixed ligature points across a number of different sites over a lengthy period of time, it was inevitable that deaths would result. It was, in my view, inevitable that some patients with acute mental health problems would try to commit suicide, it was inevitable that they would try to do so by hanging themselves, it was inevitable that they would make use of fixed ligature points if any were available to them, and it was sadly inevitable that some, at least, would be successful in killing themselves. The fact that, even where there is an intent to end life, many suicide attempts are unsuccessful does not mean that the likelihood of harm arising in this case was not high. Similarly, the fact that many patients in mental health units do not attempt suicide and so are not affected by the ligature points issue does not detract from my conclusion that the likelihood of harm was high.

(c) Did the offence expose a number of workers or members of the public to a risk of harm?

87. The answer is "yes". Over the 10 and a half year period, a large number of patients will have passed through the Trust's mental health inpatient wards. A substantial number of these will have been acutely ill and will have been prone to suicidal ideation. In those circumstances, failings which led to ligature points being present in some places on the wards will have exposed a number of these patients to a risk of harm.

(d) Was the offence a significant cause of actual harm?

88. Again, the answer is "yes". A "significant cause" is one which more than minimally, negligibly or trivially contributed to the outcome. It does not have to be the sole or principal cause. The failings in relation to ligature points were a significant cause of the deaths of the 11 people who died during the relevant period, and of the harm done

to the patient involved in the "near miss", because the availability of ligature points contributed to their deaths.

Conclusion on Step 1

89. Culpability was high. There was a high likelihood of harm, and the seriousness of harm risked was at Level A. This means that the offence is in high culpability harm category 1. This is the highest harm category. Factors (c) and (d) were present. As the offence was already in the highest harm category, there is no scope for moving up a harm category. Instead, it is appropriate to consider moving up from the starting point at Step 2. In the **Whirlpool** case, Lord Burnett of Maldon CJ said, at paragraph 31, that, "A consistent feature of sentencing policy in recent years, reflected both in statute and judgments of this court, has been to treat the fact of death as something that substantially increases a sentence, as required by the second stage of the assessment of harm at Step One."

Step 2: starting point and category range

The starting point and category range

90. The starting point and category range in the Guideline is different depending on whether the Defendant is a Very Large Organisation, a Large Organisation, with a turnover or equivalent of £50 million and over, a Medium Organisation, with a turnover or equivalent of between £10 million and £50 million, or a Small or a Micro Organisation.

91. I am satisfied that the Trust is a Large Organisation. A Very Large Organisation is one whose turnover very greatly exceeds the threshold for Large Organisations. That is not the position with the Trust. Its most recent annual revenue, from various sources, which is the closest equivalent to a turnover, is about £325 million.

92. The appropriate starting point and category range for the Trust, therefore, is that which applies to Large Organisations in high culpability harm category 1. The starting point is £2,400,000 and the category range is from £1,500,000 to £6,000,000.

Factors increasing seriousness and which therefore affect the starting point

93. I have already said that, because the offence exposed a number of patients to a risk of harm, and the offence was a significant cause of actual harm, I will have to consider substantially moving up the category range to reflect this. In my judgment, it would be right to do so.

94. There is, in addition, one statutory aggravating factor, consisting of one previous relevant conviction from 2014 for a breach of s3 HSWA for failing to protect service users at the Derwent Centre from falls from windows which were not adequately restricted. In July 2013, an 18-year old patient on Chelmer Ward in the Derwent Centre fell 3.4 metres from a first floor dormitory to the ground below. The window had not been restricted as it should have been. The patient broke his back. The HSE considered that the Trust did not act sufficiently robustly or speedily to ensure such incidents never happened again. There were clear similarities with the present case, in that the Trust had failed to address an environmental risk to vulnerable patients which could result in self-harm, and the Trust failed to take prompt action following the incident.

95. The prosecution does not allege any other aggravating factors in this case. The offence was not the product of cost saving or corner cutting measures.

96. Taking all of the above considerations into account, and in particular the length of time covered by the offence, but before making adjustments for mitigating factors, Steps 3 and 4, and the guilty plea, the appropriate level of fine would be £4 million.

Factors reflecting mitigation and which also affect the starting point

97. There has been a high degree of co-operation with the investigation, beyond that which will always be expected. The Trust took active steps to allocate staff to undertake work reviewing old files and records post-merger to seek out and provide documentation to the investigations team. The Trust accepted responsibility at an early stage, and arranged for an early meeting of the parties' legal teams, even before proceedings were commenced, to discuss the way forward for the case, at which point the Trust indicated that there would be a guilty plea.

98. The Trust has also taken significant steps since 2015 to improve its systems and practices and to protect its patients from ligature risks. I have described these already. The Trust is committed to best practice and has worked hard to achieve it, although there have been some difficulties along the way. The improvements are gaining momentum. The new Chief Executive, Mr Scott, who was appointed in Autumn 2020, and the leadership team have committed themselves to a "Safety First, Safety Always" approach, and a new Director of Patient Safety has been appointed. All of the signs are that the Trust is well-led and is trying to remedy the failings of the past.

99. These two factors provide substantial mitigation. When they are taken into account, and again before taking account of Steps 3 and 4, and the guilty plea, the initial level of fine, the starting point, would be £3.25 million.

<u>Steps 3 and 4</u>

100. At Steps 3 and 4, I must step back, review and, if necessary, adjust the initial fine reached at Step 2 to ensure that it fulfils the general principles of sentencing for health and safety offence, takes account of the economic realities of the Defendant's organisation, and the most efficacious way to give effect to the purposes of sentencing. I must also consider the effect of the fine on the employment of staff, service users and the local economy.

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

102. In my judgment, this is a case in which a substantial reduction is appropriate at Steps 3 and 4. The most important consideration is that the Trust is providing health services to the people of Essex and beyond, and a very substantial fine will have an impact upon its ability to provide those services to the public. The population served by the Trust is expanding and is ageing. In particular, a fine will have an impact upon the Trust's ability to make infrastructure improvements, which will, indirectly, have an adverse effect upon service users.

103. The Trust's funding regime is very complicated. Although the Trust's annual income is something over £300 million, the Trust does not make a profit, in any normal sense of the word. This impacts upon its ability to pay a financial penalty. The fine imposed on the Trust will come out of the Trust's own funds. A very substantial fine will make it difficult if not impossible for the Trust to meet its financial target for the present year, and this will have a knock-on effect on the funds that will be available to the Trust in future. The value of the Trust's assets and the cash balance it is holding are of no real relevance, because the Trust is not free to sell assets to pay for the fine (and it would not be in the public interest for it to do so), and because the cash balance is for the day to day running of the Trust. Much of the funds allocated to the trust are ring-fenced for particular purposes. A fine will increase the financial difficulties facing the Trust.

104. It is not necessary in these Sentencing Remarks to go into great detail about the Trust's financial position. The simple point is that a fine will make it more difficult for the Trust to meet its commitments and to provide services to the people of Essex and its vicinity, and, in particular, to make the infrastructure changes it wishes to make. The Trust carries out a public service. This is a matter which the court must take into account.

105. In my judgment, and bearing in mind the principles of sentencing for cases such as this, the fine should be reduced at Steps 3 and 4, to £2.25 million.

Step 5

106. Step 5 does not apply.

Step 6: credit for guilty plea

107. The Trust is entitled to a full 1/3 reduction in the fine as credit for its guilty plea at the earliest opportunity.

Other matters

108. There has been no application for compensation (Step 8). As there is only one offence, the totality principle does not apply (Step 9). The appropriate statutory surcharge applies.

Conclusion on level of fine

109. Applying the 1/3 discount for the guilty plea, the fine is £2,250,000 minus 1/3. This results in a fine of £1,500,000. This is the fine that the Trust will have to pay. In my judgment, this level of fine achieves the aims of Parliament as set out in the Criminal Justice Act 2003 and the Health and Safety at Work etc. Act 1974.

Costs

110. The court has power to award such prosecution costs as it regards as being just and reasonable in all the circumstances.

111. The Prosecution applies for costs in the sum of £86,222.23. I have been provided with a schedule of costs. They are made up of the costs of the HSE Legal Adviser's Office, the HSE Inspectors' costs and counsel's fees.

112. The Trust does not oppose an award of costs being made in the Prosecution's favour, but the Trust invites the court not to award the full amount that is sought by the Prosecution, and makes three points.

113. The first point is that the Trust has incurred substantial costs of its own. This is no doubt the case, but it is not a reason why it is not just and reasonable to award the costs sought by the Prosecution.

114. The second point is that the Trust has already paid over £40,000 to the HSE under the "Fees For Intervention" scheme. However, there is no overlap between those costs and the costs that the HSE seeks in these proceedings.

115. The third point is that the Prosecution should not be seeking the costs relating to the salaries of HSE employees and other "in-house" costs, on the basis that those costs would be incurred in any event, whether or not the HSE had investigated the Trust. However, it is clear that such costs are recoverable in principle and I do not see any reason why they should not be recovered in the present case. The case relied upon by the Trust, **BPS Advertising Ltd v London Borough of Barnet** [2006] EWHC 3335, was a very different case. In that case, the Prosecution costs were not awarded in full because the Prosecution costs were 7 and ½ times the amount of the fine (for which the statutory maximum was then £1000). No such consideration applies in the present case.

116. In my judgment, it is just and reasonable for the Trust to pay the Prosecution costs in full, in the amount of £86,222.23.

Conclusion

117. I am grateful to Ms Shauna Ritchie, Counsel for the Prosecution, Mr Bernard Thorogood, Counsel for the Defence, and their respective legal teams for the assistance which they have provided to me in this case and the sensitive and helpful way in which they have performed their functions.

118. Finally, as I have already said, and as the court fully appreciates, no financial penalty can set a price on the life of a much-loved human being, and that has not been the purpose of today's sentencing hearing. Instead, the court seeks to punish the organisation responsible in accordance with the relevant legislation and Sentencing Guidelines. I want to add my condolence to the family and friends to those that have already been expressed, to pay tribute to their courage, and to acknowledge the suffering that they have endured.

119. The costs are to be paid within six months. The fine can be paid in equal instalments over 5 years, the first instalment by 31 March 2022.