Case No.: S20220104

IN THE CROWN COURT AT SOUTHWARK

1 English Grounds, London, SE1 2HU

14 November 2023

BEFORE HIS HONOUR JUDGE BAUMGARTNER

BETWEEN:

REX (THE HEALTH AND SAFETY EXECUTIVE)

- v -

PRIORY HEALTHCARE LIMITED

SENTENCING REMARKS

Sarah Le Fevre (instructed by **Tuckers Solicitors LLP**) for the **Prosecution**
John Cooper KC with **Sandesh Singh** (instructed by **DAC Beachcroft Claims Limited**) for the **Defendant**

INTRODUCTION

1. Francesca Whyatt had just turned 21 years old when she died on 28 September 2013, three days after she put a ligature around her neck and self-asphyxiated. She was one of four girls – quadruplets – born to Deborah and Stefano on 18 September 1992. She was a sister to Daniel, Gemma, Eleonora, and Jessica. It has been ten years since Francesca died; she is not forgotten, but the immense pain of her death is still very real for those who loved her and for those whom she loved. Her sister Jessica describes her as "*our ray of sunshine, loyal, caring, a bundle of fun, creative, thoughtful, sincere, gentle, honest, and empathetic*". I heard Francesca was a loving sister, someone who put everyone before herself. Her brother Daniel says Francesca was a truly selfless, special, and unique individual.

2. Francesca's death was tragic and untimely. It came about because of a freak combination of events at the hospital which was caring for Francesca – the Priory Hospital Roehampton (the **"Priory Roehampton"**), operated by the Defendant, Priory Healthcare Limited. On Wednesday, 25 September 2013, hospital staff at the Priory Roehampton found Francesca in a communal living room on Emerald Ward, unconscious, with a ligature made from tights around her neck. She never regained consciousness, and her life support machine was switched off three days later.

3. The Defendant's duties to its patients under s.3 of the Health and Safety at Work Act 1974 (the **"1974 Act"**) included an obligation to conduct its undertaking in such a way as to ensure, so far as was reasonably practicable, that persons not in its employment who may have been affected thereby, including Francesca, were not exposed to risks to their health and safety. The Defendant failed in this duty on 25 September 2013.

4. This failure was accepted through the Defendant's guilty plea at Westminster Magistrates' Court on 20 April 2022 to a single charge, contrary to s.3 of the 1974 Act, for which the Defendant now falls to be sentenced.

THE INCIDENT

5. Francesca had had contact with mental health services from the age 13, when she developed issues around her diet and began to harm herself. Thereafter, she had a history of poor dietary intake and self-harming behaviour which included cutting herself, banging her head, burning herself, taking overdoses, and using ligatures.

6. On 20 March 2013, Francesca had been detained under s.3 of the Mental Health Act 1983 and admitted to the Emerald Ward at the Priory Roehampton. She had been an in-patient at another hospital for five months previously. Francesca had a history of self-harm during the 27 weeks she was at the Priory Roehampton: prior to the ultimately fatal incident on 25 September 2013, she self-harmed on no less than 27 occasions. Eight of these involved the use of ligatures, and one of them, on 17 June 2013, involved the use of tights.

7. Between 11 o'clock and three o'clock on Wednesday, 25 September 2013, an Emerald Ward patient called Amy engaged in acts of self-harm. Staff had managed to calm her down, but, at around half past three, another Emerald Ward patient called Angie also began to self-harm. The staff were unable to calm Angie, so the police were called; officers arrived just before four. Whilst the police and hospital staff were seeing to Angie, other staff members took the remaining Emerald Ward patients (including Amy and Francesca) outside to the garden.

8. At about four o'clock, Amy forced her way through a door from the garden into the hospital car park and absconded; at about the same time, Francesca walked back inside and up the stairs to the first floor. At least one of the healthcare assistants in the garden noticed Francesca's absence, and some of the staff went to look for her; Francesca was found behind a sofa in the lounge on the second floor, covered with a blanket. Her tights had been tied as a ligature around her neck. The alarm was activated at eight minutes past four, and a hospital doctor provided emergency assistance on the scene. Francesca was taken to Kingston hospital, but, very sadly, she died from her injuries three days later, on 28 September 2013.

THE PROSECUTION'S CASE

9. The Prosecution's case is that, in respect of the breaches of s.3(1) of the 1974 Act, the Defendant failed to ensure, as far as was reasonably practicable, the safety of the patients under its care.

10. The principal matter relied upon is the Defendant's failure to adequately monitor its patients who were at risk of self-harm and suicide, and, in particular, the practical

difficulties of a healthcare worker being responsible for observations in the Zone 1 areas split across the first and second floors; *ad hoc* alterations to the observation duty rota; and the apparent lack of awareness of the healthcare assistant responsible for Francesca's observations in the event of a crisis occurring.

THE DUTY

11. Section 3(1) of the 1974 Act placed the Defendant under a non-delegable duty to ensure, as far as was reasonably practicable, the safety of the patients under its care at the Priory Roehampton. This duty is concerned with the management of risk to safety or health.

12. In Francesca's case it was essential for the Defendant to have in place a robust system of monitoring, such that staff could rapidly and decisively intervene should she attempt to self-harm so that the risk of her inflicting life-threatening injuries was eliminated or reduced to as low as was reasonably practicable.

13. The Defendant recognised the obvious risk of suicide, violence and absconding by in-patients, including through its Policy No.H47, "Observation and Engagement". The aim of this policy was:

> "*to minimize the risk of potential suicidal, violent or vulnerable service users harming themselves or others and the risk of service users absconding from hospital. Enhanced observations should form part of the wider risk management plan for a service user.*"

14. The level of these observations was set following a detailed risk assessment, and could be general, intermittent, or constant observation (either within a staff member's eyesight or within a staff member's arm's length). Intermittent observation required a specific (named) member of staff to randomly check a patient on a specific number of occasions within one hour, but at irregular intervals. It was appropriate for vulnerable patients or those who had previously been at high risk of harm to themselves or others but who were deemed as not requiring more intensive observation. Staff were required to record their intermittent observations on a specific form. Constant observation within a staff member's eyesight required dedicated nursing observation and was appropriate for patients requiring intensive intervention when there were concerns regarding serious harm or the risk of absconding. The patient was always kept within the sight of an allocated staff member, and observations were recorded on a specific form.

15. The Defendant's failure to properly maintain and/or implement its observation system was raised in an email from Dr Adrian Lord (the consultant psychiatrist who led the Emerald Ward's clinical team and who was the clinician responsible for Francesca) just 12 days before the incident. Dr Lord warned that the front door had been left open "*more than once*"; that a patient (who happened to be Francesca) had managed to pick up a hacksaw dropped from a maintenance worker, even though at that stage she was on constant observation; that intermittent observations were "*not being done for long periods*"; and that he had "*no confidence in the staff to maintain safety*" using the observations system in place, including the zonal observations system. This, coupled with the Defendant's increasing reliance on agency staff at the Priory Roehampton, "*jeopardised safety*", as one of the ward staff nurses was to later observe.

16. On 25 September 2013, Francesca's observations had been reduced to intermittent observations at "10-minute intervals" during the day, and constant observations within a staff member's eyesight during the night. No criticism is made of this decision.

17. There was, as I mentioned, a zonal observations system in place in Emerald Ward. Zone 1 was spread over two floors, and covered the therapy room, the lounge, and the bedrooms on the first floor. Because of the way in which Zone 1 was configured over two floors, it was impossible for one person to carry out observations properly. The lounge on the second floor where Francesca was found unconscious on 25 September 2013 had no one acting as an observer between two and five o'clock that day. One of the reasons why this happened was because the crisis observations protocol had been activated by Amy and Angie's actions earlier that afternoon. The healthcare assistant allocated to observe the lounge between two and three o'clock was occupied looking after Amy, as the healthcare assistant scheduled to carry out Amy's one-to-one observations had been sent home after she had upset a patient.

18. I heard expert evidence about the events of that afternoon from Dr Shazad Amin, a consultant psychiatrist, who provided a psychiatric report dated 8 August 2022. Dr Amin described the extent of the situation on the ward at that time as "*serious, unprecedented and unforeseeable*", and he explained to me that, in his experience, it was highly unusual for two patients to simultaneously create serious incidents on the ward. I also note that, in his evidence at the coronial inquiry touching upon Francesca's death, Dr Lord described the events that day as *"very unprecedented circumstances on that afternoon, which were completely unprecedented*".

19. Dr Amin also suggests that those exceptional events could have had a "*triggering*" effect on Francesca and what he described as "*her own impulsive decision to ligature*", against the background of Francesca's reducing risk of suicide. This, he said, is unusual, and that, given his own experience in managing such patients on in-patient psychiatric units, it could not reasonably have been foreseen. In such circumstances it was simply impossible to apply normal observation policies, like the zonal observations policy which the Priory Roehampton had in place.

20. Quite remarkably, the Defendant's crisis observations policy appears to have consisted of a single sentence, found at the bottom of the daily coordination sheet like the one at EX0399. It says this:

> "*In the event of a crisis, the crisis observation allocated person should ensure that intermittent observations are being done on other patients who are not involved in the crisis.*"

It was remarked upon in a meeting note dated 18 July 2013, attended by Dr Lord, as a recent invention:

> "*The co-ordination sheet has now got a 'crisis observation' allocation on it. This person's job is to look after the other patients in the event of a crisis with one patient and ensure that the intermittent observations are maintained. The nurse in charge must ensure that this is allocated at the start of the shift, and that the person allocated understands their duties in the event of a big incident.*"

There is no dispute that what transpired on the afternoon of 25 September 2013 was either a "*crisis*" or a "*big incident*".

21. The zonal observation policy is at EX0448, and forms part of the Observations and Engagement Policy (No.H47). It makes no mention of the crisis observations protocol. I asked Dr Amin about this, because he agreed that if someone had been observing the lounge room that afternoon in line with the zonal observations policy then that person could have intervened to stop Francesca from self-harming that day. Dr Amin told me that the crisis observations protocol would have to displace the usual observations policy because of the need to manage the crisis at hand with the staff available.

22. The crisis observations protocol is not criticised by the Prosecution. While there is nothing in the Defendant's policies which suggests the zonal observations policy should give way to the crisis observations protocol, in his report Dr Amin says this:

> "*Hence in my view the standards that should be applied in a normative case should not be applied in extreme situations such as* [the one which occurred on 25 September 2013]. *Under these circumstances, it is my view that it would be practically impossible to apply normal observation policies. For example, in reacting to these two serious incidents* [that is, Amy and Angie], *staff were unable to undertake their normal duties because, due to events beyond their control, they had to undertake 'emergency' duties imposed upon them by external factors e.g.* [one of the healthcare assistants] *was tied to a phone for 20 minutes at the request of the police discussing Angie, and other staff had to leave the unit searching for Amy. Any psychiatric unit would have struggled to apply 'normal' observation policies given this scenario.*"

23. In the result – at least in Dr Amin's opinion – the Defendant's accepted deficiencies in the zonal observations policy and the Defendant's failure to ensure the crisis observations protocol was properly implemented had no bearing on the outcome of the incident on 25 September 2013, and made no material contribution to Francesca's death.

24. So, despite the Defendant's acceptance of the breaches of duty alleged by the Prosecution (that is, (a) the difficulties associated with observing Zone 1; (b) the alterations to the zonal observations duty rota on 25 September 2013; and (c) a failure to implement the crisis observations protocol on 25 September 2013), in Dr Amin's opinion, even if crisis observations had been properly implemented, this would only have resulted in Francesca being observed irregularly six times per hour.

THE BASIS OF PLEA

25. In its written basis of plea dated 15 August 2022, the Defendant accepts there were difficulties associated with observing Zone 1 when it was split over two floors; that alterations to the zonal observations duty rota on 25 September 2013 meant that nobody was allocated to Zone 1 between two o'clock and five o'clock; and that it failed to implement the crisis observations protocol on 25 September 2013, in that the healthcare assistant responsible for Francesca in the event of a crisis occurring was not aware of her role in this regard.

26. The Defendant denies, however, that any or all of those failures were a significant cause of Francesca's self-harm which led to her death, for the reasons given by Dr Amin which I have just outlined.

THE DEFENDANT

27. The Defendant was incorporated on 11 May 2007; its principal activity is the operation of hospitals, including the Roehampton, providing in-patient and out-patient treatment in the areas of general psychiatry, addiction treatment, eating disorders and adolescent psychiatry. For the year ending 31 December 2020, the Defendant reported a turnover of £149.5 million, with a net loss of £20.8 million. For the years ending 2021 and 2022, turnover was £159.4 million and £161.4 million respectively, with net losses of £3.2 million and £14.3 million.

28. The Defendant has a single previous conviction on 9 January 2019 for similar offending in 2012, when a 14-year old patient ligatured at Priory Ticehurst House Hospital (the **"Priory Ticehurst"**). She died the following day. The patient had a known, recent, history of ligature attempts and/or indications which had given rise to her admission and had continued during her time at the Priory Ticehurst. Nonetheless, she had a scarf in her possession and unsupervised access to a recognised, removable, and replaceable ligature point. The Defendant's management of ligature points and ligature risks did not result in effective measures to reduce, as far as reasonably practicable, the risks to patients of serious self-harm and suicide. The Defendant was found to have High Culpability, Harm Category 3, and fined £300,000.

SENTENCING GUIDELINES

29. The Sentencing Council has issued a Definitive Guideline for Health and Safety Offences, which I have followed. The Guideline is applicable to all organisations and offences sentenced on or after 15 February 2016, regardless of the date of the offence.

Culpability

30. I find the Defendant's culpability to be Medium. It had in place systems for monitoring its patients, but these were not sufficiently adhered to or implemented. These failings were not minor, nor were they isolated. During Francesca's time at the Priory Roehampton, as I have mentioned, she self-harmed on no less than 27 occasions, eight of which involved the use of ligatures, including one on Monday 17 June 2013 which involved the use of tights. The Defendant's failures were highlighted by Dr Lord in his email of 13 September 2013, which I have also mentioned.

Harm

31. The seriousness of the harm risked by the Defendant's offending falls into the highest category, Level A, given the risk of death. Having considered Dr Amin's findings that, despite being a potential cause of Level A harm, ligaturing very rarely results in serious harm or injury, the only reasonable conclusion I can draw is that the likelihood of such harm was low. This leads to an initial harm category of Harm Category C3.

32. I must consider two further factors in the round before assigning the final Harm category: first, whether the offence exposed a number of members of the public to the risk of harm; and, secondly, whether the offence was a significant cause of actual harm.

33. I consider this offending exposed several individuals to the risk of harm, including Francesca. All nine of the patients on Emerald Ward that day were exposed to risk as a result of the Defendant's inadequate monitoring system. That number, while not insignificant, does not, in my judgment, justify any uplift.

34. As far causation goes, John Cooper KC, who appears with Sandesh Singh for the Defendant, relied upon Dr Amin's evidence to submit that I could not be sure that the offence was a significant cause of Francesca's self-harm which led to her death. In this sense, "significant cause" means one which more than minimally, negligibly, or trivially contributed to Francesca's self-harm; it does not have to be the sole or principal cause. To be sure that the offence was a significant cause of Francesca's self-harm which led to her death, I must be able to exclude any realistic or plausible possibility that she would have self-harmed anyway, absent any causative breach of duty on the Defendant's part.

35. In his evidence, Dr Amin said that, in the days leading up to the incident on 25 September 2013, the Defendant's records disclose Francesca's presentation was not of a high or escalating risk of suicide by self-harm. Her observation levels were appropriately reduced by Dr Lord from constant observation within eyesight to intermittent observation at 10-minute intervals during the day. As I mentioned, Dr Amin describes the events that occurred during the afternoon of 25 September 2013, which involved multiple patients self-harming or absconding and the police attending the unit, as highly unusual and unforeseeable. Dr Amin says it was impossible for normal observation policies (that is, intermittent zonal observations) to have been implemented in those circumstances, such that any shortcomings in respect of the zonal observations policy or its implementation at that time did not contribute to Francesca's death.

36. There was, thereafter, a failure to properly implement the crisis observations protocol. Dr Amin's opinion, however, is that, even if the crisis observations protocol had been implemented correctly, this would have led to Francesca being observed in accordance with intermittent observations that had been appropriately prescribed for her by Dr Lord: at 10-minute intervals, or six irregularly per hour as Dr Amin described to me. Mr Cooper KC submits it is a realistic possibility, which cannot be excluded to the criminal standard of proof, that Francesca would have self-harmed in the way that she did on 25 September 2013 between those "10-minute" intervals, even if the crisis observations policy had been properly implemented.

37. Having carefully considered Dr Amin's report and Mr Cooper KC's submission, I find that I cannot be sure that the increasing risk of harm arising was a significant cause of actual harm that resulted to Francesca.

38. It follows that there was a low likelihood of such harm arising, and that, therefore, the appropriate category is Harm Category 3.

Starting Point

39. The Defendant is large organisation, with a yearly turnover in excess of £50 million in each of the last three financial years.

40. The starting point for Medium culpability and Harm Category 3 for a large organisation is a fine of £300,000, with a category range of £130,000 to £750,000.

Aggravating factors

41. I do not consider the Defendant's previous conviction from 2019 to be a statutory aggravating factor. This is not a case where the Defendant has offended after a conviction.

42. However, the underlying offending for the conviction pre-dated this offending by only about a year and, as such, it indicates to me a trend in offending behaviour that I can properly consider as an aggravating factor, and I do. Having said that, there has not, to my knowledge, been any further offending behaviour since, which balances out this aggravating feature.

Mitigating factors

43. Mitigating features are the Defendant's voluntary closure of Emerald Ward and its co-operation with the authorities in the investigation which followed the incident. I also note the remorse express by the Defendant through Mr Cooper KC during the course of yesterday's sentencing hearing.

44. I recognise the substantial delay in bringing these proceedings, which to a large extent are the result of an extended coronial inquest touching upon Francesca's death. The inquest jury found that Francesca's death was contributed to by the Defendant's neglect, in that there were no observations undertaken in the lounge between five past four and twenty past four that afternoon. (I should add that that finding proceeded on a different basis to that applicable in this sentence.) This resulted in significant changes being made by the Defendant, with Emerald Ward being closed down.

45. I do not consider there are any other financial factors which impact upon the proportionality of the fine.

Credit

46. The Defendant pleaded guilty at the earliest opportunity, and I give it full credit for that plea.

SENTENCE

47. For this offence, I fine the Defendant the sum of £140,000. This will be paid through the Magistrates' Courts and must be paid within 28 days.

48. The Defendant will pay the applicable statutory surcharge, for which an order will be drawn up by the Court. The Defendant will also pay the Prosecution's costs to be assessed by me if not agreed.

49. Finally, I add this. No fine that I impose can ever reflect the truly awful loss suffered by Francesca's family. No family should ever have to go through a loss like that. Daniel's hope out of it was that the Defendant would finally take stock of the situation which he set out in his victim personal statement and make tangible changes to benefit the health and safety of the patients in its care. Thankfully, lessons do appear to have been learned by the Defendant in the changes which it has since made at the Priory Roehampton.