Staffordshire
POLICE

Mid Staffordshire NHS Trust

A report into the Police-led multi-agency review of the high mortality rates at the Trust between 2005 and 2009

Report by Staffordshire Police

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Foreword

This report has been produced by Staffordshire Police following more than 18 months of work with partners and agencies to review incidence of high mortality rates at Mid Staffordshire NHS Trust between January 2005 and March 2009.

The report could not have been completed without the support and assistance of those bodies that we worked with during this time, and in particular our colleagues at the Health and Safety Executive.

Staffordshire Police took the decision to review the incidence of high mortality rate at Mid Staffordshire NHS Trust following publication of the Francis report in 2013. Our decision was driven by the damning findings in the report, and the palpable concern of the families and the Staffordshire public.

Throughout the process of the review we have maintained regular contact with the families of those patients who died. Indeed, supporting the families throughout this process has been a priority for this police force.

True to this, in writing this report we have maintained the anonymity of those patients whose cases we examined, but whose deaths were not subject to criminal proceedings. In these cases we have referred to their case number. Where the death of the patient resulted in a prosecution, and the associated publicity, we have named them.

Prior to publication of this report we have shared the findings with the families of those whose cases we examined in more detail. I would like to thank them for their patience, and for the support they have given our officers in conducting the review.

Finally, I would like to extend my thanks to those officers who undertook the review and examined thousands of documents, often containing quite distressing details, relating to the 214 individual deaths that we have examined in this review.

Deputy Chief Constable Nicholas Baker
Staffordshire Police

Introduction

The failure of care at Mid Staffordshire NHS Foundation Trust in the mid to late 2000s is widely regarded as one of the great scandals of the National Health Service (NHS).

It is self-evident that a catalogue of organisational and individual failings took place over a number of years, and these failings have been well documented in reports from several official inquiries.

Given the "appalling care"[1] the Francis Inquiry uncovered, and the high mortality rates at the Trust, Staffordshire Police, working with a number of partners and other agencies, undertook to review deaths at the Trust between January 2005 and March 2009, to determine whether criminal investigations were required.

As of 16 December 2015 criminal prosecutions against the Trust have now concluded. There were two prosecutions brought by the Health and Safety Executive (HSE) for health and safety failings, involving the Trust exposing five patients (three from the review period[2]) to risk, which were causative of at least four deaths (the evidence was not sufficient to determine causation in the fifth case)[3].

Now that prosecutions have concluded, it is timely to report in detail on the process by which Staffordshire Police and the agencies it worked with reviewed the deaths at Mid-Staffordshire NHS Trust; the approach taken by the review team and the quality assurance process that was put in place; the outcome of the review; and, finally, our observations on the lessons for the police and other relevant agencies.

1 As described by Robert Francis QC, Chair of the 2013 Public Inquiry into Mid Staffordshire NHS Foundation Trust

2 The cases of Gillian Astbury, Ivy Bunn and Lillian Tucker

3 The cases of Patrick Daly and Edith Bourne; in the case of Edith Bourne the evidence was insufficient to determine causation.

Background

Mid Staffordshire NHS Trust was granted foundation trust status in 2008. The Trust was responsible for two local hospitals – Stafford Hospital and Cannock Chase Hospital. The Trust's 3,000 staff served a population of more than 320,000 people covering the Stafford, Cannock and Rugeley areas.

Quality of care at the Trust first came under scrutiny in 2008, when the healthcare regulator at the time, the Healthcare Commission, undertook a review of emergency care at Stafford Hospital, following reports of higher-than-expected mortality rates.

Amongst many criticisms, the Commission set out its belief that the Trust had focused far more on meeting the financial and performance targets necessary to achieve foundation trust status than it had on patient care.

As the Healthcare Commission report was being prepared, the Secretary of State for Health and the foundation trust regulator, Monitor, commissioned an independent clinical review of emergency services at the Trust, by Prof Sir George Alberti. Alongside this, a separate but related review, under Dr David Colin-Thomé, was launched into why other parts of the healthcare system responsible for overseeing the performance of the Trust, namely the South West Staffordshire Primary Care Trust and West Midlands Strategic Health Authority had been, apparently, unaware of the issues emerging at the Trust.

Both reports were published in April 2009: Alberti made 23 recommendations for improvement at the Trust; Thomé's review found that while nationally recognised approaches to managing performance had been followed, local indicators were missed.

Following these reports the Secretary of State announced a further inquiry, chaired by Sir Robert Francis QC, in July 2009.

Francis' initial report, published in February 2010, made 18 local and national recommendations, including that Monitor revoke the Trust's foundation status.

The Secretary of State then commissioned a further inquiry into the arrangements for commissioning, supervising and regulating foundation trusts.

Following the 2010 election, the new government announced a full Public Inquiry, again under the chairmanship of Sir Robert. His report, published in 2013, set out starkly how poor standards of patient care had existed at all levels

throughout the Trust; in the introduction to the Report he states: "the story it tells is first and foremost of appalling suffering of many patients"[4].

Given the finding of the Francis Review, the high mortality rates at the Trust, and the public outcry, Staffordshire Police took the decision to conduct a proactive, detailed and thorough review of deaths at the Trust, with the aim of identifying whether criminal investigations against the Trust, or any of its employees, was warranted. Nicholas Baker[5], Assistant Chief Constable (ACC) for Staffordshire Police at the time, was tasked with overseeing the police response, and declared the review a 'critical incident'[6], as defined by the Association of Chief Police Officers (ACPO)[7].

To ensure that the police could undertake the review effectively, ACC Baker established a 'Gold' Group[8], with representatives from those partners and agencies that could provide expert input into the review of the Trust. The Group met for the first time on 15 February 2013, and then eleven times subsequently, and all decisions were recorded, distributed and agreed.

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4 2013 Public Inquiry into Mid Staffordshire NHS Foundation Trust

5 Now Deputy Chief Constable at Staffordshire Police.

6 A critical incident can be declared for 'any incident where the effectiveness of the police response is likely to have a significant impact on the confidence of the victim, their family and/or the community', as defined by the College of Policing in its authorised professional practice

7 Now superceded by the National Police Chiefs' Council (NPCC).

8 A Gold Group is a meeting designed to add value to the police response to an incident, crime or other matter. This involves bringing together appropriately skilled and qualified internal or external stakeholders who can advise, guide or otherwise support the management of an effective response to the identified incident, crime or other matter.

Preparing the review

The Gold group was chaired by ACC Baker, and included representatives from those organisations that ACC Baker believed would contribute to the review process[9]. Primary representatives included:

- Nic Rigby, Principal Inspector (Health and Safety Executive)
- Mary-Clare Grant, Unit Head (CPS Crown Prosecution Service, Special Crime Division)
- Andrew Haigh, Senior Coroner (HM Coroner – Staffordshire South)
- Andy Davies, Compliance Manager (Care Quality Commission, Central Region)
- Jill Williams, Employer Liaison Advisor (General Medical Council)
- Sarah Page, Director of Fitness to Practice (Nursing and Midwifery Council)
- William Vineall, Deputy Director (Dept of Health – CQC Sponsorship & Quality Regulation)

The terms of reference for the Gold Group were established and agreed at the first meeting of the Group in February 2013. In summary, its task was to gather, and thoroughly review, all relevant material relating to the deaths of patients at the Trust, in order to determine whether a formal investigation of the circumstances was necessary. A key role of the Group was to ensure that the families of those patients who had died during the review period were kept informed of progress. The full terms are set out in Appendix A.

A central decision of the Gold Group was to agree the parameters for the review, and specifically the time frame. Given the large number of deaths that will take place at any hospital, it was agreed by all parties at the initial meeting of the Group that there was a strong rationale for matching the period covered by Sir Robert in his Public Inquiry – namely, patient deaths between January 2005 and March 2009[10]. This was accepted as the period during which there was believed to be higher than expected mortality rates at the Trust, and was

9 A representative of Staffordshire's Police & Crime Commissioner was present as an observer. There were also a number of regular attendees on behalf of different departments within Staffordshire Police, including Detective Chief Superintendent Laurence Whitby-Smith, Head of Crime, Chief Superintendent Jon Drake, local policing, and Ian Fegan, Head of Communications; in addition to those involved in delivering the review itself.

10 Gold Group meeting held on 15 February 2013

commonly used by all those who had previously reviewed standards at the Trust.

The Staffordshire Police Major Investigation Department[11] was tasked with undertaking the review. Given the complexity and sensitivity of the work, a small, dedicated team was established which had the knowledge and understanding to work methodically and with consistency through the substantial number of cases, and the information associated with each one, and would be able to build a relationship with the families of those who had died.

The team was made up of a small number of highly trained officers, led by a detective inspector (the senior investigating officer or SIO) and supported by a detective sergeant and three detective constables. All had relevant 'PIP'[12] accreditation, homicide investigation backgrounds, substantial family liaison experience, knowledge of the coronial process, and experience working on health and safety prosecutions. Details of the individuals involved in the investigation are set out in Appendix B.

In preparation for the review, in February 2013 Staffordshire Police sought specialist guidance[13] from the Crown Prosecution Service (CPS) Special Crime Division in those areas of criminal law that would mostly likely apply, if the

11 Now called Major and Organised Crime Department

12 The Professionalising Investigation Programme (PIP) ensures that officers are trained, skilled and accredited to conduct the highest quality investigations.

13 See Appendix C: CPS guidance note on gross negligence manslaughter and corporate manslaughter (both common law and that defined by the 2007 Corporate Manslaughter and Corporate Homicide Act)

review were to lead to formal criminal investigations. This included the offence of misconduct in public office, and the law around gross negligence manslaughter and corporate manslaughter (both common law and that defined by the Corporate Manslaughter & Corporate Homicide Act 2007). The Health and Safety Executive (HSE) representative on the Gold Group provided guidance on relevant health and safety legislation.

The guidance provided by the CPS on the offence of misconduct in public office outlined 'the very high threshold of misconduct required'[14]. This guidance note concluded that 'the fact… a public officer has acted in a way that is in breach of his or her duties, or which might expose him/her to disciplinary proceedings, is not in itself enough to constitute the offence.'

The guidance on gross negligence manslaughter made clear that to be successful in a prosecution, four 'tests' would need to be proved: that there was a duty of care; that the duty of care was breached; that the breach caused the death; and that the defendant's neglect was gross, showing a disregard for the life and safety of others that it was 'appalling' or 'abysmal'. Mistakes – even very serious mistakes – were insufficient grounds for a prosecution.

Similarly, for common law corporate manslaughter, the above tests would need to be applied to an individual of such seniority within the Trust that they could be determined as a 'controlling mind'– and who had breached the duty of care, to have caused the deaths, and to be negligent to the level of 'gross'.

Under the Corporate Manslaughter and Corporate Homicide Act 2007, CPS guidance indicated that similar tests to those set out above would be required, albeit an accumulation of the way things are managed or organised by a number of individuals at the Trust may be sufficient, as long as the individuals can be proven to be senior management. Under this legislation, which was not retrospective and came into force in April 2008, any action would only apply to a minority of the cases covered during the review. The maximum punishment under this legislation was an unlimited fine against the organisation or company found guilty, as well as a publicity order[15].

With this guidance in mind, ACC Baker instructed the review team to examine all of the deaths, individually, which occurred during the review period against a set of criteria. With limited precedents, these criteria, set out in detail in the next section, provided direction to the review team in prioritising the patient deaths to be reviewed.

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14 See Appendix D, CPS guidance note on misconduct in public office

15 See Ministry of Justice guide: http://www.hseni.gov.uk/guidetomanslaughterhomicide07.pdf

To record the work of the review team all information and records relating to the deceased patients were placed in the Home Office Large Major Enquiry System (HOLMES), which is routinely used by all UK police forces for major investigations, and Major Incident Room Standardised Administrative Procedures (MIRSAP) was adopted, in line with policing guidelines.

From the outset Staffordshire Police was clear that robust quality assurance processes should be in place. To support this, ACC Baker requested the assistance of Merseyside Police, who agreed in August 2013 to provide independent quality assurance[16]. This would take two forms: an initial peer review of the proposed methodology of the review; and a peer review of a sample of the individual case files that were presented to the multi-agency panel.

16 See Appendix E: Merseyside Police terms of reference

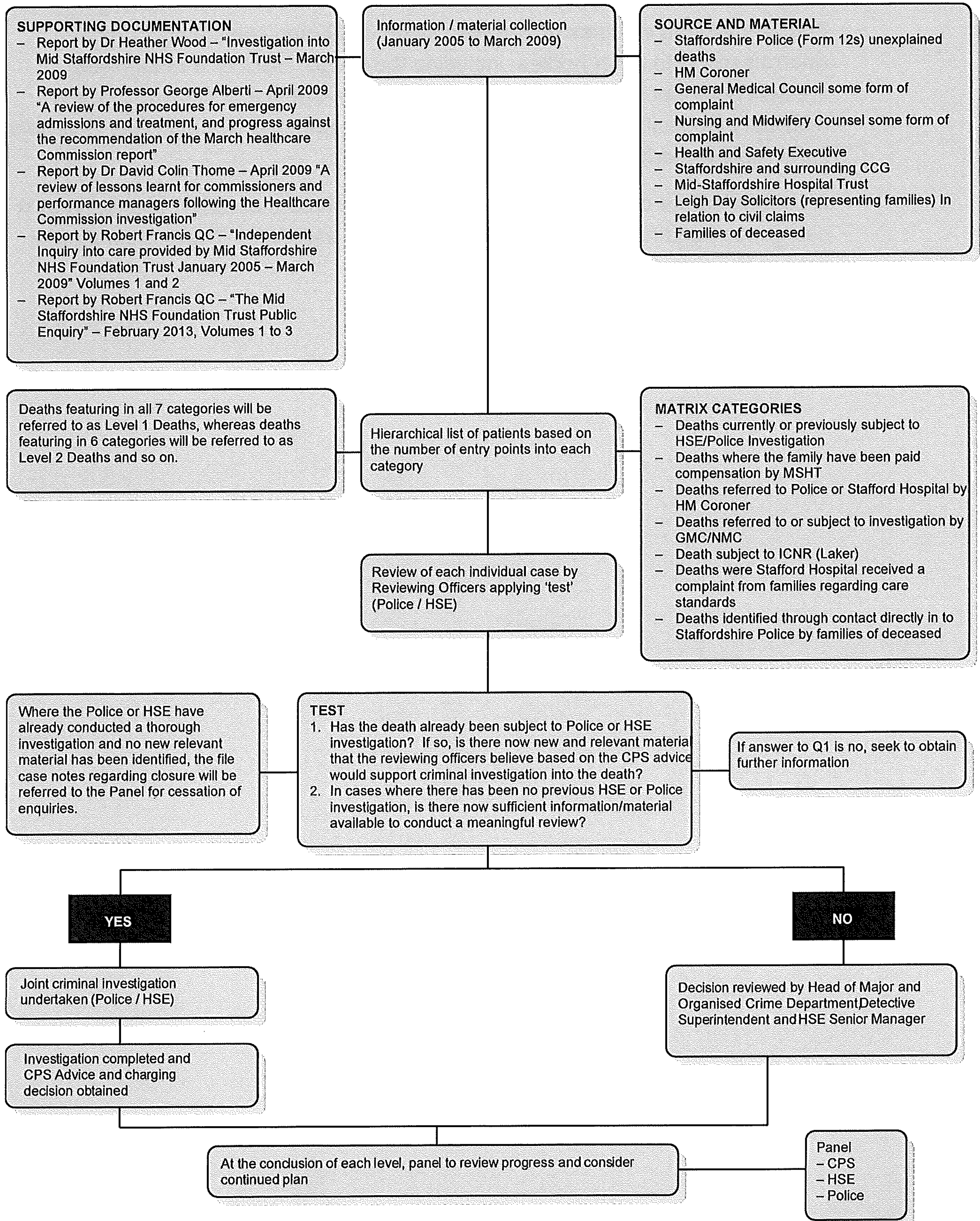
The review process

Between January 2005 and March 2009, the coroner recorded 2,510 patient deaths at Stafford hospital[17]. The task of the review team was to assess the information available surrounding each death, and establish which should be examined in further detail given the information available; given the volume of information this was the only means available to the team to focus the review on those deaths that could potentially lead to criminal prosecutions.

The process was developed by the review team, approved by ACC Baker, and noted by Gold Group at its meeting on 3 October 2013. It was felt that the approach would enable the team to prioritise those patient deaths that might result in further police or HSE action. This process map is set out diagrammatically overleaf.

17 A total of 4,253 deaths took place during this time; the Coroner examined 2,510 of these.

Plan for review of deaths at Stafford Hospital



The process set out clearly all of the information sources that would be referred to against each of the 2,510 patient deaths. This included information gathered from the various inquiries undertaken since 2009, and complaints or legal referrals made to other bodies, including the police, HSE, or a recognised medical body (for example, the General Medical Council or the Nursing and Midwifery Council). It also included information gathered by Leigh Day Solicitors (who represented the majority of the families).

A central feature of the process was the establishment of seven criteria ('matrix categories') against which each death could be assessed. These criterion are set out in Table 1.

Table 1

Matrix Category
Deaths currently or previously subject to Police/HSE investigation
Deaths where the next of kin has been given financial compensation by the Trust
Deaths referred to the Police or Trust by HM Coroner
Deaths referred to or subject to an investigation by the GMC or NMC
Deaths previously subject to an Independent Case Note Review
Deaths where the Stafford Hospital received a complaint from families regarding care standards
Deaths identified through contact directly into Staffordshire Police by families of the deceased

Using HOLMES to map each case against the categories above, it was the intention of the review team to prioritise those cases that appeared in multiple categories, as these would, by their nature, be more likely to require further investigation.

Of the 2,510 patient deaths, 214 were matched against one or more of the above categories. Table 2 sets out the distribution of the 214 cases against each category.

Table 2

Matrix Category	Number of patient deaths
Deaths currently or previously subject to Police/HSE investigation	3
Deaths where the next of kin has been given financial compensation by the Trust	30
Deaths referred to the Police or Trust by HM Coroner	25
Deaths referred to or subject to an investigation by the GMC or NMC	15
Deaths previously subject to an Independent Case Note Review	155
Deaths where Stafford Hospital received a complaint from families regarding care standards	87
Deaths identified through contact directly into Staffordshire Police by families of the deceased	1

Note: the table above 'double counts' cases, as one patient can appear in multiple categories.

The category that incorporated most cases was deaths previously subject to an Independent Case Note Review (ICNR). According to the Royal College of Pathologists, ICNRs provide an independent expert opinion on whether the management of a case has met the relevant standards of care[18].

In the cases above, a significant proportion of the ICNRs were overseen by Dr Mike Laker, on behalf of approximately 60 families concerned about the circumstances surrounding the death of a family member following publication of the original Healthcare Commission report in 2009. The rest were undertaken by clinicians appointed by the Primary Care Trust[19], subsequent to Dr Laker's initial work.

One of the immediate issues faced by the review team was the significant challenge the team faced accessing ICNRs from the two clinical commissioning groups (CCGs): Stafford and Surrounds CCG and Cannock Chase CCG, who were now responsible for their stewardship.

Due to patient confidentiality and the need to protect sensitive personal data, the CCGs would not release contact details for the families without express consent. The review team agreed a process that, although time-consuming was appropriate when dealing with sensitive material: the CCGs would approach relevant next-of-kin; with their consent contact details would be passed to the review team to then approach the families for consent to examine the relevant ICNR; only then would the CCGs release the document.

The complexity of gathering the information, working with the different authorities, locating and liaising with the affected families, meant that the process took several months and significantly extended the timeframe of the review team.

Given this, the SIO took the decision to undertake a review of each death in any category, based on the information available.

Each member of the review team was given a caseload and, working to the process set out earlier, undertook an evidential review based on the information available and the legal guidance provided by the CPS.

This information included any (and all) of the material that was held under any of the above matrix categories that had been triggered for a patient. This included previous statements taken by the police or HSE, advice files to CPS, civil statements made by family members, Sudden Death Reports and

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18 Royal College of Pathologists, Guide to Independent Case Note Reviews March 2014

19 Primary care trusts were abolished and clinical commissioning groups established by the Health and Social Care Act 2012

corresponding documents, records of GMC and/or NMC Investigations, ICNR documents, and correspondence relating to complaints.

Their findings were then presented in a summary document, reviewed by the SIO to ensure consistent rigour across all cases, and then presented to a panel established by the Gold Group, comprising representatives from the police (including the SIO and the Head of Major & Organised Crime Department) and the HSE's Principal Investigator.

The panel scrutinised the information provided by the review team, asked pertinent questions and, where necessary, requested further information from the reviewing officer. The panel would then recommend one of three possible outcomes for each of the cases with which it was presented:

- No further action[20]
- Further action required by the police
- Further action required by the HSE

The panel's decision was then reported to the families by the review team, either through correspondence or through personal contact by the relevant officer from the team.

Throughout this process, Merseyside Police provided peer review of a random sample of 10 per cent of the cases, to review consistency of the decision making process, and the application of legislation, in line with their agreed quality assurance role.

Of the 21 cases that Merseyside Police reviewed, they agreed with the review team's findings in 16 cases. In a letter to Staffordshire Police on 11 June 2015, via the NPCC, Merseyside Police set out their observations on five specific cases[21], covered in the next section.

20 No further action: this is an accepted police term, usually provided if there is insufficient evidence to take the case further

21 See appendix F: NPCC letter re. Mid-Staffordshire General Hospital – Peer Review by Merseyside Police

Outcomes

As has been referenced earlier, the volume and complexity of the review, the challenge of overcoming data protection and accessing personal records, the need for rigour and assurance in each case, and the desire to keep families regularly informed, led to a lengthy and iterative process.

In total, the panel met on 12 occasions between October 2013 and November 2014, and reviewed the information available for a total of 214 patient deaths.

At the conclusion of the review process the following decisions were taken:

- 192 required No Further Action
- 12 required further action, or clarification of findings, by the police
- 11 required further action, or clarification of findings, by the HSE.

NB: one case required further joint action by the police and HSE and is, effectively, double counted in the bullets above.

Cases requiring further police action

This section sets out the background behind each of the 12 cases that required additional clarification from the police; a brief explanation of the case is provided, alongside an explanation of what was requested by the panel and the clarification provided to enable the panel to conclude each case.

Patient 2613: was admitted to hospital following a collapse at home. He suffered from high blood pressure and chronic lung disease; 9 years previously he had suffered a stroke. He died 15 days later and cause of death was given as aspiration pneumonia and posterior circulation stroke.

On his initial assessment a CT scan was requested but never carried out and this failing was highlighted within the ICNR, which made two recommendations to the trust.

The reviewing panel requested that the CQC provide reassurance that recommendations made in the patient's ICNR, including the introduction of a stroke assessment unit and the use of CT scans within 24-48 hours of suspected stroke, had been implemented. The reviewing officer contacted CQC to understand better the arrangements at the Trust; the CQC confirmed that a stroke team now worked on the wards. This update was sufficient to satisfy the review panel at a subsequent meeting.

Patient 2530: was admitted to Stafford Hospital with severe pains in his head, having collapsed at home. He had suffered a stroke and his prognosis was clearly poor; he died eight days later, with cause of death given as non-traumatic intra-cerebral haemorrhage.

Although unrelated to this patient's death, and not leading to any injuries, ICNR and civil action documentation referred to an 'assault' on this patient by a fellow patient. The review panel requested additional work to understand how the Trust responded to patient assaults. This further work established that an incident reporting policy was in place at the time and provided clear instructions when such an incident occurs. A copy of this policy was sufficient to conclude the case at a subsequent panel meeting.

Patient 62: was initially seen as an outpatient, before being admitted to hospital and subsequently undergoing an operation to remove a tumour. Her condition deteriorated and ultimately, in view of the medical team, recovery was so unlikely that continued treatment was not in her best interests. Respiratory support was withdrawn resulting in the patient's death. At the subsequent Inquest cause of death was given as adult respiratory distress syndrome and right hemicolectomy for carcinoma of colon; chronic obstructive pulmonary disease.

The review panel requested further police action to review the process that was followed when deciding to withdraw respiratory support, given the family's belief that no consent had been given. The review officer presented the Trust's policy for decisions relating to cardiopulmonary resuscitation, including the use of Do Not Attempt Cardiopulmonary Resuscitation Orders. This was supported by the ICNR, which clearly stated that the decision to withdraw treatment was correct and was fully recorded in the medical notes. With this additional investigative work concluded, the review panel accepted that, while there had been a misunderstanding between the family and the medical team, the information provided was sufficient to conclude the case.

Patient 84: was initially seen as an outpatient, discovered to have cancer of the rectum, and subsequently admitted to hospital and undergoing surgery. It was also established that he suffered from ischaemic heart disease. The patient never fully recovered, suffered a number of setbacks before passing away. An Inquest took place and cause of death was given as pulmonary oedema, acute renal failure and hypertensive heart disease; abdominal-perineal resection for carcinoma of rectum.

This patient's ICNR made reference to claims by the family that three nurses had completed incident forms stating that, in their view, the patient had been transferred from Intensive Care too early. The panel requested that the review team try and locate the incident forms and establish if this was an issue raised

at the Inquest. This additional work uncovered an incident report form in relation to the failure of the Prismu machine being used to treat the patient; three members of staff are named on this form. The reviewing officer also listened to the audio recording of the Inquest; the family do not mention incident reporting forms but did state that some nurses felt that the patient had been moved too early and should have been kept in Intensive Care for longer. These questions were directed at, and answered by, a Trust clinician during the Inquest. This additional investigative activity satisfied the panel and the case was concluded at a subsequent meeting of the panel.

Patient 950: was admitted to hospital via the A&E department following a fall at his home. He suffered a number of injuries and underwent numerous treatments and contracted infections over the following weeks before his death three months after the fall. Cause of death was given as sepsis, bedsore and immobility, and frailty following clostridium difficile; fast atrial fibrilation, fractured humerous displacement.

Following this patient's death, the GMC had been asked to investigate the clinician involved. The GMC investigation had concluded that that there would be no further action taken against the clinician. The review panel requested that contact was made with the GMC to establish what material they had reviewed and ensure that they had been able to access the ICNR. The GMC confirmed that their investigation reviewed several documents including the ICNR. This confirmation reassured the panel and the case was concluded.

Patient 1903: was admitted to A&E following a fall at her home address where she sustained a fracture to her left femur. She had a history of respiratory problems with repeated chest infections and lung fibrosis. The patient died just three days later and at Inquest, cause of death was given as pneumonia, bronchiectasis and usual interstitial pneumonitis; fractured neck of femur.

At the Inquest HM Coroner expressed concern about the treatment provided and contacted the Trust under Rule 43[22] of the Coroner's Rules in connection with their responsibilities to take action to prevent further deaths. The review panel requested further work to establish what the Rule 43 commented on and what the response from the Trust was. This established that HM Coroner specified concerns relating to two key areas: a) the delayed communication between medical and nursing staff regarding recommencement of feeding, drinking and oral medication administration when the decision was made to

22 Coroners' Rule 43: One of the powers available to a Coroner was the power to make a Rule 43 Report. If the Coroner feels that the evidence gives rise to a concern that circumstances creating a risk of other deaths will occur or continue to exist, he/she may make a Rule 43 Report which is sent to the organisation that has responsibility for the circumstances. Now replaced on implementation of the Coroners and Justice Act 2009 with Reports on Action to Prevent Future Deaths (PFD)

postpone surgery; and b) the workload of the junior doctor during the weekend period.

The review officer was provided with the detailed response submitted to the Coroner by the Trust, which addressed the above issues and set out the subsequent activities that had been implemented and on-going action plans. This update satisfied the panel and the case was concluded.

Patient 1282: suffered from recurring cancer of the pancreas. He was admitted to hospital with abdominal symptoms and died unexpectedly only 14hrs after arrival. There was no post-mortem examination, cause of death being recorded as bowel obstruction, carcinoma of pancreas, and diabetes and hypertension.

In this case the reviewing officer examined material relating to the ICNR and also papers relating to a civil claim. The concerns from the family were highlighted in these documents. When the matter came to the panel, surprise was expressed that there had not been an Inquest and clarification of Inquest procedures was requested. This issue was subsequently addressed by a response from the SIO, who had sought guidance from the Coroner's Office and also the Coroner, which was provided. This additional detail enabled this case to be finalised at the next meeting of the panel.

Patient 237: had previously been subject to a surgical procedure to remove a tumour behind his eye. While still taking steroid treatment for this surgery, the patient was involved in a serious road traffic accident. Following the collision the gentleman was taken to hospital, where no steroid treatment was provided, and died two days later. At the Inquest cause of death was given as multiple injuries in association with myocardial fibrosis and lack of steroid therapy.

The team reviewed the Coroner's material and a police sudden death report, along with correspondence relating to a civil claim. The reviewing panel instructed that the Coroner be contacted in order to fully understand the significance of the failure to receive the steroid treatment and the link to the patient's death. The response from the Coroner was that the words he used were phrased in such broad terms because precise assessment was impossible. The reviewing officer also provided further details from statements provided by a number of clinicians that suggested this omission had made some sort of contribution but nothing further could be established. As a result of this information the panel concluded this case at a subsequent review panel.

Patient #1853: was admitted as a medical emergency; she was breathless and had a low level of oxygen in her blood. Within hours of being admitted the patient passed away. Cause of death was given as pulmonary oedema, left ventricular hypertrophy.

The only material available for this case was the ICNR, which was very critical of the care and treatment of the patient. The panel requested that further contact be made with the family to establish greater detail about any action taken to try and address the issues raised by the ICNR. The officer established that the Trust had accepted some of the criticism detailed within the document and had implemented new procedures. The family also stated that they had taken legal advice and had been informed that they were unable to take action against the Trust. In these circumstances the panel felt that all avenues had been exhausted and at the next panel meeting the matter was finalised.

Patient 3021: a young child, arrived at Stafford Hospital after her parents had initially rung the emergency doctor, but with their concerns growing over a rash rang 999 prior to the arrival of the doctor. The attending Paramedics noted a series of symptoms including the rash; they stated that they did not suspect a meningococcal rash but arrangements were made for admittance to Stafford Hospital where further tests and assessments commenced. The child was initially suspected of having a viral infection; however an increasing number of non-blanching spots appeared on her body and despite intensive care treatment, and being transferred to the University Hospital of North Staffordshire, she tragically died the following day.

There was no post-mortem or Inquest; cause of death is recorded on the certificate as multi organ failure, septicaemia – purpura fuminani.

The reviewing officer examined documents and correspondence from the patient's family relating to a civil claim. When this case was presented to the panel they requested further work to understand more fully the involvement of the Coroner, pathology and any police response. As a result of this request it was established that a death certificate was issued by the Trust. It was treated as death due to natural causes and the concerns of the family about a delay in diagnosis were not known until a significant time later. There was no involvement from the Coroner or police. As there were no outstanding matters, the case was concluded at the next panel meeting.

Patient 2167: this patient was admitted to hospital with a history of shortness of breath and right sided chest pain. It was recorded that she suffered from chronic obstructive pulmonary disease (COPD).

Unfortunately issues relating to her severe COPD worsened and she died the following day as a result of her condition. There was no post mortem carried out.

During her short admission, three chest drains were inserted and the corresponding ICNR stated that the overall management of her chest drains did not demonstrate good care.

It was also noted within the ICNR that the British Thoracic society had issued recommendations stating that the hospital should implement a local chest drain policy for the safe insertion and management of chest drains.

As a result, the Panel requested that further work was undertaken to establish if this recommendation had been progressed. This was subsequently referred to the CQC who were grateful to the review team for drawing the report to their attention; as a result they carried out further patient reviews and also included this issue in future inspections.

This case was the concluded with no further action required.

Patient 2510: had fallen from his bicycle on Cannock Chase, sustaining painful abdominal injuries. He was then taken by ambulance to Stafford Hospital, where he was assessed and examined prior to being discharged later that evening. The following day, after becoming acutely unwell at home, he was admitted Leicester Royal Infirmary where he subsequently died.

The circumstances of this patient's death were subject to criminal investigation by Staffordshire Police at the time, and to a second Inquest while the review process was being undertaken.

The review officers examined a vast amount of material relating to this case. At an initial Inquest held in 2007, a finding of accidental death with a narrative verdict was presented. The patient's family campaigned relentlessly against the findings and verdict of this Inquest. They brought a successful civil claim and fought for a second Inquest and subsequently reported matters to the health authorities and Staffordshire Police. As a result, the Major Investigation Department undertook a review of the evidence, including an independent clinical review and engaged the CPS, who allocated a Specialist Crown Prosecutor.

This work concluded with the Specialist Crown Prosecutor's conclusion in October 2011 that the basic elements of causation for an offence of gross negligence manslaughter could not be satisfied (nor could 'grossness'), nor could possible offences of Perverting the Course of Justice or Misconduct in Public Office. As a result the matter was not pursued further.

At the time of this review process the panel were aware that a second Inquest had been granted and was to be held in 2014, where on the 26 September the Coroner delivered a lengthy and detailed 17 page narrative verdict[23] that

23 Summary of the Coroner's findings at http://coroners.leicester.gov.uk/completed-inquests/?entryid78=131858&p=15&char=M

highlighted 11specific areas. The reviewing officer from Staffordshire Police attended throughout the Inquest.

The verdict and evidence presented at the Inquest was then examined, to ascertain whether the earlier decision by the CPS should be reviewed. This was undertaken and the panel agreed that, as no new evidence had come to light, it was not appropriate to submit the case again to the CPS[24] and the panel concluded the case.

Cases requiring further HSE action

For the 11 cases that the review panel requested additional review by the HSE, all relevant material was taken by the HSE Principal Investigator for detailed examination and consultation with HSE medical experts. In eight cases the HSE returned to the review panel and set out the HSE's rationale for undertaking no further action:

Patient 265: attended hospital through A&E, with suspected deep vein thrombosis; before being seen by a clinician, the patient had a fit, suffered a cardiac arrest and died. Following post-mortem, cause of death was given as pulmonary thromboembolism – due to (or as a consequence of) deep vein thrombosis.

An Inquest subsequently took place before a jury; their verdict and conclusion was that "the jury believe that the lack of care provided prior to 2210hrs fell far short of that expected, and in our opinion was just short of gross". HM Coroner also wrote to the hospital Chief Executive in accordance with Rule 43 highlighting several issues in his criticism of the incident.

HSE confirmed to the review panel that, following review, the death fell outside the scope of HSE's remit and, as such, would not be taking this forward to investigation.

Patient 2454: was admitted to hospital following presentation at A&E complaining of sudden onset of dizziness and nausea; he had a known medical history. In hospital his condition deteriorated and he also suffered a fall from his bed. Within a few days he was placed on a palliative care pathway and died a few days later. A post mortem gave cause of death as cerebellar haemorrhagic infarct, and ischaemic heart disease.

24 As did the HSE, who alongside the police reviewed the second Inquest report to ascertain whether this would lead to action under health and safety legislation. See next section.

The HSE confirmed to the review panel that, following review, the death fell outside the scope of HSE's remit and, as such, would not be taking this forward to investigation.

Patient 2558: was admitted to hospital with worsening pain in her hip. She also suffered from Parkinson's disease and dementia. Five weeks after being admitted, the patient died with cause of death given as advanced Parkinson's disease and advanced dementia.

The review panel felt that there were issues relating to non-adherence to a nutritional assessment plan for the patient that warranted further consideration by the HSE. The HSE concluded that the matters related to clinical care, and did not demonstrate the degree of management failings that would result in it being appropriate for the commencement of an HSE investigation.

Patient 2443: was described as having complex underlying medical problems with his heart and chest. He was admitted to hospital following a fall at his home address and there were also a series of further falls while in hospital, despite falls assessments being in place. Four months after his initial admittance, the patient died. A post-mortem gave cause of death as acute myocardial ischaemia and emphysema, fractured neck of the femur, atheroscleererosis.

The review panel felt that HSE should examine the care of the patient further, and the issue of the falls assessment. HSE confirmed to the panel that, having examined the documentation relating to this case, it was a clinical care matter and did not demonstrate a degree of management failing that would result in it being appropriate for an HSE investigation.

Patient 2087: had a background of osteoarthritis in both knees, gout and alcohol dependence and was admitted as an emergency to hospital with decompensated alcoholic liver disease.

After initial improvement the patient was diagnosed as being MRSA positive and never recovered, passing away 6 weeks after admittance. Cause of death was given as MRSA and septicaemia; gram negative spontaneous bacterial peritonitis and severe decompensated alcoholic liver disease; alcoholic hepatitis.

There was no post-mortem or Inquest.

The review panel felt that the issue of MRSA and infection control warranted further examination by the HSE. HSE found the evidence to link the patient's MRSA infection to the work activity to be weak and insufficient. The family solicitor's own expert medical report only stated the *likelihood* of the disease being contracted because of failures which would amount to management issues as being likely on the balance of probabilities. In the view of the HSE the likelihood of evidence being available this long after the incident that would

strengthen this expert opinion was very remote, and as such would not be taking forward an investigation.

Patient 2529: was admitted to hospital following a severe left sided stroke and fall at his home address. Four days after being admitted he was transferred to Cannock hospital where he suffered a further fall whilst sitting on a chair next to his bed. He was subsequently returned to Stafford Hospital where he died two days later.

Cause of death was given as right middle cerebral artery infarct and atrial fibrillation.

The review panel felt that the fall incident warranted further consideration by the HSE. Whilst there appeared to be clear failings in the care given to the patient, the HSE felt the evidence was insufficient to link his death to the 'falls' incident, and would not, therefore, satisfy HSE's criteria to commence an investigation.

Patient 3014: had been admitted to hospital on several occasions with severe back pain. He was elderly, deaf and had very poor eyesight. He suffered from multiple falls while at hospital and was also diagnosed with MRSA. When he sadly passed away, the cause of death was given as bronchopneumonia, depression and high-grade non-hodgkin's lymphoma.

The review panel request that the HSE give further consideration to the issue of the falls. Although the HSE recognised there were failings in the care provided to the patient, it found that the evidence was insufficient to link his death to the 'falls' incident and therefore would not satisfy HSE's criteria for investigation.

Patient 2510: *See earlier entry for background.* Following the review panel's request that this case be reviewed (alongside a further review by the police), HSE confirmed that, while in their view his death arose from poor clinical judgement (in respect of his triaging, subsequent treatment by medical practitioners and discharge) they found no evidence to suggest that his death arose from systemic failures in the management of health and safety, and as such would not be taking forward an investigation.

Cases subject to health and safety prosecutions

In the three remaining cases, full HSE investigations have been undertaken into the deaths of Gillian Astbury, Ivy Bunn and Lillian Tucker.

In the case of Gillian Astbury, 66, who suffered from diabetes at the time of her death in 2007, the Trust was accused of failing to provide the insulin necessary to keep her alive. The HSE launched a criminal prosecution in 2013 against Mid-Staffs NHS Foundation Trust for systemic and fundamental failures under the Health & Safety At Work Act. The Trust admitted liability from an early

stage, and was fined £200,000 for what the judge described as "the wholly avoidable and tragic death of a vulnerable patient".

In November 2015, the Trust (which in 2014 had been placed in special administration and is now effectively a shell organisation[25]) admitted liability for contravening health and safety legislation in the case of Ivy Bunn and Lillian Tucker. Ivy, 90, died in 2008 after being admitted to the Trust following a fall at her home, and then suffered further falls while in hospital before passing away a week later. The Trust admitted that it had failed to comply with its own 'falls' policy. Lillian, 77, died in 2005, following her admittance to hospital with a fractured pelvis. Despite informing clinicians that she was allergic to penicillin, she was injected with the drug and died. The Trust admitted failing to comply with its own medicines management policy.

During the same hearing the Trust admitted liability for health and safety failings for two other patients, Patrick Daly, 89 and Edith Bourne, 83, who died outside of the period covered by this review. At a hearing at Stafford Crown Court, held on 16 December 2015, the Trust pleaded guilty to breaching the Health and Safety at Work Act 1974 in relation to all four patients. It was fined £500,000 and ordered to pay costs.

Merseyside Police feedback

Merseyside Police completed their peer review of 21 cases and wrote, via the NPCC, to DCC Nick Baker in June 2015.

They made comments on five of the cases they reviewed: specifically Gillian Astbury and Lillian Tucker (who were already the subject of HSE criminal prosecutions), and Patient 2454, who was subject to HSE review (see above); and two other cases that had not been subject to review – patient 2538 and patient 101.

Patient 2538: The review team noted the comments from the Merseyside peer review team and particularly the section around 'the (to date) unexplained and abrupt cessation of the beta-blocker Atenolol, together with the potential impact of that on the cause of the heart attack soon after, is worthy of further investigation.'

As a result the review team revisited the earlier panel decision. While Merseyside Police was correct that the drug Atenol was ceased, the following day the patient was prescribed the drug Nicorandil.

25 http://www.uhnm.nhs.uk/aboutus/MSFT-PubsAndReports/Pages/default.aspx#

Both these drugs are used to treat angina. The two medications are from the same group, but both work in slightly different ways and it is not uncommon for the two medications to be swapped; medical notes did not offer any explanation as to why the drugs were changed. It was simply not possible to establish the reason, but what is clear is that this was not an unusual clinical decision.

This was re-presented to the review panel, and the panel endorsed their previous decision that there should be no further action.

Patient 101: Merseyside Police stated in the NPCC letter that: "we recommend the HSE may feel it appropriate to review the current 'Fall risk assessment', together with the adherence to that process by staff within the Trust".

Although the original Inquest found cause of death to be Ischaemic heart disease and fracture of the left femur, and recorded a verdict of accidental death, the death of this patient was reviewed under the process set out as an ICNR had been carried out.

After initial work by the review officer and then further work requested by the review team lead, the matter was presented to the panel on the 8 October 2014 and the decision was made that no further action was required, as the view was, that despite the best efforts of staff (including completing a Fall risk assessment), the patient had tried to get out of bed unaided, during a confused state, and fallen.

The HSE principal investigator reviewed the fall risk assessment and concluded that this did not require further HSE investigation.

Conclusions and observations

This review was clearly defined by the agreed terms of reference: 'to undertake a thorough and detailed review of incidents of high mortality and alleged neglect at the Trust... and to provide reassurance to families and the local community'[26].

The review was not a criminal investigation. It was an examination of material by the police, with the assistance of the HSE and other agencies, relating to 214 patient deaths between 2005 and 2009, where alleged neglect may have been a contributory factor, and to determine whether sufficient evidence existed for criminal investigations.

In preparation for the review, CPS specialist prosecutors provided the force with advice on the legal grounds for potential criminal prosecutions, and the threshold for successful prosecution of individuals under relevant legislation.

A process was established for reviewing the deaths at the Trust during the agreed period. Suitably experienced officers then reviewed all available information and material relating to each of these patients.

As a direct result of this work, three criminal prosecutions against the Trust for serious breaches of health and safety legislation were concluded successfully. Without the review it is highly unlikely that the Trust would have been prosecuted for the deaths of Ivy Bunn, Lillian Tucker or Gillian Astbury.

Our extensive examination of the available material, peer reviewed by an independent police force, found no grounds for conducting a criminal investigation against any individual clinician or manager at the Trust.

That there were no grounds to support individual criminal investigations should not detract from the appalling care that many patients suffered during the period of this review; patients and their families were badly let down by the Trust, and some of its clinicians and their management.

In undertaking the review, we have identified a number of observations that we believe will contribute to the ongoing debate about preventing neglect and ill-treatment in health care settings. This includes:

- That police-led criminal prosecutions will not, and cannot be, a mechanism for maintaining care quality in the health service. While we recognise there will always be a duty for the police to investigate incidents that may breach

26 See Appendix A

criminal thresholds this will never be the precursor to stopping another Mid Staffordshire NHS Trust.

- That the legal grounds for investigating criminal offences in healthcare settings, with the advent of the criminal offence relating to 'ill-treatment or willful neglect', is in our view sufficient. It is noted that the Law Commission is launching a national debate over the appropriate use of the law relating to Misconduct in Public Office.
- That while the successful HSE prosecutions led to financial sanctions against the Trust, there were no findings of individual culpability.
- While criminal sanction may not be the avenue to hold individuals to account there are other bodies that do and have used their powers at Mid Staffordshire. The GMC and the NMC have both taken disciplinary action against a number of clinicians, nursing staff and healthcare professionals for failings between 2005 and 2009 (see appendix G).
- While the public frustration concerning the apparent lack of accountability at Mid Staffordshire can be mitigated by the sanctions administered by the GMC and NMC, this cannot, however, be said of those in senior non-medical roles.

A number of these observations were provided to the Department of Health while it considered the Francis report, following which a number of reforms of the healthcare, health and safety and coronial systems have been implemented that are designed to prevent a scale of failure as found at Mid-Staffordshire.

These include:

- A review of the arrangements put in place by the CQC[27] to monitor hospitals, and joint licensing of trusts by the CQC and Monitor[28].
- A 'memorandum of understanding'[29] that seeks to clarify the respective roles of the HSE and CQC in investigating failures of care in healthcare settings, and to close the 'regulatory gap' as identified by Francis.
- The creation of the Office of the Chief Coroner in 2009[30] that has enabled the development of national guidelines for coroners and strengthened the coronial process.

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27 The CQC was created through the Health and Social Care Act 2008, and came into being as the second Francis report was published. Its terms of reference were adjusted to take into account the findings from the Francis report.

28 The independent sector regulator of NHS foundation trusts

29 http://www.hse.gov.uk/aboutus/howwework/framework/mou/mou-cqc-hse-la.pdf

30 Created through the Coroners and Justice Act 2009

- The introduction of a new criminal offence of 'ill treatment or wilful neglect'[31] which applies to clinical and non-clinical staff in health and social care settings.
- The review and refresh of the NPCC's guidance[32] regarding deaths in healthcare settings.
- The establishing of a 'duty of candour', to prevent contractual clauses aimed at silencing so-called whistle blowers.

We believe the improvements made to the way different agencies work together, the regulatory and reporting framework, and the systems in place to report deaths in healthcare settings to appropriate authorities has strengthened the system considerably. Indeed, the prosecution of the Trust by the HSE over the deaths of Edith Bourne and Patrick Daly in 2013 and 2014, respectively, reinforces our view.

However, deaths in healthcare settings remain high in the public consciousness, as the recent case at Southern Healthcare and the recent case at Maidstone & Tunbridge Wells NHS Trust, have illustrated.

Given the learning gathered through this review, and the desire to consult with policing colleagues nationally, as set out in our terms of reference, we have recommended to the National Police Chiefs' Council that a national policing forum is held through which the police can satisfy itself that the arrangements that have been put in place to monitor deaths in healthcare settings are now sufficiently robust for the purpose to which they are designed. Invites to this forum will be extended to the HSE, NHS England, CQC, Monitor, the CPS and the Coronial service.

[31] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/319042/Ill-treament_or_wilful_neglect_consultation_response.pdf

[32] See NPCC guide: http://library.college.police.uk/docs/NPCC/2015-SIO-Guide-Investigating-Deaths-and-Serious-Harm-in-Healthcar-Set.pdf

Appendices

Appendix A: Terms of reference for Gold Group

Terms of Reference

Background

In February 2013 the Francis Inquiry published its recommendations concerning its review of Mid Staffordshire hospital. This review had been commissioned due to the excessive mortality rates between 2005-2009. These findings have caused much public concern which has also led to some calls for a criminal investigation. This incident is declared a critical incident within the definition adopted by ACPO which is 'any incident where the effectiveness of the Police response is likely to have a significant impact on the confidence of the victim, their family and/or the community'. A Gold group has therefore been established to provide the Gold Commander with valuable consultation and decision support. Any conclusions will require the full involvement and engagement of key stakeholders who will be integral members of this Gold Group. All Gold Group meetings and decisions will be documented. The following are the stated objectives for the Gold Group.

Objectives

- To ensure a thorough and detailed review by Staffordshire Police to ensure a considered and proportionate response is made to the incidents of high mortality rates and alleged neglect at Mid Staffs Hospital.
- To provide reassurance to families and communities identified as being affected by this incident.
- To coordinate the media/communication strategy in respect of the investigation.
- To identify any issues that may become critical and affect Staffordshire Police and the trust and confidence in which it is held.
- The group will ensure the provision of any necessary support and resources to appropriately deal with this enquiry.
- To ensure an appropriate response to the impact of the incident on the community to deal with their needs/interests/views/priorities.
- To ensure appropriate coordination with Stakeholders.
- To ensure consultation with the wider UK Police community.

Appendix B: The review team

The team responsible for reviewing the 214 individual cases was comprised of five highly experienced Staffordshire Police detectives. This included:

Detective Inspector Pattinson, PIP3[33] accredited, who oversaw the review process and presented the findings to the Review Panel.

Detective Sergeant Jeffries, who supervised the team, was a 'PIP2[34]' accredited investigator and trained Family Liaison Coordinator[35]. In addition to supervising the team, DS Jeffries role was to ensure that all contact with the families concerned was formally recorded.

Detective Constable Miller, 'PIP2' accredited investigator and trained Family Liaison Officer.

Detective Constable Price, 'PIP2' accredited investigator and trained Family Liaison Officer.

Detective Constable Cox, 'PIP2' accredited investigator and trained Family Liaison Officer.

33 PIP level 3 accreditation means that the investigator is trained to manage the major investigations

34 PIP level 2 accreditation means that the investigator is trained to manage the most serious and complex criminal cases.

35 A Family Liaison Coordinator is trained to manage and coordinate the work of family liaison officers to the highest ethical standards.

Appendix C: CPS guidance note on gross negligence manslaughter and corporate manslaughter

(both common law and that defined by the 2007 Corporate Manslaughter and Corporate Homicide Act)

Advice to Staffordshire Police on Corporate and Medical Manslaughter

Following the initial meeting of the Stafford Hospital Gold Group on 15 February 2013 I have prepared this short advice in order to provide an overview of the relevant manslaughter offences which may fall to be considered following the report of the Francis Inquiry.

The purpose of this advice is to assist the police in assessing the available material in order to decide whether there are grounds for conducting a criminal investigation into any of the deaths which occurred at Stafford Hospital. The decision about whether to conduct a criminal investigation and the scope of any investigation remain matters for the police.

The offences which are outlined and discussed in this advice are:

- **Gross Negligence Manslaughter**
- **Corporate Manslaughter (common law)**
- **Corporate Manslaughter (Corporate Manslaughter and Corporate Homicide Act 2007)**

This advice does not address the issue of potential offences under the Health and Safety at Work Act which are strictly within the purview of the Health and Safety Executive. However the relevance of health and safety breaches in relation to the statutory offence of corporate manslaughter is discussed.

I have also not discussed the potential for offences under s44 of the Mental Capacity Act 2005 (wilful neglect or ill-treatment of a person lacking mental capacity) or s127 of the Mental Health Act 1983 (wilful neglect or ill treatment of a (Mental Health Act)patient) but either I or my colleagues in the Complex Casework Unit can provide that advice if it becomes apparent that it is required.

Gross Negligence Manslaughter

In order to prove the offence of gross negligence manslaughter it is necessary to prove the following:

1. the defendant owed a duty of care to the deceased
2. the defendant breached this duty
3. the breach caused the death of the deceased
4. the defendant's negligence was gross, that is it showed such a disregard for the life and safety of others as to amount to a crime and deserve punishment.

Duty of care

Any doctor or nurse who has been charged with the care of a patient will owe that patient a duty of care.

Breach of Duty

Those with a duty of care must act as the reasonable and competent person should do in their position. So in this context the relevant standard would be that of the reasonable and competent doctor or nurse in the same circumstances. Only if we can show that the doctor or nurse fell below that standard (i.e. behaved in a way that no reasonable and competent doctor or nurse should have) can we prove a breach of duty.

Causation

It is necessary to prove that the breach of duty was a substantial cause of, or contribution to, the death. This has been defined as meaning 'more than minimally, negligibly or trivially contributed to the death.' The breach need not be the only cause.

Where the cause of death is shown as 'multifactorial' or 'unascertained' there may be nothing which proves to the criminal standard that the acts or omissions of the suspect were an operative cause of death. In these circumstances it is essential to obtain the opinion of an expert on causation if the offence is to be proved. A starting point is often the pathologist who performed the post mortem operation, but if the pathologist feels unqualified to offer expert opinion upon causation, the evidence may need to be reviewed by an appropriate expert (e.g cardiologist, toxicologist etc). If this is felt to be necessary in relation to any particular death we will be able to assist with the drafting of appropriate terms of reference to assist you in instructing the expert. The expert will need to be sure that the defendant's act/omission was an operative cause of death. In other words that, but for the defendant's negligent act/omission, the victim would not have died when they did.

Gross negligence

The definition of grossness in the leading authority on this offence (Adomako) is as follows:

"This will depend on the seriousness of the breach of duty committed by the defendant in all the circumstances in which the defendant was placed when it occurred. The jury will have to consider whether the extent to which the defendant's conduct departed from the proper standard of care incumbent upon him, involving as it must have done a risk of death to another, was such that it should be judged criminal."

You will note from this that the risk which has to be foreseeable is a risk of **death** and that **all the circumstances** in which the suspect was placed have to be taken into account. This means that we would need to take account of such things as staffing levels and systems and processes in place at the hospital in assessing an individual doctor or nurse's conduct.

The definition of grossness has been further articulated in other cases as meaning behaviour which 'abysmal' and 'appalling'; mistakes, even very serious mistakes, are not enough.

It is also important that you bear in mind that to prove gross negligence manslaughter the four elements of the offence must be proved against each suspect individually and in respect of each individual death. This means that it is not possible to prosecute on the basis of an accumulation of a number of non-gross breaches by different people in respect of a patient; nor is it possible to prosecute an individual on the basis of an accumulation of various non-gross breaches in respect of a number of different patients.

Corporate Manslaughter

The period of time which was looked at by Francis Inquiry pre-dates the Corporate Manslaughter and Corporate Homicide Act 2007, which came into force on 6 April 2008. Accordingly, both the common law and statutory offences are potentially relevant.

Common Law

Under the common law, in order to prove that a corporate body (such as an NHS Trust) is guilty of corporate manslaughter it is necessary to prove that an individual who can properly be regarded as a 'controlling mind' of that corporate body is themselves guilty of gross negligence manslaughter. Historically this has made proving corporate manslaughter against all but the smallest corporate bodies extremely difficult under the common law.

I have set out the elements of the offence of gross negligence manslaughter above. In the context of this case, this would mean that we would have to identify someone who was senior enough to be regarded as a 'controlling mind' of the Trust who had breached their duty of care (which we would have to define) to individual patient(s) in a way which could be proved to have caused their death(s)

and which could be proved to be gross. Again the conduct of that individual (including grossness of any breach) and causation would have to be considered separately against each individual patient.

Corporate Manslaughter and Corporate Homicide Act 2007

To prove the statutory offence of corporate manslaughter we would need to prove that the way in which the Trust's (or other relevant corporate body's) activities were managed or organised **caused** the death and amounted to a **gross breach** of a relevant duty of care to the deceased. A substantial part of the breach must have been in the way that activities were managed or organised at **senior management** level.

Senior management is defined as those persons who play a significant role in making decisions about how a substantial part of the organisation's activities are managed or organised or the actual management or organising of a substantial part of those activities.

Neither 'significant' nor 'substantial' are defined but the former is likely to be limited to those whose involvement is influential and will not include those who simply carry out the activity. In order to assess which individuals may fall into this category in relation to the Trust you will need to obtain or create an 'organogram' of the trust showing the structure and hierarchy as well as roles and responsibilities. Once you had this we would be happy to assist you in making that assessment.

Causation is not defined under the Act but as the intention was to follow aspects of the law on gross negligence, it must be assumed that the test will be the same.

A **gross breach** is defined as one which in which the alleged conduct falls far below what can reasonably be expected of an organisation in the circumstances. It is for the jury to determine and there is a clear emphasis on compliance with health and safety legislation and guidance, as outlined below:

The jury **must** consider whether the evidence shows that the organization failed to comply with any health and safety legislation that relates to the alleged breach, and if so:

(a) how serious that failure was

(b) how much of a risk of death it posed

The jury **may** also consider the 'attitudes, policies, systems or accepted practices...that were likely to have encouraged the breach or produced a tolerance of it' and may have regard to any health and safety guidance issued by the relevant enforcement authority that relates to the breach. (This doesn't

include internal guidance as the organisation is not an 'enforcement authority'.) The jury may also consider any other matter they consider relevant.

It follows from this that if a decision to pursue a corporate manslaughter investigation is taken some input from the Health and Safety Executive (or other relevant body) is likely to be required. Again, as with the other manslaughter offences, each element of this offence must be proved in respect of each individual death. However, in contrast to the common law offence, the gross breach in respect of the statutory offence can be an accumulation of the way that things are managed or organised by a number of different individuals, as long as they can be proved to be senior management.

I should also flag that there are a number of exemptions under the Act which include decisions by public authorities on matters of public policy (e.g. a policy decision to spend money on heart operations instead of kidneys) and emergency responses by a rescue service which would include triage decisions in relation to the order of treatment of patients.

If there is anything in this advice which requires further clarification or anything in particular which arises during your consideration of the material which you would like to discuss please do not hesitate to contact either me or Rosemary Ainslie.

CPS Special Crime Division
27 February 2013

Appendix D: CPS guidance note on misconduct in public office

Advice to Staffordshire Police on the Offence of Misconduct in Public Office

This advice is being provided at the request of ACC Baker of Staffordshire Police to assist the police in assessing the available material in order to decide whether there are grounds for conducting a criminal investigation following the report of the Francis Inquiry. It follows the provision of an initial advice, dated 27 February 2013, which dealt with the offences of corporate and medical manslaughter.

The offence which is the subject of this advice is the common law offence of misconduct in public office, which carries a maximum sentence of life imprisonment. The decision about whether to conduct a criminal investigation and the scope of any investigation remain matters for the police.

The offence of misconduct in public office was the subject of a reference to the Court of Appeal by the Attorney General in 2003 (A.G.'s ref (No3 of 2003) [2004] 2 Cr. App. R. 23 CA) and the elements of the offence are set out and considered in their ruling. The offence is, in essence, serious abuse or neglect of the power or responsibilities of the public office held. There must be a direct link between the misconduct and an abuse of those powers or responsibilities.

The offence is committed when:

- a public officer acting as such
- wilfully neglects to perform his duty and/or wilfully misconducts himself
- to such a degree as to amount to an abuse of the public's trust in the office holder
- without reasonable excuse or justification

A public officer

The prosecution must have evidence to show that the suspect is a 'public officer'. There is no simple definition (the courts have been reluctant to provide one) and each case must be assessed individually, taking into account the nature of the role, the duties carried out and the level of public trust involved. The case-law tends to define a public officer as a person who carries out a public duty or has an office of trust and this will have to be inferred from the facts of particular cases.

In relation to the events at Mid Staffordshire Hospital, it is unlikely that any of the hospital staff (medical or management) would be deemed to be public officers. However, members of any statutory body with oversight of the hospital would be likely to come within the definition.

Acting as such

The suspect must not only be a 'public officer'; the misconduct must also occur when acting in that capacity.

In the case of a member of a public body, for example, it will be necessary to show that the misconduct was closely connected with exercising (or failing to exercise) the relevant public function. There must be a direct link between the alleged misconduct and an abuse, misuse or breach of the specific powers and duties of the office or position.

Wilfully neglects to perform his duty and/or wilfully misconducts himself

The neglect or misconduct must be **wilful** and not merely inadvertent; and it must be culpable in the sense that it is without reasonable excuse or justification. It can be the result of a positive act or a failure to act. There must also be an element of knowledge or at least recklessness about the way in which the duty is carried out or neglected.

In the Attorney General's Reference the Court of Appeal approved the definition of 'wilful' as *'deliberately doing something which is wrong knowing it to be wrong or with reckless indifference as to whether it is wrong or not'.*

To such a degree as to amount to an abuse of the public's trust in the office holder

The behaviour must be serious enough to amount to an abuse of the public's trust in the office holder. The element of the culpability must, according to case law, "*...be of such a degree that the misconduct impugned is calculated to injure the public interest so as to call for condemnation and punishment.*"

The Court of Appeal has stated that the misconduct must amount to "... *an affront to the standing of the public office held.* ***The threshold is a high one*** [my emphasis] *requiring conduct so far below acceptable standards as to amount to an abuse of the public's trust in the office holder. A mistake, even a serious one, will not suffice. The motive with which a public officer acts may be relevant to the decision whether the public's trust is abused by the conduct*".

The Court also considered that "*it will normally be necessary to consider the likely consequences...there will be some conduct which possesses the criminal quality even if serious consequences are unlikely but it is always necessary to assess the conduct in the circumstances in which it occurs.*" In other words, the

more serious the consequences, the more likely that misconduct will be established.

Without reasonable excuse or justification

It is not necessary for the prosecution to prove the absence of a reasonable excuse or justification. However, the nature of the prosecution evidence should in practice address the point and we would certainly have to consider it as part of the review process.

Misconduct in public office is widely acknowledged as being a difficult offence to define with absolute clarity. What is clear from the authorities is the very high threshold of misconduct required. The fact that a public officer has acted in a way that is in breach of his or her duties, or which might expose him/her to disciplinary proceedings, is not in itself enough to constitute the offence.

Examples of behaviour that have in the past fallen within the offence include:

- wilful excesses of official authority;
- 'malicious' exercises of official authority;
- wilful neglect of a public duty;
- intentional infliction of bodily harm, imprisonment, or other injury upon a person;
- frauds and deceits.

CPS Special Crime Division
19 June 2013

Appendix E: Merseyside Police: Terms of reference for peer review team

Mr Michael Cunningham Chief Constable, Staffordshire Police

HQ Weston Road, Stafford ST18 OYY

12 August 2013

Dear Mike

You will be aware that I met with D/Ch Superintendent Nick Baker on 06 August to discuss the joint agency review process of cases that feature in the Mid-Staffordshire hospital inquiry. It was agreed during those preliminary discussions that Merseyside Police will carry out a Peer Review of the proposed process up to the point of the "Test" stage being applied to cases.

Merseyside Police will then conduct a further Peer Review of cases that have progressed to the second stage of your process, being those that have been considered by the Panel of local CPS, HSE and Police representatives.

The Terms of Reference for this Peer Review will therefore be:

1. To review and Quality Assure the process agreed between Staffordshire HSE, Staffordshire Police and CPS, implemented to review the deaths at Mid Staffordshire Hospital that occurred between January 2005 and March 2009.

2. To conduct a Peer Review by random selection on a sample of one in every ten cases that have been considered by the multi-agency panel, this being the final stage of the process.

All costs incurred by Merseyside Police during the above Peer Review will be met by that Force. Any necessary changes to the Terms of Reference will lead to a review of any arrangements regarding costs.

Yours sincerely

Jon Murphy QPM
Chief Constable Merseyside Police
Head of National Policing Crime Business Area

Appendix F: Merseyside Police: Peer review feedback

DCC Nick Baker Staffordshire Police

Weston Road Stafford ST18 OYY

11June 2015

Dear Nick,

Re: Mid Staffordshire General Hospital – Peer Review by Merseyside Police

In confirmation of my email to you dated 2nd March 2015, after completion of the review of all files by the Staffordshire Multi Agency Panel, Merseyside Police have now completed a Peer Review on 21 files. This process has been conducted in line with the agreed Terms of Reference for this process, whereby a random selection was made (through reference to the HOLMES nominal number), of one in every 10 files that have been subject to review by the Staffordshire multi-agency panel.

As previously agreed, Merseyside Police will retain and file all documentation that we have received from Staffordshire Police as part of this review process.

You are aware that any recommendations that we have felt it appropriate to make during our review process have been forwarded to Staffordshire Police as and when they have arisen. However, and for completeness, I have detailed these recommendations below:

With regard to the deceased Gillian Daphne Freda Astbury

We note that the Health and Safety Executive became involved in this case in November 2008. The Health and Safety Executive investigation was pended, on the advice of Counsel, until April 2013, this being at the conclusion of the Public Inquiry. Prosecution proceedings relating to the Trust, by the Health and Safety Executive, were then commenced in August 2013.

We have now been informed, through an e-mail from the Health and Safety Executive to Staffordshire Police dated 15 April 2014, that three improvement notices have recently been served on the Trust, two of which relate to issues which were directly relevant to the HSE prosecution following their investigation into the death of Gillian Astbury. In considering this situation, it is therefore the opinion of the Merseyside Police Peer Review team that whilst we agree with

the overall decision of the panel in the Gillian Astbury case, we feel that any case that is reviewed by the Staffordshire Panel, that involves an issue whereby any 'record keeping, patient information, communication and handover procedures' is found to be a significant breach in the duty of care owed to a patient who has died, consideration should be given to the offence of Corporate Manslaughter, based on the principle that the Trust were aware of the consequences of these flawed procedures as a result of the death of Gillian Astbury and the subsequent investigation.

With regard to the deceased #2538

Whilst there is evidence of misdiagnosis by a number of the medical team that has led to the premature discharge of the patient, together with incorrect information provided to the GP, we agree that the circumstances of this case would appear to fall short of any criminal offence. However, we feel the issue regarding the (to date) unexplained and abrupt cessation of the Beta Blocker (Atenolol), together with the potential impact of that on the cause of the heart attack soon after, is worthy of further investigation – if indeed this is now possible. The rationale for this view is that when taken together, the deliberate cessation of the Beta Blocker, together with the missed / incorrect diagnosis, has the potential to create a more serious aspect to this case and that this may be considered worthy of some further investigation.

The Peer Review team are aware that the medication in question is also prescribed for high blood pressure and therefore the sudden withdrawal may have been in response to this patient's decreasing blood pressure. However, according to the records that we have reviewed, the withdrawal of this drug was made prior to the ECGs and the recording of a drop in blood pressure for this patient.

With regard to the deceased #101

We recommend that the HSE may feel it appropriate to review the current 'Fall Risk Assessment', together with the adherence to that process by staff within the Trust – an issue that was also raised by the Staffordshire Review Panel and so this may have already been actioned.

With regard to the deceased #2454

We recommend that the HSE may feel it appropriate to review the use of moveable lockers positioned at the bedside of patients in view of the accident (albeit apparently unrelated to his death) that this patient was involved in.

With regard to the deceased Lillian Jane Frances Tucker

We note and endorse the recommendations from the Staffordshire Review Panel – that the processes relating to the issue and use of appropriate

wristbands, when patients are allergic/intolerant to certain drugs, that are now in place at the MSGH, should be subject of a review by the Health and Safety Executive.

Outstanding Issues

1. We will now await your decision as to your preferred option relating to the final handover of our review records on the 21 cases that we have completed.

2. You mentioned at our meeting at Merseyside Headquarters on 5th December 2014 that you were intending to draft a press/media release relating to the completion of the review of all cases by the Staffordshire Panel and the associated Peer Review process by Merseyside Police. As discussed, and if this course of action is still intended, we would like to take up your offer to have sight of that draft release prior to issue.

Yours sincerely

Brian McNeill

Staff Officer to Sir Jon Murphy, Chief Constable Merseyside Police

National Crime Operations Co-ordinating Committee

Copies to:
Sir Jon Murphy, Chief Constable, Merseyside Police
DCC A Cooke, DCI N Pereschine, DCI J Webster, Merseyside Police

Appendix G: Action taken against professionals working at Mid Staffordshire NHS Trust

General Medical Council

As of September 2013, the GMC had undertaken investigations on 66 cases associated with the Mid Staffordshire Inquiry, relating to 44 doctors. The GMC took the following action against 43 doctors:

- 1 doctor has been erased from the register
- 1 doctor has been issued a warning and been given conditions
- 1 doctor has accepted undertakings
- 1 doctor has been issued with advice and agreed undertakings
- 1 doctor has received a warning and been issued advice
- 22 doctors have been issued advice
- 16 doctors have had cases concluded with no further action

The case against the 44th doctor was closed, following a fitness to practice hearing at which the doctor was found not impaired.

Nursing and Midwifery Council

As of March 2014, the NMC had considered 37 cases associated with the Mid Staffordshire Inquiry related to 36 nurses and midwives. The NMC took the following action:

- 2 caution orders were imposed
- 4 striking off orders were imposed