



JUDICIARY OF  
ENGLAND AND WALES

District Judge Grace Leong  
In the Nottingham Magistrates' Court

Between

The Care Quality Commission

v

NOTTINGHAM UNIVERSITY HOSPITAL NHS TRUST

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SENTENCING COMMENTS 27<sup>th</sup> January 2023

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Mr R Donoghue represents the Care Quality Commission

Mr B Thorogood represents the NHS Trust

1. I begin by expressing my deepest sympathy to Mr and Mrs Andrews for the loss of their child, Wynter. Instead of bringing home their baby to love and to nurture, Mr and Mrs Andrews found themselves dealing with the death of their first child and planning a funeral. Mrs Andrew also had to cope with a severe infection. I have read their victim personal statements. No words are sufficient to describe their unimaginable suffering. It is clear to me that their pain continues and may never fully go away. I am acutely aware that this prosecution may not bring them closure. I have to make everyone present aware that the legislation directs that these offences can only be marked with a financial penalty although there is no limit to the fine. I have no doubt that any fine, whatever the amount will appear like an insult or a slap in the face for Mr and Mrs Andrews whose lives are changed forever as a result of the failures of the Trust. Many will feel that no fine could ever be sufficient to reflect adequately the impact of the offences that I am dealing with.
2. The facts have been fully opened by Mr Donoghue on 25<sup>th</sup> January 2023. I don't propose to summarise the facts all over again but will only make reference to some of the facts as and when the need arises.
3. Sarah Andrews was aged 33 when she became pregnant in early 2019. Her pregnancy was uncomplicated until about week 37 of her pregnancy term, her third trimester.

Complications arose after 37 weeks and 1 day where Mrs Andrews sustained abdominal pain. What followed from then was a series of failures by the Trust to provide safe care and treatment which ultimately resulted in Wynter being delivered but dying soon afterwards in her mother's arms.

4. Mr Taylor, an independent consultant obstetrician and gynaecologist was commissioned to report on whether the Trust had failed to provide safe care and treatment. He conducted his investigation and wrote a report identifying a number of failings:
  - a. The baby should have been delivered earlier by emergency Caesarean section.
  - b. There was a considerable delay from the transfer of care from the midwife to care by the obstetrics team in Mrs Andrew's case. I can see from the chronology that she was not seen by an obstetrician until 11.06am on the 15<sup>th</sup> September 2019 when the complications had become acute.
  - c. Where there was uncertainty over whether there was a pre-labour rupture of the membranes, there was a failure by the staff to perform a speculum procedure.
  - d. There was a failure to keep the number of vaginal examinations down to a minimum due to the risk of membranes rupturing. The number of vaginal examinations would have increased the risk of ascending and neonatal infection. Mrs Andrews underwent at least 7 vaginal examinations since her waters broke.
  - e. There were failures to escalate concerns to senior members of staff but that was not the principal reason that delivery of the baby was not done in a timely fashion.
  - f. The cardiotocography or CTG which is a technique for measuring foetal heart beats and uterine contractions was incorrectly interpreted but Mr Taylor was unclear if that was due to any lack of hourly systematic reviews or whether that was due to staffing incompetence. Certainly the medical notes do not provide a clear reason as to why the CTG was incorrectly interpreted.
5. The identified problems lead me to conclude that
  - a. There was a failure to ensure that the decision concerning an induction of labour was documented clearly.

- b. There was a failure to follow the guidance provided by the National University Hospital NHS Trust when Mrs Andrews decided against an induction of labour.
  - c. When there was evidence of hypertension in Mrs Andrews, there was a failure to follow the guidance on blood pressure fluctuations including a failure to escalate the problem to the obstetric team.
  - d. When Mrs Andrew was admitted to hospital with an episode of hypertension, there was a failure to ensure that CTG was recommenced as required by the local and national guidance.
  - e. Where the prescription of diamorphine was concerned, there was a failure to ensure that guidelines issued by the Trust were adhered to and in particular there was a failure to ensure that a doctor should be requested to deal with that prescription.
  - f. There was a failure to monitor Mrs Andrew's temperature due to a lack of thermometers and that was contrary to the issued guidance.
  - g. There was a failure to ensure that a senior obstetric clinician was involved in the planning for the ongoing care of Mrs Andrews given the issues that confronted the staff.
  - h. The communication systems were inadequate and failed to provide clear and complete information sharing.
  - i. After Mrs Andrews' spontaneous rupture of the membranes, there was a failure to follow the issued guidance in relation to the assessment and management of Mrs Andrews when her waters broke. A speculum examination after that would enable the staff to detect the offensive liquor and Mrs Andrews would have been transferred to the delivery suite for an emergency caesarean section after 1944 hours on the 14<sup>th</sup> September 2019 or at the latest sometime that evening or in the morning of the 15<sup>th</sup> September 2019.
6. Ultimately the catalogue of failings and errors exposed Mrs Andrews and her baby to a significant risk of harm which was avoidable. Such errors ultimately resulted in the death of Wynter and post-traumatic stress for Mrs Andrews as well as Mr Andrews.

7. Wynter died from a combination of hypoxic ischaemic encephalopathy that is a lack of oxygen to the brain, acute chorioamnionitis which is an infection in the tissues or membranes around a foetus or in the placenta and in addition, the umbilical chord was entangled around the baby's neck.
8. The Trust in February 2022 wrote to the Care Quality Commissioners accepting a number of failures and in particular in failing to ensure that staff were adequately trained to follow local and national guidance and that it failed to ensure that the staff were adequately supported in order to comply with such guidance. In short the Trust admitted that staff were not provided with the training that they should have been and there were insufficient number of midwives to provide the necessary level of care to both Mrs Andrews and to Wynter. The Trust through Mr Thorogood pleaded guilty at the first opportunity before me on the 23<sup>rd</sup> January 2023 to two offences of failing to discharge its duty in providing safe care and treatment to both Baby Wynter and Sarah Andrews in contravention of its obligations under the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.
9. I consider how I should approach the sentencing exercise. I am very grateful to both counsel for their helpful written and oral submissions.
10. There are no definitive sentencing guidelines for the offences under the 2014 Regulations. I have to consider the statutory maximum sentence but there is no ceiling to the level of fine that I can impose. It is a matter of discretion after considering other sources of guidance such as any High Court or Court of Appeal judgments and any other sentencing guidelines for analogous offences. The advocates agree that I should follow the approach set out in the Health and Safety sentencing guidelines. Mr Thorogood submits that the figures set down in the guidelines do not apply as the Defendant is a publicly funded body whereas Mr Donoghue is more muted in that he says that it is a relevant consideration when setting the level of penalty.
11. There are 4 steps that I must take. Step 1 is where I have to determine culpability. This means responsibility for wrongdoing or in this case, responsibility for failures. The scale ranges from low to medium to high and then very high.
12. Mr Donoghue states that these offences fall into the high culpability bracket namely that the Trust failed to put in place measures that were recognised standards in the care industry. Mr Thorogood submits that the offences fall within the medium culpability bracket namely that the systems were in place but these were not sufficiently adhered to or implemented. Mr Thorogood submits that the maternity unit was only one part of the organisation and I have to consider the overall context in which the failures occurred. He further submits that there was indeed a structure

where thousands of babies were born safely and cared for over the years and that suggested that there was a sound system in place.

13. My assessment is that the level of **culpability** is **high** where offences on Wynter and Mrs Andrews are concerned. There were systems in place but there were so many procedures and practices where guidance was not followed or adhered to or implemented that in combination and collective accumulation, the failings result in a finding of high culpability. The fact that the hospital had safely delivered thousands of babies and ensured the appropriate care of their mothers is a mitigating feature for consideration under step 2. I am here concerned with the Trust's culpability or blameworthiness in relation to Wynter and Mrs Andrews.
14. It is appropriate for me to consider the issue of harm here. What I must consider here is the risk of harm created by the offences. At this point, my focus is upon the risk of harm created by the failures of the Trust rather than actual harm occurring.
15. The risk of harm has 2 elements to it. The first element is the seriousness of the harm risked. That is again measured with a scale. The scale for harm risked begins with level A which includes death or physical or mental impairment resulting in lifelong dependency on third party care for basic needs. That means that such were the failings of the Trust that death or really serious injury could arise.
16. The next level is B which includes physical or mental impairment, not amounting to level A but which has a substantial and long term effect on the sufferer's ability to carry out normal day to day activities or on their ability to return to work. Level C harm deals with all cases not falling within level A or B.
17. Where Wynter is concerned, there is no disagreement between the advocates that the court is dealing with Level A.
18. The second element for me to consider is the likelihood of harm arising. There is again a sliding scale of a low likelihood of harm, a medium likelihood of harm and a high likelihood of harm.
19. Mr Donoghue submits that Wynter's case falls within the medium likelihood of harm because while there were failures, it cannot be said that death would be the inevitable consequence from the failures. He submits that it also cannot be said that risks to unborn babies were remote or unforeseeable. Mr Donoghue submits that the risk is also assessed as Level A but with a low likelihood of harm to Mrs Andrews.

20. Mr Thorogood submits that where Wynter is concerned, harm is assessed as level A but with a low likelihood of harm. In reaching a conclusion on the assessment of harm, I would need expert evidence in reaching a conclusion as to the likelihood of harm. Again Mr Thorogood prays in aid of the large numbers of mothers and babies born at the hospital who were properly cared for. Mr Thorogood submits that it is level B harm for Mrs Andrews. He further submits that there is a low likelihood of harm.
21. I cannot agree with Mr Thorogood that there is no expert evidence here. Mr Taylor's report greatly assisted me in coming to my conclusion that the likelihood of harm to Wynter is most certainly at the medium level. This is a conclusion I reach with the assistance of an expert rather than by taking an impressionistic view. The systematic failures in procedures resulting in too many vaginal examinations after the spontaneous rupture of the foetal membranes caused a heightened risk of infection to the baby; the misinterpretation of the CTG results and the substantial delay in a referral to an obstetrician in combination are more than sufficient to bring about the medium likelihood of harm to an unborn baby when time was of the essence in the face of escalating complications. My assessment is that this is a level A case with a medium likelihood of harm.
22. I have a difficulty where Mrs Andrews is concerned as the gist of Mr Taylor's report is focused upon the failures of care and treatment to Wynter that ultimately resulted in her death. Consequently I am inclined to agree with Mr Thorogood's submission that it is level B with a low likelihood of harm. That is only an initial assessment.
23. I have to consider two other factors :
- A) whether the offence exposed a number of members of the public to the risk of harm. I am mindful that there are two offences to which the Trust has pleaded guilty. If the Trust had been charged with just one offence in relation to Wynter, I would of course consider that the offence also exposed Sarah Andrews to the risk of harm. Consequently, I do not consider this particular factor in arriving at my decision as it would involve double counting and would be unjust.
  - B) I consider whether the offence was a significant cause of actual harm. The combination of failings did result in the death of Wynter. The combination of failings also resulted in Mrs Andrews being readmitted to hospital where she spent several weeks. She was initially discharged from hospital with a severe uterine infection from the birth of her baby. That healed eventually leaving her with excessive scar tissue. This is against the backdrop of having lost her first child and dealing with the trauma and bereavement after the ordeal of a pain filled labour and Caesarean operation. Consequently, I consider these particular circumstances

justify a move up the category within level B to a medium likelihood of harm from an initial assessment of a low likelihood of harm.

24. For the avoidance of doubt, my assessment is that the offence concerning Wynter falls within **Level A with category 2 harm**. The offence concerning Mrs Andrews falls within **Level B with category 3 harm**.
25. I proceed next to deal with Step 2 where I am required to consider the annual turnover of the Trust to reach a starting point for a fine. I have been provided with 3 sets of accounts for the Trust as well as the statement of the Acting Chief Financial Officer, Mr Orme. I have been told that the Trust which is publicly funded has operated on a deficit for many years and continues to do so. The money in the possession of the Trust is committed to other responsibilities such as meeting the liabilities of creditors and suppliers and that amounts to some £259 million. The Trust has commitments such as the salaries of staff as well as the normal running costs. Mr Orme provides a detailed statement of how the Trust is unable to pay a substantial fine as any such fine will increase further the deficit and will adversely affect the other range of services that the Trust can offer.
26. The Guidelines deal with turnovers categorised as large, medium, small or micro. A large turnover is defined as £50 million or above. The guidelines do state that where an offending organisation's turnover or equivalent greatly exceeds the threshold for large organisations, it may be necessary to move outside the suggested range to achieve a proportionate sentence.
27. I am mindful that the NHS Trust is a publicly funded body albeit it is a very large organisation. It does not operate for gain or profit. Its primary goal is to deliver quality healthcare and related services to patients. I am acutely aware that the funds are all accounted for and the Trust is operating with a continuing deficit. It is for those reasons that I am not intending to depart from the suggested starting points or the category range within the guidelines. Had this been a private large organisation with the same turnover, I would be considering a move outside the starting point and the suggested range.
28. Dealing with the offence on Wynter, the starting point after a contested hearing on an assessment of high culpability and a category 2 harm is £1.1 million with a range of £550,000 to £2.9 million. Where the offence on Mrs Andrews is concerned, the starting point after a contest hearing on an assessment of high culpability and a category 3 harm is £540,000 with a range of between £250,000 to £1,450,000.

29. There are no factors in either case to increase seriousness. As for mitigating factors, I bear in mind that the Trust has never been prosecuted for any offences. It has no previous convictions. Further there is evidence of steps taken to remedy the problem as I can see from the document provided today setting out the implemented changes although that is tampered by a recent Inspectors' report in May 2022 that states that the services provided by the Maternity unit still requires improvement. The changes should provide assurance to expectant mothers and their families.
30. There are two further steps to be considered here. At Step 3, I must consider whether the proposed figure that I have in mind is proportionate to the means of the NHS trust. I have to bear in mind that the fine should meet the objectives of punishment and deterrence. In Step 4, I have to consider the impact that such a fine will have upon the Trust's ability to provide services to healthcare users and its ability to secure more staff to deal with the backlog of delayed services.
31. In deciding the appropriate sentence, the court has to strike a delicate balance. On the one hand, a significant financial penalty has to be fixed at such a level as to mark the seriousness of these offences. On the other hand, the court cannot ignore the negative impact that the fine will have upon services to patients at a time when the Trust is facing unprecedented challenges both in terms of its workload and staffing levels to say nothing of the financial pressures.
32. As I have said earlier, many people would say that no fine is too high to impose in a case such as this. In some ways, they would be right to think that because no penalty that I pass can bring Wynter back or ease the pain of Mr and Mrs Andrews. What may be of more benefit to Mr and Mrs Andrews is for them to have held the Trust to account for its failings in the hope and expectation that lessons will have been learned so that in the future, these tragic events would not be repeated. Expectant mothers should be able to give their trust to the doctors, the nurses and the midwives and be assured that their babies would be safely delivered.
33. Having considered all matters urged upon me, the starting point after a trial is £900,000 where the offence on Wynter is concerned. In giving weight to the principle of totality to achieve a proportionate and just result, the starting point for the offence on Sarah Andrews is a lot lower than it would otherwise have been. If a trial had taken place, the fine on the offence on Sarah Andrews would have been £300,000. The total fine would have been £1.2 million. In giving the Trust full credit for its early guilty pleas, the fine is £800,000. The Trust will pay the surcharge of £181.

34. The costs of the prosecution are reasonable and are proportionate to the fine. In the circumstances, it is just and reasonable to direct that all the prosecution's costs be met by the Trust.