EVERSHEDS SUTHERLAND

Sentencing: The Priory Group

The Priory Group has received a fine of £300,000 following the tragic death of a 14 year old girl in its care.

The Priory Group pleaded guilty to an offence under section 3(1) of the Health and Safety at Work etc. Act 1974 in a case which highlights the importance of accountability of mental health professionals in health care settings and, more specifically, the deaths of children in private mental health institutions. Duties do, of course, extend to any situation where a service provider has responsibilities to third parties in a mental health context.

On 12 November 2012, Amy El-Keria was found locked and hanged in her hospital room at the specialist children's unit at Ticehurst House in East Sussex. In sentencing remarks issued on 17 April 2019, Mr Justice Dingemans summarised the causative failures as follows:

- The Care Quality Commission ("CQC") of June 2012 report showed ligature audits were not being updated into care plans and there had been no specific ligature audit before Amy moved in to her room;
- A Healthcare Assistant ("HCA") did carry out an audit in early November 2012, but had no prior training of how to carry them out;
- The HCA noted several risks on the audit, none of which were changed to lower the risk, as a result of the audit;
- The Priory held product information since 2008 about the availability of protection equipment for ligature risks. At the time of Amy's death, this equipment was not yet implemented;
- On the date of death, the HCA who attended Amy's room did not have a master key to open it and none of the colleagues present at the scene had been trained in life support. Ligature cutters were not immediately available.

The Prosecution

Culpability was judged to be High. The Priory permitted these breaches over a long period of time and only took remedial actions after the death.

"There was, in my judgment, insufficient urgency demonstrated in dealing with these problems."

The seriousness of harm risked was death. However, the likelihood of harm was deemed to be low. Predicting suicide in children, even in specialist healthcare facilities, was accepted to be extremely difficult and statistically less likely than in adults

With an estimated turnover of £134 million, The Priory Healthcare was identified as a large turnover offender. The starting point was therefore £540,000.

In addition to a guilty plea, The Priory had no previous convictions and had a good health and safety record (demonstrated by the CQC 2018 report). It voluntarily took steps to refurbish the areas of concern and improve the patient service. These mitigating factors reduced the fine to £300,000.

Takeaway points

It took over six years to reach a conviction and sentence. Six years is not an uncommon timeframe for a fatal investigation.

It is vitally important to act on the findings of audits.

Rick assessments don't just apply to heavy manufacturing situations – education and care providers are likewise tasked with considering their risk profiles.

The HSE are currently undertaking investigations into several other deaths relating to young hospital patients.

This case may not be the first of its kind for very long.

Paul Verrico
Partner

T: +44 113 200 4084
M: +44 777 067 8808
paulverrico@
eversheds-sutherland.com

Surekha Gollapudi
Senior Associate

T: +44 113 200 4247
M: +44 791 900 5078
surekhagollapudi@
eversheds-sutherland.com

eversheds-sutherland.com