Inner London Crown Court
Newington Causeway,
London, SE1 6AZ.

Date: 27 January 2016

Before:

THE HON MR JUSTICE COULSON

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Between :

R	**Prosecution**
- and -	
Dr Errol Cornish	**1st Defendant**
- and -	
Maidstone and Tunbridge Wells NHS Trust ("The Trust")	**2nd Defendant**

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- -

Mr John Price QC and **Ms Sarah Campbell** (instructed by **CPS**) for the **Prosecution**
Mr Ian Stern QC and **Mr James Leonard**
(instructed by **Radcliffes LeBrasseur**) for the **1st Defendant**
Mr John Cooper QC and **Mr Michael Atkins**
(instructed by **DAC Beachcroft**) for the **2nd Defendant**

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RULING

A. INTRODUCTION

1. At 08:28 on 9 October 2012, Mrs Frances Cappuccini gave birth by Caesarean section to her second son, Giocomo at Pembury hospital in Kent, a hospital for which the Trust is responsible. Later that morning, she suffered from significant bleeding and at 11:15 Mrs Cappuccini was transferred to the hospital's High Dependency Unit. Following further blood loss, at 11:35 she was transferred to theatre for an Examination Under Anaesthetic ("EUA"). As part of the preparation for surgery, she was given a general anaesthetic. A piece of placental tissue was removed from the uterus and the EUA was finished at 12:05. Mrs Cappuccini remained under observation for about 15 minutes and no further bleeding was noted.

2. Just over 4 hours later, at 16:20, Mrs Cappuccini died following a cardiac arrest and lengthy but unsuccessful attempts at resuscitation. Her unexpected death can only properly be described as a tragedy. The Coroner's investigation into her death was suspended when it became apparent that the police were investigating the circumstances of her death[1]. Their investigations focused on two anaesthetists: Dr Nadeem Azeez, who was responsible for Mrs Cappuccini's anaesthetic care before, during and after the EUA, and Dr Errol Cornish, a locum consultant who provided assistance to Dr Azeez for a maximum period of about 40 minutes, between about 13:00 and about 13:40 that day.

3. Dr Azeez travelled to Pakistan following these events and he has not returned to the United Kingdom. He has therefore played no part in these proceedings. However the Crown have indicated (because they say it is relevant to their case against the Trust) that, if he was within the jurisdiction, Dr Azeez would have been charged with gross negligence manslaughter. Dr Cornish is charged with gross negligence manslaughter. In addition, the Trust is charged with corporate manslaughter under the Corporate Manslaughter and Corporate Homicide Act 2007 ("the 2007 Act").

4. After 7 days of evidence, the Crown closed its case on Friday 22 January 2016. On Monday 25 January 2016 I heard 3 hours' worth of argument relating to two separate applications, one made by each defendant, that there was no case for them to answer. At the end of the hearing I indicated that, since it was going to be appropriate to provide a ruling in writing, and since there were a large number of matters to cover, I would provide my ruling at 10:00 on Wednesday 27 January 2016.

5. The applications are made by reference to the well-known test in ***R v Galbraith*** [1981] 73 Crim. App R 124:

> "(1) If there is no evidence that the crime alleged has been committed by the defendant, the case should be stopped.
>
> (2) If there is some evidence but it is of a tenuous character, *i.e.* because of inherent weakness or vagueness or because it is inconsistent with other evidence:

[1] For the record, I should make clear that, as often happens in cases like this, the police originally became involved at the request of the coroner.

> (a) where the judge comes to the conclusion that the prosecution evidence, taken at its highest, is such that a jury properly directed could not properly convict upon it, it is his duty, upon a submission being made, to stop the case.
>
> (b) Where, however, the prosecution evidence is such that its strength or weakness depends on the view to be taken of a witness's reliability, or other matters which are generally speaking within the province of the jury and where on one possible view of the facts there *is* evidence upon which a jury could properly come to the conclusion that the defendant is guilty, then the judge should allow the matter to be tried by the jury."

B. THE LAW

B1. Gross Negligence Manslaughter

6. In one way or another, I have been referred to a number of authorities on this topic, including ***R v Adamako*** [1995] 1 AC 171; ***R v Singh*** [1999] Crim. L R 582; ***R v Jessey*** (1999, Steel J, unreported); ***R v Prentice*** [1994] QB 302; ***R v Misra*** [2005] 1 Crim. App R 21; ***R v Network Rail and Others*** (2005, Mackay J, unreported); and ***R v Lion Steel Equipment Ltd and Others*** (2012, HHJ Gilbart QC, unreported). ***Adamako*** explained the development of the offence of gross negligence manslaughter. ***Singh*** emphasised that: "The circumstances must be such that a reasonably prudent person would have foreseen a serious and obvious risk not merely of injury or even serious injury but of death." ***Jessey*** was a case in which the judge's directions stressed that the jury had to be convinced that "the negligence was bad enough to be condemned as the grave crime of manslaughter…that the shortfall from a reasonable standard was so flagrant, so atrocious, that it can properly be categorised as a serious criminal offence, namely manslaughter."

7. In ***Misra*** the Court of Appeal stressed that the jury had to consider whether the breach of duty should be categorised as gross negligence and was *consequently* criminal. They endorsed what the judge had said in his summing up to the effect that "…Mistakes, even very serious mistakes, and errors of judgment, even very serious errors of judgment, and the like, are nowhere near enough for a crime as serious as manslaughter to be committed." And in ***Lion Steel Equipment***, the most recent of the authorities/rulings cited to me, the then Honorary Recorder of Manchester, made clear that "…a defendant is only to be convicted of [gross negligence manslaughter] in a case such as this if his conduct is truly reprehensible and deserves criminal sanction of a kind appropriate to justify a conviction for manslaughter. There are many circumstances in life where mistakes or poor judgment can lead to the death of another…any death caused thus is tragic and one must do what one can to reduce the risks. But that does not mean that the law brings the full weight of criminal sanction for a very serious offence – manslaughter – to bear on any but very few such deaths."

8. This is, on any view, a very high hurdle for the Crown to meet. Thus in ***Prentice***, the Court of Appeal quashed the convictions of two doctors because the trial judge had not adequately directed the jury as to the extent to which the failure to ascertain the correct mode of administering the drug, and to ensure that that mode was adopted, was "grossly

negligent to the point of criminality". In both ***Network Rail*** (a case coming out of the Hatfield rail crash) and ***Lion Steel***, submissions by the defendants of no case to answer were successful.

9. In this case, the Crown will need to identify the following five ingredients in order to establish the guilt of Dr Cornish:

   (1) That he owed a duty of care to Mrs Cappuccini;

   (2) That he was responsible for acts or omissions which amounted to a breach of that duty of care;

   (3) That any such breach fell so far below the standards to be expected of an anaesthetist with his qualifications and experience, was so flagrant and so atrocious, that it would consequently amount to a crime;

   (4) That his breach of duty caused or made a significant contribution to the death of Mrs Cappuccini; and

   (5) That a reasonably prudent person would conclude in all the circumstances that an obvious and serious risk to the life of Mrs Cappuccini was thereby created by Dr Cornish.

10. It is accepted that, for the period in which Dr Cornish was involved, he owed a duty of care to Mrs Cappuccini. But the four remaining ingredients, namely breach, gross breach, cause of death and obvious and serious risk of death, are all in issue at this trial.

B2. Corporate Manslaughter

11. The relevant sections of the Act are as follows:

> "**1 The offence**
>
> (1) An organisation to which this section applies is guilty of an offence if the way in which its activities are managed or organised–
>
> (a) causes a person's death, and
>
> (b) amounts to a gross breach of a relevant duty of care owed by the organisation to the deceased.
>
> …
>
> (3) An organisation is guilty of an offence under this section only if the way in which its activities are managed or organised by its senior management is a substantial element in the breach referred to in subsection (1).
>
> (4) For the purposes of this Act–

(a) *"relevant duty of care"* has the meaning given by section 2, read with sections 3 to 7;

(b) a breach of a duty of care by an organisation is a "gross" breach if the conduct alleged to amount to a breach of that duty falls far below what can reasonably be expected of the organisation in the circumstances;

(c) *"senior management"*, in relation to an organisation, means the persons who play significant roles in–

(i) the making of decisions about how the whole or a substantial part of its activities are to be managed or organised, or

(ii) the actual managing or organising of the whole or a substantial part of those activities.

…

8 Factors for jury

(1) This section applies where–

(a) it is established that an organisation owed a relevant duty of care to a person, and

(b) it falls to the jury to decide whether there was a gross breach of that duty.

(2) The jury must consider whether the evidence shows that the organisation 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.

(3) The jury may also–

(a) consider the extent to which the evidence shows that there were attitudes, policies, systems or accepted practices within the organisation that were likely to have encouraged any such failure as is mentioned in subsection (2), or to have produced tolerance of it;

(b) have regard to any health and safety guidance that relates to the alleged breach.

(4) This section does not prevent the jury from having regard to any other matters they consider relevant.

(5) In this section *"health and safety guidance"* means any code, guidance, manual or similar publication that is concerned with health and safety matters and is made or issued (under a statutory provision or otherwise) by an authority responsible for the enforcement of any health and safety legislation."

12. The Trust accepts that it is an organisation to which the 2007 Act applies and accepts that it owed Mrs Cappuccini a duty of care. The remaining ingredients of the offence (each of which is in issue at this trial) are as follows:

(1) Activities were managed or organised by senior management in a way which:

(a) Comprised a breach of the Trust's duty of care;

(b) In all the circumstances comprised a gross breach of the Trust's duty.

(2) That the gross breach of duty caused or made a significant contribution to the death of Mrs Cappuccini.

13. Section 8 demonstrates that Parliament anticipated that the 2007 Act would usually be engaged in circumstances where it was alleged that the corporate defendant was in breach of relevant health and safety legislation/regulations/guidance. No such breach is alleged in this case.

14. There is no definition in the 2007 Act of the word "gross" in section 1(1)(b). In my judgment, it must be given the same grave meaning as in the common law, and must therefore be applied in the same way as noted in paragraphs 6-8 above.

C. THE RELEVANT EVENTS

15. Over the last 7 days of evidence the Crown have called a large number of doctors and other medical staff. They have also called an expert anaesthetist, Professor Hopkins, and an expert toxicologist, Dr Smith. My typed notes of that evidence currently run to 131 pages. In addition, there are three lever arch files of documents including around 100 pages of various medical notes relating to Mrs Cappuccini. I have had regard to all of that evidence, as well as the contents of the three files, in preparing this ruling. In the interests of economy, I identify below only the more important events and evidence, about which there is no, or no significant, dispute.

16. At about 12:20, Dr Azeez removed the tube from Mrs Cappuccini's airway. The nurse responsible for the two operating theatres in the maternity unit, Dawn Warboys, heard Dr Azeez calling Mrs Cappuccini's name and gently shaking her shoulder, but did not see or hear any response. Rebecca Shaw, an operating department practitioner ("ODP") who was also present at the time, saw Mrs Cappuccini lift her arms towards her face. Ms Shaw did not see any other movement and did not hear her speak. Dr Azeez later

told Dr Sommerville, a consultant anaesthetist who attended at about 13:40 that Mrs Cappuccini had shown other 'appropriate' signs of revival such as opening her eyes and becoming more conscious.

17. However the signs of revival did not continue. Her breathing was irregular. Accordingly she needed to be ventilated. For this, Dr Azeez used an oxygen bag and face mask in order to maintain her ventilation. He manipulated the bag with one hand, and placed the mask over her face with another. The bag was attached to a machine which showed readings for various things, including oxygen saturation levels and CO_2 levels. It sounded alarms if the readings warranted it. The evidence was that the use of the mask and bag was standard procedure in such situations. Reference was made to the Trust's Obstetric Anaesthesia Guidelines which concluded: "IF IN DOUBT, TAKE IT [the tube] OUT and VENTILATE WITH BAG AND MASK and/or LMA". This last was a reference to a laryngeal mask, described in the evidence as a sort of half-way house between the use of a mask and bag, on the one hand, and intubation, on the other. Dr Sommerville, a consultant anaesthetist who became involved later, expressly agreed with the advice in the Guidelines. No witness disagreed with it.

18. At about 12:35, a midwife, Ann Lodej told Sarah Woodward, the senior midwife, that Mrs Cappuccini would not wake up and was not breathing on her own. At about 12:40 Mrs Woodward went to the theatre to see for herself. She told Mrs Warboys that if a consultant anaesthetist was required, there was a consultant, Dr Cornish, in the theatre next door. Throughout the period up to about 13:00, Ms Shaw assisted Dr Azeez in moving Mrs Cappuccini into various positions so that she could breathe more easily by herself. Dr Gabriella Gray, the Obstetric Registrar who had performed the EUA and had removed the piece of placenta, also looked in during this period to make sure that Dr Azeez was alright. He told her that he was, so she left to attend other patients. She confirmed that, at this point, Dr Azeez "looked calm and in control".

19. Shortly before 13:00, Terry Murphy, the ODP from the other maternity unit theatre next door, came in to the theatre where Dr Azeez, Mrs Warboys and Ms Shaw were dealing with Mrs Cappuccini, in order to borrow a piece of equipment. Ms Shaw asked him if he could ask Dr Cornish to come in. At the time Dr Cornish was providing direct solo anaesthetic care to a patient in the adjoining theatre who was having an elective Caesarean. That operation started at 12:48 and finished at 13:40.

20. Dr Cornish arrived at about 13:00 and took a history from Dr Azeez as he continued to manipulate the oxygen bag and provide oxygen to Mrs Cappuccini. Mrs Warboys said that, after Dr Cornish and Dr Azeez had discussed the case, they asked for help from the ITU ("intensive care") consultants. Ms Shaw said that Dr Cornish used her phone to call ITU. The evidence was that the call went first to Dr Sigston off-site and he called Dr Sommerville, a consultant anaesthetist and intensivist.

21. In addition to making the call that alerted Dr Sommerville to Mrs Cappuccini's situation, Dr Cornish did a number of things whilst he was with her in the theatre with Dr Azeez. These included reviewing Mrs Cappuccini's oxygen saturations (which gave no cause for alarm); listening to the patient's chest to check her breathing and the airway, referred to in the notes as 'auscultating' her chest; taking a variety of temperature, haemoglobin and blood sugar readings; and checking the extent of Mrs Cappuccini's continuing paralysis with two nerve stimulators. No criticism was made by anyone of any of these actions.

22. Mr Kavoor was the Consultant Obstetrician and Gynaecologist who had overseen the EUA. He was alerted by a member of the theatre staff to the ongoing problem with Mrs Cappuccini. He went back to the theatre at about 13:20. He saw Dr Cornish there and saw Dr Azeez ventilating Mrs Cappuccini with a bag and a mask. Mr Kavoor said that he was told that Mrs Cappuccini was being transferred to the ITU because her breathing had not picked up. He was clear that a decision had already been made to that effect. He said that Mrs Cappuccini's failure to revive naturally "was completely unexpected". He also noted at the time that her blood pressure and pulse rate were within normal limits and that she was haemodynamically stable. He said that she did not seem to be in a critical state and nobody was suggesting that she was in a critical state. He thought that she might recover breathing spontaneously at some point because, as he put it, "most patients do". He did not realise that she was critical until she had a cardiac arrest at 15:17.

23. Dr Grey also returned to the theatre at about the same time as Mr Kavoor, having been told by Mrs Woodward that there were problems with the airway and that the anaesthetists wanted help. She saw that Dr Azeez was continuing to use the bag and mask, with Dr Cornish at Mrs Cappuccini's side. She was told that there had been some signs that the patient was waking up and the tube was removed, but after the removal of the tube her breathing was irregular and had not been fully re-established. She thought that Dr Cornish had said to her: "We are trying not to reintubate. Is there anything that may contribute obstetrically [to the diagnosis]?" Dr Grey confirmed that she understood from this that the possibility of reintubation had been considered.

24. Dr Sommerville said that he went to the labour ward straightaway after getting the call referred to in paragraph 20 above. It appears that he arrived at around 13:30 or 13:35. Following the arrival of Dr Somerville, at no later than about 13:40 and possibly a little earlier, the weight of the evidence was that Dr Cornish left Mrs Cappuccini and went back to his own patient next door. A number of the witnesses said that they had no recollection of seeing Dr Cornish in the theatre once Dr Sommerville (and almost simultaneously) Dr Chung arrived. William Penta, another ODP, said that he was not present. That is also what Dr Cornish said in his statement to the coroner, read to the jury as part of the evidence about his police interview. The only contrary evidence came from Dr Ganesaratinam, who said in cross-examination that he was 'almost certain' Dr Cornish was there when Dr Sommerville was treating the patient, but he accepted that he could not remember precise times. All he could say was that these events had happened in the middle of the day.

25. It seems clear that, now that a more senior anaesthetic consultant had arrived, and with another patient to attend to, Dr Cornish left. No criticism was made of Dr Cornish by anyone for leaving at this point. Accordingly, his involvement in these events was for a period of about 35 minutes and not more than 40 minutes in total.

26. When Dr Sommerville arrived, he noted that the anaesthetic machine attached to the bag was not recording or showing any CO_2 levels. He said, as others had already said, that there were no alarms sounding from the machine. He noted that Mrs Cappuccini's oxygen saturation was 95%, which was, he said, "pretty acceptable". But he thought that there was a possibility that Dr Azeez's ventilation using the bag and mask "may not have been perfect", because, he said, if air is escaping round the side of the mask, a CO_2 reading is not always obtained. In addition, he said that there was a possibility that Mrs Cappuccini's stomach had a bulge. That could have been because she had been

pregnant, but he said that it could also have been a sign that there was not a good seal, so that pressure was being put on the oxygen bag, causing Mrs Cappuccini's stomach to be distended. He concluded this aspect of the evidence in his cross-examination by saying that, in his use of the bag and mask technique, he considered that Dr Azeez "was not extracting the CO_2 as quickly as he might".

27. Dr Sommerville said he asked Dr Azeez to put a laryngeal mask on Mrs Cappuccini whilst he got ready for theatre, although he did not remember if Dr Azeez acknowledged that instruction. Dr Sommerville was ready and had returned to the theatre by about 13:40.

28. By the time Dr Sommerville returned to the theatre, he noted that, in the preceding few minutes, Mrs Cappuccini's oxygen saturations had dropped to 85% which he said was 'not too bad' but meant that the delivery to the tissue was 'not too good'. This drop was confirmed by Ms Shaw, who said in her examination in chief that "they [the saturation levels] were beginning to go down. They had not been dropping for very long at all". She also confirmed in her re-examination that the saturations "did not go low enough to sound alarms".

29. In addition, the laryngeal mask had not been put on, and the evidence is that Dr Sommerville probably did this himself. When Dr Chung, the consultant anaesthetist in charge of all the intensive care at the hospital, arrived shortly afterwards, he said that he saw Dr Sommerville ventilating the patient with a laryngeal mask. Although Dr Chung's notes record his arrival as being at 'approximately 13:30', the other timings suggest that it must have been after 13:40. In this way, Mrs Cappuccini was ventilated through the laryngeal mask for a period by Dr Sommerville. It is not possible to say on the evidence how long that lasted, although a number of witnesses saw the laryngeal mask in place and reintubation did not occur until about 14:15 (see below).

30. A time came when everyone concluded that reintubation should occur. There was evidence that the situation was deteriorating. Dr Ganesaratnam, the on-call anaesthetic registrar who attended at the same time as Dr Chung, said that at about this time, in addition to the lack of a CO_2 trace, the chest wall movement seemed to be inadequate. He thought it was clear that the patient was not adequately ventilated. Dr Chung said that the situation was now urgent, and the patient was critical, because Mrs Cappuccini was now deeply unconscious, had dropping oxygen saturation levels and did not have an appropriate airway.

31. Dr Sommerville was clear that the planned reintubation had not occurred by about 14:20, which was the time when he left the theatre. 14:10 is the time shown for the reintubation on the anaesthetist's chart completed (albeit retrospectively) by Dr Azeez. The jury is therefore likely to conclude that reintubation occurred at about 14:15. Dr Chung was surprised when these timings were put to him in cross-examination; he said he thought that he had reintubated her within 5 or 10 minutes of arriving. However all the other evidence, including the medical records, contradict that.

32. The evidence was that Mrs Cappuccini was categorised as a difficult intubation. Dr Azeez told a number of his colleagues this, including Dr Cornish. That may explain why Dr Cornish had indicated to Dr Grey that they were trying not to reintubate, although that could also have been because that is what the guidelines said (see paragraph 17 above). At all events, Dr Chung now asked Dr Azeez to reintubate and he

failed to do it properly, putting the tube into her oesophagus, not her airway. The evidence was that, immediately thereafter, Dr Chung took the tube out and did it himself. On the second reintubation, a proper airway was created

33. There were some important blood gas test results taken at 13:44, although the evidence was that they were not considered by those who were there until after the decision had been taken to reintubate, and possibly not until after the reintubation itself. Dr Chung said in evidence that, in consequence, the results were irrelevant to him. The experts agreed that these results showed a high but not life-threatening potassium level (Dr Grey called it "mildly elevated"); and the experts also agreed that "ventilation was inadequate but the patient was well-oxygenated". This was in the experts' joint statement at paragraph 21, which together with paragraphs 20 and 22, was read into the record during the cross-examination of Professor Hopkins. Their conclusion was that "the results per se do not show the patient required immediate intubation".

34. Following her reintubation, arrangements were made to take Mrs Cappuccini to the ITU. Unhappily, by the time she was transferred down to that area, all the beds were taken, so she was treated in the emergency recovery area, just next door. Her pulse and blood pressure dropped and although she was given various drugs to try and correct this, she had a cardiac arrest at 15:17. Various attempts were made to resuscitate her but they proved unsuccessful, and at 16:20, she died.

35. There can be no question that Mrs Cappuccini should not have died at the Trust's hospital on 9 October 2012. It is inevitable that her family want to know why it was that she did die, and they want someone to be held accountable for their loss. They have shown restraint and dignity throughout the trial. But as I am sure they understand, this trial is not a public inquiry into her death. It is a very different thing; it is a criminal trial of two defendants for very serious offences which, because of their seriousness, require a particularly onerous series of requirements to be satisfied by the evidence adduced by the Crown. The question raised by these applications is whether that evidence, taken at its highest, is such that a jury could properly convict upon it.

D. THE CASE AGAINST DR CORNISH

D1. Breach of Duty

36. It is the Crown's case that, during his involvement between approximately 13:00 and no later than 13:40, Dr Cornish, as the senior anaesthetist, should have *immediately* reintubated Mrs Cappuccini. That was how the case was opened. In his submissions in respect of no case, Mr Price QC said that the Crown's case was very simple: that Dr Cornish had failed in this elementary task and that this was a breach – and the Crown say a gross breach – of his admitted duty of care to Mrs Cappuccini. But in my view, taking all the evidence into account, the Crown has failed to make out a case on breach against Dr Cornish that could properly be left to the jury. There are a number of reasons for that conclusion.

37. First, there was no suggestion that the continuing use of the bag and mask over the relevant period was itself negligent or contrary to any guidance or advice governing the proper practice of anaesthetics. It is commonplace in any case of breach of duty alleged against a professional person for that person's conduct to be assessed by reference to such guidance. In the present case, the only guidance that was produced in evidence

was that provided by the Trust (paragraph 17 above), which suggested that the right approach was to remove the tube and to use the bag and mask. To that extent, therefore, Dr Azeez's continuing use of this method of ventilation was in accordance with the only written guidance that the jury have seen.

38. I had anticipated that the Crown would adduce evidence of guidance which indicated how long it was appropriate to use a bag and mask before some other method of ventilation might be necessary. There was no such guidance and no such evidence. It was not something that Professor Hopkins addressed. Since the use of the bag and mask per se was accepted by everyone as a proper means of ventilation, and there was no evidence as to how long that means of ventilation could properly be used, there is no evidence on which the jury could conclude that Dr Cornish's failure between 13:00 and 13:40 to prevent the continuing use (by Dr Azeez) of the bag and mask *per se* was a breach of his duty of care.

39. Secondly, there was no evidence from anyone who was present during the time that Dr Cornish was in attendance to suggest that there was a concern about the way in which Dr Azeez was using the bag and mask. No-one there prior to the almost simultaneous arrival of Drs Sommerville, Chung and Ganesaratnam at about or after 13:40 expressed any concern about how Dr Azeez was using the bag and mask. And Professor Hopkins did not say that Dr Cornish should have recognised that, in some particular way, Dr Azeez was not using the technique properly, and did not point to anything during that period which should have alerted Dr Cornish to a failure in the way that the airway was being maintained.

40. Thirdly, there were no warnings or signals to cause concern. Alarms were not sounding from the machine to which the oxygen bag was connected, despite the fact that the evidence was that they would have sounded, and would have been expected to sound, if there was a problem. The oxygenation levels remained good throughout the period between 13:00 and 13:40, demonstrating that oxygen was plainly passing into Mrs Cappuccini's lungs. Although it was noted at about 13:40 that there were no CO_2 readings, there was no evidence that this was the case any earlier. Neither Mrs Woodward, nor Ms Warboys, nor Mr Kavoor, nor Dr Grey, gave any evidence about the absence of such readings before 13:40. Moreover, once there was a definite reading, when the blood gas test was done at 13:44 (after Dr Cornish had left), although there was a high CO_2 level, the notes written by Dr Chung later that day made clear that this was subsequently reduced to a much lower level following reintubation.

41. Fourthly, those blood gas test results are important to the issue of breach in another way. The experts agreed, as noted in paragraph 32 above, that those blood gas results do not show that, as at 13:44, Mrs Cappuccini required immediate intubation. Accordingly, on behalf of Dr Cornish, Mr Stern QC asked Professor Hopkins the perfectly valid question: if immediate reintubation was not required on the basis of the fullest set of results available, at 13:44, how could it possibly have been required between 13:00 and 13.40? In my view, there was no proper answer to that question, because no such answer existed.

42. Fifthly, the reason why Dr Cornish's breach of duty can only be measured by reference to the period up to 13:40 at the latest is because it was at that time that Dr Sommerville, the on-call consultant anaesthetist, arrived and took over supervisory responsibility from Dr Cornish. Importantly, and consistent with the blood gas test results (which he

had probably not seen), based on his assessment of Mrs Cappuccini, Dr Sommerville did *not* advise immediate reintubation. Instead, he advised that a laryngeal mask be used. This is the half-way house between using a bag and mask, on the one hand, and reintubation on the other, and Dr Sommerville agreed that it was "not without its issues".

43. The fact that Dr Sommerville did not immediately reintubate Mrs Cappuccini at or shortly after 13:40 demonstrates the artificiality of the suggestion that Dr Cornish should have reintubated 30 minutes earlier. The jury cannot properly find a breach by Dr Cornish in failing to reintubate, in circumstances where, even though he was involved at a later stage, Dr Sommerville is not criticised for doing exactly the same thing.

44. Finally, there is what I consider to be a myriad of difficulties in the evidence of Professor Hopkins, the Crown's expert anaesthetist. The high watermark of the Crown's case was Professor Hopkins' evidence in chief, and the assertion – without any cogent reasoning – that Dr Cornish should have reintubated immediately, and that this was a basic and fundamental failure for an anaesthetist. But I have already pointed out the various matters which Professor Hopkins failed to address in his evidence which I consider to be critical. Moreover his cross-examination revealed a number of vital qualifications even to his initial assertion that immediate reintubation was required.

45. First, Professor Hopkins made it clear that he would have expected reintubation within 15 minutes from a consultant arriving and getting information about the patient. Given that Dr Cornish was there for a total of 35-40 minutes at most, a period of 15 minutes prior to intubation was obviously an important concession. It meant that, even on this view of Professor Hopkins' evidence, the relevant period of Dr Cornish's culpability was between 13:15 and, at the latest, 13:40.

46. Secondly, Professor Hopkins then accepted that it *could* be reasonable for Dr Cornish to decide not to reintubate, but to call a consultant to attend instead. In essence, of course, that was what Dr Cornish did. Since Professor Hopkins accepted that the course he adopted *could* be reasonable, it cannot be said, on the Crown's own expert evidence, taking it at its highest, that Dr Cornish was in breach of his duty of care for taking that course. On that evidence, the jury simply could not be sure.

47. Thirdly, another important qualification emerged from Professor Hopkins' evidence about paragraph 20 of the experts' joint statement. This was read into the evidence during his cross-examination. It was in these terms:

> "All agree that, in general terms, a situation where a solo anaesthetist has more than one anaesthetised patient under their care may justify differences in management compared to the management that would normally be given. These situations are not black and white and the experience of the anaesthetist is important in balancing risk."

48. Professor Hopkins confirmed in his cross-examination his agreement with that statement. He reiterated that each case depended on its merits. He agreed that it was not an easy task facing Dr Cornish. Eventually there was this exchange:

"Q: So does it [the patient in the other room] make a difference to the conclusion?

A: It could have a bearing. But in these circumstances it did not matter.

Q: So the reasonableness of what Dr Cornish did or did not do would be affected by what was in Dr Cornish's mind about he other patient?

A: Yes. There are circumstances where something is happening with the original patient and that might have a bearing on what you do.

Q: And you don't know what was in Dr Cornish's mind?

A: No I don't."

49. Again therefore it seems to me that Professor Hopkins' admission means that, because of the complications introduced by the presence of the other patient, the jury could not be sure that Dr Cornish was in breach of duty. How could they be sure that Dr Cornish was in breach in circumstances where, taking it at its highest, Professor Hopkins was agreed that it was not an easy task; that it was not black and white; that each case depended on its merits; and that the anaesthetised patient in the next door theatre could have a bearing on what Dr Cornish said or did.

50. For all these reasons, therefore, I consider the evidence as to breach – Dr Cornish's alleged failure to reintubate between 13:00 and no later than 13:40 – is either non-existent or, taken at its highest, tenuous to a highly significant degree. It fails the test set out in either the first or the second limbs of ***Galbraith.***

D2. Gross Breach

51. However, let us assume that I am wrong in the above analysis, and the evidence is sufficient to allow the jury safely to conclude that there was a breach of duty on the part of Dr Cornish. Could the jury go on safely to conclude that that breach was so 'reprehensible', so 'atrocious' (to use the words in the cases) that, in committing it, Dr Cornish was consequently guilty of gross negligence manslaughter?

52. In my view, the question only has to be posed to be roundly answered in the negative. Of course I accept that this would normally be a matter for the jury and if there is any evidence which is more than tenuous which might allow the jury to be sure that the test, however onerous, had been met, then it is appropriate to leave the matter to them. But if there is no such evidence then, as a matter of law, the case must be stopped.

53. In the present case, my conclusion that there is no such evidence is based on the analysis set out above. The absence of any suggestion of a failure to adhere to written guidance or rules; the apparent adherence to the only written guidance that was in evidence; the common use of a bag and mask in these circumstances; the absence of any evidence that, between 13:00 and 13:40, Dr Cornish should have realised that Dr Azeez was not using the bag and mask properly; the absence (during the same period) of any warning sign or signal (such as the alarms) that Mrs Cappuccini was not being

adequately ventilated; the good oxygenation levels throughout the period; the relatively short period for which Dr Cornish could be culpable when measured against the overall period with which we are concerned; the fact that after he had left, when Mrs Cappuccini was in the care of Dr Sommerville and then Dr Chung, immediate reitubation did not take place; and the fact that reintubation did not occur for another 35 minutes after he had left; all these factors mean that, realistically, there is no prospect of a jury, properly directed, concluding that Dr Cornish was guilty of gross negligence manslaughter.

54. Gross negligence manslaughter cases are relatively rare. That is because they have at their heart mistakes or errors of judgment which are so crass, so obvious, and should be regarded as so reprehensible, that they are consequently a crime. So by way of example only, in ***R v York College and Another*** [2014] EWHC 122 (QB), the case was based on the fact that the girl had been missing for 20 minutes without her teacher realising that she was absent (although it worth saying that the teacher was acquitted of gross negligence manslaughter). And in ***Misra***, where the appeals against conviction were refused, it was a failure by two doctors to identify severe and persistent signs of infection which would have been obvious 'from a glance at the relevant charts'; ignoring advice from other members of the medical team that further treatment was needed; and failing to seek help from other doctors.

55. Here, the only evidence on this issue is Professor Hopkins' assertion that the failure to reintubate was fundamental and that Dr Cornish's seniority compounded his failings. But that assertion has to be set against all the rest of the evidence summarised in **Section C** above, and the analysis in **Section D1** above. By way of example only, it has to be considered in the light of the fact that Professor Hopkins agreed that the matter was not black and white; that calling for assistance without reintubation could be reasonable; and the fact that Dr Cornish had another patient was also relevant to his decision. These are all matters which demonstrate that this was the exercise of a clinical judgment by Dr Cornish. Unlike ***Misra***, there were no obvious signs of concern, let alone signs that were persistent and which could have been identified by a glance at a chart; Dr Cornish did not ignore the advice of others; and he almost immediately sought further help. It is as far removed from a gross negligence manslaughter case as it is possible to be.

56. Another way of putting my conclusion is this. The authorities and rulings to which I have referred talk about 'very serious errors of judgment', 'recklessness' and 'indolence' not necessarily being enough to meet the common law test for gross negligence manslaughter. But in the present case, there is no evidence that there was a definite error of judgment *at all*, let alone one which could be described as serious or even very serious. And far from this being a case of recklessness or indolence, the evidence was clear that reintubation had been considered by Dr Cornish, and for the time being he had decided against it (see his comment to Dr Grey). It is unsurprising that, after Mrs Cappuccini's death, he wondered in his statement to the coroner if reintubation should have been carried out earlier, but for the reasons I have given, that is simply not the sort of decision-making process which meets the relevant test.

57. For these reasons, I have concluded that (even if I am wrong, and there is some evidence as to breach) there is no evidence which supports the suggestion that the clinical misjudgment made by Dr Cornish (if that is what it was) was capable of being

classified as gross, and therefore a crime. That is therefore the second reason why I consider that the application made on behalf of Dr Cornish should be allowed.

D3. Cause of Death

58. It is agreed that the probable cause of Mrs Cappuccini's death was a cardiac arrest caused by hyperkalemia, a build up of potassium in the blood. Professor Hopkins said that this was caused by respiratory acidosis, which itself was caused by what he said was the inadequate ventilation. The case on cause of death advanced by Dr Cornish, and put to Professor Hopkins with some care by Mr Stern QC, is that the hyperkalemia arose from acute kidney injury and/or sepsis, and was thus unrelated to the respiratory acidosis. Professor Hopkins was consistent in denying the existence of either of those conditions in this case. They cannot therefore be prayed in aid of a submission of no case to answer.

59. What matters, therefore, is Professor Hopkins' own case as to causation. When taken at its highest, is his evidence sufficiently robust (i.e. more than tenuous) to allow a jury properly to conclude that the failure to reintubate between 13:00 and 13:40 caused or significantly contributed to Mrs Cappuccini's death? In my view, for two separate reasons, it is not.

60. The first difficulty is the mechanism relied on by Professor Hopkins, in order to be able to say that the high levels of potassium were the result of the inadequate ventilation prior to reintubation. The records do not support that mechanism. Immediately prior to reintubation, the blood gas test at 13:44 (to which I have already referred) demonstrated that Mrs Cappuccini had a high, but not life-threatening, potassium level. Following reintubation, and once the test result was noted, medical notes completed by Dr Chung recorded that that level was "now corrected with ventilation". The question was therefore, how the inadequate ventilation *prior* to reintubation could have caused an increase in the rise in potassium *after* reintubation, and when the notes indicated that reintubation had corrected the potassium level? Why and how could the respiratory acidosis continue, and get worse, after Mrs Cappuccini was breathing properly on the ventilator?

61. Professor Hopkins had to say that the respiratory acidosis would not have been corrected by the reintubation and that, unknown to anyone it seems, the potassium levels would have continued to rise. On that basis, he was saying that Dr Chung was wrong to say that the potassium level was corrected by reintubation, although there was no evidence to support that view. Moreover (as was put to Professor Hopkins in cross-examination) his theory – that potassium levels rise even after full ventilation is provided – would or could have a significant effect on how all ventilated patients might be treated.

62. On any view, Professor Hopkins' evidence about the support for this theory was entirely unconvincing. He was unable to point to any written paper which made this point good. The best he could do was to say that it was supported by experiments in rats and dogs during the 1950's and 1960's. But even then, the highest he could put it was that "this *could* reflect the same phenomenon as seen in humans".

63. Again, therefore, it is very difficult to say that there is any proper evidence on which, taking it at its highest, the jury could conclude that, despite the reintubation at 14:15

Mrs Cappuccini's potassium levels continued to rise because of the allegedly inadequate ventilation which had occurred before the reintubation. It was plainly contrary to received wisdom (as can be seen in Dr Chung's note as to the effect of reintubation). It was put forward merely as a possibility ("could"). In a case of this sort, I consider that such matters cannot safely be left to the jury.

64. I should add for completeness that Professor Hopkins at one point referred to the possibility of toxic shock to the heart, but it was clear that this was speculation and it had not been something referred to in any of his many reports. He did not develop it further.

65. As noted above, there is a second causation issue which Mr Stern QC raised and with which Mr Price QC did not deal in any detail, although I consider it to be significant. It concerned the particular issue of causation which arises in the case of Dr Cornish. Assuming against him for this purpose that he was in gross breach of duty, that breach was only effective from about 13:15 (the time by which, taking his evidence at its highest, Professor Hopkins would have expected reintubation to have taken place) and about 13:40, the latest time when Dr Sommerville took over the anaesthetic care of Mrs Cappuccini. That was a period of 25 minutes in a total period of just under 2 hours (between 12:20, when she was extubated and 14:15, when she was reintubated).

66. It is important to set that 25 minutes against the total period of 1 hour and 55 minutes, because Professor Hopkins' answers in cross-examination made plain that what he said were the consequences of the inadequate ventilation and the increase in potassium levels could have occurred at any time during this total period.

67. Of course, I am well aware of the dangers of a judge being over-precise and too scientific in considering causation in a case of this sort. On the other hand, I have to remind myself that Dr Cornish faces the grave charge of gross negligence manslaughter because of an alleged failure to intervene or be more proactive in another anaesthetist's case for a maximum period of 25 minutes. In those circumstances, it is necessary for the jury to be sure that his alleged breach (i.e. the 25 minutes when she was not reintubated) caused or made a significant contribution to Mrs Cappuccini's death.

68. The Crown called no evidence in support of such a case. Indeed, Professor Hopkins' evidence went the opposite way, namely that the respiratory acidosis could have been present shortly after extubation (12:20) or at any time before reintubation (14:15). He could not say when in that period of 1 hour and 55 minutes the critical change took place. On his express evidence, it was perfectly possible that Dr Azeez was ventilating the patient successfully during some or all of the period that Dr Cornish was present and that any failures occurred before or after that 25 minute period. Conversely, it was equally possible on his evidence that, even if Professor Hopkins' theory is right, the rise in potassium was not caused at a time that Dr Cornish was present.

69. Accordingly, I accept Mr Stern QC's submission that there is no evidence upon which the jury, properly directed as to the law, could conclude to the requisite standard that anything which happened whilst Dr Cornish was attending Mrs Cappuccini as the senior anaesthetist caused or significantly contributed to Mrs Cappuccini's death.

70. For those reasons, therefore, I conclude that the causation ingredient is also missing in this case and is a third reason why the evidence supporting the gross negligence manslaughter charge fails the test in ***Galbraith***.

D4. Serious and Obvious Risk of Death

71. The final ingredient which the Crown has to establish against Dr Cornish is that, to a prudent person, there was a serious and obvious risk of death arising from Dr Cornish's acts and omissions. Although this is in many ways a less significant matter than breach, the gross nature of the breach, and causation, I have also concluded that, on their own evidence, the Crown cannot establish this element either.

72. The Crown's principal difficulty is that, despite the presence of numerous medical staff between 13:00 and 13:40, nobody considered that Mrs Cappuccini was in any significant danger. Indeed, even after Dr Cornish had gone, and the situation was regarded as urgent, there was no anticipation of any further problems arising from the ventilation once Mrs Cappuccini had been reintubated: see Dr Chung's note. The case was opened on the basis that, at the time when Dr Cornish left, "Mrs Cappuccini was dying". Not only was there not a shred of evidence to support such an assertion, but all the evidence (including the experts' agreement that the blood gas results at 13:44 did not even require reintubation) pointed in exactly the opposite direction. Accordingly, I consider this final element of the Crown's case is also missing and thus a further reason why, on ***Galbraith*** grounds, there is no case for Dr Cornish to answer.

E. THE CASE AGAINST THE TRUST

E1. Senior Management

73. I start with this topic, not because I regard it of any significance, but because it was the principal complaint made by Mr Cooper QC in his written submissions. Although this matter was dealt with in my ruling in October ([2015] EWHC 2967 (QB)), Mr Cooper QC revisited both the history of that application, and its resolution, to suggest that, in some way, the particulars provided by the Crown pursuant to my order were not adequate and that the evidence which had been adduced meant that there was no proper case as to the levels of senior management at the Trust who were involved.

74. I reject that submission for three reasons. First, I consider that the particulars that were provided were adequate, referring as they do the clinical director as the lowest tier of management with an involvement. I note that no point was subsequently taken before me, either before or at the start of this trial, as to the adequacy of the particulars. It would be wrong in principle to rule that there was no case to answer because of a pleading point which had not been raised with the court before evidence was called.

75. Secondly, I consider that of much more relevance to this issue was the evidence called by the Crown. Professor Hopkins gave a good deal of evidence about clinical governance and how a Trust should approach the issue. He said that the Chief Executive Officer of the Trust was ultimately accountable and that each Trust should have a lead medical practitioner on the Trust's Board. Commonly that would be the medical director. It was for the Board of the Trust to ensure that it had an appropriate structure and practices to maintain proper clinical governance.

76. In addition, Professor Hopkins gave evidence about what was involved in clinical governance including education and training; clinical audits; comparing outcomes with benchmarks; clinical effectiveness; risk management which involved compliance with the law and codes of practice and so on; making sure there were appropriate procedures for appointment, performance management; and discipline of doctors and healthcare workers. He went on to explain why, in his view, the Trust did not meet the statutory duty of clinical governance.

77. In my judgment, therefore, there was plenty of evidence for the jury to conclude that the level of senior management responsible had been sufficiently identified in the evidence. It was either the CEO, or the medical director, or (if that was a different person) the clinical director.

78. Thirdly, I consider that, having heard Professor Hopkins' evidence, the jury would be entitled to conclude that, if they found gross breaches in the way in which the Trust's activities were organised and managed, which were causative of Mrs Cappuccini's death, they would be entitled to assume that these were matters which were, or should have been, the responsibility of senior management.

79. For these reasons, therefore, I reject the submission that in some way the case against the Trust should be stopped because the precise tier or the precise individuals involved in the Trust's management had not been identified. I express my surprise that this point was raised to support an application of no case to answer.

80. Instead, I have focused on the actual issues between the Crown and the Trust, namely whether or not there were breaches in the management and organisation of the activities; whether those could be said to be gross breaches; and the case as to causation. I have been anxious about these matters throughout the trial, and in the light of the Court's duty as set out in ***Galbraith***, I went through them in some detail with Mr Price QC, in order to seek his assistance. Because of their potential importance, I was anxious to ensure that the Crown had a full opportunity to deal with my queries.

E2. Management/Organisation of Activities: Breach of Duty?

E2.1. General

81. On the evidence there seemed to me to be three parts of the case on breach identified by the Crown: the interview/appointment process; the appraisal and general supervision of the doctors; and the supervision on 9 October 2012. Mr Price QC accepted that analysis. I therefore deal in turn with each point below.

E2.2. Interviews/Appointments

82. It is the Crown's case that Dr Azeez should not have been appointed by the Trust because he was insufficiently qualified. This was an issue which featured prominently in the Crown's Opening and in the subsequent reporting of the trial. In my judgment, there is no evidence at all to support this assertion, let alone as an alleged breach of section 1(1) of the 2007 Act. There are a whole series of reasons for that conclusion.

83. The first is that the allegation was unsupported on the facts. It was agreed that Dr Azeez was suitably qualified if he had the equivalent of 3 years' training in the United

Kingdom. This was known as 'equivalence'. According to his CV, prior to being engaged as a staff anaesthetist by the Trust, Dr Azeez had (amongst other things) practiced in general practice for 4 years and 4 months in rural Punjab, and 6 years and 6 months as an anaesthetist in hospitals in Lahore. There was also a period of 18 months as an anaesthetist at a hospital in Goodmayes, in North East London.

84. On the face of it, that record might be thought to be more than equivalent of 3 years in a UK training post. Plainly that was the view of Dr Lawton, who interviewed Dr Azeez and recommended his appointment.

85. Secondly, there was no evidence on which Professor Hopkins was entitled to take a different view. He said that equivalence would depend on what precisely Dr Azeez had been doing during his time in Pakistan. But he had no information about that, so the best he could say is that Dr Azeez may or may not have been suitably qualified, but he could not say one way or the other because – unlike Dr Lawton – he was not aware of the detail.

86. Thirdly, the appointment of Dr Azeez had occurred before 6 April 2008, when the 2007 Act came into force. As I ruled in October, it could not therefore form a particular of breach arising under the Act in any event.

87. Fourthly, if I was wrong on each of the above points, then the highest that this case could be put was that it was an error of judgment on the part of Dr Lawton to treat Dr Azeez's extensive experience in Pakistan as the equivalent to 3 years training in the United Kingdom. That was a one-off failure: it was not a deficiency in the Trust's management and organisation of its activities. It was not systemic. I did not understand Mr Price QC to dispute that conclusion.

88. For all those reasons, therefore, there is no evidence before the jury that the Trust was in breach of its duty by appointing Dr Azeez. The same issues, so the same conclusion, arises in respect of his 'upgrading' (as part of a nationwide scheme) to the new rank of Specialty Doctor.

89. The criticisms made by the Crown of Dr Cornish's appointment by the Trust were similar although, because his final appointment as a locum consultant was after 6 April 2008, there is no statutory difficulty as there is with Dr Azeez (paragraph 84 above). There seemed to be two particular criticisms of the Trust: first, that there was no record of a relevant interview, and second that Dr Cornish's CV was in some way open to question. With great respect, I consider that both of these points are simply untenable on the evidence.

90. There was no record of a final interview with Dr Cornish before his last appointment by the Trust prior to 9 October 2012. But this was because Dr Cornish had twice before worked for the Trust as a locum, with his services supplied through an agency. The Trust had been entirely happy to take him, from the bank of locum doctors and consultants who had worked for them before, as and when they required him. Accordingly, the fact that there was no note of his most recent interview was nothing to the point. The Trust was plainly entitled to use their previous experience of Dr Cornish in deciding whether or not to engage him again. Professor Hopkins' insistence that there should have been an interview was in my view perverse.

91. As to his CV, Dr Cornish has had on the face of it, an extremely impressive career, which included working as a registrar under Dr Christian Barnard in a large hospital in South Africa, where he was for over 15 years. Professor Hopkins' criticism was that, since moving to the United Kingdom, Dr Cornish had been employed by a number of different Trusts and that this was, in some way, "a cause for concern". This concern was not explained. Moreover, although Professor Hopkins kept referring to the Trust's failure to identify Dr Cornish's deficiencies, he was himself quite unable to identify any such deficiencies. In answer to the obvious point that it followed from Professor Hopkins' criticism that all the other hospitals that had employed Dr Cornish as a locum had also been wrong to do so, Professor Hopkins said (cryptically, and without explanation) that Dr Cornish might not have had those deficiencies (whatever they were) at the time that he was employed by the other hospitals. Again, I regard the criticism as perverse.

92. If I am wrong about that, there is of course also the point that the failure to interview and the decision that there was equivalence were one-off errors made by reference to this particular doctor, as opposed to some sort of systemic failure. Again therefore, section 1(1) of the 2007 Act is not engaged.

93. For all these reasons, therefore, I am confident that there is no evidence at all of any case against the Trust under the 2007 Act arising out of the appointment of either Dr Azeez or Dr Cornish.

E2.3. Appraisal/Supervision

94. I conclude that this part of the case, which arises out of the continuing professional development of Dr Azeez only, is also unsupported by the evidence.

95. There was evidence that, at the relevant time, some NHS Trusts were not undertaking regular or any appraisals. That is the sort of systemic failure which, had it arisen in this case, might well be regarded as a breach of the sort of management/organisational function that is caught by section 1(1) of the 2007 Act. But it did not arise here. On the contrary, the evidence was that this Trust undertook appraisals on an annual basis. There were three appraisals in respect of Dr Azeez: 12/2/10; 6/12/10; and 30/12/11.

96. It is not appropriate, in what is already an over-long ruling, to set out the paperwork relating to these three appraisals. But it was extensive. In my view, it showed beyond doubt that detailed appraisals of Dr Azeez were carried out on each of these occasions. Amongst other things, the appraisals made plain that Dr Azeez was undertaking extensive CPD as a specialty doctor; that any complaints or criticisms raised in respect of him were minimal; and that the 360 degree appraisal in late 2010 was a significant success, indicating that a range of both his colleagues and his patients rated him highly.

97. In order to counter this, Professor Hopkins was driven to take wholly unrealistic points in his answers to Mr Cooper QC's effective cross-examination. For example, he said that the 360 degree appraisal was unreliable because it was a well-known fact that medical colleagues were too generous in their comments. It was unclear what the jury were to make of that; on one view it made the whole appraisal system worthless, which is clean contrary to the Crown's case. More importantly perhaps, he said that there was a lack of evidence that the CPD recorded in the appraisals had actually been carried out. Although the appraisals showed that Dr Azeez had done many hours by way of CPD,

there was no independent record of these hours. Professor Hopkins' principal criticism, therefore, was that the appraiser had been wrong to accept Dr Azeez's word as to the amount of CPD that he had undertaken.

98. I regard that as a wholly bad point. Professor Hopkins agreed that it was not a contractual requirement that Dr Azeez undertook any CPD at all: on one view, that is the end of the point altogether. To suggest that this non-mandatory work should be ignored because there was no separate record of it, and that the failure to ignore it on this ground was in some way a failure of management or organisation referable to section 1(1) of the 2007 Act was, in my judgment, unarguable.

99. If that were not enough, I would again categorise this alleged failure – namely the absence of backup of the CPD record – as being a one-off. There was no evidence that this was a systemic failure of management or organisation of activities.

100. Finally on this point, I note that in any event the criticism goes nowhere because, a month before 9 October 2012, as part of his CPD, Dr Azeez attended a Skills and Drills course, which dealt with, amongst other things, what the anaesthetist should do in precisely the situation that was to arise here. Accordingly the jury would be obliged to conclude that the Trust did all they reasonably could to ensure that Dr Azeez was equipped to deal with the situation that actually arose on 9 October 2012.

101. For all these reasons, the case against the Trust in respect of appraisal and ongoing professional supervision was not supported by any evidence (or any evidence that was other than tenuous) and could not properly be left to the jury.

E2.4. Supervision on 9 October 2012

102. The position as to who was supervising Dr Azeez on 9 October 2012 was unclear. Mr Bentley, a member of the Trust's senior management, said in his police interview, that the supervising consultant was Dr Chung. Dr Chung appears to be the person named on the rota, although there is also a reference to Dr Sigston (which is why he was originally contacted by the switchboard when Dr Cornish asked for assistance). Dr Chung was in another part of the building, and he denied that he was Dr Azeez's consultant. Dr Chung said that custom and practice dictated that the supervising consultant was Dr Cornish. But there was no rota or any other document which identified Dr Cornish as the relevant supervisor, and he was in any event the solo anaesthetist in respect of the patient in the theatre next door.

103. Accordingly, in my view, there is evidence which is not tenuous which supports an allegation of breach of duty in the management or organisation of activities – namely anaesthetic supervision in the labour and maternity unit – on 9 October 2012.

E3. Gross Breach

104. It follows from my analysis in respect of interviews/appointment and appraisals/general supervision, that even if I am wrong in respect of breach, and there is sufficient evidence to go to the jury of breach of section 1(1) of the 2007 Act, there is no evidence that could possibly lead to a proper finding of gross breach of that same duty. To take the Crown's case at its highest, the failure of the Trust to require an independent record

of the CPD hours spent by Dr Azeez is nowhere near the sufficient gravity required to categorise their failure as criminal.

105. As to the supervision point, this is a potential breach because there was a lack of clarity as to who Dr Azeez's supervisor was (paragraph 102 above). But in order for the jury to conclude that that was a gross breach, there would have had to have been some evidence that, in this case, Dr Azeez thought he needed a supervisor but did not call for one, or delayed in calling for one, because he did not know who that supervisor was. In other words, gross breach could only be properly an issue for the jury if there was evidence that the lack of clarity about who the supervisor was created a significant problem in fact. I accept that that may shade into questions of causation. I therefore deal with both points below at **Section E4.1**.

E4. Causation

E4.1 The Identity of the Supervisor

106. There was no evidence that Dr Azeez did not know who his supervisor was or, more importantly, that if he did not know who his supervisor was, that ignorance had any effect on Mrs Cappuccini's care. On the contrary, as Professor Hopkins expressly agreed in cross-examination, all of the relevant people were present as the situation developed to provide direct supervision to Dr Azeez.

107. In particular, in relation to the anaesthetic care, Dr Cornish came in at 13:00. At his suggestion, the matter was escalated to the consultant, Dr Sommerville, and finally Dr Chung attended. Thus, three further anaesthetists, each more senior than the last, came to provide supervision for Dr Azeez. There was no evidence that, in some way, these three should have come earlier, or would have done but for the alleged lack of clarity. Dr Cornish's call went to Dr Sigston, who then called Dr Sommerville, but there was no evidence that any or any significant time was lost as a result. In addition, Dr Sommerville said that the rotas were subject to change. He was called, he said, because he was on call for the ITU and was therefore the logical person for Dr Sigston to call.

108. Neither was there any case or any evidence that, if one or more of the three senior anaesthetists had arrived earlier, this would or should have made any difference to the sequence of events. Accordingly, even if there was evidence of breach in respect of the arrangements for supervision, there was no evidence of gross breach of the type required, and no evidence that the potential uncertainty about the identity of Dr Azeez's supervisor caused or materially contributed to Mrs Cappuccini's death.

E4.2 Causation More Generally

109. There was no evidence that any of the alleged breaches against the Trust, even if they were gross, caused or contributed to the death of Mrs Cappuccini. The finer points of equivalence and an independent record of CPD have not been demonstrated to have any possible causative relevance. I have dealt above with the issue of supervision on 9 October 2012 and the absence of any relevant causation evidence in respect of that aspect of the case.

110. I should add this. The Crown opened the case on the basis that they had to establish gross negligence manslaughter against Dr Azeez and/or Dr Cornish in order for their

case against the Trust to get off the ground. In answer to questions from the Court, Mr Price QC said that this was in order to establish the necessary causation under section 1(1)(a) the 2007 Act.

111. In my view, Dr Cornish's conviction on count 1, or a conclusion by the jury that Dr Azeez was guilty of gross negligence manslaughter, would not necessarily establish the required causation against the Trust. The case against Dr Cornish, and the theoretical case against Dr Azeez, exists wholly independently of the case against the Trust under the 2007 Act. Indeed it is perfectly possible to see ways in which, on other facts, the Trust could have been liable under the 2007 Act whilst Dr Cornish and Dr Azeez were not guilty of gross negligence manslaughter.

112. It follows that, because I consider that count 2 is independent of count 1, the issue of causation as against the Trust may be rather different to that which the Crown had anticipated.

F. CONCLUSIONS

113. For all the reasons set out above, these applications of no case to answer are allowed.

114. I should add this. Mr Price QC, whose preparation and knowledge of this case cannot in any way be faulted, asked me at one point to consider the evidence against each defendant in the round, and not to get too bogged down in the detailed ingredients of each offence. I have looked at the individual elements, because that is required by ***Galbraith***. But I have also considered the evidence in the round. Having done so, I am firmly of the view that it would be unsafe, and unfair to everyone (including Mrs Cappuccini's family), to leave this case to the jury.