Neutral Citation Number: [2019] EWHC 77 (QB)

Case No: HQI5C04901

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 22/01/2019

Before:

HHJ COE QC SITTING AS A JUDGE OF THE HIGH COURT

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Between:

Gloria Esegbona (on behalf of the estate of Christiana Esegbona, deceased)	**Claimant**
- and -	
King's College Hospital NHS Foundation Trust	**Defendant**

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Mr A Henderson (instructed by **Leigh Day**) for the **Claimant**
Miss K Scott (instructed by **Kennedy Shaw LP**) for the **Defendant**

Hearing dates: 26th, 27th and 28th November 2018

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JUDGMENT

HHJ Coe QC :

The Claim

1. The claimant, Dr Gloria Esegbona, brings this claim as administrator of the estate of the deceased, her mother, Christiana Esegbona. The action is brought in negligence and false imprisonment. The amended claim form states that the claimant's claim is a claim in clinical negligence and/or pursuant to the Fatal Accidents Act 1976 and/or the Law Reform (Miscellaneous Provisions) Act 1934.

2. The claimant claims damages for pain, suffering and loss of amenity as well as damages, including aggravated damages, for false imprisonment.

3. It is the claimant's case not only that the medical, nursing and other staff at the defendant's hospital owed her mother a duty to treat her with reasonable care and skill but also that the defendant had duties under the Mental Capacity Act 2005: to take reasonable steps to establish whether Mrs Esegbona lacked capacity before doing any act in connection with her care or treatment; and further that if the defendant reasonably believed that Mrs Esegbona lacked capacity whether it would be in her best interests for any act in connection with her care or treatment to be done; and to take steps to obtain a court order or the relevant authorisation under schedule A1 to the Act before depriving Mrs Esegbona of her liberty. The claimant says the defendant acted in breach of these duties.

Background

4. Christiana Esegbona had a history of insulin-dependent diabetes (including

diabetic retinopathy in her right eye, which meant she was registered blind), hypertension, atrial fibrillation and glaucoma. She also had a history of depression, arthritis and schizophrenia. Up until October 2010 she was living in her own home with one of her adult daughters and was independent and self-caring. English was not her first language.

5. Mrs Esegbona attended the accident and emergency department of King's College Hospital in the evening of 19th October 2010 with shortness of breath and was admitted in the early hours of 20th October. She was found to have pulmonary oedema caused by acute left-sided heart failure in the context of fast paroxysmal atrial fibrillation. She was treated and deemed medically fit for discharge by 27th October, but on the evening of 27th October she suffered a hypoglycaemic episode. She suffered a further severe hypoglycaemic episode on 28th October at around 3:45pm during which she had a seizure and aspirated. She was intubated and admitted into the intensive care unit ("ICU") in a coma.

6. Following unsuccessful attempts to extubate Mrs Esegbona on 3rd November a percutaneous tracheostomy was inserted and removed on 20th November. However, Mrs Esegbona's airway became obstructed again on 21st November and the tracheostomy tube was reinserted on 23rd November.

7. Mrs Esegbona remained in ICU until 30th November when she was transferred to Lonsdale Ward. However, the tracheostomy tube became blocked by a mucous plug on 1st December requiring readmission to ICU and

Mrs Esegbona's condition deteriorated over the next two weeks. A CT scan of her brain on 12 December 2010 showed small left cerebellar and pons infarcts. There was some improvement by 17th December. A percutaneous gastrostomy was inserted on 29th of December in order to feed Mrs Esegbona directly into her stomach.

8. On 14 January 2011 she was transferred back to Lonsdale Ward under the care of Dr Surinder Birring, consultant respiratory physician. She had developed some cognitive impairment. Her right arm had become paralysed. She needed a speaking valve to talk with the tracheostomy. Her ability to communicate was limited. During her time in the defendant's hospital, Mrs Esegbona became confused and incontinent of urine.

9. The notes for 9th February 2011 refer to plans to discharge the deceased home with family being trained in basic and emergency tracheostomy care. Mrs Esegbona wanted to go home but wanted to have the tracheostomy removed. The issue of her capacity was raised, and she was seen by the older adult psychiatric liaison doctor, Dr Bhavsar, on 15th February. There were communication difficulties including the presence of the tracheostomy. Mrs Esegbona was discharged by the psychiatric team on 1st March.

10. On 3rd March a full continuing healthcare funding ("CHC") assessment was undertaken by a multi-disciplinary team from the defendant and the local authority. Their recommendation that Mrs Esegbona was eligible for CHC was accepted by the Lewisham Multi-Agency Continuing Care Panel on 28th March.

11. Whilst on Lonsdale Ward on 8th March 2011 there is a note which indicates that Mrs Esegbona pulled her tracheostomy tube out resulting in a cardiac arrest call. There is a note for 9th March saying that Mrs Esegbona "appeared to obstruct her tracheostomy… leading to a peri-arrest situation". Both events required brief admissions to ICU. She required CPR on 10th March after she was found distressed and cyanosed.

12. It was noted that the tracheostomy required frequent, regular suctioning and cleaning of its inner tube.

13. The defendant's initial plan to discharge Mrs Esegbona to Fairlie House nursing home could not occur because on 31st March Fairlie House decided it would not accept Mrs Esegbona as she was considered to be too medically unpredictable.

14. A psychiatric review on 7th April found that Mrs Esegbona did not have capacity to make the decision to have a CT angiogram.

15. On 26 May 2011 Dr Bhavsar proposed an assessment of her capacity to decline placement and return home. He noted the need to optimise communication using the speaking valve and assessing Mrs Esegbona in the presence of her family. No assessment took place until 6th June.

16. The defendant’s plan on 27th May was to identify a nursing home without

consultation or discussion with the family.

17. A further psychiatric assessment on 6th June found that Mrs Esegbona did not have the capacity to make decisions about her future residence and regarding her tracheostomy.

18. Mrs Esegbona remained on Lonsdale Ward until her discharge to Wilsmere House nursing home on 14th June 2011.

19. On 23rd June 2011 Mrs Esegbona sadly died. She had been found by staff at Wilsmere House unresponsive and with her tracheostomy tube removed.

20. Following an inquest, the cause of death was given as: 1a) a sudden cardiac arrest and; 1b) lymphocytic myocarditis and self-extubation of tracheostomy tube.

21. Mrs Esegbona was born on 1st January 1943 and was 68 years old at the date of her death.

The Issues

(i) Negligence

22. It is the claimant's case that the defendant was negligent, when Mrs Esegbona was discharged, in failing to provide Wilsmere House with sufficient information about her tracheostomy care needs. It is the claimant's case that this very specific information arising in very specific circumstances was important and should have been passed on. In particular the defendant failed to

inform Wilsmere House that: Mrs Esegbona had previously pulled out her tracheostomy tube on 8th March 2011; she had had her tracheostomy tube obstructed on 10th March and required extensive and urgent suctioning or replacement of the inner tube on several occasions; that she had expressed a wish to remove her tracheostomy tube on discharge; and that Mrs Esegbona wanted to go home and not to a nursing home.

23. It is the defendant's case that this information was provided to Wilsmere House and in particular that the defendant's discharge coordinator provided the CHC documents to Wilsmere House. The defendant contends that Wilsmere House was provided with: the CHC assessment; the discharge notification; the letter prepared for discharge by Lauren Miller, senior physiotherapist dated 13th June 2011; the nursing transfer letter dated 13th June 2011; the letter from Dr Tranah dated 14th June 2011 and; the handwritten note entitled "nursing information for Christiana Esegbona".

24. In their joint report (Bundle 1 tab 28 p172), Mr Olarinde and Dr Vletsi agree that if Wilsmere House was not informed that the deceased had previously been found with her tracheostomy tube out on 8th March, that would amount to breach of duty. Similarly, they agree that if Wilsmere House was not told about the obstructed tracheostomy on 10th March and that the deceased had required extensive and urgent suctioning or replacement of the inner tube on several occasions, then that would amount to a breach of duty. Further that if the court finds that Mrs Esegbona had specifically expressed a wish to remove her tracheostomy tube herself once discharged and that information was not

passed on to Wilsmere house, then that would constitute a breach of duty. The allegation in the particulars of claim in respect of equipment is not pursued.

25. Having heard the evidence, I need to consider the defendant's argument that Lynne Phair gave a slightly nuanced view on breach of duty with regard to the failure to pass on the information that Mrs Esegbona said that she wanted to pull her tracheostomy out. This is on the basis that if I accept what Dr Esegbona said in her oral evidence about not being aware that her mother had tried/would try to pull the tube out, then I could find that it would not be a breach to fail to pass that information on.

26. Subject to the latter issue raised in consequence of Dr Esegbona's oral evidence, the defendant does not seek to go behind the agreement of the clinical experts in respect of the three breaches of duty, if I find that the information was not in fact provided to the nursing home.

27. The first issue therefore is what information was provided on discharge.

28. The second issue is, did Mrs Esegbona try to and/or had she pulled out her tracheostomy tube whilst at the defendant's hospital?

29. Dr Olarinde says that although it is his view that the defendant should have told Wilsmere House that the deceased wanted to be discharged home he considers that the issue is not within his primary area of expertise. Dr Vletsi considers that not mentioning that the deceased wanted to be discharged home

was not a breach of duty.

30. Lynne Phair, the claimant's nursing expert says that this would have been a breach of duty.

31. The next issue for me to decide therefore is whether or not there was a breach of duty in respect of the failure to tell Wilsmere House that Mrs Esegbona did not want to be in hospital and expressed a wish to be discharged home and not to a nursing home.

(ii) Causation in relation to negligence

32. In respect of the negligence claim, if I find that there were failures in the discharge process including the negligent failure to provide sufficient information to Wilsmere House I then have to consider whether or not that caused or contributed to Mrs Esegbona's death and meant that she died in a more traumatic manner than she would otherwise have done. The claimant relies upon the experts' evidence that the provision of information to Wilsmere House would have meant that the staff would been better equipped to respond to an acute incident involving Mrs Esegbona's tracheostomy tube and the risks of injury or death would have been much lower. Had they been properly informed, the nursing home might have carried out their own capacity assessment and risk assessment. It is the claimant's case that the risk of Mrs Esegbona dying in the manner and at the time and place that she did was materially increased by the failure to provide sufficient information to the home.

33. The claimant concedes that it cannot be said on the balance of probabilities that Mrs Esegbona would not have died if it were not for the breaches of duty, merely that the risk of her dying in the manner and at the time and place that she did was materially increased. As set out above, the coroner's inquest concluded that the primary cause of death was a heart attack. Of course, that conclusion is not binding on me. The conclusion from the inquest is that the heart-attack was either caused by a fatal arrhythmia due to the lymphocytic myocarditis or airway obstruction/asphyxiation from the removal of the tracheostomy. It is for me to determine in these proceedings what, on the balance of probabilities, was the cause of death.

34. If I find that not all of the information which should have been passed on to Wilsmere House was passed on, it is the defendant's case that it would not have altered the care plan. So, the defendant says causation is not established. Further, if the cause of Mrs Esegbona's death was a fatal arrhythmia, then it would have occurred irrespective of the level of care with which she was being provided.

35. The evidence before the coroner suggests that Mrs Esegbona's cause of death is unclear. There were two factors at play, the removal of the tracheostomy and the cardiac arrest in the context of an underlying heart condition. The question is what caused the heart failure. And therefore, the claimant says this is a "material contribution" case. The claimant's argument is that the risk of the tracheostomy tube being pulled out was materially contributed to by the

defendant's failures and the risk increased because Wilsmere House were not provided with the information. The increased risk was the risk of death.

36. Finally, the defendant says that given the information they had, if there was any failure to provide care at Wilsmere House it arose from the failings of staff there who did not act on that information.

37. If I find causation established, I will need to assess the quantum of damages.

(iii) False Imprisonment

38. The claimant's case is that Mrs Esegbona was falsely imprisoned between 10th February 2011 and 14th June 2011. At paragraph 33 of the defence the defendant admits that she was falsely imprisoned between 1st March 2011 and 14th June 2011. I therefore have to determine the length of any period of unlawful detention. It is now accepted on behalf of the claimant that there is no false imprisonment claim for the period of time whilst Mrs Esegbona was in ICU and that there is no false imprisonment claim for any period during which she had capacity and consented. Further the claimant accepts that there is no false imprisonment claim for the period of time that the deceased was in Wilsmere House because it is not clear who had responsibility for keeping the deceased there at that time.

39. In terms of causation I also need to consider the effect, if any, of such false imprisonment on Mrs Esegbona and, in assessing that effect, identify the quantum of damages.

40. The claimant additionally claims an award of aggravated damages in light of: the alleged deliberate exclusion of the family in the decision-making process; the fact that the detention occupied the last months of Mrs Esegbona's life; and that the defendant failed to act upon the clear advice of its own psychiatrist about the need for a capacity assessment and a best interests meeting.

41. It is the claimant's case that Mrs Esegbona and her family all wanted her to go home but were told that it was not possible, and she required nursing care because of the risk of death. The claimant says there was a very dramatic deterioration in her mother. She was kept in acute hospital setting for a very, very long time (eight months) including for six months after she came out of ICU. The claimant says that the defendant failed to follow the deprivation of liberty safeguards even though its own psychiatric registrar indicated that they needed to be followed on three different occasions. The claimant says that the family were deliberately kept out of the decision-making process and her mother was discharged to a care home a long journey away where she died alone and without her family in distressing circumstances.

42. The claimant contends that the issues for me in deciding these details are: firstly, when did the deceased say she wanted to leave; secondly, how did being kept in hospital and the family being "shut out" affect her; and thirdly, what would have happened if the safeguards had been in place? On this last point, it is the claimant's case that she would have been discharged sooner.

43. In essence, it is the defendant's contention that Mrs Esegbona would have been detained in any event and so she is only entitled to nominal damages. Even had there been a referral to the Court of Protection, the defendant says it would have resulted in her staying in hospital or being discharged to a nursing home. This was not an urgent case and so would not have been resolved quickly.

44. The entitlement to aggravated damages is denied.

45. It is set out in the defendant's skeleton argument at paragraph 107c that whilst the question of whether or not Mrs Esegbona was fit for discharge from hospital is a clinical decision to be made by the defendant, the question of where she was to be discharged to would be a best interests decision made pursuant to the Mental Capacity Act. On this latter decision however, the defendant says that it was not the decision-maker. That is, the defendant denies being the decision-maker with respect to where Mrs Esegbona was to go on discharge. The defendant alleges that responsibility for commissioning and funding any placement in the community was that of the Lewisham Primary Care Trust (now the Clinical Commissioning Group) and therefore the defendant says it was the PCT who was the decision-maker for this purpose. Lewisham PCT delegated that responsibility to the defendant's discharge team or the Lewisham brokerage team and in this case the process of identifying a suitable care home fell to the Lewisham brokerage team. Thus, as set out at paragraph 6(d)(ii) of the defence the defendant says that any

obligation to obtain authority to move Mrs Esegbona from the hospital fell on Lewisham PCT. This is a matter which I need to resolve.

The Law

46. In respect of negligence, the skeleton argument on behalf of the claimant sets out the basic legal principles which are not controversial. The issue is whether or not the alleged act or omission fell below the standard of skill and competence required of a reasonable practitioner.

47. "*The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill; it is well established law that it is sufficient if he exercises the ordinary skill of a competent man exercising that particular art.*": *Bolam* v *Friern Hospital Management Committee* [1957] 1 WLR 582, at 586 per McNair J.

48. The practice relied on has to be respectable, responsible and reasonable and has to have a logical basis; and where it involves weighing comparative risks, it has to be shown that those advocating it had directed their minds to the relevant matters and reached a defensible conclusion: *Bolitho v Hackney HA* [1998] AC 232, at 241H-242A per Lord Browne-Wilkinson. In *Bolitho* Lord Browne-Wilkinson went on to remark, at 243C-D:

> "*I emphasise that in my view it will very seldom be right for a judge to reach the conclusion that views genuinely held by a competent medical expert are unreasonable. The assessment of medical risks and benefits is a matter of clinical judgment which a judge would not normally be able to make without expert evidence. As the quotation from Lord Scarman makes clear, it would be wrong to allow such assessment to deteriorate*

into seeking to persuade the judge to prefer one of two views both of which are capable of being logically supported. It is only where a judge can be satisfied that the body of expert opinion cannot be logically supported at all that such opinion will not provide the benchmark by reference to which the defendant's conduct falls to be assessed."

49. A second area of law is in dispute between the parties. The issue is whether or not this is a "material contribution" case within the ambit of *Bailey* v *Ministry of Defence* [2009] 1 WLR 1052. It is the claimant's case that whilst the burden is on her to prove that the breach was a material cause of the adverse result of which she complains (*Wilsher* v *Essex Area Health Authority* 1988 AC 1074), it need not be the sole cause or even the main cause but must make a material contribution, that is, a contribution which is more than minimal. The claimant contends, and it was not challenged that if this is a material contribution case then there was more than a trivial increase in the risk of the adverse outcome.

50. The claimant relies on the fact that the cause of death, namely the cardiac arrest, was identified as having two potential causes and it was not possible to ascertain which was the actual cause. The argument is that this is the clear evidence of the coroner and therefore this case falls squarely within *Bailey*. The pathologist having initially thought that the cause was the arrhythmia then said that there were two scenarios and he simply could not say which one was the cause. The claimant relies on the analogy with *Bailey* which at paragraph 7 reads:

"Put shortly the case on the facts was (1) there was lack of care in resuscitation, not ultimately in issue; (2) proper care would have led to early intervention and prevented her becoming as ill and weak as she became; and (3) it was that weakness caused, or materially contributed to by lack of care that led to her being unable to prevent herself aspirating."

51. At paragraph 46 Lord Justice Waller said:

"I would summarise the position in relation to cumulative causes as follows. If the evidence demonstrates on a balance of probabilities that the injury would have occurred as a result of the non-tortious cause or causes in any event, the claimant will have failed to establish that the tortious cause contributed. Hotson's case exemplifies such a situation. If the evidence demonstrates that "but for" the contribution of the tortious cause the injury would probably not have occurred, the claimant will (obviously) have discharged the burden. In a case where medical science cannot establish the probability that "but for" an act of negligence the injury would not have happened but can establish that the contribution of the negligent cause was more than negligible, the "but for" test is modified and the claimant will succeed".

52. The defendant argues that the alleged breaches did not materially increase the risk of fatal arrhythmia. The fatal arrhythmia arose by reason of the pre-existing condition of lymphocytic myocarditis. The loss has to be linked to the breach. In other words, this is not a cumulative cause case.

53. Thus, the defendant contends that this is a "but for" case and not a material contribution case. It is argued that the court can and should make findings as to whether or not what happened in Mrs Esegbona's case was (i) that she developed a fatal arrhythmia, the symptoms of which caused her to panic/feel that she could not breathe and thus she pulled out her tracheostomy tube or (ii) that she pulled out a tracheostomy tube and thus caused the cardiac arrest. In the former scenario the defendant says the claimant's claim must fail because she cannot establish causation. The cardiac arrest following the arrhythmia would have occurred in any event. In the latter scenario the defendant agrees that the claimant would have established causation, and this is not a material contribution case.

54. Both counsel agreed that this is not a case in which it would be appropriate for me to find that I cannot decide which was the cause of the cardiac arrest and that therefore the claimant fails on the burden of proof. I agree. There are two causes. I have to decide which is more likely to have occurred.

55. The next issue is the claimant’s argument that there should be substantial damages in respect of the period of false imprisonment. The defendant argues, relying in particular on the case of *Bostridge* v *Oxleas NHS Foundation Trust* [2015] EWCA Civ 79, that since the outcome would not in fact have been any different only nominal damages should be awarded. *Bostridge* concerned a technical procedural flaw in a detention under the Mental Health Act 1983 and neither the appellant nor anyone responsible for his mental health care was aware that his detention was unlawful. Had the appellant been detained

lawfully he would have suffered the same unhappiness and distress that he suffered anyway. He would have been detained in any event.

56. *Bostridge* reiterates that in assessing damages for the tort of false imprisonment the court seeks to put the claimant in the position he would have been in had the tort not been committed and to do that the court must ask what would have happened if the tort had not been committed. In *Lumba* and *Kambadzi*, the court found that the claimants would still have been detained. Thus, they sustained no compensatable loss. Similarly, in *Bostridge* the court said the answer to the question of what would have happened, "was obvious". It was clear that the appellant had sustained no loss because he would in fact have been lawfully detained had the technical error been appreciated.

57. In this case the defendant says that since Mrs Esegbona would have been detained in any event damages should be nominal.

58. The claimant argues that this is not an "obvious" case. There is a great deal of speculation about what would have happened and what effect there might have been on Mrs Esegbona had the requirements of the Mental Capacity Act been followed.

59. The other relevant authorities to which I have been referred address issues of quantum which I refer to below.

60. The defendant relies in addition, upon the documents at Tabs 18 and 19 in

the Authorities Bundle, namely the Mental Capacity Act 2005 Code of Practice and the National Framework for NHS Continuing Healthcare (July 2009 edition). First of all, the defendant says that the Code of Practice document rebuts Lynne Phair's evidence that there is only one decision-maker because it says in that document there are *"also times when a joint decision might be made by a number of people. For example, when a care plan for a person who lacks capacity to make relevant decisions is being put together, different healthcare or social care staff might be involved…"*

61. The framework document for NHS Continuing Healthcare and NHS Funded Nursing Care provides that the primary care trust should identify and arrange all services required to meet the needs of all individuals who qualify for NHS continuing healthcare and by reference to paragraph 100 the defendant relies on the wording that *"where a person qualifies for NHS continuing healthcare, the package to be provided is that which the PCT assesses as appropriate for the individual's needs"*, in support of the argument that it was not the decision maker.

62. The claimant says that this is simply not the legal position pursuant to the Mental Capacity Act and further that whoever is responsible for the discharge placement, the key information was with the Trust and the duty of care must be on the Trust. Furthermore, there is no positive evidence whatsoever from the defendant, even though the notes name the discharge coordinator. The claimant relies on the fact that the expert evidence of Lynne Phair and Dr Vletsi supports the claimant's position.

Evidence

(i) The lay evidence of Dr Gloria Esegbona

63. I heard evidence from the claimant Dr Gloria Esegbona. She is an obstetrician and gynaecologist and one of 6 siblings. Her statement is at p190 in Bundle 1. She sets out that Mrs Esegbona was independent and self-caring before she was admitted to the defendant's hospital, living in her own home, going to the local market and shops and cooking for the large extended family. This is confirmed by reference to the entries at p351-352.

64. She makes it clear that her mother and her family were adamant that Mrs Esegbona should be allowed to come home to be cared for by them. She refers to the records setting out that the defendant was insistent that Mrs Esegbona could not come home because she would be dead within days unless she was placed in a specialist environment. She sets out the notes which say that Mrs Esegbona would be at great risk if she was not managed effectively and she needed at least two hourly suctioning. Following the cardiac arrest on 9th March the note says that Mrs Esegbona needed to be in an environment where an occluded tracheostomy could be detected immediately and acted on accordingly and in May that Mrs Esegbona was at risk of obstruction which could potentially be fatal. Mrs Esegbona was told that she needed regular suctioning and had to be in the care of professionals.

65. It is apparent from Dr Esegbona’s statement that the family were very

unhappy indeed about the hypoglycaemic attacks, the need for the tracheostomy and the fact that Mrs Esegbona could not be weaned off it. They were also obviously concerned about the paralysis to her right arm which does not seem to have been addressed for some time. The family wrote letters of complaint including to the health ombudsman in order to get some information identifying the nature of damage to Mrs Esegbona's throat which meant that she could not be weaned off the tracheostomy. Dr Esegbona sets out that she received no response. It is her case that the family's suggestion that Mrs Esegbona could be looked after at home was "vehemently refused".

66. It is a matter of significance to the family that their ethos would not be to put a parent into a nursing home. Dr Esegbona agrees that the plan made in January for transfer to Fairlie House was something which the family agreed with in light of this adamant refusal but were told that it would be an interim stay where Mrs Esegbona would be cared for and could be weaned off the tracheostomy. The family were not happy for this to be a long-term plan. The family were involved actively in the preparation for the transfer to Fairlie House but unfortunately it fell through and Dr Esegbona describes being left in limbo for several months whilst Mrs Esegbona's demands for clarification grew and she was increasingly distressed.

67. Dr Esegbona sets out that the family were unaware that Wilsmere House had been found and her mother was transferred there without notice to the family until the day before and there was not the "transparent, robust" planning which there had been in respect of Fairlie House, so the family could not

review the home. Moreover, the family were particularly distressed because the home was more than two hours away, so Mrs Esegbona could not be visited as often as the family would want to.

68. Dr Esegbona sets out that the family did not receive the letter about the discharge. The matter has been investigated. The tracking number is not recognised, and the letter was delivered on 14th June if it was delivered at all.

69. She describes the frantic attempts by the family to contact the defendant's staff because of their concerns about the transfer to Wilsmere House. Contact was not made, and the transfer went ahead. When she did see her mother in Wilsmere House, Dr Esegbona sets out that the first thing that mother said was that she had been sent there to die.

70. It is apparent from paragraph 24 of her statement that Dr Esegbona was not convinced about the "self-extubation" part of the conclusion of the coroner because there was no evidence that her mother forcibly removed her tube and it would be difficult for her to do so particularly given the problems with her right arm. Dr Esegbona refers to the notes in support of this view, in particular Miss Mullen (p461) who says, "I do not believe she removed it on purpose". It was considered that she might have lost her balance while reaching for water or tried to remove the "Swedish nose" dislodging her tracheostomy accidentally.

71. Dr Esegbona feels very strongly that her mother did not lack capacity, but

she could not communicate because she could not talk or swallow unaided because of the damage to her throat and the tracheostomy. It is Dr Esegbona's view that her mother was "in sound mind". She cites the entry for 1st February 2011 (p399) from Dr Banham who discharged Mrs Esegbona from the psychiatric point of view noting it was very difficult to assess her in light of her only being able to speak for short bursts. Dr Esegbona points out that the advice of the defendant's psychiatrist Dr Bhavsar was not followed.

72. She was asked if she considered whether her mother had capacity to make decisions. Dr Esegbona said that of course her mother was not medically qualified, and difficulties arose because when her mother was seen by the various doctors, it was often when the family were not around, and she struggled to explain to the family what had happened during the course of the day. In particular that was because English was not her first language and she often did not have her speaking valve. Dr Esegbona told me that her mother could tolerate the speaking valve for one-and-a-half to two hours and that there were no issues from February/March onwards with the speaking valve after she came out of the intensive care unit. The only issue after that was that she did not always have access to the speaking valve.

73. However, Dr Esegbona said that her mother was clear that she wanted to go home and had the mental capacity to decide that she wanted to go home.

74. Nonetheless she agreed that Dr Bhavsar is a professional and where he has indicated that it was his view that Mrs Esegbona lacked capacity, she would accept that although she did not consider that in light of her mother's

communication difficulties, the assessment would have been ideal.

75. Dr Esegbona said that she thought that her mother should have been making her own decisions but that she would have taken it on board if the family had been told that an assessment had been done and it was felt that Mrs Esegbona lacked capacity and so there would be a best interests meeting. She said the family would not have had a problem with that. She said that she would have loved to have been there when such a decision was made, so that she could be sure that her mother had understood. She felt that attempts were made to speak to Mrs Esegbona when she was not able to communicate properly.

76. Dr Esegbona was cross-examined at length. She was asked about the meeting documented at p417. Dr Esegbona said she was told by her sister Deborah that she had not gone to the meeting. The family wanted to have a response to their complaint about what was wrong with their mother's throat and why she could not be decannulated. She said that the defendant was not forthcoming on this issue and only want to talk about discharge. She said that she had this discussion with her sister. She could not attend the meeting. She says that meetings were organised at very short notice by the defendant and she was not able to attend at such short notice because of her work commitments. She said that her sister Deborah was very reluctant because there had been no formal response to the letter. So, Dr Esegbona knew there was a meeting, but her sister told her it was about discharge. She said that she has “lived the case” over the last seven years and has no difficulty in accurate recollection. She said that her sister was not comfortable about going to the

meeting especially by herself.

77. She told me that she and her family were willing and keen to engage with the defendant trust and between them never missed a day visiting her mother during the whole of the eight months that she was in hospital. Dr Esegbona said that she saw her mother every third day when she was doing shifts at Woolwich and would see her every day when she was off. She said that her sisters Naomi and Deborah took the lead on behalf of the family. In particular that was because Deborah lived very close, about a five-minute walk away and Naomi was more flexible working in Paddington. Her mother had previously been living with Naomi. She described her mother as being very happy to see all her children but very distressed and upset because she wanted to go home.

78. She told me she had several meetings with consultants about what had caused the damage and why her mother was so dependent on the tracheostomy. At previous meetings to discuss discharge she said that the defendant had not been willing to discuss the tracheostomy. She said that the offer of a meeting was not to talk about the injury but just about discharge.

79. When asked, Dr Esegbona said that she knew that the care that her mother would require at home would need some support and machinery/equipment and it would take some time to set up, but she said there are people with tracheostomies living in the community. It was her view that Mrs Esegbona was aware that she needed the tracheostomy and the family knew she needed

it and that it frequently obstructed. She felt that either nurses or family members could have been taught to deal with it. She says that at the nursing home her mother was just in an ordinary room with a portable suction machine and she felt that the family could have done that at home. She said that the defendant never had a conversation with the family about having their mother at home, being trained to care for her or having nursing agencies in place. By reference to the entry for 9th February at p412 which sets out the need to teach the family tracheostomy care, she said that they were never offered or given training in basic tracheostomy care and although they asked about Mrs Esegbona coming home and having equipment for the care, they were told it was "out of the question".

80. She said that at the meeting about placement at Fairlie House on 16th February, to which the family agreed, it was indicated that this would be in order for work to be done to decannulate Mrs Esegbona so that she could go home. She agreed that the family would have accepted a nursing home nearby and they did look for other nursing homes as a family, but the discussions were about decannulation and the option of her coming home was never put on the table. She was clear that her mother did not want to stay in hospital and wanted to go home. Her mother wanted to know what was wrong, and why the tracheostomy could not come out, and she wanted the tracheostomy out so she could go home. She said that her mother never agreed that she wanted to stay in hospital and was insistent about going home from one week after she came out of intensive care.

81. Dr Esegbona confirmed that she did not agree with the contents of the notes but said that she had no control over what the defendant's staff put in the notes. Her evidence was clear that the family were never told that the tracheostomy was permanent. Their understanding even at Wilsmere House was that the attempt would be made to wean her off it. They considered that the nursing home placement was temporary until their mother could go home without the tracheostomy. She was adamant that they were never told that the tracheostomy was permanent.

82. When asked about the funding, she agreed that she and her sister knew that decisions and assessments were being made about who would fund their mother's care and she knew that the defendant had considered Fairlie House best. It was her understanding that it was the trust that had sorted out the placement at Fairlie House. It was the defendant who planned and arranged the funding with the local authority and the CHC and the family were not involved in arranging the funding. They were involved in the process in the sense of speaking to Fairlie House's manager and visiting the home and feeding back to their mother. She had heard of "Victor" at Lewisham brokerage but had never spoken to him. Her sister Deborah did and forwarded emails from him to the family. The family were not aware as to why Fairlie House fell through, but her mother was distraught about staying in hospital. She knew that Victor had said it was almost impossible to find a suitable nursing home in London and had suggested some that were way outside of London, but the family needed a nursing home where they could visit. She was taken to p416 where the note refers to the family wanting Mrs Esegbona

to come home, and she agreed that that was what they kept saying. Mrs Esegbona thought that she was not getting the help she needed in hospital and felt that she would be better at home. She describes her mother as being upset because she felt that she would never see her home again or go shopping again. She was clear that her mother wanted to go home, to her own home. Her mother wanted the care that she was given in hospital to be given at home.

83. Dr Esegbona denied that the family stopped responding. She said that her sister Deborah had a form of mini breakdown with post-traumatic stress disorder because the matters were weighing on her. She was dealing with the phone calls et cetera. She is not medically qualified, and she was extremely stressed. She said that Deborah bore the brunt of the short notice meetings at which there were no answers about her mother's deterioration so that her sister reached a point where she did not want to attend any more. She said her sister became overwhelmed in particular because of the refusal to answer the family's questions. She said that the note saying "refusing to meet" is therefore not accurate.

84. Dr Esegbona's evidence was that her mother never told her personally that she wanted to remove her tracheostomy herself. She did say that she wanted it to be removed so that she could go home. She said that Mrs Esegbona was assessed three times by Dr Bhavsar without the family's knowledge. She said there was no previous suggestion that her mother had wanted to harm herself. She was concerned that an assessment had been carried out immediately after

an incident of obstruction which would have left her mother feeling "groggy". Dr Esegbona did not think that her mother was at risk of pulling out her tube because she knew it was keeping her alive. Dr Esegbona says that her mother knew that she needed to have the tracheostomy tube, but she seemed to be frightened and would try to tug on it. She said that she became distressed, frustrated and would cry. She stopped self-caring. She was frustrated and did not understand the extent of the damage which had occurred, and which required the tracheostomy.

85. Dr Esegbona said that she would have been happier with somebody independent looking at the case, that is, somebody trying to get to the bottom of what was going on. She said that she had no problem with a capacity assessment and best interests meeting to ensure that her mother was safe, but the issues were not just clinical. The issues were that her mother wanted to go home and was not able to go home. She said no family member ever had a formal power of attorney in respect of their mother.

86. She said that her mother was not happy at the nursing home. Dr Esegbona was unhappy that when they visited, a nurse took her to see her mother, said that her mother just stayed in her room and the nurse gestured to the family to indicate that in her view Mrs Esegbona was "cuckoo".

87. At Wilsmere House nursing home, Dr Esegbona described how her mother seemed almost to have given up. She was downcast and would not look up. She complained it was such a long journey. Her spirit had gone, and she cried

a bit.

Expert Evidence

(i) Lynne Phair

88. Lynne Phair is the claimant's expert. She is a registered mental nurse, registered general nurse and she specialises in the care of older people in both physically frail and mental health settings. She has experience as an independent consultant nurse for older people and safeguarding adults. She is an adviser to groups of care homes. Lynne Phair told me that she has 40 years' experience and writes independent reports for the Court of Protection and is a qualified best interests assessor.

89. Lynne Phair's original report at tab 25a (p83) is dated 15th June 2016. She was asked to provide a medicolegal report to comment on causation of injuries and condition and prognosis of Mrs Esegbona prior to her death; to consider whether she was unlawfully deprived of her liberty; whether the defendant's staff failed to complete the necessary best interests meeting; and the impact of the same. Her conclusion was that the discharge planning process fell below a reasonable standard. She felt that the staff did not follow the requirements of the Mental Capacity Act 2005; did not implement an urgent deprivation of liberties safeguards authorisation; did not apply for standard authorisation; failed to hold a best interests meeting; and failed to make an application to the Court of Protection.

90. She says that as a result Mrs Esegbona was unlawfully detained and

deprived of her liberty. She suffered anxiety, distress, agitation and psychological injury because she was not involved in the process and staff did not explain to her what was happening and why. Mrs Esegbona was not supported throughout the discharge process. Her family was also not appropriately involved in the process which should have occurred in light of the fact that Mrs Esegbona lacked capacity to make decisions regarding her discharge. It is her view that this added to the distress.

91. As is apparent from her report and was confirmed at the trial Lynne Phair was only asked to consider the notes from 9th May onwards.

92. Her report of 1st March 2018 (which is at 25b p97) is a report which was prepared essentially for these proceedings and it copies the first report almost in its entirety but adds in some matters which are specific to this hearing.

93. I therefore refer to her report dated 1st March 2018.

94. In her review of the records she notes that whilst the staff felt that a nursing care environment was required by Mrs Esegbona, there is no reference to the need for a capacity assessment, nor is there any reference to the need for such an assessment in respect of the procedure to try to improve the weakness in her hand.

95. Lynne Phair highlights that there was no evidence that the staff were assessing Mrs Esegbona's capacity until two weeks before she was discharged. There was no evidence that Dr Barker, the decision-maker in respect of making decisions regarding Mrs Esegbona's discharge, understood

or complied with his duty under the Mental Capacity Act. There is no evidence that following the capacity assessment by Dr Bhavsar on 26th May the trust followed his advice (which was correct advice) and arranged a best interests meeting involving the family. There is no evidence that the staff assessed the benefits or burden of Mrs Esegbona's expressed desire to go home and not to have the tracheostomy. There is no evidence that the possibility of Mrs Esegbona's daughter being trained to suction the tracheostomy and care for her were considered or whether a community care package could be set up. The assumption was that there was no alternative but to move to a care home.

96. There was no assessment as to whether or not Mrs Esegbona had the mental capacity to make an unwise decision (to go home) or whether she lacked capacity and it would be unsafe to let her go home in which case they would deprive her of her liberty and make an application for further assessment of whether deprivation of liberty was in her best interests. If she had capacity she could have taken her own discharge and she was entitled to make that unwise decision.

97. Lynne Phair identifies that it was the defendant's duty to act in Mrs Esegbona's best interests and obtain an urgent deprivation of liberty authorisation which would have triggered a standard authorisation application and would have required an independent best interest assessor to assess Mrs Esegbona's desires and listen to the family and other interested parties. In short Mrs Esegbona should have been under a deprivation of liberty safeguard authorisation.

98. She refers to the note at p297 in which the defendant says that the family are making decisions on behalf of Mrs Esegbona despite the fact there was no formal power of attorney in place.

99. The defendant should have ensured that a family member was there when the assessment was done so that Mrs Esegbona was given every opportunity to understand. The assessment should have been done as recommended by Dr Bhavsar certainly with the speaking valve in place and possibly with an interpreter and at a time when Mrs Esegbona was not agitated.

100. Lynne Phair gives her opinion that evidence of a psychiatric assessment of the mini mental state examination, a continuing care assessment, a health needs assessment or the review by the psychiatrist are not evidence of a mental capacity assessment having been undertaken and do not amount to such an assessment regarding Mrs Esegbona's capacity to make a decision about residence or whether to have the tracheostomy removed.

101. She states that staff did not have a legal right to deprive Mrs Esegbona of her liberty without her capacity to understand the risks and benefits of going home being assessed. Further, if the decision-maker, who Lynne Phair identifies as the consultant, felt she was at harm to herself because she lacked capacity to make this decision she could have been deprived of her liberty and adequate safeguards explored and put in place. She says that the trust had a legal duty to follow the principles of the Mental Capacity Act. By putting an urgent deprivation of liberty authorisation in place, a standard authorisation

would have been requested and as part of this, there would have been an independent assessment of whether depriving Mrs Esegbona of her liberty was the least restrictive option. She says that the best interest assessor would have assessed capacity and considered conditions on the restriction and would have spoken to the family and would probably have identified that there was a dispute between the trust, Mrs Esegbona and the family. The matter would then have been referred to the Court of Protection.

102. In her response dated 24th October 2018, to the questions relating to the joint report of Mr Olarinde and Dr Vletsi, Lynne Phair sets out that given that Mrs Esegbona made repeated requests to go home and she was assessed as lacking capacity to make a decision regarding her tracheostomy and regarding her future placement, there was a dispute between what the trust thought was in her best interests and her wishes. Therefore, the matter should in accordance with the Mental Capacity Act have been referred to the Court of Protection and that referral should have been made while Mrs Esegbona was still in hospital as part of the discharge planning process.

103. It is her view that the outcome of whether or not Mrs Esegbona would have been ordered by the Court of Protection to move to a care home rather than go home with a package of care cannot be second-guessed. In two proposed scenarios she says that even had the Court of Protection ordered discharge to a care home in Mrs Esegbona's best interests the matters at issue in this case would have been identified and the risks exposed and there would have been a clear and detailed care plan and risk assessment particularly with regard to the tracheostomy and that would have led to an increase in

supervision reducing the risk of her pulling the tube out. Had she gone home with a care package, her distress would have been reduced and her levels of distress and risk of self-harm reduced and so she may not have removed the tube.

104. She said that it was not her view that the failings identified by the experts on the part of the trust were merely procedural. The defendant failed significantly in not following the Mental Capacity Act. It was Lynne Phair's impression that an impasse was reached between the trust who felt the family were not engaging and the family who had lost trust in the defendant. She identifies that this situation is a classic case for the Court of Protection. She considered that the notes indicated the defendant was not really listening to the family and she was very concerned indeed about the records at pp564, 566 and 575 where the defendant was taking the decision that the family should not be informed about discharge decisions when Mrs Esegbona had been assessed as lacking capacity. She described the entries as "appalling".

105. She was straightforward in saying that if the matter had been referred to the Court of Protection one could not say what the outcome would be. The court is independent for everybody.

106. If it was found that she lacked capacity to understand the risks, then since Mrs Esegbona's desire was to go home it was Lynne Phair's view that there was no reason why that should not have been explored. An assessment should have been made of her living accommodation, the care required over 24 hours, how much the family were able to do and if the family could be trained and what would be funded by the PCT. These matters should all have

been considered with the family leading to a best interests decision. The process would probably take two or three weeks. There is no evidence that that was done. (The defendant does not suggest that it was done). If the discharge home looked possible then a home care team would have to have been identified, the total process taking about a month and if Mrs Esegbona could go home that would have happened then.

107. If discharge home was not possible and/or affordable then the matter should have been referred to the Court of Protection.

108. It was Lynne Phair's view that one can go to the Court of Protection quite quickly and an interim arrangement could be made and whilst it might take five months for a final decision (or more or less) it was her view that Mrs Esegbona would not have been sitting on an acute ward for that period of time, provided she was medically fit for discharge. (I note that the defendant was looking at a discharge plan from about the end of January). Lynne Phair agreed that it was reasonable for the defendant to want to discharge her if she was medically fit.

109. An independent assessor would have been required to determine capacity and best interests issues if Mrs Esegbona was being deprived of her liberty. It was Lynne Phair's view that at the time of these events, if Mrs Esegbona was constantly saying "I want to go home" over a period of 4, 5 or 6 days then consideration should have been given to whether or not she was being deprived of her liberty. The records show (p528/535) that she wanted to go home "today" which was 3rd May and 9th/10th May. Although Lynne Phair said that Mrs Esegbona's capacity should have been assessed on 9th May she

was clear in her evidence that had capacity been considered by the defendant, an independent assessment might have meant that she could have gone home on trial. An independent assessor would have taken all the factors into account including the frequency of suctions and the resources at home.

110. As Lynne Phair pointed out when the independent assessor is looking at the situation, quality of life comes before length and/or location of life and that is factored into the risk assessment and it is not just the medical aspect which is considered. An independent assessor would be asking the defendant where their evidence was that the care could not be provided at home and that is exactly what the Court of Protection does. She was unwilling to second-guess how long it might take before Mrs Esegbona could have been moved home.

111. Lynne Phair sets out "in my opinion the trust was the decision-maker in respect of the discharge planning process; part of which was identifying whether [Mrs Esegbona] could return home safely. The discharge nurse liaison team were involved as it was a complex discharge and they are trust employees". She says that the trust had a responsibility to refer the dispute to the Court of Protection because Mrs Esegbona was an inpatient at the time and was asking to leave. It was the defendant's responsibility to complete an urgent authorisation and apply for a standard authorisation which they failed to do. A decision to remove the tracheostomy was a serious medical intervention and that should have been referred to the Court of Protection who could then have taken an independent view.

112. It is her opinion that understanding and implementing the requirements

of the Mental Capacity Act is the legal duty of all health practitioners. She says that failing to understand the legal obligations is not justification for the trust failing to carry out their legal duty. She sets out "a person who is responsible for making the capacity assessment and, if the person lacks capacity, the best interests decision is the decision-maker. This will be the consultant responsible for her care." Where, as here, there was a dispute, the clinician responsible for the patient's care has a duty to refer the matter to the Court of Protection.

113. Lynne Phair confirmed that the defendant is responsible for the patient until the moment of discharge and the decision as to when the patient is ready for discharge is that of the consultant. The defendant had the duty to make sure that Mrs Esegbona had somewhere safe to go. The defendant does not give out money or commission care. The PCT commissions care but the commissioning issue is different to who is the decision maker. She said that the decision-maker in terms of the Mental Capacity Act is the person who decides if the patient lacks capacity and Mrs Esegbona was the responsibility of the trust until she moved out. Lynne Phair said that under the Mental Capacity Act, the decision-maker had to be an individual. She was referred to the National Framework at paragraph 100 but said that the decision maker in terms of the Mental Capacity Act is the person who decides if the patient lacks capacity.

114. With regard to the transfer to Wilsmere House, Lynne Phair considers that the defendant failed to provide information at the time of the assessment and failed to produce an adequate discharge or transfer summary informing

the nursing home that there had been an unexplained removal of the tracheostomy tube, that it had become obstructed and that Mrs Esegbona had repeatedly expressed a wish to be discharged home and had a desire to remove the tube herself. Had they notified the care home, the care home would have been able to carry out a risk assessment and implement safeguards from an informed perspective. The funding assessment documentation was not current and was written before the incident in which the tracheostomy was removed.

115. She says that the most important aspect of discharge when a person requires ongoing care is to transfer all relevant information, medicines and any immediate equipment that the person needs as well as organising outpatient appointments and visiting specialists. Importantly she says the discharge liaison team should also have been initiating a referral to the Court of Protection before the discharge occurred as stated above.

116. She did not consider that the document at p2120 would have been particularly useful to the nursing home even if it had gone to them because it is dated 3rd March 2011 and was therefore four months out of date.

117. The CHC documentation is a funding recommendation. It was Lynne Phair's opinion that no family would refuse that because care is going to be funded entirely by the NHS with no contribution from the family (which there would be if the funding came from social services). She explained that once CHC funding is in place it can provide care in any environment including in a patient's home and sometimes the patient is simply given the money to which they have been assessed as eligible.

118. She was firm in her view that the duty of care to pass on information is with the defendant. The local authority brokerage service and the PCT would work on the information from the defendant and the defendant decides when Mrs Esegbona is medically fit for discharge. The responsibility for Mrs Esegbona remained that of the defendant until she was discharged.

119. She said that she had not seen pp2052, 2086 and 2086a before she wrote her report although she had seen p2087. She did not think she had seen p288. She said that p2089 was for the general practitioner and may or may not have been given to the nursing home and p2092 is a health needs assessment which again may or may not been given the nursing home.

120. Lynne Phair agreed that the defendant never made any definitive decision about how Mrs Esegbona's tube came out in March. It may have been accidental. Information from Dr Esegbona may suggest that Mrs Esegbona had not in fact expressed the desire to remove her tube after discharge and so the risk of deliberate removal would not be information which should have been passed on. However, she said that the fact that the tube came out, however it came out, represented a risk which the nursing home did need to know about.

121. She said that p243 box 13 dated 14th June which reads "wants to have trach tube removed and go home" does not make a difference to her view and anyway she does not know where it came from. The importance of the information about wanting to go home was that it might affect planning at the nursing home, for example, if it was to be temporary/rehabilitative or if Mrs

Esegbona had agreed to go to the nursing home on the basis that it was a temporary arrangement.

122. Looking at the documents, Lynne Phair said that suctioning "as required" is a standard instruction for tracheostomy patients. If the nursing home had the information at p2086a then she would expect it to be in the plan at p289. She described the care plan as like a prescription. Similarly, if p2087 was provided she would expect it to be reflected in the plan at p289. But that would not in any event discharge the need to pass on concerns about the tube coming out. If the information in p2120 and p2152 was shared then it indicated that Mrs Esegbona should have had the highest level of supervision, but not as high as one-to-one. However, it is dated March. It was 3 months old. Lynne Phair said in any event, the CHC documentation is a decision support tool which assists in the assessment of eligibility but is not an assessment tool for a patient's care needs. She said that "constant supervision" means someone around all the time. It was Lynne Phair's view that if one-to-one was intended she would expect it to say one-to-one because in those circumstances the panel dealing with funding would need to know that this patient required somebody with them all the time.

123. The nursing home could have said that in order to accept Mrs Esegbona they would need more funding. The significance of the date of this report is that it was written before the events of the 8th and 9th/10th March after which the risks increased, and these documents do not suggest that there was a risk of the tube coming out.

124. She said that the obstruction issue was very specific and not the same as a general suction instruction. She said that p569 (Mrs Esegbona was struggling to breathe with occluded tube on 6th June and no documented tracheostomy care for many hours) is consistent with what she was saying, and she would have expected the plan (dated 15th February) at p426 for capacity assessment to be followed.

125. Lynne Phair sets out the breaches of duty of care as being: failing adequately to assess Mrs Esegbona's capacity to make decisions in a timely manner; failing to involve the family appropriately; failing to heed the advice of the psychiatrist and ensure that Mrs Esegbona had appropriate communication aids to help her understand and communicate her wishes; failing to carry out a best interests meeting correctly once her capacity had been assessed; failing to implement a deprivation of liberties safeguards urgent authorisation and make a standard authorisation application; failing to give correct and honest information to the independent mental capacity advocate ("IMCA") service; failing to refer the dispute regarding discharge and serious medical intervention to the Court of Protection; failing to give correct information to the nursing home about the risk of Mrs Esegbona removing the tracheostomy or the risk of it mysteriously becoming dislodged; and failing to inform the nursing home at the time of the preadmission assessment that a deprivation of liberty safeguards authorisation would be required because Mrs Esegbona was consistently saying she wanted to go home.

126. In consequence Lynne Phair considers that: Mrs Esegbona was

unlawfully detained in hospital without the appropriate safeguards in place; she was not assessed for her mental capacity in a timely manner; she was not supported to make decisions; she was not given the right have an independent assessment of the disputed issues; she was unable to be supported by her family who were actively excluded from the final plans to find a care home and move her; and she was not provided with her legal right for the opportunity to be assessed for representation in the Court of Protection.

127. She considers that the impact of these failings on Mrs Esegbona who was a frail individual would have caused Mrs Esegbona significant anxiety and stress. Her lack of capacity did not mean that she was devoid of emotions. She tried to leave the hospital and did not want to go to a nursing home. She was unable to understand why and would have been caused agitation, distress, despair, anger and frustration. She is likely to have lost hope. In Lynne Phair's opinion, on a balance of probability Mrs Esegbona suffered these things and the psychological harm to her would have been significant.

128. She confirmed that her experience and her review of the records led her to the clear opinion that the defendant's failings would have caused distress and that the false imprisonment would have caused significant distress to Mrs Esegbona. She described the domino/last straw effect of multiple conditions and stress/upset. Mrs Esegbona may or may not have understood the risks and could not understand why she was being sent to a nursing home. She said that in these situations people lose hope. The Court of Protection "gives them a voice".

129. She did not consider that the letter from the general practitioner at

Wilsmere House changed this opinion. Her view was that maybe the GP did not know Mrs Esegbona very well or maybe he saw her at a good moment or maybe she was putting a brave face on. It is apparent that he only saw her once.

130. She considered that on the balance of probabilities Mrs Esegbona would have experienced distress by reason of her false imprisonment although she accepted that she might sometimes have seemed happy. Mrs Esegbona had serious medical issues and was unhappy about being fed through her stomach and being nil by mouth and she wanted the tracheostomy removed. That poor health would cause distress and anxiety anyway, but matters would be cumulative and going to the nursing home would be taking away her hope. If the discharge had been following the intervention of the Court of Protection she may have been told that it was temporary and going home was being explored.

131. The failings of the trust meant staff at Wilsmere House were not given the correct information regarding the risk of the tracheostomy tube becoming mysteriously dislodged. Had they had all of the information they would have been able to conduct a more suitable risk assessment regarding how to support Mrs Esegbona during the transition period and to increase the likely level of observation. This would have enabled staff to monitor her actions more closely and reduce the risk of serious harm.

132. She felt that if the nursing home had been aware of Mrs Esegbona's agitation, anxiety and desire to go home they would have been looking at her psychological care as well as her physical care and maybe there would have

been closer monitoring at least initially. There might have been heightened monitoring and heightened activities and perhaps one to one care at least for the first two or three weeks.

133. She explained what would have happened had the process been followed properly. Firstly, in February, when Mrs Esegbona said that she wanted to go home the defendant should have assumed capacity and then done an assessment to see whether or not she had capacity to make that decision, in other words does she understand the risks? Her history of schizophrenia and cognitive impairment would be taken into account. Responsibility for that assessment lay with her consultant. If the assessment showed that she had capacity and the risks were explained and she was still determined to go home, she could have taken her own discharge and gone home, and she was entitled to make that unwise decision.

134. It was her view that the nursing home would have been more vigilant if they had known about the risk of Mrs Esegbona taking a tube out. She repeated that after the funding decision been made Mrs Esegbona's needs could have been explored to see if they could have been met at home.

135. Lynne Phair said that she did not accept that the nursing home did not put in place a care plan based on the information they had been given.

136. Lynne Phair was asked about discharge in cross-examination. She agreed that the role of the discharge nurse is a specialist role, but the principles are set out in guidance and she has some experience albeit from many years ago. In brief, someone makes contact with the nursing home, the

nursing home would take the initial information and reach a decision as to whether or not to say "yes" in principle. The nursing home would then have a legal duty to assess that person. The assessment on the ward would take about an hour. She told me that the practices about the sharing of information before that assessment are very variable. For example, the CHC documentation is not shared in all parts of the country. The assessors on the ward are not always made privy to the contents of the records. They would be able to speak to the nurse in charge, but it would be unusual for them to speak to the doctor or occupational therapist. They have to assess whether or not they can offer the particular patient a place. Despite these variations, Lynne Phair said that she would have expected the defendant to have shared information about Mrs Esegbona but in this case, they did not even fill out all the boxes on the transfer form.

137. She was asked about the false imprisonment. She agreed that she had been asked to focus on the last two months' records, but at the end of her evidence in re-examination she said that she had seen the particulars of claim and the defence and she was supportive of the allegations from the information in the particulars of claim which date false imprisonment from February. She considered that Mrs Esegbona was likely to have lacked capacity had she been assessed on either 6th or 9th May and if she was to be detained there would have to be an authorisation which would be an urgent authorisation which is automatic for a week and then a standard authorisation and/or reference to the Court of Protection.

(ii) Mr Olarinde

138. I heard evidence from the claimant's expert Mr Olarinde who is a consultant ear nose and throat/head and neck surgeon. His report is at tab 26 p113 and is dated 10th February 2018.

139. He was specifically asked to consider whether or not appropriate measures were put in place to ensure Mrs Esegbona's safe discharge from hospital to the nursing home; whether or not it would have been appropriate for Mrs Esegbona to have been discharged home and cared for in the community; and whether or not the tracheostomy care provided at the nursing home was of an appropriate standard. In summary he concludes that the discharge process from the defendant's hospital fell below an acceptable standard of care.

140. He sets out the history of Mrs Esegbona's admission and refers in particular at paragraph 4.9 to the incident on 8 March when she accidentally pulled out her tracheostomy tube resulting in an airway obstruction. He then gives his opinion which is that the discharge of a patient from a tertiary care hospital to a nursing home lies outside his expertise and he would defer to an expert witness district nurse who looks after patients with tracheostomies.

141. He says that the known risks in caring for Mrs Esegbona were that she had once pulled out a tracheostomy tube and that it had once been completely obstructed with a mucous plug and that those facts should have been communicated to any facility that was to care for her.

142. He says that it is unclear how the best interests decision was arrived at when the principles of best practice do not appear to have been followed in

the way set out in the Mental Capacity Act. He considers that Mrs Esegbona could only have been discharged home if she had carers living with her all the time.

143. When he gave his evidence, Mr Olarinde confirmed that he has considerable experience of performing tracheostomies in both in and outpatients and those with and without cognitive impairment. Whilst suctioning might be three or four hourly in a cancer patient, it would probably be hourly if it was to deal with secretions as in Mrs Esegbona's case. He was referred to the joint report and gave his opinion that regular suctioning is part of the care of a tracheostomy but if it is known that a patient might remove their tube, that is a separate piece of information apart from the general need for suctioning and there is obviously the risk of a significant adverse event. He said that the general need for suctioning cuts across all patients but there are not very many patients who would remove their tube. He said that if the nursing home had known of the risk they might, for example, have bandaged Mrs Esegbona's hands or provided one-to-one care or come up with something to mitigate the risk such as positioning her closer to the nurses' station so that any response would be quicker. In that way any tube removal would be noticed sooner (or any asphyxiation presumably) and the risk would have been much lower. He says that the risk is more than trivial. A quick response would mean that the tracheostomy would have been put back within seconds, not 2, 3, 4 or even 10 minutes.

144. He was referred to the document at p2086a and agreed that if the nursing home had received that then he would expect the information in it to

form part of the care plan. He considered that "as required" would be less frequently than half hourly or hourly. Similarly, with regard to p2087 he said that if it had been received he would expect that information to be included in the nursing home's care plan. When he was referred to the Continuing Healthcare Checklist at p2152 he said that "constant supervision and prompting" is a purely nursing issue and is a matter for the nurses who would be the healthcare professionals. He said that he would be straying out of his expertise to comment on the nursing care of a tracheostomy patient.

145. He was unable to express an opinion as to which cause of death was more likely. He said that those are matters for a pathologist. However, he said that there would be an immediate loss of breath if the tracheostomy tube came out.

146. He was referred to p303 at tab 34 Bundle 1 dealing with when the nursing home staff found Mrs Esegbona unresponsive. Looking at p302, he agreed that it seems that hourly checks were being maintained and it is apparent that Mrs Esegbona was in a room of her own.

(iii) Dr Vletsi

147. Dr Vletsi is the defendant's expert. She is a consultant in respiratory medicine. Her report is at tab 27 p137 in Bundle 1. It is dated 4th April 2018. In that report she said that in her opinion there is no clinical negligence in the case. She identified one episode of substandard care, but that breach did not, in her opinion, materially contribute to or cause any harm suffered by the

deceased. She notes from Dr Leonard Peter's statement that there were "appropriate instructions from King's College Hospital for the care of a tracheostomy patient… including a full medication record". She refers to the letter from Lauren Miller, senior physiotherapist giving information about the type of tracheostomy with a proposed plan for four weekly changes, speaking valve and humidification. The letter refers to regular suctioning every half to one hour to maintain patency and refers to the history of tenacious secretions and the need for cleaning the inner tube as well as suctioning. Dr Leonard Peter was aware of the previous psychiatric history.

148. The breach of duty Dr Vletsi identified is the failure to inform the nursing home that Mrs Esegbona had previously pulled out her tracheostomy tube. This incident was not witnessed, and Dr Vletsi sets out by reference to a statement from Dr Amin that the nurses thought that the tube had been dislodged "when the patient was reaching for some water". Dr Vletsi says that "according to my experience this would have been possible only in the case that tracheostomy was left unsecured and there is no evidence of that in the notes". She considers that the event could have been accidental due to the loosening of the support around the neck which is not uncommon but there is no evidence of that. In this case she said, "usually it takes considerable effort for the whole tracheostomy to be pulled out but a strong cough reflex (which the deceased had according to the nursing and physiotherapist notes) could have dislodged it". However, she says that Wilsmere House did not need to know about this because (on the defendant's case) they had enough information. Similarly, in respect of the requirement for extensive and urgent

suctioning and replacement of the inner tube and the fact that the inner tube had been obstructed on 10th March she says that this information was provided by the head physiotherapist in the discharge notes.

149. In respect of Mrs Esegbona's repeated wish to be discharged home and not to a nursing home, by reference to Mrs Esegbona's fluctuating capacity Dr Vletsi's view was that it would not constitute a breach of duty and would not have materially affected the claimant's outcome. However, she does agree that the failure to provide information that Mrs Esegbona had expressed a desire to remove her tracheostomy tube herself once discharged did fall below the standard expected of a reasonably competent practitioner and it should have been mentioned. That is particularly so in light of her history of paranoid schizophrenia.

150. Dr Vletsi's view is that on the balance of probabilities the alleged negligence has not caused or materially contributed to the injury complained of. The nursing home had information in particular from the physiotherapist's letter. The information about the wish to remove the tracheostomy on discharge would not have altered the outcome and Dr Vletsi says, "the most probable scenario of death is arrhythmia on the background of lymphocytic myocarditis with tracheostomy removal by the patient being the result of an imminent feeling of asphyxia due to arrhythmia". She says "asphyxia could also have resulted from a blocked tracheostomy tube which could have led to the patient pulling out her tracheostomy. Either of the two scenarios would be very difficult to establish but on the balance of probabilities would have led to the patient's asphyxia either way". She says that there could have been

mucous blocking off the inner part of the endotracheal tube (despite adequate suctioning and clearing by Wilsmere House staff).

151. She says at the end of her report (10.07) "I would further like to note that in relation to the deceased being discharged home, there are cases of tracheostomised patients being discharged for care at home, but these would probably be with less comorbidities and more stable conditions" and "24-hour supervision and care of a tracheostomy is very challenging in home settings". She therefore considers that the decision to discharge to a care home was justified and while she does not say that care of a tracheostomy at home is impossible she says it is "highly challenging and families can very easily become fatigued and panic in the case of obstruction or inadvertent removal".

152. The joint report between Mr Olarinde and Dr Vletsi is at p172. As is apparent from that joint statement Dr Vletsi's opinion has clearly changed significantly in several respects.

153. In her oral evidence, Dr Vletsi told me that she deals very, very frequently with patients with tracheostomies who are often on the respiratory ward as a step down from ICU or because they are chronic patients. She says that patients with tracheostomies are discharged home or to a nursing home. She said that she would have to make sure that they were medically stable or medically fit for discharge and give instructions to the discharge team as to the best place.

154. She repeated the view set out in her report that lymphocytic myocarditis can lead to fatal arrhythmias and her view is that that was the

cause of Mrs Esegbona's death particularly in light of the fact of no pulmonary oedema having been found at post-mortem.

155. She agreed that it is possible for a patient to be discharged home with a tracheostomy but that would depend on the clinical severity of the patient. She said that if she thought it was not safe for a person to be looked after at home then she would try to rationalise with the patient and the family. She said she would explore the possibility, but she would want to know that there would be a suitable care package for the patient available with someone nearby and appropriate equipment. She said a whole assessment would be required of the accommodation and how much a family could contribute. She would explore with the family if they were happy and able to cope with the burden of someone with such a severity of problems.

156. It is her opinion from the medical notes that this was discussed with the family in Mrs Esegbona's case. She said that she saw areas in the notes where "communication was pursued".

157. She maintained her view that it was not a breach of duty not to tell Wilsmere House that Mrs Esegbona wanted to go home and not to a nursing home. She said that since she felt that this information would not affect the care she would not defer to the opinion of a nursing expert. She said that most patients want to go home and would say so. She said it was not something that would have to be passed on by the nurses to the nursing home. It should not make a difference, she said, if a patient is a bit frustrated because it is quite easy to identify, and all patients have different needs. She said that it would not change the level of care.

158. She has not worked in a nursing home and is not a nurse or trained as a best interests adviser. She says she does best interests capacity assessments for her patients. She said that if she knew that deferring to a nursing expert's expertise would make a difference then she would, but she considered her knowledge was adequate to make that decision.

159. She considered that it was her responsibility as a respiratory physician to decide if the patient was fit to be discharged.

160. She was challenged about her view that Mrs Esegbona died of a fatal arrhythmia and she said that she considered that there was a sequence of events involved. She was asked about the pathologist's addendum reports and change of opinion. She expressed her view that the medical cause of death does not explain if there were two different events or an arrhythmia which led to self extubation. However, on a balance of probability she felt the fatal arrhythmia happened first and then the tracheostomy was pulled out. She said that a longer course of asphyxiation would cause changes and she would expect pulmonary oedema and she thought it was more probable that it was an arrhythmia and then cardiac arrest. She said it is very difficult to tell what happened. She had never had a patient with lymphocytic myocarditis and is not a cardiologist.

161. She agreed that the phrase "much lower" in relation to the risk of an adverse event at the nursing home meant more than trivial. She said if the nursing home had known that the pulling out of the tracheostomy was

intentional that it would mean ultimately that this patient would have needed increased supervision “either one-to-one or constant”. It was her opinion that “one-to-one” and “constant” mean the same. She said someone would have to sit by Mrs Esegbona side or her bed would have to be near to the nurses’ station. She would probably require 24-hour support. She felt that if Mrs Esegbona was prone to pulling out her tracheostomy she would require 24 hour a day care/strict supervision. If she had had 24-hour support clearly the risk would be reduced, but she was unable to give a figure as to by how much.

162. By reference to the CHC assessment at page 2152 she said that "constant supervision and prompting" would mean that somebody must be at her side 24 hours a day. She would have expected there to be an increased level of care. She said that if patients were in separate rooms with doors in the nursing home supervision would not be constant. Constant supervision would be either beside the nurses’ station or nursed on a one-to-one basis.

163. In the joint statement the issues are identified firstly as whether Mrs Esegbona was unlawfully detained from March 2011 to 14 June 2011; secondly whether the defendant should have informed Wilsmere House that: (a) the deceased had previously been found with her tracheostomy tube out on 8 March 2011; (b) the deceased had had her tracheostomy tube obstructed on 10 March 2011 and required extensive and urgent suctioning replacement of the inner tube on several occasions; (c) the deceased had repeatedly expressed a wish to be discharged home, not to a nursing home; and (d) Mrs Esegbona had specifically expressed a wish to remove her tracheostomy tube herself once discharged; thirdly, it was identified that there was a dispute between the

parties as to whether the defendant should have informed the nursing home of the above matters; and fourthly the issue of whether it would have made any difference to the outcome if they had been informed of those matters.

164. The experts were asked to consider whether or not failures to pass on any of that information would amount to a breach of duty. They agreed that the failure to pass on information as to (a) was a breach of duty. They agree that failing to pass on the information at (b) would have been a breach of duty, but they say, "we however note that there are extensive references in the discharge summary referring to the need for frequent suctioning and the need to frequently replace the inner tube". Dr Vletsi says that the failure to pass on information as to (c) was not a breach of duty "and would not change the deceased's management in the nursing home". Mr Olarinde says that he is of the opinion that the defendant should have told the nursing home about (c) but "it is extending out of his expertise to comment on if this was a breach of duty or not as this is not a primary area of his expertise". As to (d) the experts agree that if Mrs Esegbona had specifically expressed a wish to remove her tracheostomy tube herself once discharged and the nursing home were not aware of this this then it would constitute a breach of duty by the defendant. They say, "we are of this opinion, as this is an important piece of information that Wilsmere House would need to know".

165. In respect of whether or not the discharge process overall fell below a reasonable standard of care, Mr Olarinde again says that it lies outside his expertise and he would defer to the opinion of an expert witness district nurse. Dr Vletsi says that her overall impression is that the discharge fell below a

reasonable standard of care. She says that the opinion of a qualified nurse/discharge facilitator would also be advisable as parts of the discharge process fall outside her experience and expertise.

166. The experts considered whether or not it would have made a material difference to the risk of the Mrs Esegbona pulling out a tracheostomy tube if the pieces of information had been conveyed to the nursing home and if so how. In relation to the risk of Mrs Esegbona pulling out a tracheostomy tube the experts agree that the risk would have remained the same, but the chance of appropriate action being taken would have been higher if the information had been relayed to the nursing home. "In other words, the chance of an adverse event e.g. death occurring from the deceased pulling out a tracheostomy tube would have been much lower had Wilsmere House been given the pieces of information set out in 1 (a) to (d) above". I note that they appear to refer here to all of the pieces of information.

167. Mr Olarinde felt that Wilsmere House might have put measures in place to reduce the likelihood of the deceased's tracheostomy tube being removed by herself or being dislodged and that had they been informed they would have been better prepared to take preventative action. They would also been prepared to prevent Mrs Esegbona from removing her tracheostomy if they knew she had previously expressed a wish to remove it. It was his view that this was important considering her fluctuating capacity.

168. Dr Vletsi was also of the opinion that if the nursing home had been better informed about Mrs Esegbona's wish to pull out her tracheostomy tube especially against the background of mental illness they would have been

better prepared to deal with such situations, and that on a balance of probabilities that would have increased the chances of staff dealing with an acute incident successfully. She says however "according to the notes though, there seemed to be adequate response by the staff at the time of the deceased pulling out her tracheostomy, and appropriate actions were taken to try and save her life".

169. In terms of the best interests decision, Mr Olarinde says that this is outside his area of expertise. Dr Vletsi says that she considers that there is appropriate documentation on discussions of best interests with the family with the only exception being the failure to use an interpreter which would on the balance of probabilities have assisted in understanding Mrs Esegbona's wishes better. On that basis whilst Mr Olarinde cannot comment on whether or not the process fell below a reasonable standard of care Dr Vletsi says that her overall impression was that the process did fall below it. Dr Olarinde repeats his view that it would have made a difference to the outcome whereas Dr Vletsi states that although the discharge fell below a reasonable standard of care "on the balance of probabilities this would not alter care at the nursing home to an extent capable of preventing the patient's death by pulling out her tracheostomy tube. This is reinforced by the coroner's opinion that the death was precipitated by lymphocytic myocarditis and fatal arrhythmia".

The Inquest

170. I have reviewed the bundle of records from the inquest. I do not have the full transcript of the inquest itself. The coroner initially recorded the cause

of death as lymphocytic myocarditis. This was amended to read: 1a sudden cardiac arrest and then 1b lymphocytic myocarditis and self extubation of tracheostomy tube. The record says that Mrs Esegbona was found unresponsive at about 8.20 in the evening of 23rd June having removed her tracheostomy tube.

171. The post-mortem examination showed abnormalities in the heart consistent with the lymphocytic myocarditis. There was no obvious obstruction to the trachea despite the presence of the tracheostomy. It was also noted that it was not obvious macroscopically what the disease process was that required the tracheostomy and PEG feeding tube.

172. Dr Jarmulowicz noted the presence of near-normal lung weights being most indicative of a sudden cardiac standstill rather than a period of heart failure prior to death. In light of the unequivocal finding of lymphocytic myocarditis which can induce a sudden fatal cardiac arrhythmia it was the pathologist's view that that was the cause of death in Mrs Esegbona's case.

173. The pathologist was asked to provide a supplementary statement which he did. This followed conversations with the family confirming that there was no evidence of a stroke and that the histology of Mrs Esegbona's brain was irrelevant in identifying the cause of death. Tracheomalacia would not be a cause of death. He again concluded that the only objective evidence he had that would explain sudden death was the presence of unequivocal myocarditis which can cause ventricular arrhythmias.

174. He provided a second addendum dated 2nd March 2014, following a

pre-inquest review and he was asked to reconsider his opinion in light of the evidence presented by Dr Oakley. This evidence was to confirm that Mrs Esegbona did not have tracheomalacia but had multiple problems suggesting that removal of the tracheostomy was very likely to lead to obstruction of the airway. The pathologist was therefore asked to consider the scenario that removal of the tracheostomy would have led to airway obstruction which in turn led to her death. Having done a literature search, Dr Jarmulowicz identified that there is an association between airways obstruction and pulmonary oedema where lung congestion and oedema develop in consequence of upper airways obstruction. Asphyxia is considered to be a consequence of the struggle to breathe against some mechanical interference with respiration. General autopsy findings in asphyxial deaths include pulmonary oedema, right ventricular dilatation, bulky, crepitous and over distended lungs, and petechial haemorrhage of the conjunctival/facial tissue. There is usually darkening of the blood.

175. However, these classical features of asphyxia may not be seen in some deaths which appear to have occurred in an asphyxial setting because of vagal inhibition (vagal reflux cardiac arrest) which leads to abrupt cardiac arrest. Vagal inhibition can be caused by compression of the vagus in the neck compression of the larynx, a blow to the abdomen or shock of cold water et cetera.

176. He went on to consider two scenarios. The first is that Mrs Esegbona removed the tracheostomy leading to upper airways obstruction resulting in death. The second is that she had some sort of distress caused by the cardiac

arrhythmia causing her to remove the tracheostomy. In that event it would be the cardiac event which was the cause of death. None of the classical features of asphyxial death are present but they are not always present, and it is possible that this was a vagal inhibition case. This would be based purely on the circumstantial evidence of finding the dislodged tracheostomy tube and the known potential for airways obstruction.

177. The features are those of a sudden (short time period) cardiac standstill supported by the lymphocytic myocarditis which is well known to cause cardiac arrhythmias including fatal arrhythmias. Against that it is also known that histological evidence of lymphocytic myocarditis can be seen in cases of traumatic death when it is an incidental finding. He concludes that he favours the cardiac arrhythmia because there is the presence of lymphocytic myocarditis and the arrhythmia could have caused symptoms and confusion leading the patient to remove the tube. This would be based on specific physical findings. He also relied on the evidence of Dr Oakley that the removal of the tube would not "unequivocally" cause obstruction. In scenario one he considers that one would have to opt for an uncommon cause of vagal inhibition.

178. There is then a third addendum because Dr Jarmulowicz was erroneously sent the transcript of Dr Oakley and now had to consider his opinion in light of the evidence of Dr Dawson. He now had information that the tracheostomy tube was hanging from the stoma and blood was seen on Mrs Esegbona's index finger and thumb. In light of his own contemporaneous description he can only conclude that subsequent to Mrs Esegbona's death the

tracheostomy tube was reinserted and the blood on her fingers was removed. However, the evidence of Dr Dawson indicated to the pathologist it seems for the first time that there had been the two previous occasions; one where the tracheostomy tube was found pulled out and the second when it was blocked, and Mrs Esegbona had rapidly suffered a respiratory arrest followed by an atrial fibrillation and then cardiac arrest from which she had been resuscitated.

179. He considers that the new evidence is of two occasions when removal/blockage of the tube led rapidly to cardiac standstill. In other words what he had previously considered to be uncommon (and his reason for favouring the other scenario) had in fact occurred on two documented occasions. He says this has to change the probability of which is the more likely scenario. He says that on the basis of this new information he is willing to accept that the removal of the tracheostomy tube is likely to be causally related to death. He cannot offer an explanation as to why Mrs Esegbona removed it which would have required considerable effort. It may be that there was an arrhythmia which caused an acute feeling of breathlessness so that she was trying to pull the tracheostomy out in an effort to breathe. In those circumstances the lymphocytic myocarditis would not be excluded either. He says, "I am unsure on what basis to prescribe one cause over the other and it may be appropriate to have both lymphocytic myocarditis and removal of tracheostomy tube under part 1a". It is that that was recorded by the coroner.

180. The coroner's notes contain the letter from Dr Leonard Peter dated 9th

September 2011 where he states that he saw Mrs Esegbona on 16th June and she was "well and happy and pleased to be under the care of the nursing home and there were no outstanding problems". He only saw her, from the contents of his letter, on one occasion.

Records/Chronology

181. Although there are a very large number of documents in this case, I was in fact only taken to a limited number. Counsel have provided me with a list of the documents they ask me to consider and I have done so. There are also useful chronologies in both parties' skeleton arguments which I do not need to repeat, but which I have also considered.

Analysis/Findings

182. I find that Mrs Esegbona pulled out her tracheostomy tube on 8th March and did so again whilst at the nursing home. I consider that this is more likely than accidental dislodgement. Although it seems there was some water spilled on the floor the first occasion and a suggestion that it may have been accidental I find that in order to pull out the whole of the tube and for Mrs Esegbona to have had blood on her fingers on the last occasion indicates to me that this is very unlikely to have been accidental. The tube was not dislodged it was removed in its entirety. There is no evidence that it was not adequately supported around her neck or insecure.

183. I note the evidence of Dr Esegbona who does not consider that her mother would have self-harmed or would have pulled the tube out. She does not accept that her mother did not understand the importance of the tracheostomy tube in keeping her alive. In fact, she says that her mother was aware that the tracheostomy tube was necessary for her to be able to breathe. Dr Esegbona considers that her mother did not lack mental capacity but merely had communication difficulties. However, Dr Esegbona did say that her mother could become frightened and would tug at the tube.

184. I accept the evidence that Mrs Esegbona lacked capacity when she was assessed on 7th April and on occasion when she was assessed thereafter. I think that her mental state and confusion fluctuated but generally deteriorated. It seems to me likely that had a full capacity assessment been possible in February (with all the appropriate aids to communication and assistance from the speaking valve, an interpreter, a family member et cetera) she would probably have been found to be capable of making a decision, even if it was an unwise one. However, the defendant did not comply with its duties and monitor capacity on an ongoing basis nor was capacity assessed in optimal circumstances at any point. The defendant did not follow the recommendations of its own psychiatrist. I find that there were very many occasions from about March onwards when Mrs Esegbona lacked capacity. I find that her capacity fluctuated. I find the periods when she may have had capacity diminished significantly towards the last two or three months of her life.

185. It seems to me that Dr Esegbona and the rest of Mrs Esegbona's family, particularly at an early stage, formed the view that their mother appreciated the risks and was able to express a clear and capacitous desire to go home. In particular, I find that this was because in the ordinary course of social visiting Mrs Esegbona would have been relaxed and comfortable and less distressed than she was for much of the time on the ward. The family would have been more likely to understand her impaired communication and to have given her the time and prompting to express herself. I find that in more relaxed and supportive conversation with her family Mrs Esegbona probably was able to realise that the tracheostomy tube was vital. However, I do not find that this understanding was consistent, and it diminished in any event as her mental capacity diminished.

186. It seems to me that on the first occasion in March Mrs Esegbona may have removed the tracheostomy tube for one of two reasons. Firstly, because it was blocked, and she could not breathe properly. Secondly because in her confused state and given her absolute desire to go home she blamed the presence of the tracheostomy for her inability to go home and did not understand why she could not be decannulated and so removed it with those considerations in mind.

187. There is no doubt about the fact that without regular suctioning and changing/cleaning of the inner tube Mrs Esegbona tracheostomy could become occluded so as to lead to complete airways obstruction and to cause sudden cardiac arrest. This was the case on the two occasions in March. From

the evidence I have seen and as I find it seems that the inner tube cleaning/replacing was a reflection of the severity of the problem of blockage in Mrs Esegbona's case which seems to me to have been more extreme than would normally be expected. I accept Dr Olarinde's evidence that this kind of chronic tendency to obstruction might give rise in an ordinary patient to the need for half hourly/hourly suctioning, but I consider that regular monitoring in Mrs Esegbona's case was more vital, in particular because of the speed with which occlusion seems to have occurred.

188. In this respect I note that the cardiac arrest call record (for 9th March) shows that Mrs Esegbona's heart rate dropped to 29 for 2 to 3 minutes and she was taken to ITU.

189. On 9th March the note reads "she appeared to obstruct her tracheostomy while sitting in a chair leading to a peri arrest situation" and "the inner tube was partially occluded with purulent sputum and has been changed". It was following this that the care plan changed to two-hour suctioning, regular inner tube changes and regular nebulisers. It was considered likely that the secretions were pooling in the inner tube. At 16.36 on 6th June Mrs Esegbona was confirmed to have visible difficulty in breathing, suction was not possible, and the inner tube was completely occluded with dried secretions. It is noted that there was no documented tracheostomy care since the end of the night shift at 07:00 hours. The importance of regular suction and inner tube changes to maintain a patent airway was reiterated.

190. The heightened risk of sudden cardiac failure/arrest seems to have been identified in March. It is known that Mrs Esegbona had the pre-existing lymphocytic myocarditis which can give rise to sudden fatal arrhythmias. It is unfortunate that the pathologist seems to have been given inadequate and/or incorrect information so that his opinion started from one position and then developed rather than being formed initially. There is no doubt about the fact that there were changes seen in the heart which are consistent with lymphocytic myocarditis and it is known that this can give rise to a sudden fatal arrhythmia. There is also no doubt that there was no pulmonary oedema consistent with typical asphyxiation. On the other hand, there is no evidence of any prolonged period of heart failure. This was a sudden arrest.

191. I have to reach a conclusion about what caused Mrs Esegbona's death. I am entitled to go behind the coroner's conclusion if appropriate particularly following hearing all the evidence which I have heard and my consideration of it. I think that the two previous occasions where removal/blockage of the traffic tracheostomy resulted in cardiac arrest/peri arrest are significant. In fact, it is the factor which causes me to reach the conclusion I have. The conclusion which I have reached is that Mrs Esegbona pulled out her tracheostomy on 23rd June and in consequence went into sudden cardiac arrest. She may have pulled it out because it was blocked, and she felt that she could not breathe. She may have pulled it out in a state of confusion believing that it was what was preventing her from going home. It is apparent, in particular from the report of the pathologist, that she would have suffered an

almost immediate airways obstruction given the multiple causes which had prevented her from being decannulated earlier. Moreover, it is apparent that on this occasion as on a previous occasion reinserting the tracheostomy was very difficult. It seems to have closed up very quickly. That was the case even when the tracheostomy had not been out for very long. I find that this was either a sudden and complete airways blockage (in other words not prolonged asphyxiation) so as to create the kind of vagal heart attack which the pathologist refers to or as per the opinion of Dr Vletsi to be the cause of the kind of sudden physical or psychological stress that would have resulted in an immediate fatal arrhythmia consequent upon the pre-existing lymphocytic myocarditis. It does not seem to me that I need necessarily to make a decision in respect of these possibilities, since on a balance of probability my conclusion is that Mrs Esegbona removed her tracheostomy and that that is what triggered the cardiac arrest. The absence of pulmonary oedema is on my interpretation explicable by reason of the sudden nature of the arrest following the very sudden obstruction of the airways. This is a pattern which had occurred before requiring ICU admission.

192. Of course, Mrs Esegbona had very many comorbidities and the heart condition which could have given rise to her sudden death at any point and I find that the claimant is right to accept that the claim here is limited to a claim for damages for the circumstances and location of Mrs Esegbona's death being more traumatic and frightening than it would otherwise have been. It is not possible to say that she was not liable to die at any time. However, she should have been constantly supervised so that her tube did not become

blocked and she was not able to pull it out.

193. It is a striking feature of this case that the defendant did not call any evidence apart from that of Dr Vletsi. I heard from no-one involved in Mrs Esegbona's care. She was a patient in the defendant's hospital for eight months. This is not the sort of single episode encounter where it would be perfectly understandable that a nurse/doctor would have no independent recollection. I heard no positive evidence about any information that was passed on to Wilsmere House. Neither did I hear any generic evidence about the defendant's and its staff's usual practice in relation to capacity assessments, best interest decision meetings, discharge procedure/provision of information. I did not hear from Mrs Esegbona's consultant on the issues of his understanding of his duties under the Mental Capacity Act or his view as to the role of decision-maker. Neither did the defendant call evidence from the PCT or Lewisham about their roles, even on a generic basis. I did not hear from any of the defendant's psychiatric or nursing teams about Mrs Esegbona's care/wishes/feelings.

194. Dr Esegbona and Lynne Phair were cross-examined at length on wide-ranging topics. It seemed to me that the defendant was trying to establish its case through the claimant's witnesses, I accept of course that the burden of proof is on the claimant, but the defendant has not put any positive evidence forward save for the opinion of Dr Vletsi.

195. Dr Vletsi seemed to me to be overly willing to give her opinion on

areas outside her expertise and in particular where she expressed an opinion on nursing practice, I prefer the evidence of Lynne Phair, who is not only a nursing expert, but who has considerable experience in precisely the sort of case with which I am concerned. I find that Dr Vletsi's approach to the assessment of breach of duty is inappropriately influenced by her view on causation, namely that it would have made no difference to the care. Of course, there can be a breach even if it is not a causative one. However, I do find that Dr Vletsi was doing her best to help the court.

196. I found Lynne Phair to be an impressive expert witness. She has considerable experience and expertise. She was measured and careful in her evidence and I accept what she said.

197. In the event the evidence of Mr Olarinde was limited in its scope, but I accept it was given in a balanced and fair way.

198. I do not find that Dr Esegbona was following any sort of a "script". It is apparent that as set out in her statement she and her family feel bitterly, angrily and adamantly that following a routine admission for heart failure their mother deteriorated in distressing circumstances over eight or so months and that they were not given proper explanations. However, when she gave her evidence it did not seem to me that Dr Esegbona was unreasonable or blinkered.

199. The claimant contends that the defendant should have informed Wilsmere House that: (a) the deceased had previously been found with her tracheostomy tube out on 8 March 2011; (b) the deceased had had her tracheostomy tube obstructed on 10 March 2011 and required extensive and urgent suctioning replacement of the inner tube on several occasions; (c) the deceased had repeatedly expressed a wish to be discharged home, not to a nursing home; and (d) Mrs Esegbona had specifically expressed a wish to remove her tracheostomy tube herself once discharged. Even in the documents which the defendant relies on as having been provided, (a) and (b) were not specifically referred to. These were breaches of duty as agreed by the experts and I find that they were negligent in this regard. The generic references to the need for suctioning do not address these risks.

200. I specifically find and accept the evidence of the experts, that in light of these specific risk factors, Mrs Esegbona required either one-to-one nursing or to be nursed where she was in constant sight of the nurses' station.

201. Despite Dr Vletsi's opinion on causation and despite her expressed view that "one-to-one" and "constant" mean the same, I consider it is important that when she was asked about the phrase "constant supervision and prompting" in the CHC assessment, she said that constant supervision would be either beside the nurses' station or nursed on a one-to-one basis and that if Mrs Esegbona was in a separate room with a door in the nursing home (which she was) then that would not be constant supervision.

202. In the circumstances I find that the failure to provide Wilsmere House with these particular pieces of information did affect the care given to Mrs

Esegbona and that had the home had that information she would have been the subject of constant supervision and never left on her own in her own room.

203. In light of those findings I find that the defendant was negligent and causatively negligent.

204. I find that not all of the documents that the defendant relies on as having been provided to Wilsmere House were in fact provided. Primarily this is because the expert witnesses agreed that one would expect that the nursing home's care plan would detail the information received on discharge. As was rehearsed in the evidence it does not. The defendant made this point to suggest that the fault lay with Wilsmere House. There is no evidence that the nursing home was negligent. I cannot make that inference. It seems to me more likely that the information is not included in the care plan because the nursing home did not have it. The absence of any positive evidence from the defendant that the documents were provided and the lack of any reference to the specific pieces of information in the care plan causes me to reach the conclusion that the home did not have the information,

205. The claimant was properly willing to accept that the CHC document would usually be provided to a nursing home. I accept the point that the CHC documents are not only out of date but also their purpose was for the CHC funding decision. The defendant asked me to infer therefore that it was in this case. I do not draw that inference in the absence of any positive evidence. Indeed, it seems to me that the way in which Mrs Esegbona was nursed at

Wilsmere House (and perhaps the fact that they took her in the first place) reflects the fact that they were not aware of the extent of the care and supervision required. I accept the evidence of Lynne Phair that had Wilsmere House known that Mrs Esegbona required one-to-one care, they may have sought a review of the funding available.

206. I find that had the information been provided it would have been apparent as was agreed by all the experts in fact that Mrs Esegbona required one-to-one nursing or nursing where she was in constant sight of a nurse. She had been left unattended for a period of time at the time of her death. It seems to me that she needed to be in constant sight so that she could not have pulled out her own tube and so that the tube could not have become blocked so as to stop her breathing.

207. I accept Lynne Phair's evidence that one-to-one care would be the phrase that would be used if that is what was meant, but as set out above the important point here is that Mrs Esegbona was not nursed on a one-to-one basis nor was she under constant supervision.

208. In any event even had the CHC documentation been provided to Wilsmere House it did not contain, as it could not, the information about the incidents on 8th/9th/10th March, since it predated them. The risk of removal of the tube/occlusion of the tube such as gave rise to sudden cardiac arrest or the risk thereof was a vital piece of information which the care home needed to have.

209. The letter from Dr Tranah does not refer to the incidents of 8th/9th/10th March nor does it address the specific issues relating to tracheostomy care for Mrs Esegbona. Lauren Miller's letter does not refer to the March incidents and only specifies half hourly to hourly suctioning. It seems to me that this does not address the need for one-to-one care or being in constant sight of a nurse and does not therefore address the risk, even if it was passed on. The nursing note at p2087 refers to strict hourly suctioning and not the need for constant supervision. In any event I have no information as to when or for what purpose it was written, and I cannot and do not find that it was provided to Wilsmere House. The rest of the information at tab cc is out of date and generic in relation to tracheostomy care and would not put the home on notice of the specific risks in this case. I find it more likely than not that Wilsmere House only had the form at p2085 and the letters at p2086 and 2086a which were written for the purposes of discharge.

210. For the sake of completeness, I find that Wilsmere House was not told that Mrs Esegbona had repeatedly expressed a wish to be discharged home, not to a nursing home; and had specifically expressed a wish to remove her tracheostomy tube herself once discharged. In relation to the latter I specifically find that she did express such a wish. In circumstances where the defendant had not reached any definitive conclusion about whether or not Mrs Esegbona deliberately removed her tube, the risk that she would and the risk that she would do so in order to achieve (in her confused thought processes) discharge home were risks that the home needed to know about. In light of

my finding that she needed one-to-one nursing or constant supervision, these failings would not have altered her care. But this information on its own would have mandated as per the evidence of Lynne Phair and Mr Olarinde (which I prefer on this point) a period of heightened monitoring at least in the early weeks.

211. I accept the evidence of Lynne Phair that in its dealings with Mrs Esegbona, the defendant did not comply with its duties pursuant to the Mental Capacity Act. The defendant has admitted that Mrs Esegbona was falsely imprisoned by reason of those failings in its defence. I heard no evidence which would entitle the defendant to resile from that position. The focus of the defendant's argument was on the length of such false imprisonment and whether or not it would attract an award of substantial rather than nominal damages.

212. The defendant did attempt to argue that it was not the decision maker when it came to where Mrs Esegbona should be discharged. I reject that submission and accept the evidence of Lynne Phair. Of course, the defendant's own expert, Dr Vletsi confirmed that as the consultant she would be the decision maker for her patients and she described the sort of assessment that she would be responsible for before deciding where a patient should be discharged. I have set out her evidence and that of Lynne Phair on this point and I accept it. I reiterate that if the defendant wished to press this issue they could have called evidence from the PCT, Mrs Esegbona's consultant and the local authority. They did not. I have no doubt and find that

for the purposes of the Mental Capacity Act whilst in the defendant's hospital Ms Esegbona's consultant was the decision-maker. Nor do I have any difficulty in finding that it would be the defendant through its staff that would be responsible for identifying whether or not Mrs Esegbona was medically fit for discharge.

213. In any event the defendant had the clear direction from Dr Bhavsar and the psychiatric team about the need to and how to comply with its duties under the Act and the staff failed to follow it.

214. The defendant not only failed to comply with its duties but specifically overrode the statutory process.

215. I accept the evidence of Lynne Phair to the effect that from no later than early February, when Mrs Esegbona was saying she wanted to go home until the date of her discharge there was no proper and ongoing capacity assessment, best interests meetings or as became necessary, referral to the Court of Protection.

216. I agree that the notes from about May onwards show an "appalling" disregard for the Mrs Esegbona and her family's rights, let alone their wishes and feelings.

217. Although the hospital seemed to think that Victor in brokerage at Lewisham social services had provided details of two nursing homes to Mrs

Esegbona's family, the family confirmed that that was not the case. They were only told about one. The planned meeting for 27th May did not take place and the family did not attend. There is nonetheless a note on 25th May which reads "if family do not attend meeting we are able to place patient in her best interest". Dr Bhavsar expressed the opinion on 26th May that in order to assess her capacity to decline placement and return home Mrs Esegbona required optimisation of her communication with the speaking valve, the presence of family members to aid interpreting and a clear statement of what is being offered to her in terms of future placement. These measures were not taken. There is a note on 31st May saying that the family needed to make a decision by Friday and "if there has been no decision made by Friday then we as a team will pick a suitable nursing home for her with advice from the discharge coordinator".

218. Having spoken to Lewisham brokerage there were no beds available at one nursing home and the defendant was advised to contact another nursing home (neither of them Wilsmere House). The discharge coordinator has written in the notes "not be discussed with patient's family". And again, on 3rd June the discharge coordinator has written "family are not to be informed until we receive a decision from the care home. I have contacted Wilsmere House".

219. On 6th June a psychiatric liaison assessment was carried out on Mrs Esegbona regarding her capacity to decide about her tracheostomy and future placement and the conclusion was that she lacked capacity. The note reads

"we would support plans for a best interests meeting in the near future to discuss future care planning, in light of the above and of the involvement of a family in the case to date". On 7th June the discharge coordinator indicated that Dr Barker " should write a letter to patient's daughters stating that [Mrs Esegbona] will be discharged on a specific date and provide details of the care home". On 13th June the note reads "plan is for discharge tomorrow morning from the ward at 9am hours tomorrow. Any issues with family call me and I will speak to them if we have to move down the route of removing family then we will if the family become obstructive or cause an issue on the ward. I am aware the letter went to the family on Friday stating discharge from hospital on Tuesday. 14th June is classed as a reasonable amount of time for family to react to that letter".

220. The notes say that contact was made by the family to indicate that they were unhappy because the home was too far out of London. There is a note also on 13th June which reads "spoke to the registrar and request for a capacity test to be carried out, spoke to Dr Barker he confirmed that the letter should have been sent by recorded delivery by his secretary Mary, unfortunately she's off today and I was unable to confirm. I was unable to liaise with Victor from brokerage as he is off today will try again tomorrow". Also, on 13th June a note reads "Discharge coordinator requested to contact IMCA service regarding this patient in the current situation. IMCA will not be able to assess as [Mrs Esegbona]'s family have been involved in the decision-making process regarding best interest of her medical condition and treatment and also best interest of her ongoing care needs and discharge

plans". The note maker goes on to suggest that in light of the information received from the consultant and from the team at St Thomas's, best interests have been addressed and goes on "best interest has also been addressed regarding placement. The family and independent group social services have agreed with MDT recommendation for placement and agreed with recommendation for NHS funding". The note continues "discharge patient tomorrow morning at 9am to the nursing home if the family arrive on ward… advice from matron and call security if required".

221. On 31st May Diane Nelson, the discharge coordinator, made an entry in the notes regarding possible placement at two homes. The note reads in capitals "not to be discussed with patient's family". On 3rd June when contact had been made with Wilsmere House, Diane Nelson's note reads, amongst other things, "family are not to be informed until we receive a decision from the care home". On 4th June 2011 Dr Hinds noted that she been asked to see Mrs Esegbona because she was dressed and ready to leave the ward. The note reads "I did not reveal any possible place of discharge as suggested by Diane Nelson however the family are keen to know this". On 7th June, Diane Nelson wrote to say that if Wilsmere House could take Mrs Esegbona then "Dr Barker should write a letter to the patient's daughters stating that she will be discharged with specific date and provide details of the care home". The note suggests that this letter was written and sent on Monday 13th June. Mrs Esegbona was discharged to Wilsmere House on Tuesday 14th.

222. It seems that Deborah Esegbona was spoken to on 13th June after 3

o'clock in the afternoon and told that her mother would be discharged the following day to Wilsmere House and that Deborah was very unhappy and claimed "they were not informed by the discharge coordinator that their mum was going to be discharged in a nursing home out of London, we are discharging her mum against her wish, the nursing home is far and regular visits by family will be". This was explained to Mrs Esegbona who is described as being very upset and stating that she would prefer to go home rather than going to a nursing home.

223. Dr Barker confirmed that a letter should "should have been sent out by recorded delivery by his secretary". A note on 13th June from Jane Mitchell Riley sets out that she had been requested to contact the IMCA service regarding Mrs Esegbona and "the current situation". However, she understood that an IMCA could only be instructed if the patient had no family of her own or the family members have caused harm physically and psychologically to her and she needed to be safeguarded against them. The note goes on to read "best interests have also been addressed regarding placement. Family and an independent group of social services have agreed with the MPT recommendation for placement and agreed with recommendation for Cat 1 NHS funding to be obtained if possible" which it was. The note goes on "plan as follows: discharge patient tomorrow morning at 9am to the nursing home" and finally "if family arrive on ward seek advice from matron… And call security if required". There is a further note saying, "if we have to go down the route of removing family then we will if family become obstructive or cause an issue on the ward".

224. I find that Mrs Esegbona was falsely imprisoned from the time of Dr Bhavsar's attendance on 15th February. At that point Mrs Esegbona and her family wanted her to go home and there should have been an urgent, comprehensive and optimal assessment of her capacity followed by either her taking her own discharge or a best interests meeting.

225. I find that Mrs Esegbona was saying she wanted to go home from no later than 11th February. I find that she and her family said it repeatedly. I acknowledge that she said she wanted to have the tracheostomy removed before she went home, but I do not find that the defendant can rely on this to suggest a shorter period of false imprisonment. Primarily this is because the failure to comply with the duties under the Act meant that there was no proper consideration/assessment of her capacity and her needs. Secondly, there was no proper consideration of discharging Mrs Esegbona home with the tracheostomy in situ, which would likely have been her preferred option rather than remaining in the hospital.

226. I agree with the claimant that the analogy with *Bostridge* is not apt here. The outcome had there been proper compliance with the Mental Capacity Act is not "obvious". I accept Lynne Phair's evidence. It may be that there would have been an assessment and an exploration of the possibility of being discharged home, perhaps on a trial basis. That assessment might have taken a month. It may be that a best interests assessor and/or the claimant and her family would have concluded that an interim discharge to a nursing home

was the appropriate way forward. Had that been the case, however, following a full assessment whether by an independent assessor or the defendant the true state and nature of Mrs Esegbona's needs would have been explored fully and wherever she had been discharged to, she would have been better looked after.

227. I accept Lynne Phair's evidence that she would not have remained on an acute hospital ward for as long as she did. This would have as I find reduced Mrs Esegbona's distress.

228. Moreover, and more importantly, I find that had the defendant complied with its duties there would have been, from February, proper and ongoing assessment of Mrs Esegbona's capacity. That assessment would have been optimised with the use of proper communication including the speaking valve, an interpreter and involvement of a family member. They would have been full best interests meetings which would have involved the family and in respect of which Mrs Esegbona's views would have been received and matters would have been explained to her (and her family) more fully. In those circumstances as Lynne Phair said Mrs Esegbona would have had "a voice". Although her capacity clearly fluctuated I find that her frustration and distress would have been significantly reduced had she better understood and been more involved in what was happening and had she had, (as I find she would have done) some hope that measures were being taken to explore the possibility of her going home, even if only on a trial basis.

229. I cannot second-guess what an independent assessor may have identified as being in her best interests. For example, since I accept Lynne Phair's evidence I cannot reject as one of the possibilities the fact that an independent assessor would have formed the view that whilst there was a real risk to life in being cared for at home, in circumstances where she had two medically qualified children and a total of six children who may all have been available to care at various times, that discharge home particularly taking into account cultural sensitivities would have been the best interests decision.

230. With regard to causation in respect of the cause of death, I do not accept the claimant's argument that this is a material contribution case. I consider it is clearly distinguishable from *Bailey*. In *Bailey* there was one cause of the claimant's aspiration, namely weakness. The weakness could have been caused by a negligent or a nonnegligent cause. In this case death could have been cardiac arrest caused only by reason of the underlying heart problem or by reason of the removal of the tracheostomy tube leading to the cardiac arrest.

231. I think that this is a straightforward "but for" case in terms of causation. On the basis of the findings I have made I am satisfied on the balance of probability that but for the defendant's breaches of duty Mrs Esegbona would not have pulled out her tracheostomy tube at Wilsmere House because she would have been being monitored more closely so that occlusion or the removal of the tube would have been identified and prevented. Had she not pulled her tube out she would not have had the cardiac

arrest.

Damages and Quantum

232. In light of my conclusions I need to assess the appropriate quantum of damages for false imprisonment, aggravated damages, if appropriate, and for pain, suffering and loss of amenity.

233. I find that Mrs Esegbona was unlawfully imprisoned from the date of Dr Bhavsar's recommendation on 15th February until her discharge to Wilsmere House on 14th June, a total of 119 days. For the reasons set out above, there had been preliminary plans on 9th February to discharge Mrs Esegbona home and it was clear that she and her family wanted her to go home. Dr Bhavsar set out what was required for a capacity assessment to be made. That was not done. On the same day the defendant decided Mrs Esegbona could not go home. From this point it seems to me clear that the defendants were in breach of their duties pursuant to the Mental Capacity Act and Mrs Esegbona was unlawfully imprisoned.

234. For the reasons set out above I do not consider that this is a case in which only nominal damages are payable.

235. The claimant argues that this period of unlawful detention should attract an award of damages in the region of £30,000. The defendant argues that this figure is far too high in circumstances where Mrs Esegbona needed to be in hospital anyway. Of course, I have not found that that is the case.

236. I was referred to the cases of *MK (Algeria)* v *SSHD* [2010] EWCA 1617, *AXD* v *The Home Office* [2016] EWHC 1617 and *Alseran v MOD* [2018] 3 WLR 95. Although they identify some principles and parameters, I do not find these comparisons particularly helpful. Each case has to be looked at on its own merits and taking into account the individual circumstances. There is no "initial shock" of detention here. I find that Mrs Esegbona would have been less distressed and frustrated had the defendant complied with its duties. Her voice would have been heard. I accept the evidence of Lynne Phair that she would on the balance of probabilities not have remained an inpatient on an acute ward. She may have gone home either on a trial basis or permanently. She may have been moved to a nursing home on a temporary basis, but in any event her needs, wishes and feeling would have been fully and accurately identified.

237. I have considered the authorities and the submissions, and I award £130 per day, making a total of £15,470.

238. The defendant argues that I should not award aggravated damages where Mrs Esegbona was not the victim of clinical negligence, she was a very unwell patient who was given appropriate medical care. Without calling any evidence, the defendant urges me to find that the exclusion of Mrs Esegbona's family from the decision to discharge to Wilsmere House on 14th June was not "deliberate". I interpret the written notes as showing in the clearest possible way that the defendant was deliberately excluding the family. It intended that the family should have the minimum possible notice.

The location and identity of the nursing home was deliberately not disclosed. The defendant made its decision and was determined to implement it without the family's involvement.

239. By reference to the principles summarised at paragraph 22 of *AXD* v *The Home Office*, I find that that behaviour falls squarely within the definition of "high-handed" and "oppressive". Taken together with the additional features in this case of the defendant's failure to follow the advice of its own psychiatrist on three occasions and their failure to call any evidence in this case to explain the tenor of the notes, I find that it is appropriate to make an award of aggravated damages.

240. Having looked at some of the authorities, I award £5,000 under this head.

241. In terms of pain, suffering and loss of amenity, the claimant refers me to the Judicial College Guidelines chapter 1 (E) and relies on the fact that Mrs Esegbona would have been in distress and unable to breathe and would have known she was going to die and thus the award should be (with the uplift), £4,100.

242. The defendant says that since her distress lasted minutes only on any view, the "immediate unconsciousness" category at 1(D) is more appropriate the bracket with the uplift being £1,200 - £2,450.

243. On the basis of my findings, Mrs Esegbona either pulled her tube out because she could not breathe or because she was very confused and wanted to go home. She would therefore clearly have been very frightened, distressed and alone (when she should not have been) at the time of her death. However, again on the basis of my findings as to the cause of death she would have died very quickly. For these reasons I assess the quantum of damages in the sum of £3,500.

Conclusion

244. There will be judgement for the claimant in the sums identified above.