Kenyatta National Hospital v Kenya Medical Practitioners & Dentists Council & another (Civil Appeal E038 of 2023) [2025] KEHC 11202 (KLR) (Civ) (22 July 2025) (Judgment)

Neutral citation: [2025] KEHC 11202 (KLR)

REPUBLIC OF KENYA

IN THE HIGH COURT AT NAIROBI (MILIMANI LAW COURTS)

CIVIL

CIVIL APPEAL E038 OF 2023

LP KASSAN, J

JULY 22, 2025

BETWEEN

KENYATTA NATIONAL HOSPITAL .... APPELLANT

AND

KENYA MEDICAL PRACTITIONERS & DENTISTS COUNCIL .... 1ST RESPONDENT

PATRICK NGOTHO MAINA (ON BEHALF OF DMK MINOR) .... 2ND RESPONDENT

(Being an appeal from the ruling of the Disciplinary & Ethics Committee of the Kenya Medical Practitioners & Dentists Council delivered on 21.12.2022 in PIC Case No 80 of 2019)

JUDGMENT

1. The 2nd Respondent filed a complaint with the 1st Respondent against the Appellant. After conducting an inquiry, the 1st Respondent found the complaint as lodged by the 2nd Respondent was merited and entered the following recommendations and orders:

   i. The Committee notes that while the complaint was filed against the Hospital, it would be in derelict of its duty should it fail to address the noted breaches of standards by the medical practitioners. Consequently, the Committee issues the following orders:

      a. Dr. F.O. be and is hereby admonished for failing to supervise the procedure as there is no evidence on record to indicate he was present in theatre as the senior consultant

      b. Dr. P.M.M. be and is hereby admonished for failing to review the patient pre-operatively, failure to keep and maintain a proper patient record, and failure to consult.

c. Dr. P.G. be and is hereby admonished for failing to monitor the patient, for poor decision making on post-cardiac arrest care management of the patient, and for failure to exercise the expected standard of care.

ii. K.N.H. (Respondent) be and is hereby admonished for following systemic lapses:

a. Failure to ensure that the professionals working therein record and maintain properly documented patient records. There is no evidence of the surgeon, medical officer, or intern admission notes prior to surgery.

b. Inadequate documentation of clinical notes which includes the discharge summaries which were very brief and lacked in-depth information and post-operative review notes.

iii. K.N.H be and is hereby directed to prepare and submit the following documents to the Council within three (3) months from the date hereof;

a. A protocol for the management of patients who undergo cardiac arrest while in surgery;

b. A standard anaesthetic chart document that captures both the preoperative and postoperative review segments of care;

c. Standard operating procedures (SOPs) on pre and post-anaesthetic review of patients

d. Amend the hospital's informed consent form to include information that KNH is a teaching hospital, that doctors in training may be involved in surgical and anaesthetic procedures and the extent of their involvement, and

e. A standard form for documenting family conferences that are held on patient care matters and duly witnessed/signed by both the hospital team and the delegated next of kin.

iv. K.N.H. do pay a fine of Kenya Shillings Five Hundred Thousand (Kshs 500,000/=) to the Kenya Medical Practitioners and Dentists Council within thirty (30) days from the date hereof.

v. K.N.H. do enter into a mediation agreement with the Complainant with a view of compensating the latter and thereafter inform the Kenya Medical Practitioners and Dentists Council within one hundred and twenty (120) days from the date hereof.

vi. In the event of non-compliance with the orders in (iii), (iv) and (v) above, the Kenya Medical Practitioners and Dentists Council shall be at liberty to issue any such further orders and directions as it deems fit.

2. The complaint, lodged on behalf of a minor, detailed allegations of medical negligence against Kenyatta National Hospital. It asserted that during a hernia surgical procedure, there was a failure in oxygen delivery which led to the minor falling into a coma and subsequently developing cerebral palsy. Key issues raised included the hospital's failure to detect intestinal volvulus during the surgery, resulting in a post-surgical incisional hernia. The complainant also highlighted the involvement of medical students in the surgery, a lack of proper pre-operative assessment and post-operative review notes, and a general breach of professional standards. It was specifically claimed that there was no evidence of blood pressure monitoring during a cardiac arrest event, and a delay in providing critical care, which exacerbated the minor's neurological injury. Ultimately, the complaint argued that these failures

constituted negligence, leading to the minor's severe condition and causing significant distress and financial hardship to the family.

3. The Appellants have now appealed against the decision of the Disciplinary and Ethics Committee the grounds on the Amended Memorandum of Appeal dated 20.06.2024 are:

    1. The 1st Respondent erred in fact and in law in directing the Appellant to pay a fine of Kshs 500,000/= to the 1st Respondent in the absence of any complaint by the 1st Respondent against the Appellant

    2. The 1st Respondent erred in fact and law in holding that the case was proved on balance of probabilities

    3. The 1st Respondent erred by admonishing the Appellant's Dr. F.O., Dr. P.M.M., and Dr. P.G.

    4. The 1st Respondent erred by neglecting Appellant's evidence submission oral arguments

    5. The Ruling is against the weight of evidence and facts as presented before the 1st Respondent by the Appellant

    6. The 1st Respondent erred in fact and law by holding that the hospital was negligent in the treatment and handling of the patient.

    7. The 1st Respondent erred in fact and law by holding that the hospital breached the standards of medical while attending the patient.

    8. The 1st Respondent erred in fact and lawn by holding that there was delay in neurological and critical care intervention of the patient.

    9. The 1st Respondent erred in fact and law in holding that there was lack of documented preoperative assessment notes, signifying a breach of standards.

4. The appellant seeks that:

    i. The order and ruling of the 1st Respondent dated 21.12.2022 be and is hereby set aside in entirety.

    ii. This Honourable Court be pleased to order the 1st Respondent herein to bear the costs of this appeal.

    iii. This Honourable Court be pleased to make any such or further orders as it may deem necessary to grant in the interest of justice.

Appellant's submissions

5. The Appellant contests the ruling delivered by the Kenya Medical Practitioners & Dentists Council, which found Kenyatta National Hospital and its doctors negligent in the treatment of a minor. The Appellant asserts that the Council's decision was erroneous, particularly in permitting a complaint that, in their view, lacked proper evidentiary grounding and in issuing broad orders that had not been specifically sought by the complainant.

6. From the Appellant's perspective, the minor was admitted to the hospital in October 2014 presenting symptoms of vomiting, failure to pass stool, and a right inguinal swelling. Following examination,

the patient was diagnosed with an obstructed and irreducible right inguinal hernia and was taken in for emergency herniotomy. During the surgery, the child developed abdominal distension and bradycardia, prompting resuscitation and intubation. The intraoperative findings revealed an obstructed hernia and small bowel volvulus, both of which were addressed successfully during the procedure. In the days that followed, the patient experienced bronchospasms, respiratory distress, and convulsions, but eventually recovered from sepsis and disseminated intravascular coagulation (DIC), allowing for transfer to a general ward by the end of October 2014. The child was discharged in November 2014 under the care of a paediatric neurologist and was later readmitted in September 2017 for incisional hernia repair and a craniotomy.

7. The Appellant maintains that neither the hospital nor its doctors were negligent in their management or treatment of the patient. They argue that medical professionals can only be found negligent if their care falls below the standards of a reasonable practitioner, and not simply because an error in judgment may have occurred. According to the Appellant, all protocols and standard operating procedures were followed, and informed consent was duly obtained from the minor's parents. They further contend that the injuries complained of, specifically cerebral palsy, cannot be directly attributed to any action or omission on the part of the hospital staff. The Appellant insists that the burden of proof lay with the complainant to demonstrate both a breach of duty and a direct causal link between that breach and the injuries suffered, which was not done.

8. In challenging the evidentiary foundation of the Council's decision, the Appellant notes that the complainant failed to present any expert testimony to substantiate the allegations, relying instead on lay statements. In contrast, the Appellant produced three expert witnesses who, in their professional capacity, affirmed that the care provided met the requisite medical standards. They argue that the Council failed to properly evaluate this expert evidence and instead reached a conclusion unsupported by the factual record. The Appellant also disputes the inference drawn by the Council that seizures alone indicate cerebral palsy or that a CT scan is sufficient to diagnose the condition. They submit that the bradycardia experienced during surgery was not necessarily caused by a lack of oxygen and point out that, had there been a cardiac arrest, the surgical procedure would not have continued to completion. They also highlight that, ten days after the operation, the patient exhibited no signs of neurological deficit and maintained stable oxygenation.

9. Additionally, the Appellant argues that a mere difference in medical opinion regarding treatment or diagnosis does not, by itself, amount to negligence. They assert that in the absence of proof that their course of action deviated from an acceptable standard of care, such differences should not form the basis of liability. They emphasize that there is no substantive evidence linking the alleged neurological injuries to the conduct of their doctors, nurses, or staff. In conclusion, the Appellant urges this Court to allow the appeal, set aside the ruling of the Council, dismiss the complaint in its entirety, and award the costs of the appeal to the Appellant.

1st Respondent's submissions

10. The 1st Respondent's submissions support the decision of the Kenya Medical Practitioners & Dentists Council, which found Kenyatta National Hospital and its doctors negligent in the treatment of a minor. They oppose the appeal lodged by the hospital and urge this Honourable Court to uphold the original decision in its entirety.

11. They begin by arguing that the appeal is fundamentally flawed, containing errors in both fact and law. According to the 1st Respondent, the Council was correct in finding the case proven on a balance of probabilities and in admonishing the doctors involved. They assert that the Appellant's challenge fails to meaningfully engage with the evidence, submissions, and oral arguments that were tendered

during the disciplinary proceedings. In particular, they refute the Appellant's claim that there was no negligence in the treatment and handling of the patient, no breach of medical standards, and no delay in providing neurological or critical care. They also reject the assertion that there was no failure in maintaining documented preoperative assessment notes.

12. The 1st Respondent maintains that the Council properly evaluated all the evidence placed before it and applied the correct legal principles in arriving at its decision. They emphasize that negligence, in law, involves acts or omissions that a reasonable and prudent person in similar circumstances would not have committed, reflecting a degree of carelessness or professional misconduct. In this context, they underscore that the four essential elements of a negligence claim—duty of care, breach of duty, causation, and resulting damage—were all established in this case. Doctors, hospitals, and healthcare institutions are required to exercise a reasonable standard of skill and care. The 1st Respondent notes that hospitals are vicariously liable for the actions of their employees, and negligence arises where conduct falls below the accepted professional standard, not simply because of a difference in medical judgment.

13. Turning to the specific findings, the 1st Respondent outlines that the hospital failed to undertake a thorough pre-operative evaluation, including the omission of diagnostic imaging such as abdominal x-rays and the absence of detailed clinical assessments. This failure, they argue, led to a missed diagnosis of intestinal obstruction and a possible volvulus, which in turn compromised surgical planning and constituted a breach of duty. They further submit that there was no evidence of blood pressure monitoring during the surgery, which could have alerted the medical team to a cardiac arrest. The lack of timely and effective intervention during this event, they claim, aggravated the patient's condition and deviated from established standards of modern care.

14. The submissions also highlight the absence of proper documentation, including post-anaesthetic reviews, surgeons' intraoperative notes, and nursing observations. These lapses, in their view, point to institutional weaknesses in record-keeping and undermine accountability. The 1st Respondent argues that the failure to perform essential diagnostics, maintain vigilant intraoperative monitoring, and provide timely postoperative care constituted an unequivocal breach of the hospital's duty of care. They emphasize that these shortcomings were not isolated but systemic, leading to a cascade of preventable harm. The causal connection between the lapses and the neurological injury suffered by the minor was clearly established. In their view, the hospital failed to identify and mitigate foreseeable risks, and its actions, when viewed in totality, revealed a pattern of avoidable errors and omissions that contributed to the patient's deterioration.

15. In conclusion, the 1st Respondent submits that the Disciplinary and Ethics Committee properly held the hospital and its doctors accountable and that the admonishment imposed was both lawful and appropriate. They maintain that a professional must adhere to established norms of medical practice and that a divergence of opinion does not absolve a practitioner from liability where clear negligence is found. Accordingly, they urge this Court to dismiss the appeal with costs, affirming that the decision of the Council was sound, well-reasoned, and firmly grounded in both law and evidence.

2nd Respondent's submissions

16. The 2nd Respondent submits that the Appellant, Kenyatta National Hospital, has presented a distorted and selective account of the facts and improperly introduced new matters and documents that were not part of the original proceedings before the Kenya Medical Practitioners & Dentists Council. This, it is argued, amounts to an attempt to mislead the court and constitutes an abuse of the appellate process. Specifically, the 2nd Respondent points to the inclusion of handwritten notes and new claims—such as suggestions that the minor had delayed developmental milestones or that the mother had a urinary

tract infection—as examples of matters that were never raised before the disciplinary committee and therefore should not be entertained at this stage of appeal.

17. In support of the Medical Council's findings, the 2nd Respondent asserts that the ruling correctly found the hospital and its medical personnel negligent in the management of the minor's hernia procedure, which resulted in cerebral palsy. The Council determined that Kenyatta National Hospital owed a duty of care to the patient and that this duty was breached through multiple failures by both individual practitioners and the institution itself. The 2nd Respondent highlights that specific doctors were admonished for distinct shortcomings: one for failing to supervise the procedure, as there was no evidence of his presence as the senior consultant; another for failing to conduct a pre-operative review, maintain proper records, and consult appropriately; and a third for failing to keep adequate post-operative notes and issuing incomplete discharge summaries, thereby creating a significant gap in the patient's documentation.

18. The 2nd Respondent further emphasizes that the hospital was justifiably directed to implement several institutional reforms. These included developing protocols for managing cardiac arrest during surgery, standardizing anaesthetic charts, and adopting comprehensive standard operating procedures for both pre- and post-operative care. These measures, in the 2nd Respondent's view, were necessary and proportionate responses to the systemic lapses identified in the handling of the minor's case.

19. The 2nd Respondent reiterates that the Council's decision should be accorded due respect, as it is the body best placed to determine the applicable standards within the medical profession. They maintain that the Appellant has failed to establish any legal or factual error on the part of the Council that would justify interference by this Court. The finding of negligence was well-supported by the record, particularly given the hospital's failure to conduct an adequate pre-operative assessment, the absence of critical diagnostic imaging, and lapses in documentation at every stage of care.

20. Further, the 2nd Respondent draws attention to the admissions made by some of the Appellant's own witnesses regarding the lack of essential records, including pre-operative notes, ICU documentation, and comprehensive surgical reports. The Council also concluded that a cardiac arrest had occurred due to poor ventilation, a finding that one of the attending doctors reportedly could not satisfactorily explain. Reference is also made to a previous case in which the hospital was held liable for negligence, in part due to its failure to produce relevant documents, a pattern the 2nd Respondent argues is replicated in the present matter.

21. On the basis of the foregoing, the 2nd Respondent urges this Honourable Court to dismiss the appeal with costs, affirming that the Medical Council's decision was well-founded and that negligence on the part of Kenyatta National Hospital and its medical staff was clearly and convincingly established.

22. The following issues arise for determination:

    a. Whether the Disciplinary and Ethics Committee (the 1st Respondent) observed the principles of natural justice and complied with the statutory procedure in conducting the disciplinary proceedings against the Appellant.

    b. Whether the 1st Respondent properly applied the standard of proof required in disciplinary proceedings and correctly found the Appellant and its medical officers negligent.

    c. Whether the orders and sanctions issued by the 1st Respondent, including the fine and systemic directives, were lawful and justified.

Analysis and Determination

23. This appeal is against the decision on liability and damages, I am guided by the decision of the Court of Appeal in Bashir Ahmed Butt v Uwais Ahmed Khan [1982-88] KAR 5 where the court held that;

> " An appellate Court will not disturb an award of damages unless it is so inordinately high or low as to represent an entirely erroneous estimate. It must be shown that the judge proceeded on wrong principles, or that he misapprehended the evidence in some material respect, and so arrived at a figure which was either inordinately high or low"

24. As a first appellate court, I am bound by the principle in Selle v Associated Motor Boat Co. Ltd (1968) EA 123 to re-evaluate and re-analyze the evidence afresh while bearing in mind that I did not have the opportunity to see or hear the witnesses testify.

 1. Whether the 1st Respondent complied with the Procedure Rules and principles of natural justice

25. The Medical Practitioners and Dentists (Disciplinary Proceedings) (Procedure) Rules provide the framework within which the Disciplinary and Ethics Committee is required to operate. Rule 10D expressly provides that the Committee is not bound by legal or technical rules of evidence but must have due regard to natural justice.

26. Rule 10U obligates the Committee to afford each party:

 a. A reasonable opportunity to be heard,

 b. To submit evidence,

 c. And to cross-examine witnesses.

27. From the record, the Appellant participated in the inquiry, presented expert evidence, and submitted written submissions. There is no indication that they were denied the right to cross-examine or were otherwise ambushed. The Committee's hearing procedure was therefore compliant with Rules 10N and 10U, which mandate that parties be given the opportunity to address the Committee, give evidence, and be heard in full.

28. Further, in accordance with Rule 10Z, the Committee issued a detailed written decision with specific findings of fact, conclusions on breach, and reasons for the sanctions imposed. The Appellant's argument that the procedure was flawed or that the Committee ignored their evidence is therefore not supported by the record.

29. In Republic v Public Procurement Administrative Review Board & 3 others Ex-Parte Olive Telecommunication PVT Limited [2014] eKLR, the High Court held that where a statutory tribunal follows the laid down procedures and accords the parties a fair hearing, its decisions ought not to be lightly interfered with.

30. The Committee adhered to the procedural requirements and did not violate principles of natural justice.

Whether the Committee properly applied the standard of proof and correctly found negligence

31. The applicable standard of proof in professional misconduct cases is on a balance of probabilities: see Omollo t/a Kamoti Omollo & Company Advocates v Director of Public Prosecutions & 2 others;

Wanjiku & 2 others (Interested Parties) (Petition E005 of 2024) [2025] KEHC 5238 (KLR) (14 March 2025) (Judgment).

32. In this case, the Committee found that the Appellant hospital and its officers failed to:

    a. Conduct a proper pre-operative assessment (absence of admission notes);

    b. Monitor the patient during surgery (absence of anaesthetic documentation and monitoring data);

    c. Respond adequately during the cardiac arrest (absence of blood pressure readings or ICU notes);

    d. Document post-operative care and family briefings.

33. The requirement in a- d above oscillates on keeping of records. Records are crucial in any hospital because it is impractical for one Doctor or a group of Doctors to treat a patient continuously for the rest of his life. It is therefore important for records to be kept for those who will handle the patient in future. The reality is that some diseases exhibits similar symptoms and without records, a doctor treating a patient in future will waste a lot of precious time in diagnosis when the history is clear on the ailment. Besides, a patient has a right to know every treatment he is receiving and this can only be done through recording every action because he has an absolute right on anything being done to his body- the subject matter of treatment and also because some patients are known to seeking second or third opinions.

34. These findings were supported by clear gaps in the medical records and by the testimony of the hospital's own witnesses who conceded that key documentation was missing. The Committee correctly relied on this in drawing the inference of systemic failure and breach of duty of care.

35. Moreover, the burden of proving that the condition (cerebral palsy) was caused by KNH's negligence was discharged by the 2nd Respondent to the satisfaction of the Committee. The Appellant argued that the cerebral palsy experienced by the minor could not be directly attributed to any action or omission by the Hospital. Their submission was that the seizures alone were not indicative of cerebral palsy and that a CT scan alone could not be used to diagnose the same.

36. The committee in its findings concluded that the minor's cerebral palsy was a direct result of a failed oxygen delivery during surgery, leading to a coma and later cerebral palsy. This hypoxic event had occurred on the operating table and was exacerbated by continued hypoxia in the ward, which the CT scan confirmed. There was, therefore, a direct cause link between the Hospital's acts/omissions and the minor's cerebral palsy. In Bolam v Friern Hospital Management Committee [1957] 1 WLR 582, it was held that a doctor is not negligent if he acts in accordance with a practice accepted as proper by a responsible body of medical men. However, where no standard practice is followed or recorded, liability arises.

37. The Appellant's vehemently denied any negligence on their part or its doctors asserting that a doctor is only negligent if they fell short of the standard of reasonable medical care and an error of judgment did not automatically constitute negligence. This is contrary to the Committee's finding that there was negligence in the management of the minor's hernia procedure.

38. Further, the Appellant contended that the 2nd Respondent failed to call an expert. However, the Committee itself, although performing a quasi-judicial function in itself are members who are experts and thus the Appellant and its doctors appeared before a panel of peers. The Committee's finding that there was inadequate documentation of notes indicated there was a lapse in the pre-

operative evaluation. This showed there were significant and critical deficiencies in the Appellant's documentation and pre-operative assessment, which directly contradicted the Appellant's claim of no gaps and adherence to protocol.

39. The Appellant further argued that the observed bradycardia was not necessarily caused due to a lack of oxygen. They argued that had a cardiac arrest had occurred, then the surgical procedure would not have continued. The Committee, on the other hand, found that there was no evidence of blood pressure monitoring during the surgery, as the same could have alerted the medical team to a cardiac arrest. The cardiac arrest had occurred due to difficulty in ventilation, and the lack of timely and effective intervention during this event aggravated the minor's condition as the surgery continued despite the critical event. This view is contrary to the Appellant's claim of the cause of the bradycardia and its management. The committee's findings showed there was a lapse in monitoring and intervention during the surgery.

40. The 1st Respondent contended that the Appellant had introduced certain patient notes that were not availed to the Committee. However, this claim was made without specifying which documents were allegedly missing. While the record of appeal includes a bundle of documents from the Appellant, there is no indication that this bundle, in its entirety and current form, was ever submitted to the Committee. What is evident is that the Committee considered all the evidence placed before it, including witness testimonies and the patient records that were actually supplied. In the absence of proof that the complete bundle now relied upon was part of the material before the Committee, the 1st Respondent's assertion cannot be sustained.

41. I find that the standard of proof was correctly applied and the finding of negligence on the part of Appellant and its officers was thus supported by the evidence.

Whether the sanctions and orders issued were lawful and justified

42. The sanctions against KNH included:

    a. A fine of KShs. 500,000;

    b. Orders to implement systemic changes (protocols, SOPs, consent forms, etc.);

    c. Mediation and compensation;

    d. Admonishment of the named doctors.

43. Rule 10Y of the Procedure Rules grants the Committee wide discretion to reprimand, suspend, or issue such other orders as it deems fit. Furthermore, Rule 4(3)(e) allows the Preliminary Inquiry Committee to recommend corrective action such as institutional reforms. The Appellant's informed consent was duly obtained from the minor's parents. However, the Committee noted that the Appellant's informed consent form failed to include that the Appellant was a teaching hospital and that doctors in training may be involved in the surgical and anaesthetic procedures and the extent of their involvement. Therefore, the Committee's recommendation was in line with it's role of giving corrective action.

44. These orders are not punitive in nature but corrective, aiming at ensuring non-repetition and higher standards of care. The fine was within statutory limits (Rule 10B(1)(d)), and the hospital was granted time to comply.

45. Additionally, under Rule 4(1)(c), the Committee is empowered to promote mediation, which it did in this case by directing the hospital to negotiate compensation.

46. The orders and sanctions issued were within the powers of the Committee and were justified in light of the systemic lapses identified.

47. Having re-evaluated the entire record as a first appellate court I find that:

    i. The disciplinary process was conducted fairly and lawfully;

    ii. The decision of the 1st Respondent was supported by evidence and applicable standards;

    iii. The sanctions imposed were lawful, reasonable, and aimed at institutional improvement.

48. The upshot of the above is that:

    i. The appeal lacks merit and is hereby dismissed in its entirety.

    ii. The Appellant shall bear the costs of the appeal.

    Orders accordingly.

DATED, SIGNED AND DELIVERED VIRTUALLY THIS 22ND DAY OF JULY 2025

LINUS P. KASSAN

JUDGE

In the presence of:-

Kimutai for Appellant

Osiemo holding brief Kitinyo for 2nd Respondent

James for 1st Respondent