**Ndungu & another (Suing as the Legal Represetatives of the Estate of Godfrey Ndungu Mwaura) v Kenya Hospital Association t/a Nairobi Hospital & another (Civil Case 382 of 2010) [2024] KEHC 15215 (KLR) (Civ) (4 December 2024) (Judgment)**

Neutral citation: [2024] KEHC 15215 (KLR)

**REPUBLIC OF KENYA**

**IN THE HIGH COURT AT NAIROBI (MILIMANI LAW COURTS)**

**CIVIL**

**CIVIL CASE 382 OF 2010**

**AN ONGERI, J**

**DECEMBER 4, 2024**

**BETWEEN**

**IRENE WAIRIMU NDUNGU ..... 1ST PLAINTIFF**

**GODFREY KINANGU NDUNGU ..... 2ND PLAINTIFF**

**SUING AS THE LEGAL REPRESETATIVES OF THE ESTATE OF GODFREY NDUNGU MWAURA**

**AND**

**THE KENYA HOSPITAL ASSOCIATION T/ATHE NAIROBI HOSPITAL ..... 1ST DEFENDANT**

**DR CK MUSAU ..... 2ND DEFENDANT**

## JUDGMENT

1. IRENE WAIRIMU NDUNGU and ROBERT KINANGU NDUNGU (hereafter referred to as the 1st and 2nd plaintiffs respectively) filed suit dated 27/7/2010 and later amended on 13/4/2012 as against THE KENYA HOSPITAL ASSOCIATION T/A NAIROBI HOSPITAL and DR. C. K. MUSAU (hereafter referred to as the 1st and 2nd defendants respectively) seeking the following remedies;

    i. Damages under the *Fatal Accidents Act* Cap 32 Laws of Kenya for the benefit of the dependants of the deceased.

    ii. Damages under the *Law Reform Act* Cap 26 Laws of Kenya for the benefit of the estate of the deceased.

    iii. Special damages of kshs.4,786,233.00 as set out in paragraph 30 of this plaint.

iv. Costs of the suit.

v. Interest on (i), (ii), (ii) and (iv) above at court rates.

vi. Any other or further relief that this honourable court may deem fit to grant in the circumstances.

2. It was averred that the First Defendant is a limited company ordinarily involved in the business of providing medical services for reward and trades in the name and style of The Nairobi Hospital, along Argwings Kodhek Road Nairobi.

3. The Second Defendant is a male adult of sound mind, a medical doctor by profession and was at all material times to this suit one of the primary medical care givers to the deceased.

4. At all material times relevant to this suit, the deceased was an in-patient at the First Defendant's Nairobi medical facility popularly known as The Nairobi Hospital in the city of Nairobi (hereinafter 'the Hospital') having been admitted at the Hospital on 17th March 2009 where he was diagnosed with aneurysm of the right carotid artery.

5. On 18th March,2009, the deceased underwent a successful surgery at the Hospital and was placed in the high dependency unit where he progressed well with his recovery and was later transferred from the high dependency unit to the general ward on 21st March, 2009.

6. While at the general ward, the deceased continued with his recovery process to the extent that he was able to talk, eat, move around and even take himself for nature calls unassisted. However, as is generally expected of a person who has undergone surgery on the head, the deceased was experiencing confusion which occasioned memory lapses and the deceased would at times be disoriented as to time and place.

7. The confusion and disorientation was so apparent even to a lay person like the First Plaintiff that on 21st March 2009, the First Plaintiff requested the attending nurse that the First Plaintiff be allowed to stay by the deceased's bedside to watch over him. This request was however declined with an assurance by the attending nurse that she would watch over the deceased.

8. The First Plaintiff was not satisfied and she went ahead to request the said attending nurse as well as Second Defendant who was the attending doctor, to have the deceased strapped to the bed to prevent any possible wandering owing to his confused state of mind. This request was again declined.

9. The following day on the morning of 22nd March, 2009 between the hours of 4am and 5am, the First Plaintiff received a phone call from one of the First Defendant's personnel and was advised to rush to the Hospital as the deceased had fallen from his hospital ward window which was on the first floor to the ground.

10. Upon arriving at the Hospital, the First Plaintiff came to learn, and which fact was later confirmed by a nurse and a night watchman at the Hospital, that the deceased had been left to wander on his own without supervision despite his apparent confused state of mind and despite the request by the First Plaintiff to have the deceased supervised.

11. This led to the deceased falling off from his ward window. The said window was placed at a low level and had no safety grills.

12. From the fall, the deceased sustained head injury to the left side, injury to the abdomen and multiple femoral fractures. He also lost four teeth and as a result, the deceased was admitted to the Intensive Care Unit, unconscious. Indeed the deceased was later taken to theatre for where he was scheduled to

undergo surgery and in particular laparotomy due to retro-peritoneal haematoma and also an open reduction and fixation of the femoral fractures.

13. As the deceased underwent the operation, the First Defendant's Chief Executive Officer, one Dr. Mailu continuously assured the First Plaintiff that the Hospital would have the best specialists attend to the deceased on injuries sustained from the fall at no extra costs to the Plaintiffs.

14. In the course of undergoing the laparatomy, the deceased went into cardiac arrest causing and the second procedure to correct the femoral fracture to be discontinued until later when the cardiac arrest was brought under control.

15. After the fall and the subsequent procedures, the deceased remained in a state of semi-consciousness wherein he could not talk, move or even feed himself. Due to this state of affairs, he developed bedsores and a bacterial infection while still at the Hospital. The deceased remained in this unstable, semiconscious condition which degenerated and he later developed renal failure.

16. On or about 14th April, 2009 the First Plaintiff received a letter from the First Defendant requiring her to settle an outstanding hospital bill amounting to Kshs.1,590,388.00. This amount included the costs incurred to treat the deceased after his fall on 22nd March, 2009.

17. All along, the Plaintiffs were able and willing to pay the Hospital bill for the initial operation Performed on the deceased before the fall. This was communicated expressly to the First Defendant in the Plaintiffs letter of 28th April 2010.

18. In the meantime, and owing to the injury on the left side of the deceased's head occasioned by the fall, cerebral spinal fluid began to build up excessively within the cavities of the brain leading to hydrocephalus, Indeed the First Defendant indicated to the First Plaintiff that the deceased required a ventricular peritoneal shunt operation to drain the excessive cerebral spinal fluid.

19. In a surprising tum of events, the First Defendant in their letter of 24th April 2009 demanded for immediate payment of the monies outstanding which according to the Defendant stood at Kshs.1,740,077,89 excluding doctor's bills. The First Defendant in their said letter categorically stated that it would not conduct the operation unless its bills were paid, failure to which it would transfer the deceased to another hospital for the operation and continued care.

20. These demands and threats were made despite the First Defendant having assured the Plaintiffs that the Hospital would foot the cost of treatment incurred from the deceased's fall. Indeed as at 25th April 2009, the Plaintiff had paid a total of Kshs.348,000.00 to the First Defendant which was in excess of the deceased's medical expenses incurred until the time of the fall.

21. True to the First Defendant's threat, and without informing the Plaintiffs, the First Defendant on 30th April 2010 transferred the deceased from the Hospital to Kenyatta National Hospital. Even more bizarre is that the First Defendant did not leave the details of the deceased next of kin with Kenyatta National Hospital yet these were details within the First Defendant's knowledge.

22. The First Plaintiff came to learn of the transfer on 1st May, 2009 when she went to visit the deceased at the Hospital and failed to find him on his hospital bed. The plaintiff, out of her own efforts managed to locate the deceased at the Kenyatta National Hospital. At the time, treatment of the deceased was yet to commence because there had been no indication of a next of kin who would have given consent to the treatment. The deceased did not have capacity to consent owing to his condition.

23. Seeing that the deceased's condition had deteriorated and that the facilities at Kenyatta National Hospital were really stretched, the First Plaintiff, on 2nd May, 2009 opted to transfer the deceased to M.

P. Shah Hospital where according to the personnel at Kenyatta National Hospital, the deceased would receive more immediate attention. For the one night that the deceased had spent at Kenyatta National Hospital, the Plaintiffs paid Kshs.17,000.00.

24. The deceased remained at M. P. Shah Hospital where he underwent two operations, with no improvement to his condition until sometime on 28th June 2009. By this time, the cost of treatment had reached unmanageable levels and Plaintiff had no option but to have the deceased re-transferred back to Kenyatta National Hospital where cost of treatment is relatively cheaper. At MP Shah Hospital, the Plaintiffs paid a bill of Kshs.1,555,449.75 and a sum of Kshs.580,000.00 in doctor's fees remains unpaid to date.

25. The deceased died on 18th August, 2009 at Kenyatta National Hospital while still undergoing treatment. All this while, the deceased never came out of his semiconscious state that he had slipped into after the fall on 22nd March 2009.

26. A postmortem on the deceased conducted on 21st August, 2009 revealed that the deceased succumbed to raised inter-cranial pressure due to hydrocephalus. The postmortem further revealed that at the time of the deceased death, the craniotomy surgical incision on the right parietal region of 9 cm long which the deceased had gotten after the initial surgery had already healed at the time of death.

27. The Plaintiffs aver that the fall from his hospital ward window occasioning injuries to the deceased resulted ultimately to his death. That the said fall was foreseeable and preventable and would not have occurred were it not for the negligence and/or recklessness of the First Defendant its employees, servants and/or agents.

    Particulars of the First Defendant's neglignce

    a. Failing to pay adequate attention to the deceased after the initial surgery and yet the First Defendant knew or ought to have known that the deceased disoriented as to time and place and would therefore require adequate attention.

    b. Negligently and recklessly leaving the deceased unattended or properly restrained thus allowing him to wander around dangerously a fact which they foresaw or ought to have foreseen.

    c. Negligently and recklessly failing to ensure that the exits to the deceased's ward were secured to ensure the safety of the deceased at all times.

    d. Letting and/or causing the deceased to fall from his ward window and sustain injuries which ultimately led his death.

    e. Unconscientiously and insensitively transferring the deceased from the defendant's hospital to Kenyatta National hospital without paying regard to his life threatening condition.

    f. Failing to inform the Plaintiff of the above-mentioned transfer.

    g. Failing to inform Kenyatta National Hospital of the deceased's next of kin who would have consented to commencement of the deceased's timely treatment and yet that information was within the defendant's knowledge.

28. The Plaintiffs' further state that the Second Defendant being one of the attending doctors to the deceased and also one of his (deceased) primary care givers, owed a duty of care to the deceased to prevent the fall. In breach of that duty of care, the Second Defendant was negligent and/or reckless in the way he handled the deceased during his recovery after the initial surgery.

    Particulars of the Second Defendant's negligence

a. Failing to pay adequate attention to the deceased after the initial surgery and yet the Second Defendant knew or ought to have known that the deceased disoriented as to time and place and would therefore require adequate attention.

b. Negligently and recklessly leaving the deceased unattended and/or properly restrained thus allowing him to wander around dangerously and harm himself a fact which Second Defendant foresaw or ought to have foreseen.

c. Without prejudice to the particulars of the First Defendant's negligence, failing to advice the First Defendant that due to the disorientation and confusion suffered after the fall, that the deceased required special care while during his recovery at the ward.

29. The plaintiffs relied on the doctrine of Res Ipsa Loquitor.

**Particulars pursuant to the Statute**

30. The plaintiffs bring this suit on behalf of Godfrey Ndung'u Mwaura (deceased). At the time of his death, the deceased was aged 69 years. He was a business man and a coffee farmer earning a monthly income of Kshs.20,000/=per month. He was the sole bread winner for his family.

31. By reason of the aforesaid, the deceased suffered pain and anguish after which he succumbed to the injuries and the Estate of the deceased has suffered mental anguish loss and damage.

Particulars of Special Damages

a. Hospital bills -Nairobi Hospital Kshs.1,979,784.00
M.P.shah Hospital Kshs.2,135,449.75

b. Refund of medical bill paid to Kenyatta
National Hospital Kshs.500,000.00

c. Mortuary and Funeral expenses Kshs.157,000.00

d. Post mortem report investigation Kshs.14,000.00

Total Kshs.4,786,233.00

AND the Plaintiffs claim damages.

32. The First Defendant, its employees, agents and/or servants together with the Second Defendant are solely to blame, for the deceased's fall and the Defendants are therefore liable jointly and severally for the damage and loss occasioned to the Plaintiffs and the entire estate of the deceased.

33. The 1st and 2nd defendants filed their statements of defence dated 3/9/2010 and 22/5/2022 respectively denying the plaintiffs' claim.

34. IRENE WAIRIMU NDUNG'U testified as PW1. She adopted her witness statement dated 17/4/2012.

35. It was her evidence that she was the wife to the late Godfrey Ndung'u Mwaura, the decease and the 1st Plaintiff in this matter. The Second Plaintiff and I are the personal representatives of the Estate of the said deceased pursuant to limited grant of letters of administration ad litem issued on 25th May, 2010. On behalf of myself and the Second Plaintiff, I state as follows.

36. In support of this statement relied on the bundle of documents filed on the 16th March,2010.

37. Sometime within the month of March 2009, Godfrey Ndung'u Mwaura, the deceased started complaining of intermittent severe headaches and he started consulting Dr. Musau as an outpatient in his clinic at Aga Khan.

38. To establish the cause of the severe headaches, an x-ray was performed on the deceased's head and it revealed that he had a blocked vein which was causing what the doctor called an aneurism to form and that the deceased therefore had to undergo an emergency skull surgery in order to repair the aneurism.

39. It is then that Dr. Musau advised that the deceased gets admitted at The Nairobi Hospital (hereinafter referred to as "The Hospital") for the emergency skull surgery.

40. As at this time, and save for the intermittent severe headaches, the deceased was in good physical condition.

41. Following Dr. Musau's advice, the deceased was admitted on Tuesday 17 March 2009 at the Hospital in the St. George's ward and was scheduled for a surgery to his head the following day. On 18th March 2009, the deceased underwent the scheduled head surgery successfully after which he was transferred to the High Dependency Unit (H.D.U.) to recuperate after the surgery.

42. While during his recovery at the H.D.U., the deceased was strapped to his hospital bed to limit his movement and wandering around because he was in a state of confusion after the surgery to the head. However by the following day on 19th March 2009, the deceased had registered marked improvement especially in regaining his cognitive functions and a reduction in his state of confusion.

43. The deceased stayed in the H.D.U. up to 20th March 2009 and on 21st March 2009, he was transferred to the General Ward of St. Georges. By the time of his transfer, from the H.D.U to the General ward the deceased was in good spirits and his condition had improved considerably, so much so that he could easily recognize people and even go for nature calls unassisted.

44. PW1 stayed with the deceased the whole day of the 21st March 2009, and although his cognitive skills had improved, she noticed that he sometimes experienced episodes of confusion, memory lapses and disorientation. Seeing that he was in a general ward PW1 got so concerned that she requested the attending nurse at the time of St. George's ward (whose name she now cannot remember) to let her stay with the deceased overnight.

45. The attending nurse declined her request and explained to PW1 that the reaction she was observing with the deceased was normal and expected after a surgery to the head. She however assured PW1 that there would be a nurse watching the deceased throughout.

46. Although this assurance gave PW1 some relief, she was still not fully convinced. PW1 was still concerned about the deceased's lapses into confusion and disorientation that she even went ahead to ask Dr. Musau, the attending doctor, together with the said St. George's attending nurse to have the deceased strapped to the bed like had been done when the deceased was at the H.D.U.to prevent any possible wandering and harming himself.

47. Again, her request was declined and she was assured by both the doctor and the attending nurse that the deceased would be watched round the clock. With this assurance, PW1 left the hospital a 5:00pm on 21st March 2009, and by the time she left, the deceased was conscious, upbeat and could even feed himself save for the episodes of confusion, memory lapses and disorientation. The deceased did not have any physical injuries to his body save for a healing scar on the right side of his head where the surgery had been performed.

48. At 5:00am on the morning of 22nd March 2009, PW1 received a call from an officer of the hospital, which call informed her that the deceased had fallen out of his hospital ward window and that she should immediately go to the hospital.

49. Once at the hospital, PW1 learnt that the deceased had actually fallen out of his ward bed window which is located on the first floor. On falling, the deceased hit a concrete slab sustaining the following injuries:

    (a) Injury to the left side of the head;

    (b) Injury to the abdomen;

    (c) Multiple fractures to his legs; and

    d) He also lost four front teeth

    And as a result of the injuries, the deceased had lost consciousness and had been admitted to the Intensive Care Unit while unconscious.

50. Despite several assurances PW1 had previously received from the hospital that the deceased would receive supervision round the clock, he actually was left alone without any supervision on the night of 21st March 2009. The deceased had been left alone while suffering confusion and disorientation in a ward bed on the first floor, which had with a low level window that had no grills. The windows were precarious enough for a healthy person, let alone the deceased who was confused after a major head surgery.

51. On that morning of 22nd March 2009, PW1 sought further information from one Dr. Mailu, the Chief Operating Officer of the hospital who confirmed that indeed the deceased had fallen from his hospital ward window to the ground and that at the time he was scheduled to undergo surgery to the head and legs owing to the injuries that had been sustained after the fall.

52. Seeing that the deceased was at the time unconscious and in since PW1 was his next of kin, she gave consent to the hospital to conduct the said surgeries as proposed.

53. The said Dr. Mailu continuously assured PW1 that despite the fall, the deceased's health was in the best hands and that the costs that would be incurred as a result of the fall would not be charged on the deceased or his family.

54. While undergoing surgery to his left side of the head after the fall, the deceased developed complication which led into his going into cardiac arrest while still at the theatre. This forced the hospital to postpone the other scheduled operation to his leg until when the cardiac arrest was brought under control. The deceased remained in the hospital's Intensive Care Unit (I.C.U.) in critical condition.

55. As a result of the injury on the left side of the deceased's head occasioned by the fall, fluid began to build up excessively within the cavities of the brain causing an increase in pressure on the brain. PW1 was informed by the hospital officers at the time attending to the deceased that the deceased needed another operation to the head to drain the excessive cerebral spinal fluid.

56. In the meantime, on or about 14th April 2009 PW1 received a letter from the hospital that required her to settle an outstanding hospital bill amounting to Kshs.1,590,388.00.

57. That amount included the costs incurred by the deceased after the fall despite the assurances by Dr. Mailu that the costs would not be loaded onto the deceased or his family.

58. As at 22nd March 2009 when the deceased started receiving treatment for the fall, he had incurred a bill of Kshs. 321,206.49 from the initial surgery which had already been settled out of our deposit of Kshs.348,000.00.

59. PW1 held meetings with Dr. Mailu to try and sort out the issue of the bill which meeting bore no fruit and on 24th April 2009, the hospital sent another letter stating that despite the life threatening condition of buildup of pressure in the deceased's brain, the hospital would not conduct the operation unless and until PW1 had paid the outstanding medical fees which by then stood at Kshs.1,740,007.89 excluding doctors bills.

60. They also threatened to transfer him to another hospital if the bills were not paid. (See page 2 of the bundle of documents.) This was despite the fact that that condition had been occasioned to the deceased after he fell from the hospital's ward through a window on the first floor while under the care of the hospital.

61. During this entire time up until his death, the deceased remained in a state of semi-consciousness; he could not talk, move or feed himself. His condition was worsened by the fact that he developed bedsores, a bacterial infection and renal failure while still at the hospital all being complications which developed the fall.

62. On 28th April 2009 PW1, through her lawyers, subsequently wrote to the hospital asking them about the same issue. PW1 reminded them of their undertaking to look after the deceased's injuries incurred after the fall at no cost.

63. PW1 also reminded them that by this time my family and I had already paid a total of kshs.348,000.00 to the hospital which was in excess of the deceased's medical expenses incurred until the time of the fall. (See page 75 of the bundle of documents.)

64. On 1st May 2009 in the morning, PW1 went to the hospital to visit the deceased and was surprised to find him missing from his room. She enquired as to his whereabouts and learnt that on 30th April 2009, the hospital had transferred him to Kenyatta National Hospital.

65. There was no communication from the Hospital as where at Kenyatta Hospital PW1 would find the deceased so she embarked on a search at the Kenyatta Hospital to try and trace the deceased.

66. PW1 was finally able to trace him at the 10th Floor of Kenyatta Hospital in the late afternoon of 1st May 2009. By then, treatment had not commenced because according to the attendants at the Kenyatta Hospital, consent to start treatment had not been given and Nairobi Hospital had not left any details of the deceased's next of kin who could be contacted by Kenyatta Hospital. This was despite the fact that all the details were with Nairobi Hospital.

67. The deceased had been removed from Nairobi Hospital isolation ward unconscious, on 30th April 2009, he was transferred to Kenyatta National Hospital without as much as informing PW1 yet they had all my contacts include those of my family member.

68. In addition, Nairobi Hospital did not leave any next of kin details with Kenyatta Hospital and therefore treatment did not start on the deceased until late afternoon the following day on 1st May 2009 when PW1 traced the deceased and gave consent for treatment to start.

69. In view of the strained resources of Kenyatta national Hospital, the deceased could not immediately receive the brain surgery to drain fluid from his brain so PW1 decided to transfer him to M.P. Shah Hospital where he could receive immediate treatment.

70. The deceased was transferred from Kenyatta National Hospital to M.P. Shah Hospital on 2nd May 2009. As at the time of transfer the deceased had incurred a bill of Kshs.17,000.00 at Kenyatta National Hospital which PW1 settled at the time of transfer.

71. While at M.P. Shah, the deceased underwent two surgeries to the head at M. P. Shah with no improvement to his condition. The deceased stayed at M. P. Shah Hospital from 2nd May 2009 until sometime on 28th June 2009. By this time, the cost of treatment had reached unmanageable levels and PW1 had no option but to have the deceased re-transferred back to Kenyatta National Hospital where costs were considerably cheaper.

72. By the time PW1 moved the deceased back to Kenyatta National Hospital, she had paid a bill of Kshs.1,555,449.75 to M. P. Shah but a sum of Kshs.580,000.00 remained unpaid.

73. Even as at this time, the deceased's fractured legs had not received proper treatment since the emphasis was still on his head and he was still in a state of semi-consciousness.

74. The deceased passed away on 18th August, 2009 at Kenyatta National Hospital while still undergoing treatment at the age of 69.

75. A postmortem on the deceased conducted on 21st August, 2009 revealed that the deceased had succumbed to death due to the increased pressure on the brain. This pressure on the brain was caused by the accumulated fluid to the brain which was a result of the deceased falling from his first floor ward window to the ground floor while in the care of Nairobi Hospital.

76. The postmortem further revealed that at the time of death, the surgical incision on the right side of his head which he had gotten after the initial surgery had already healed. (see page 16 of the bundle).

77. In a nutshell, the deceased died from injuries sustained from falling off the window of St. George's ward at Nairobi Hospital on the first floor to the ground.

78. Had the deceased not fallen as he did, his chances of recovery from the initial surgery were more than high seeing even at the time of his death, the scars occasioned by the initial surgery had already healed.

79. The fall from the hospital and window and untimely death of the deceased were caused by the negligent and reckless acts of the Nairobi Hospital and the admitting doctor.

80. The said fall and eventual death was foreseeable and preventable and it would not have occurred were it not for the negligence and/or recklessness of both of the Defendants.

81. PW2, Dr. JOSEPH NDUNGU a consultant a pathologist did the postmortem on the deceased and produced a post mortem report dated 21/8/2009.

82. PW2 said there were 3 pathologists when he did the postmortem on 21/8/2009 himself, Dr. Byakika and Dr. Ndegwa.

83. PW 2 said that the cause of death was intracranial pressure due to hydrocephalus (or increased fluid in the brain).

84. DW1, EVERLYN KERUBO OSINDE who was working as a nurse at the Nairobi Hospital said she was the one attending the deceased after surgery.

85. DW1 said the deceased was recovering well after surgery and he would talk and walk from the toilet and back.

86. She said he was stable and he was allowed to sleep at 10.00pm.

87. At 3.00am he was assisted to go to the toilet and he returned to the bed and slept until 5.00am.

88. DW1 checked him at 5.00am and he was still asleep. At 5.10am the patient opposite the deceased pressed the bell and told DW1 that the deceased had jumped out of the window.

89. DW1 looked through the window and saw the deceased lying in the garden. She called for help and the deceased was rescued and taken to the resuscitation room and admitted at ICU.

90. DW1 said in cross examination that she was not told that the deceased needed extra-vigilance by PW1.

91. She said the bell at the bed of the deceased was not working but it was fixed at 8pm.

92. DW2, DR. JOAN OSORO who was working at Nairobi hospital as a medical officer managing the hospital staff produced the 1st defendant's list of documents and exhibits. DW 12 said she did not have physical contact with the deceased.

93. DW3, DR. SAMUEL ODEDE said he is a medical director at the Nairobi Hospital.

94. DW3 said he is the link between the management and the medical staff.

95. DW3 said DR. Musau, the 2nd defendant, one of the consultant surgeons at the hospital had admitting rights at the Nairobi hospital.

96. DW3 said the deceased fell on 22/3/2009. There was a police abstract showing that the report was made to the police on 4/3/2010 which was a year later.

97. He said on 30/4/2009 the patient was transferred to KNH.

98. After the close of the 1st Defendant case, the 2nd defendant moved the Court seeking to set aside default judgment as entered as against him.

99. The same was compromised by way of a consent who gist was that leave was accorded to the 2nd defendant to file defence, list of witness and documents.

100. Later, a further consent was recorded wherein parties agreed that PW1 and 1st Defendant's witnesses be recalled for purposes of cross-examination by the 2nd defendant's counsel.

101. In cross-examination, PW1 said she had taken the deceased to other hospitals such as Thika Hospital & Aga Khan before he was taken to the Nairobi Hospital.

102. She said he was suffering from forgetfulness and Musau recommended surgery.

103. PW1 said the deceased appeared confused after the surgery and further that Dr. Musau ought to have given instructions to have the patient tied to the bed.

104. PW1 said she talked to a nurse and a watchman at the hospital who told her that the deceased was wondering at the hospital.

105. Later PW1 denied that she was told anything by a watchman and she said a nurse told her that her husband had fallen through the window.

106. PW1 said her husband fell because Dr. Musau failed to instruct someone to look after him.

107. She said she is the one who strapped her husband to the bed at HDU with a piece of cloth and the hospital did not raise any issues.

108. DW1 was also recalled for cross-examination by the 2nd defendant's counsel.

109. DW1 said in cross examination that there are two types of restraint a patient can be given. Physical restraint and chemical restraint. DW 1 said the deceased was in a stable condition and did not require any restraint.

110. She said the deceased was forgetful and that his condition did not require physical or chemical restraint.

111. DW1 said the deceased was given Dormicum only once at HDU. She said Dormicum was sedative.

112. DW1 said she had worked at the Nairobi Hospital for 21 years and she said no relative is allowed to tie a patient at the hospital.

113. DW1 said there was no record that the deceased was tied while at HDU.

114. DW3 was also recalled for cross-examination by the 2nd defendant's counsel.

115. He confirmed that the deceased was attended to by nurses at the hospital and the 2nd Defendant who was his attending doctor.

116. That the 2nd Defendant would have been informed if there was any deterioration of the deceased while he was in admission.

117. He stated that for a patient to be restrained he has to be extremely violent and there was no reason for the deceased to be categorized as a violent patient.

118. The 2nd defendant testified as DW4. He adopted two witness statements dated 22/5/2022 and 26/9/2023 as his evidence in chief.

119. DW4 said he first met the deceased in February 2009 when the deceased with his brother and wife went to consult him.

120. The deceased had presented with sudden onset of headache accompanied by collapse and loss of consciousness.

121. A brain scan at Aga Khan hospital revealed sabarachnoid intracranial hemorrhage (blood over the surface of the brain).

122. DW4 stated as follows in his supplementary statement dated 26/9/2023.

123. The late Mr. Godfrey Ndungu Mwaura first consulted him at his office in the Aga Khan University Hospital Doctors Plaza in February 2009. He was taken to his consulting office by the 1st Plaintiff amongst others with a history of confusion and disorientation on and off.

124. He had suffered an earlier acute event about two months earlier, during which time he had sudden onset of severe headache, neck pain and collapse. He was taken to the Aga Khan University Hospital Nairobi where upon evaluation, he was suspected to have had suffered spontaneous intracranial haemorrhage most likely secondary to a ruptured intracranial aneurysm.

125. A non-contrast brain CT scan had been done and this confirmed evidence of subarachnoid haemorrhage. The blood was mainly in the region of the anterior cranial fossa highly suggestive of a ruptured Anterior Communicating Artery Aneurysm (A Comaneurysm). A brain Angiogram (study of arteries) done at the time was negative for an aneurysm hence the patient had been advised to seek further opinion.

126. Upon review of the history and CT scan done earlier, the blood was mainly in the subarachnoid space in the region of the circle of willis and tended towards the frontal region. PW4 formed an opinion, that the blood distribution was highly suggestive of a ruptured A Com Aneurysm despite an earlier negative

angiogram, hence PW4 advised on the need to perform a Digital Subtraction Angiogram study (DSA) to further confirm the diagnosis.

127. This was done and confirmed that indeed the patient had the aneurysm as suspected earlier.

128. After confirming the presence of the A Com Aneurysm, we had a thorough and detailed consultation with the patient and the 1st Plaintiff. PW4 explained the diagnosis, what an aneurysm and how they develop and eventually rupture.

129. DW4 explained that in the event of a rupture, the patient presents with severe headache, neck pain and collapse which was actually the way Mr. Godfrey had presented in the first instance. With this it was possible to explain why he was confused. The basis of the confusion is reduced blood supply to the brain as a result of vasospasm which sets in after ancurysm rupture, a common complication of subarachnoid bleed.

130. The risk of rebleed and the known poor outcome in the event of no treatment was discussed. Other potential complications of subarachnoid haemorrhage including delayed development of hydrocephalus were also discussed.

131. The need for interval brain CT' scans to rule out delayed development of hydrocephalus was also highlighted. DW4 discussed the treatment options available, endovascular techniques as well as craniotomy and microscopic clipping of the aneurysm.

132. The patient and 1st Plaintiff having understood the diagnosis, asked DW4 to make arrangements for surgical clipping of the aneurysm.

133. DW4 gave them an admission letter to the Nairobi Hospital on 5/3/2009 for surgery in the Nairobi Hospital booked for 18/3/2009.

134. The late Geoffrey Ndungu Mwaura was admitted to the Nairobi on 17/3/2009, for elective craniotomy and microscopic clipping of an A Com Aneurysm.

135. A well-informed consent had already been discussed from DW4's office and they did sign the consent prior to the surgery that was scheduled for 18/03/2009.

136. In the preoperative assessment, DW4 noted he was fully conscious, speech was normal and could answer questions appropriately.

137. He said, he would lose his way back if he went to a place and stayed for more than twenty minutes.

138. Pw4 took him to theatre on 18/3/2009 and performed a successful craniotomy and microscopic lipping of the aneurysm, a major delicate brain surgery.

139. He recovered well from the surgery and was subsequently admitted to the High Dependency Unit (HDU) for close monitoring.

140. We reviewed him on 19/3/2009, the first post operative day in the HDU and noted he was doing well. He was talking and obeyed commands. He could move all limbs.

141. The patient scored 13/14 on the Glasgow Coma Scale, thus he was in the same state as before the surgery.

142. Mild confusion reported; however, he was calm, cooperative and obeyed instructions.

143. Pw4 assessed the patient on 20/3/2009 and we noted the patient was continuing to recover as expected for a patient who has gone through a craniotomy.

144. On 21/3/2009, DW4 reviewed the patient and noted he had continued to improve. The observations were within normal and the confusion was mild. He could obey commands and would answer questions appropriately. He scored 13/14 on the Glasgow Coma scale.

145. He was cooperative, calm and could follow instructions. He did not show any signs of someone who would need to be restrained trough strapping in bed.

146. After review, DW4 advised he be transferred to the general ward where he was to be continued on close neurological observations.

147. Later that morning, the patient was moved to a general bed in St Georges Ward. He was received in the ward at around 12.30 pm.

148. During the day and into the evening and the night, there was no notification of any unusual behaviour or any indicators to suggest agitation or tendency to self-harm. The observations made by the Nursing team were acceptable for a patient recovering from a craniotomy.

149. Pw4 did not get any information to the effect, the 1st Plaintiff would have had liked to sit by his bedside nor did DW4 receive any call from the 1st Plaintiff or Nursing staff requesting me to allow for her to sit by his side.

150. It is the normal practice that patients who have had a craniotomy will need close neurological observations and actually for those who show any sign of confusion, a nurse will normally be assigned to the room where such a patient is being accommodated for case of these observations. Patients who are noted to be confused will be nursed in a bed with side rails which should always remain raised up and secured and in that way make it difficult for one to get out of bed.

151. The nurse keeps a record of these observations, and when the consultant comes for a review, he gets a verbal report as well as look at the records. It is on the basis of these observations that adjustments to the patient's management are made.

152. In the event of any changes, the nurse will alert the consultant through a telephone call and action and advice will be given. The advice is through a telephone instruction, even before the consultant arrives to do a physical review.

153. According to the notes from the Nursing records and also verbal enquiry from the nurses on duty, the patient had had a calm day.

154. He was feeding himself and would press the bell and be escorted to the washroom to help himself.

155. DW4 noted from the nursing notes, the patient was being observed very closely during the day and evening. He was calm, fed himself and was following instructions appropriately.

156. There were entries by nurses in the nursing notes at 4.30 pm,6.00 pm,8.00 pm 9.00 pm,10.00pm, 12.00 midnight, 2.00 am. The observations were normal and patient calm. At around 3.00am (22/03/2009), he was escorted by the attending nurse to the toilet, where he passed urine and was taken back to bed and settled, and the side rails to his bed secured.

157. The nurse did her rounds at 4.00 am and 5.00 am during which time she found the patient asleep.

158. However, at around 5.10 am, a bell rang from the ward and when the nurse went to answer was informed by the patient who was in the opposite bed that Mr. Godfrey had jumped out of the window. When she looked out of the window, she saw Mr. Godfrey on the ground and hence the emergency bell was triggered.

159. With the trigger, the emergency team was able to get to the patient within a few minutes and patient was taken to the Accident and Emergency room where resuscitation was started and DW4 was also informed. He advised on the need for urgent radiological investigation after securing of the airway. DW4 also prepared to go to the Hospital urgently.

160. The patient was intubated promptly and sent for radiological investigations including a brain CAT scan, cervical CAT scan, and various X-mays to screen for skeletal injuries.

161. Upon arrival in the Accident and Emergency Department, DW4 found the patient had already been intubated to secure the airway and was in the X-ray Department

162. The brain CT scan showed the aneurysm clip, which had been used to secure the aneurysm was in place and there was no new intracranial bleed. There was some swelling in the right hemisphere in keeping with the recent craniotomy to secure the aneurysm.

163. The cervical CT scan was normal.

164. At examination in the radiology department, DW4 noted the patient had started to come round from the brief loss of consciousness with the fall. He was agitated but moving both upper limbs.

165. The right lower limb was actively moving.

166. The left lower limb had a deformity at the knee and thigh suggestive of a fracture of the femur. There was also a swelling over the left ankle.

167. He had a laceration over the left eyebrow and left lower lip.

168. The pupils were 3 mm in size and reacted to light.

169. The injuries were suggestive of landing on his left leg then falling onto the left side of the body.

170. Further radiological examination revealed a normal chest x-ray.

171. Double fracture of the left thigh bone involving the upper and the lower one third of the femur. Both ankle joints were normal.

172. DW4 advised on sedation and paralysis in view of the restlessness and the fact that the brain was swollen. We also started medical therapies for the brain swelling.

173. DW4 also advised consultation with Prof Gakuu a Consultant Orthopaedic surgeon to assist with the management of the fractures.

174. Once the patient was settled in the ICU, DW4 convened a family conference during which time he briefed them on the unfortunate event of early that morning. The family was represented by the 1st Plaintiff, son and two brothers. On the Hospital side was the Nurse in-charge of St. George's ward, St Mbelesi, the nurse who was running the night shift in the ward and the Chief Security Officer of the Hospital Mr. Chris Otieno.

175. DW4 explained the nature of the injuries sustained and emphasized that there was an urgent need to take Mr. Godfrey to theatre to rectify the injuries sustained. Informed consent was signed and DW4 went ahead and started to organize for the surgery.

176. DW4 also briefed a younger brother to the patient Mr. Karuru an advocate of the High Court.

177. On further review in the ICU at around 11.30am, DW4 noted a tachycardia and abdominal distension which are suggestive of an intra-abdominal injury. A paracentesis demonstrated free blood in the

abdomen; hence DW4 consulted a General Surgeon to be part of the team that was to take the patient for emergency corrective surgeries.

178. The orthopaedic surgeon and general surgeon and DW4 briefed the family on the nature of the injuries in their respective areas and they obtained consent for the procedures to be performed.

179. Dw4 explained that the patient was critical and needed urgent attention for he was showing signs of intra-abdominal bleeding.

180. We took him to theatre at around 12.15 pm and exploratory laparotomy was performed and the finding was a rage retroperitoneal haematoma. The supraorbital and lip lacerations were repaired.

181. The orthopaedic surgeon could only fix one of the femoral fractures, for the patient developed a cardiac arrest, during the third hour of surgery, hence resuscitation was done and further surgery withheld for a later date.

182. He was taken back to the ICU at around 5.45 pm and was continued on ventilatory support. And further stabilization.

183. On review on 23/3/2009, DW4 noted the patient had stabilized.

184. DW4 noted a derangement in renal function with an elevated creatinine, hence we brought in a Renal Physician to review and advice.

185. He advised on fluid and medications to reverse the kidneys and this treatment worked well.

186. DW4 reviewed him on 24/3/2009 and noted he had improved further hence we advised stopping the sedation and paralysis and allowing him to wake up.

187. He was extubated on 25/3/2009 and patient continued to improve.

188. On 28/3/2009, we noted the patient had improved significantly. He was conscious and obeyed instructions.

189. The pupils were reacting well to light stimulation.

190. DW4 advised a transfer to the general ward where he was to be continued on close neurological monitoring.

191. He was moved to the ward on 29/3/2009 where he was continued on neurological observations and treatment.

192. A review on 30/3/2009 showed the patent had improved further. He was alert, responsive and obeyed commands. He had a mild confusion agitation.

193. We performed a follow up brain CT scan on 2/4/2009. A small residual right frontal subdural haematoma was noted. Generalised brain atrophy was also noted. (See page 458 of the 1st Defendant's List of Documents dated 21st October 2010)

194. The patient continued to improve in the ward and was eventually taken back to theatre on 8/4/2009 for open reduction and fixation of the second fracture of the left femur.

195. A follow up x-ray of the femur showed satisfactory reduction of the fractures. The patient continued to recuperate in the ward.

196. The mild confusion persisted and in view of this, DW4 performed a follow up brain CT scan to rule out hydrocephalus.

197. A brain CT scan performed on 18/4/2009 revealed a small residual right frontal subdural haematoma, the ventricles were almost symmetrical. The right lateral ventricle which was compressed in the CT scan study of 22/3/2009 and 2/4/2009 had resolved with the brain and ventricles almost symmetrical.

198. DW4's opinion was the patient had started to develop hydrocephalus. This was not brought out clearly in the radiologists report, but as an expert in this area one has to consider the clinical state and correlate with the radiological findings as to form an opinion.

199. Raised intracranial pressure will lead to delayed neurological improvement.

200. DW4's considered opinion at the time was, the patient had raised intracranial pressure as depicted by the dilated ventricular system and this could well have had been the cause of the slow neurological improvement.

201. The patient seemed to have had reached a plateau in his improvement and started to have fluctuating level of consciousness from around 16/3/2009.

202. A review by Dr. Kiboi, a consultant neurosurgeon on DW4's behalf on 21/4/2009 also raised the possibility of hydrocephalus as a possible cause for fluctuating level of consciousness.

203. In view of the slow neurological improvement and features of fluctuating level of consciousness, DW4 firmed up the opinion this was due to raised intracranial pressure.

204. DW4 briefed the 1st Plaintiff on the clinical state and advised on the need to perform a ventriculo peritoneal shunt and the expected outcome with the procedure.

205. DW4 obtained an informed consent from the 1st Plaintiff for the VP shunt procedure on 24/4/2009.

206. Unfortunately, at around this time, the family and Hospital had been engaging on the finances, see letter from the Finance Director. Thus we were not able to perform the procedure as intended.

207. The patient was eventually transferred to Kenyatta National Hospital on 30/4/2009. From the 30/4/2009, the patient ceased to be under DW4's care.

208. The patient was transferred to the MP Shah Hospital from 2/5/2009 and was under care of a new neurosurgeon who performed the VP shunt procedure I had planned to perform while under DW4's care.

209. I also came to learn much later that the patient finally succumbed on 18/8/2009 in KNH.

210. I also note of the post-mortem report of 21/8/2009 prepared by Dr. Ndungu, whereby the cause of death is reported as raised intracranial pressure due to Hydrocephalus, a diagnosis which had been established from mid-April 2009.

211. PROFESSOR NIMROD MWANGOMBE testified as DW5 an expert witness.

212. DW5 relied on the notes from the 1st defendant to compile his report dated 19/9/2023 which DW5 adopted as his evidence in chief.

213. DW5 said he did not interact with the deceased in this case.

214. At the close of the trial, directions were taken on filing of submissions. Parties complied with the said directions.

215. Counsel for the Plaintiffs opened his submissions by restating the events and evidence before the trial Court in addressing the twin issues of liability and damages. Concerning liability counsel identified two (2) issues for the Court's consideration.

216. On whether the 1st Defendant owed a duty of care to the deceased, it was submitted that it is not in dispute that the deceased was admitted at the 1st Defendant's hospital and received treatment from the 2nd Defendant.

217. That upon the deceased's admission to the hospital, the admission was on advice and care of a consulting doctor, the hospital and its agents were in charge of the patient's safety and security, they were generally in charge of the patient during his recovery and while on admission.

218. While calling to aid the decision in Jimmy Paul Semenye v Aga Khan Hospital & 2 Others [2006] eKLR, M (a minor) v Amulega & Another [2001] KLR 420 and the authors in Medical Negligence and Compensation by Dr. Jagdish Singh & Vishwa Bhushan (2nd Edition) (1999) at Pg. 131 to assert that the hospital and its agents owed a duty of care to the patient.

219. On whether the 1st Defendant were negligent and breached the duty of care, it was submitted that it is generally expected that a person who has undergone surgery on the head, the deceased was experiencing confusion which occasioned memory lapses.

220. That DW1 confirmed that at the time, the patient expressed concern about his inability to remember and he was not happy about it which in turn corroborated PW1's evidence that the deceased was strapped to his bed while he was at the HDU in order to limit his movement.

221. That in light of the surgery the patient underwent and the fact that he had experienced memory lapses and was strapped at the HDU of which the former was drawn to the nurse's attention, the hospital, its staff and of course the consulting doctors ought to have acted with reasonable care, to offer the best protection in attending to the patient while still at the hospital.

222. That as a result of the events on 22.03.2009, the hospital, its staff and consulting doctor all breached their duty of care to the patient.

223. It was further posited that it is out of the ordinary for a patient admitted in a hospital ward to fall out of a window therefore the doctrine of Res Ipsa Loquitor is applicable in the instant matter.

224. That by DW2's evidence, the hospital ought to have carried out proper internal investigations on matter other than merely reporting the same at Kilimani Police Station.

225. Counsel went on to argue that the 1st Defendant's action of transferring the patient from their hospital to KNH while he was still in the ICU without notice to his next of kin was tantamount to the Defendants breach of duty of care and negligent, in order to avert liability in respect of the patient's fall at the 1st Defendant's facility.

226. That the 1st Defendant action of negligently discharging and transferring the patient and later abandoning him at KNH went against the expected nature of the 1st Defendant to take all reasonable steps to ensure that a patient especially one in the ICU receives proper treatment. The decision in Wishaminya v Kenyatta National Hospital Board [2004] 2 EA 351 was relied on in the forestated regard.

227. Regarding damages, counsel anchored his submissions on the decision in Herman Nyangala Tsuma v Kenya Hospital Association t/a The Nairobi Hospital & 2 Others [2012] eKLR on the Plaintiff's obligation not only to prove negligence caused but also injury, loss and damage complained of. That

after the deceased's successful surgery, he later sustained injuries as a result of the Defendants negligence on accord of falling from the 1st floor widow of his ward.

228. It was further submitted that the patient's subsequent admission to the ICU and attendant medical complication he developed were as a direct consequence of the Defendants negligence thus leading to his death on 18.08.2009 while at KNH.

229. That the autopsy report confirmed that the cause of the deceased death was intracranial pressure due to hydrocephalus. On the award on special damages, while referencing the evidence and receipts adduced, the Court was urged to award Kshs. 2,675,033/- as specifically pleaded and proved as having been incurred as a result of direct negligence by the Defendants.

230. With respect to the award of general damages, the Court was urged to award Kshs. 700,000/- as damages for mental and emotional distress given that the deceased died six (6) months after the initial fall.

231. On pain and suffering the Court was urged to award Kshs. 2,500,000/- on accord of the fact that the deceased slipped into a semiconscious state after the fall on 22.03.2009 and never regained consciousness until his death on 18.08.2009.

232. On loss of expectation of life, the Court was implored to award Kshs. 1,000,000/- for reasons that notwithstanding the deceased being 69 years of age he would have led an active life for many more years.

233. The decisions in LWW (suing as the administrators of the estate of BMN-deceased) v Charles Githinji [2019] eKLR, Benedeta Wanjiku Kimani v Changwon Cheboi & Another [2013] eKLR, Sanya Hassan & Anor v Somar Properties Ltd NRB HCCC 1517 of 2002, Kazosi Kalama & Anor v Rea Vipingo Plantation Ltd [2012] eKLR and Hardev Kaur Dhanoa v Multiple Hauliers (E.A) Limited [2017] eKLR were respectively called to aid.

234. On loss of dependency while placing reliance on the decisions in Albert Odawa v Gichimu Gichenji [2007] eKLR and Mary Njeri Murigi v Peter Macharia & Another [2016] eKLR it was iterated that the deceased was 69 years, a businessman and farmer at the time of his untimely demise whereas he was survived by a widow and sons while being the sole breadwinner for the family.

235. The Court was thus urged to apply the global sum approach in awarding damages under the head to the tune of Kshs. 5,000,000/-.

236. In conclusion, it was submitted that the Defendants were in breach of their duty of care whereas the 1st Defendant's action of unilaterally transferring the patient at the time, aggravated the situation by negligently causing the death of the deceased therefore the suit ought to be allowed as prayed.

237. On the part of the 1st Defendant, counsel equally addressed the twin issues of liability and quantum of damages. Restating the factual and evidentiary material before this Court, counsel acceded to the fact that the deceased was a patient at the hospital and underwent and successful surgery on 18.03.2009.

238. While calling to aid the English decision in D v South Tyneside Health Care NHS [2003] EWCA Civ 878 counsel further acceded to the fact that the deceased who was a patient at the 1st Defendant's facility jumped out of the 1st floor window however in light of the hourly check-ups by the 1st Defendant nurses while the patient was in the general ward, the latter cannot be held to be negligent.

239. That the incident occurred 10 mins after the last check up of the patient to which the 2nd Defendant and the patient next of kin were immediately informed of the incident and was later recorded as an attempted suicide on 22.03.2009 when it occurred.

240. It was further submitted that upon the patient's successful surgery, the 2nd Defendant did not issue any instructions for specialized care of the patient whereas it is only the former who can issue instructions to restrain a patient.

241. Therefore, the Plaintiffs cannot blame the 1st Defendants for failing to restrain the patient when the 2nd Defendant had not issued such instructions.

242. It was further posited that there was no expert evidence from the Plaintiffs that on accord of the patient's surgery he ought to have been restrained. That in any event the windows did not require to be grilled as the ward was not a mental institution meanwhile the patients bed had side rails to prevent him from falling off the bed.

243. Concerning the Plaintiff's transfer, counsel relied on the of-cited decision in National Bank of Kenya Ltd v Pipeplastic Samkolit (K) Ltd & Another [2001] eKLR, to contend that pursuant to the admission form, which was a contract, the hospital was not under any obligation to continue treating the patient at the hospital under any circumstance whatsoever in the event that the Plaintiffs did not pay the outstanding hospital bill on demand.

244. That the Plaintiffs were all along aware that the patient would be transferred to another hospital if they neglected or refused to pay any outstanding bill. Counsel maintained that the hospital did not waive any bill but only empathized the need to give priority to the patient's recovery meanwhile by the 2nd Defendant signing the discharge summary, he authorized the discharge of the patient on grounds that he was stable for transfer.

245. Addressing the deceased's cause of death, counsel relied on the doctrine of novus actus interveniens, the decision in James Wangui Obwogi v Lawrence John Aburi [1997] eKLR and English decision in The Oropesa [1943] 1 All ER 211 to assert that there was no proof before the Court that the cause of death as stated in the post mortem report was due to what transpired at the 1st Defendant's facility on 22.03.2009. Meanwhile, even if there was an assumption that the hospital was negligent, which counsel denied, the Plaintiff failed to demonstrate that the negligence was the proximate cause of the deceased's death.

246. Concerning whether the 1st Defendant was negligent, counsel argued that neither the hospital or its servant were negligent on grounds: - that the hospital acted reasonably in the circumstances and nothing could have been done differently from what was done; that the call bell in the patient's room was shown to be active; that the patient was assigned proper and adequate facilities and qualified staff; and that the patient was adequately monitored with all reasonable and necessary action taken.

247. Counsel iterated that the patient falling through the window was not an event which a reasonable person or institution would have foreseen. While citing Charlesworth & Percy on Negligence, 9th Edition, Para. 9-155, Lord Nathan P.C in Medical Negligence (1957) at Pg. 147 the English decisions in Cassidy v Ministry of Health (1951) 2 K.B 343 at 362, Roe v Minister of Health, Woodley v Minister of Health et. Al (1954) 2 Q.B 66, Gold v Essex CC (1942) 2 KB 293 and the Canadian decision in Yepremian v Scarborough General Hospital (1980) 28 O.R (2nd) 494 (C.A) it was posited that the 2nd Defendant was not an employee of the 1st Defendant therefore the latter cannot be held liable for acts of a consulting surgeon. The Court was urge to find the 1st Defendant was not negligent as alleged by the Plaintiff.

248. In the alternative and without prejudice to the earlier submission, counsel asserted that on damages for pain and suffering the Court ought to award Kshs. 100,000/- as the deceased did not suffer.

249. The decision in P.B.S & Another v Archdioceses of Nairobi Kenya Registered Trustees & 2 Others [2016] eKLR was relied on. Submitting on damages under the Fatal Accident Act, counsel cited the decisions in Chunibhai J. Patel & Another v P.F Hayes & Others (1957) EA 748 -749, P.B.S (supra), Francis Njeru v Geoffrey M. Ndegwa Muiruri (suing as the legal representative of the Estate of Alex Mugo Muiruri) (Deceased) [2020] eKLR and Oyugi Judith & Another v Fredrick Odhiambo Ongong & 3 Others [2014] eKLR in urging the Court to award damages to the tune of Kshs. 32,928/- calculated as Kshs. 5,488/-*1*12*1/2.

250. The calculation being premised on the fact that no evidence was produced on earnings whereas the deceased was 69 years of age and would therefore have retired at 70 years.

251. It was further submitted that a global sum award was not applicable in the instant matter. Concerning the award under the *Law Reform Act*, counsel relied on the decision in Hardev Kaur Dhanoa v Multiple Hauliers Ltd [2017] eKLR to submit that an award of Kshs. 200,000/- was reasonable for loss of expectation of life. In totality of the above, counsel cited the decision in Kemfro Africa Limited t/a Meru Express Services (1976) & Another v Lubia & Another (No.2) [1985] eKLR in urging the Court to offset the awards under the Fatal Accident Act and *Law Reform Act* from each other in order to avert double compensation.

252. On special damages, despite the Plaintiff claiming Kshs. 4,786,233.00, the Court was implored to dismiss that of which was not specifically proven by way of receipts. In conclusion, counsel submitted that the Court ought to find that the Plaintiffs had not proved their case on a balance of probabilities a consequence of which the suit ought to be dismissed with costs.

253. On the part of the 2nd Defendant, counsel equally restated the evidence before this Court and proceeded to anchor his submission on the decision in Kenya Wildlife Service V Rift Valley Agricultural Contractors Limited [2018] eKLR and the English case of Blyth v Birmingham Co. (1856) 11 Exch. 784-784 on the factors to be considered in respect of a claim founded on medical negligence

254. On whether the 2nd Defendant was in breach of his duty of care, counsel cited the decision in *Amisi v Siaya County Referral Hospital & another (Civil Suit 5 of 2019*) [2022] KEHC 12117 (KLR), the English case of Bolam v. Friern Hospital Management Committee [1957] Q.B, Ms. Ins. Malhotravs. DR. A. Kriplani and ors. JT2009 (4) SC266 as quoted in Ricarda Njoki Wahome (Suing as administrator of the estate of the late Wahome Mutahi (Deceased) v Attorney General, Ronald Kidiavai Lwegado & Geoffrey Muiruriki Ng'ang'a [2015] KEHC 4929 (KLR), and the Indian decision of Lord S Krishnan Unni, J in M Shoba vs. Dr. Rajakumari Unnithan AIR 1999 Kerata 149 who referred to in Payremalu Veerpan vs. Dr Amarjeet Kaur [2001] High Court of Malaya to submit that the deceased was successfully operated on by an experienced doctor of 48 years in the field and was recovering well in the general ward meanwhile as a result of his fall from the window, he developed hydrocephalus which triggered a raised intracranial pressure.

255. That owing to the financial dispute between the Plaintiffs and the 1st Defendant, the 2nd Defendant did not perform a VP shunt on the patient, whom was later transferred to KNH.

256. It was further submitted that from the evidence tendered by witnesses before the trial Court and hospital records by the 1st Defendant, the deceased received adequate medical attention from the Defendants meanwhile it was the 1st Defendant's nursing team that was in charge of monitoring of patients and eventually notifying the primary doctor of any incidents that require his intervention.

257. That at no material time was the 2nd Defendant notified of the patient's deterioration prior to his fall from the window as such there was no concern. Counsel went on to submit that there was no evidence

of the patient being unstable to require him being restrained meanwhile upon his fall the latter was placed under management of other doctors.

258. In the circumstance, the Court was urged to find that the Plaintiffs have failed to establish, breach of duty of care as against the 2nd Defendant.

259. On whether the deceased suffered any damages as a result of breach of duty of care, it was submitted that causation in medical negligence claims is a crucial element that ought to be established whether a healthcare provider's actions (or lack thereof) directly caused harm to a patient.

260. While calling to aid the English decision in Bolam (supra), the decisions Gideon Ndungu Nguribu & another v Michael Njagi Karimi [2017] eKLR, Statpack Industries Limited vs. James Mbithi Munyao HCCA No. 152 of 2003 (UR) as cited with approval in South Nyanza Sugar Co. Ltd vs. Wilson Ongumo Nyakwemba [2008] eKLR, K & K Amman Ltd V Mount Kenya Game Ranch Ltd & 3 Others HCC 6076/96, Amalgamated Saw Mills Ltd v Stephen Muturi Nguru HCA 75/2005 and Odero v Aga Khan Hospital Kisumu (Civil Appeal E011 of 2020) [2024] KEHC 3408 (KLR) it was submitted that from the evidence before the this Court in respect of events leading up to the patient's jumping out a window, the Plaintiffs have not demonstrated inaction, omission nor failure by the 2nd Defendant and therefore the patient jumping out of the window cannot be attributed to anything the 2nd Defendant did or failed to do in the circumstances.

261. That the evidence supplied in the form of the postmortem clearly established that the cause of death was not attributable to the 2nd Defendant therefore the Court was urged to hold that there is no linkage between the demise of the deceased with any of the purported actions and or inactions of the 2nd Defendant.

262. On damages, counsel equally qualified his submissions on a without prejudice basis meanwhile anchored his submissions on the decision in Nandwa V Kenya Kazi Ltd [1988] KLR 488. He went ahead to recapitulate the 1st Defendant's arguments and authorities on both heads under the Fatal Accident Act and *Law Reform Act*. Concerning the head under special damages, counsel relied on the of-cited decision of Hahn v Singh [1985] KLR 716 in urging the Court to dismiss special damages that have not been strictly proved by the Plaintiffs. In summation, counsel urged the Court to dismiss the Plaintiffs suit with costs.

263. In rejoinder to the 2nd Defendant's submissions, counsel for the Plaintiffs contended that there was a doctor-patient relationship between the 2nd Defendant and the deceased that obligated the former to exercise all reasonable skills and care ascribed to him to ensure the safety and care of the latter.

264. While calling to aid the decisions in Jimmy Paul Semenye (supra), Kenya Wildlife Service (supra) and R v Bateman (1925) 19 Cr. App. R 8 it was asserted that the patient's expectation at the time was that special skill and knowledge of the 2nd Defendant was to be carefully applied in his treatment and recovery.

265. On whether the 2nd Defendant was negligent, counsel reiterated that the latter ought to have known that the patient was disorienting and would therefore require adequate attention.

266. That the 2nd Defendant failed to advice on a specialized care, as to how the patient could be attended to by nurses and staff of the 1st Defendant during his recovery process, was in breach if his duty of care occasioning the deceased to fall off a window. In summation, the Court was urged to allow the suit as lodged. `

267. I have carefully considered the evidence adduced by the parties and submissions herein. It is the duty of the plaintiffs to prove their case to the required standard in civil cases which is on a balance of probabilities.

268. The issues for determination are as follows;

i. Whether the 1st and 2nd defendants are liable in negligence for the deaths of the deceased.

ii. Whether the plaintiffs are entitled to the remedies they are seeking against the defendants.

iii. Who pays the costs of this suit?

269. The issues arising for this Court's determination are whether Plaintiffs have established their case as against the Defendants on a balance of probabilities, and if so, what are the awardable damages.

270. Indubitably, this Court has on occasion addressed itself to the importance of pleadings in determining the issues before a Court.

271. As pleadings form the thrust of the respective parties' cases. See Court of Appeal decision in Wareham t/a A.F. Wareham & 2 Others Kenya Post Office Savings Bank [2004] 2 KLR 91.

272. That said, the gist of the respective parties' pleadings had earlier been highlighted in this judgment thus negating the need for restatement.

273. It is further well-trodden that the applicable law on burden of proof, in civil cases, can be clasped by reading of the provisions of Section 107, 108 and 109 of the *Evidence Act*.

274. The impetus of the forestated provisions and the standard of proof in civil liability claims in our jurisdiction, being on a balance of probabilities, was reasonably discussed by the Court of Appeal in Mumbi M'Nabea v David M. Wachira [2016] eKLR.

275. Ideally, the duty of proving the rival averments contained in the respective parties' pleadings lay squarely with the parties themselves.

276. In Karugi & Another v Kabiya & 3 Others (1987) KLR 347 the Court of Appeal stated that: -

> " [T]he burden on a plaintiff to prove his case remains the same throughout the case even though that burden may become easier to discharge where the matter is not validly defended and that the burden of proof is in no way lessened because the case is heard by way of formal proof. We would therefore venture to suggest that before the trial court can conclude that the plaintiff's case is not controverted or is proved on a balance of probabilities by reason of the defendants' failure to call evidence, the Court must be satisfied that the plaintiff has adduced some credible and believable evidence, which can stand in the absence of rebuttal evidence by the defendant...--. The plaintiff must adduce evidence which, in the absence of rebuttal evidence by the defendant convinces the court that on a balance of probabilities it proves the claim." (Emphasis added)

277. Here, for the defendants to be held liable in negligence, the plaintiffs have to prove that the defendant owed them a duty of care, that the defendants breached that duty and as a result the deceased lost his life.

278. The Court of Appeal in SO & JM v Nathan M. Murugu, Lucy Muchiri, Bessie Byakika, Nairobi Hospital, AAR Health Services & Medical Practitioners and Dentist Board [2019] KECA 709 (KLR) while addressing itself to the applicable principles reasonably observed that; -

> "..Negligence is a specific tort whose origin can be traced from the common law jurisprudence. The case of Donoghue v Stevenson [1932] ALL ER 1 established the modern law of negligence, laying the foundations of the duty of care and the fault principle. The elements which constitute a negligent tort are: a person must owe a duty or service to the victim in question; the individual who owes the duty must violate the promise or obligation; an injury then must arise because of that specific violation; and the injury must have been reasonably foreseeable as a result of the person's negligent actions. See Kenya Breweries Ltd. V. Godfrey Odoyo Civil Appeal No. 127 of 2007.

279. As stated in Halsburys Laws of England 4th Edition, Pg. 662:

> "The burden of proof in an action for damages for negligence rests primarily on the plaintiff who, to maintain the action, must show that he was injured by a negligent act or omission for which the defendant is in law responsible. This involves the proof of some duty owed by the defendant to the plaintiff, some breach of that duty, and an injury to the plaintiff between which and the breach of duty a causal connection must be established."

280. The evidence in this case is that the deceased was admitted at the first defendant hospital on 17/3/2009 by the 2nd defendant and the deceased underwent a successful operation where the 2nd defendant successfully did an elective craniotomy and microscopic clipping of a com aneurysm on 18/3/2009.

281. There is evidence that the deceased was admitted at HDU after the surgery and he was under observation and due to a steady recovery progress, he was transferred to the male ward.

282. The deceased was reviewed by the 2nd defendant on 19/3/2009.

283. There is undisputed evidence that the patient scored 13/14 on the glasgow coma scale.

284. There is evidence that the deceased was cooperative, calm and was obeying instructions though he had mild confusion.

285. I find that there was nothing to suggest that the deceased was violent or that he required physical or chemical restraint.

286. DW1 who was on duty gave details and intervals at which she observed the deceased.

287. There were entries by nurses in the nursing notes at 4.30 pm,6.00 pm,8.00 pm 9.00 pm,10.00pm, 12.00 midnight, 2.00 am. The observations were normal and patient calm.

288. At around 3.00am (22/03/2009), he was escorted by the attending nurse to the toilet, where he passed urine and was taken back to bed and settled, and the side rails to his bed secured.

289. The nurse did her rounds at 4.00 am and 5.00 am during which time she found the patient asleep

290. I find that there is no evidence that the defendants breached the duty of care they owed the deceased.

291. The conduct of the deceased was not foreseeable in the circumstances and I find that the defendants are not liable in negligence.

292. There is also evidence that the deceased was making good recovery after the fall.

293. The 2nd defendant had noticed intracranial pressure on 24/4/2009 and he advised on the need to perform a ventricule peritoneal (VP) shunt but the patient was transferred to Kenyatta National Hospital (KNH).

294. There is undisputed evidence that the deceased died on 18/8/2009 at KNH due to intra cranial pressure due to hydrocephalus.

295. The death of the deceased occurred four months after the 2nd defendant wanted to do the VP shunt to release the pressure on his brain.

296. I find that the plaintiffs have failed to prove that the 1st and 2nd defendants were negligent in the circumstances.

297. Under Section 107 of the *Evidence Act*, the burden of proof lay with the Plaintiffs and if their evidence did not support the facts pleaded, they failed as the party with the burden of proof. See Wareham t/ a A.F. Wareham (supra).

298. Consequently, the plaintiffs are not entitled to the remedies they are seeking against the defendants.

299. On the issue of costs, I find that the plaintiffs did sustain loss though it was not due to the negligent of the defendants and for that reason I direct that each party bears its own costs of this suit.

300. Had the plaintiffs proved negligence, they would have been entitled to general damages of Kshs. 2,000,000 for pain and suffering Kshs.100,000 for loss of expectation of life.

301. I find that no evidence was produced on earnings and the the deceased was 69 years of age and would therefore have retired at 70 years and Kshs. 1,000,000 would have been awarded for loss of dependency.

302. However, the plaintiffs did not prove their case to the required standard and the same is dismissed with no orders as to costs.

**DATED, SIGNED AND DELIVERED ONLINE VIA MICROSOFT TEAMS AT NAIROBI THIS 4TH DAY OF DECEMBER, 2024.**

**.....**

**A. N. ONGERI**

**JUDGE**

In the presence of

..... for the Plaintiff

..... for the 1st Defendant

..... for the 2nd Defendant