REPUBLIC OF KENYA

IN THE HIGH COURT OF KENYA AT MURANG'A

CIVIL SUIT NO. 3 OF 2013

ANTONEY KENNETH MUTIRIA MWANGI *(Suing as the legal representative of*

***the estate of* CHARITY MUGURE MUTIRIA & GRACE NJERI).....PLAINTIFF**

VERSUS

DR. JAMES KIRII.....1ST DEFENDANT

KIRIAINI MISSION HOSPITAL.....2ND DEFENDANT

JUDGMENT

1. The plaintiff is the widower and legal representative of Charity Mugure Mutiria (hereafter *the deceased*). She died on 9th July 2011 while giving birth to their third child at Kiriaini Mission Hospital (the 2nd defendant). The infant also died a few hours later.

2. The plaintiff blames the hospital and its medical officer, Dr. James Kirii (the 1st defendant), for poor management of the deceased and the infant, poor conditions at the nursery, incompetent staff, lack of blood for transfusion and a delayed referral to another facility.

3. The plaintiff brings this suit on his own behalf and that of the estate of the deceased praying for general damages under the **Law Reform Act** and the **Fatal Accidents Act**, aggravated damages, costs and interest.

4. The claim is denied *in toto*. Initially, the two defendants filed a joint statement of defence on 27th March 2013 through the firm of *Wanyonyi & Muhia Advocates*. However, the firm lodged a Notice of Motion dated 1st April 2014 seeking leave to cease acting for the 1st defendant; and, to set aside some *ex-parte* proceedings of 10th February 2014. That motion was allowed on 15th September 2014.

5. It appears that on 4th December 2014, the firm of *Ndegwa & Ndegwa Advocates* filed a Notice of Appointment on behalf of the 1st defendant but did not present a fresh statement of defence. So much so that the 1st defendant could only rely on the original statement of defence. Unfortunately for him, the pleadings were amended. The plaint was amended by leave granted on 11th June 2014. The 2nd defendant then filed an *amended defence* on 15th July 2014 which among other things, removed all references to the 1st defendant. It also contested the legal capacity of "Kiriani Mission Hospital" to be sued in this suit.

6. The net effect of the latter pleading is that the 1st defendant was left with no formal defence on record. The 1st defendant or his new counsel did not also attend the trial.

7. The plaintiff relied largely on his *witness statement* filed on 2nd February 2018. He produced a limited grant of letters of administration issued by the High Court at Nairobi in *Probate & Administration Cause 1842 of 2011* on 19th October 2011 and the death certificates of his wife and the infant (plaintiff's exhibits 1, 2 and 3).

8. On 8th July 2011, he accompanied the deceased to Kiriaini Mission Hospital. It was her expected date of delivery. At first, the deceased opted for a caesarian section but when the 1st defendant explained its risks, she changed her mind. A nurse, Nancy Thiong'o, was present during that conversation. The plaintiff said he was not worried because the deceased had delivered their two children normally.

9. He testified that the deceased was admitted and her labour induced. She was given a ½ tablet of some drug which was placed under her tongue. He said the drug was supposed to be administered after every six hours. He left hospital at around 6:00 p.m. He called the deceased at around 10.00 p.m. who told him that her water had broken. That was the last he heard from her.

10. The following morning at about 6:00, he tried calling in vain. He then dashed to Nairobi hoping to be back by the afternoon.

At 11:00 a.m., he received an urgent call from the hospital. When he returned to the facility *"Dr. Kirii explained that the deceased suffered bleeding resulting to death. The baby developed breathing difficulties and also died".*

11. On 19th July 2011, he made a complaint against the hospital and Dr. Kirii to the Medical Practitioners & Dentists Board. He blamed them for medical negligence. The complaint and his statement were produced as exhibits 5 (a) and (b). I should add that the statement is word for word with his witness statement in this suit. He also sought to rely on a ruling of the Board (exhibit 6) but the 2nd defendant objected. Although I allowed the witness to lead evidence on it, I issued a caveat that the veracity of the Board's findings was subject to a considered ruling by the High Court at Nairobi in *Petition 228 of 2013* (exhibit 7). I will revisit the matter shortly.

12. The plaintiff testified that when he returned to the hospital the following day, he spoke to the 1st defendant in the presence of his sister and the hospital administrator. He testified as follows-

> *They said my wife bled while at the theatre. There were no blood reserves. She was transferred to Nyeri PGH Hospital but it was late at 3:00 a.m. I did not see evidence she was ever admitted or received at Nyeri PGH. I found her body at Kiriaini Mortuary. I was told the child had breathing difficulties. The Medical Board at Nyeri found that she bled to death.*

13. Regarding the claim for lost years, he said that the deceased was aged 38 at the time of her death and the family relied on her salary. She was working for *Dan Owen Agencies* with a salary of Kshs 39,000 (exhibit 4). His two sons are now aged 20 and 13 respectively and the deceased's parents are still alive as pleaded at paragraph 11 of the amended plaint.

14. I must point out that the amended plaint did *not* plead the particulars of the deceased's employment or earnings. Learned counsel for the plaintiff sought to orally amend the plaint when the witness had already been cross-examined and was in the middle of re-examination. Noting that he had an opportunity to amend the pleadings earlier, and, owing to the prejudice to the defendant at that late stage, I declined the amendment.

15. In the witness statement, the plaintiff posed three questions that are at the heart of his claim. I will set them out verbatim-

> *Why Dr. Kirii and his team never prepared themselves in anticipation of an emergency?*
>
> *Why did they not give her blood and if it wasn't there why they did admit her?*
>
> *Why didn't they inform me that night when they realized she was in a state of emergency?*

16. On cross-examination, the plaintiff conceded that he left the hospital on 8th July 2011 and did not return until the next day when he learnt of the death. He said that on 6th November 2013, there was a meeting of the Medical Board at Nyeri but that the defendants walked out of the meeting. He did not know why they did so. He said he filed *Nairobi High Court Petition 228 of 2013* (exhibit 7) because he felt that an earlier decision by the Board failed to consider the issue of lack of transfusion blood at Kiriaini Hospital.

17. That marked the close of the plaintiff's case.

18. Like I stated the 1st defendant did not attend the trial. The 2nd defendant called two witnesses.

19. DW1 was Cellinamma Kuriakosse, a registered nurse and the hospital administrator at the material time. She relied on her *witness statement* dated 26th July 2011. She confirmed that the deceased had attended clinic at the defendant's satellite facility in Murang'a. On 8th July 2011, the deceased elected for a caesarian section but the 1st defendant advised her, in the presence of the plaintiff, that she could have a normal delivery as she had had two normal deliveries before.

20. She testified that the maternity register *MOH 333* with admission *No. 379/11* was issued. The patient was admitted in private ward room, St. Aloysius, and routine delivery preparations commenced. When foetal distress was detected, the Medical Officer (1st defendant) called the laboratory at around 12:30 a.m. to provide blood for the patient in readiness for an emergency caesarian section. At around 1.50 a.m., and when the condition of the mother *"rapidly deteriorated post-partum"*, the Medical Officer summoned an ambulance to transfer the patient to Nyeri PGH Hospital.

21. She said that the patient succumbed on arrival at Nyeri PGH. The Nursing Officer In-Charge directed that the body be returned to Kiriaini Hospital. A maternal death audit was carried out by the hospital. She stated that the hospital has a *"comprehensive obstetric emergency care facility with fully equipped laboratory and transfusion services [and] that all protocols were followed in this particular case".*

22. She testified that the plaintiff left the hospital after admission of the deceased and did not return that night. The hospital called him and disclosed the news of the death and gave him some counselling. It was mutually agreed that a post-mortem be carried out. This was undertaken on 12th July 2011 by Dr. Abiero Okoth, a pathologist based at Nyeri Provincial General Hospital in the presence of the 1st defendant and the deceased's kin.

23. The post mortem report was produced as defence exhibit 4. The witness also produced the hospital file pages 1 to 6, the *Cardex* and the referral letter (Defence exhibits 1, 2 and 3).

24. On cross examination, she conceded that she was not the nurse in charge of the deceased and never saw her on admission or through

labour. She was however informed by another nurse, Nancy Thiong'o, when the deceased's condition deteriorated. The witness had also been notified about cross-matching blood and the need to get an ambulance. She said that the deceased never went to the theatre as she delivered when she was being prepared.

25. She denied that the defendants were negligent. She testified that the deceased died of atony of the uterus and excess bleeding. She made reference to the doctor's notes at page 5 and the medicines administered to the deceased. She testified that the 1st defendant was seconded to the hospital by the Government and that the hospital would only pay him for overtime. She conceded that the 1st defendant was a medical officer and not an obstetrician/gynaecologist. The hospital did not also have a paeditrician and that role was being performed by the medical officer.

26. DW2 was Agnes Machira, a nurse at the hospital. She relied largely on her *witness statement* dated 28th July 2011. She said that the deceased was stable but complained of lower abdominal pains. The witness gave a detailed summary of her condition, and treatment or reviews between 7:30 p.m. and 12:17 a.m. as follows-

> *The presenting part was cephalic, with a descent of 4/5 up. The fundal height was at term Foetal Heart (FH) was 142/min and regular. The membranes were intact.*
>
> *7.30 p.m. the patient complained of lower abdominal pains FH 144 R.*
>
> *8.30 p.m. Vaginal Examination (VE) done showed a cervical os admitted a tip of a finger and she still had mild contraction. Then a ¼ tab of cytotec (Misoprostol 50mcg) sublingual was administered and the FH noted to be at 140/min and regular.*
>
> *10.00 p.m. patient then complains of draining of liquor….*
>
> *10.30 p.m. clear liquor was noted.*
>
> *11.30 p.m. patient noted to have meconium stained liquor grade 1 FH 138/min and regular with moderate contraction, a VE done showed a cervix 4cm dilated, presenting part cephalic with a descent 4/5 up with a position ROA. There was no cord prolapse with an adequate pelvis. The patient was started on Normal Saline (N/S) Intravenously (IV) 500 mls and the doctor informed.*
>
> *12.00 a.m FM was noted to be 100/min and irregular and she was still N/S 500 mls IV.*

27. She said that at 12:17 a.m., the doctor (1st defendant) reviewed the patient. Owing to the foetal distress, he directed that the patient to be prepared for emergency caesarian section and asked the laboratory to provide blood urgently. The witness said that the patient gave her consent. However, as she and a colleague were preparing for theatre, the patient delivered.

28. Upon cross examination, she said that the doctor and another nurse, Angelica, were present when the baby was delivered. The baby did not cry. She conceded that all was well until 12:00 midnight when the foetal heart rate went down to 100/min. She also said that at 11:30, the liquor was meconium which was an indication of distress. She was working alone at that point and called for the doctor who appeared at 12:17 a.m.

29. She said that she saw the transfusion blood "removed at 11:30 p.m". However, she did not know about the request form for test for group match or fill it up. She did not also know whether the emergency blood was prepared. Although she insisted that a blood sample was taken at 11:30 p.m., the detail only appears at 12:17 a.m. The lab was being manned at that time by one man. She confirmed that between 6:30 p.m. to 12:45 a.m., no blood was transfused.

30. She testified that the ½ *cycotec* administered at 2:40 p.m. in the *Cardex* must have been prescribed by the doctor. She was unaware of the nurse managing the patient at that time as she reported on duty at 6:30 p.m. On re-examination, she said that since the patient delivered normally, there was no longer need to go to the theatre or for transfusion. She could not tell whether blood had been prepared at that point.

31. That marked the close of the 2nd defendant's case.

32. The plaintiff and 2nd defendant filed written submissions. The plaintiff's are dated 12th July 2019 while those by the 2nd defendant were filed on 29th July 2019.

33. From the pleadings and the evidence, the broad issues for determination are four-pronged-

> i. Whether the defendants by negligence caused the death of the deceased and her new born: Paraphrased, whether the defendants breached their duty of care;
>
> ii. Whether the 2nd defendant has legal capacity to be sued;
>
> iii. Whether the plaintiff is entitled to general, special, or aggravated damages together with interest; and,
>
> iv. Who will meet the costs of the suit?

34. The substratum of the plaintiff's case is that the defendants had a duty of care to the deceased; and, that they breached it through *medical negligence*. There are five particulars of negligence pleaded at paragraph 10 of the amended plaint: (a) poorly managing the deceased's labour (b) incompetent staff (c) poor conditions at the hospital nursery (d) lack of blood transfusions and (e) delayed referral.

35. Parties are bound by their pleadings. It is also a cardinal precept of the law of evidence that he who alleges must prove. See sections 107 and 108 of the **Evidence Act**. That burden falls on the party who would fail if no evidence at all were given on either side. In this case the evidential and legal burden to prove medical negligence rested primarily on the plaintiff. I would add that the burden remains on a balance of probabilities.

36. Medical malpractice is defined by the ***Black's Law Dictionary***, 10th edition, 2016 at page 1103 as follows:

> *A doctor's failure to exercise the degree of care and skill that a physician or surgeon of the same medical specialty would use under similar circumstances.*

37. The duty of care owed by medical professionals and health providers was well explained in ***R v Bateman*** (1925) 19 Cr App R 8-

> *If a person holds himself out as possessing special skill and knowledge and he is consulted, as possessing such skills and knowledge, by or on behalf of a patient, he owes a duty to that patient to use due caution in undertaking the treatment. If he accepts the responsibility and undertakes the treatment and the patient submits to his direction and treatment accordingly, he owes a duty of care to the patient to use diligence, care, knowledge, skills and caution in administering the treatment.*

38. See also ***John Gachanja Mundia v Francis Muriira & another***, Meru High Court Civil Appeal 26 of 2015 [2017] eKLR*;* ***DO (a minor suing through his next friend DOO) v Nathan Khamala & another***, Nairobi High Court Civil Case 351 of 2010 [2020] eKLR; ***Jimmy Paul Semenya v Aga Khan Hospital & 2 others,*** Nairobi High Court Civil Case 807 of 2003 [2006] eKLR; ***Sidaway v. Bethlem Royal Hospital Governors*** [1985] 1 ALL ER 643 at 649.

39. In ***Magil v. Royal Group Hospital & Another*** [2010] N.I. QB 1 the High Court of Northern Ireland stated:

> *The standard of care must reflect clinical practice which stands up to analysis and is not unreasonable. It is for the court, after considering the expert evidence whether the standard of care afforded the deceased put him at risk.*

40. But the court should tread carefully because not every misadventure amounts to medical negligence and not every death of a patient is a consequence of negligence. See ***LWW (suing as the administrator of the estate of the estate of BMN) v Dr. Charles Githinji***, Nairobi HCCC 34 of 2012 [2019] eKLR.

41. The proper test is laid down in ***Halsbury's Laws of England***, 3rd Ed. Vol. 26 at 17- *The practitioner must bring to his task a reasonable degree of skill and knowledge, and must exercise a reasonable degree of care*. See also ***Roe v Ministry of Health*** [1954] 2 ALL E.R. 139. In the concurring opinion in ***Pope John Paul's Hospital & Another v. Baby Kasozi*** [1974] E.A. 221 at 228, Law, Ag. V-P, stated:

> *To that extent of <u>not confusing misadventure with negligence</u>, clear proof of negligence is necessary in cases involving medical men, but it cannot be accepted that the burden of proving such negligence is higher than in ordinary cases. <u>The burden is to prove that the damage was caused by negligence and was not a question of misadventure, and that burden must be discharged on a preponderance of evidence</u>.* [Emphasis added].

42. The defendants held themselves out as possessing necessary skill and knowledge for health providers including maternity services. The deceased had previously attended their satellite clinic in Murang'a. She had carried a foetus to full term and was in a stable condition when she sought the defendants' services. I thus readily find that the two defendants owed her a duty a care. In any case, the 2nd defendant at paragraph 7 of the amended defence *admitted* that it owed the deceased a duty of care.

43. The key question then is whether the defendants breached that duty by failing to use reasonable care and skills to save the life of the deceased and the infant. Learned counsel for the plaintiff submitted that the conduct of the defendants was "infamous and disgraceful" in the medical profession.

44. The plaintiff was the sole witness for the claimant. He is lay in the delicate matters of medical negligence though ably represented by *Prof. Kiama*. It was critical to prove that the two defendants mismanaged the patient, prescribed wrong drugs or quantities, failed to have blood ready for transfusion or made a late referral. The hospital and its two witnesses demurred. It was thus an uphill task for the plaintiff who was absent on the material afternoon and night. The plaintiff could have called a medical professional to fortify his view that both defendants were negligent. Like I stated earlier, not every misadventure amounts to medical negligence.

45. The conclusion of the pathologist was that the deceased died *"as a consequence of uterine atony and (possible) dilutional coagulopathy"*. The plaintiff's case is largely founded on the failure by the hospital to maintain blood for transfusion and failing to transfuse it when the deceased bled continuously. The two witnesses for the defence denied the allegation.

46. I have said the plaintiff was relying on hearsay. However, he found support in the ruling dated 6th November 2013 by the Medical Practitioners and Dentists Board (exhibit 7). At paragraphs 15, 16 and 17 it concluded as follows:

> *[15] The committee finds that at the material time Dr. James Kirii requested group and cross match of blood to ensure its availability when needed. <u>He failed to follow it up so as to transfuse the patient, Charity Mugure Mutiria, when the need arose and</u>*

this contributed to the death of the said patient.

[16] The post mortem report by Dr. Okoth Obiero dated 25th July 2011 confirmed the cause of death as hypovolemic shock due to post partum haemorrage as a consequence of uterine atony and possible dilutional coagulopathy. This meant that at the material time the patient was bleeding continuously because the clotting factors had been consumed and depleted by the bleeding.

[17] The committee finds that Kiriaini Mission Hospital failed to put in place systems for ensuring prompt blood transfusion in emergency situations such as the case at hand. [underlining added]

47. Like I stated before, the admission of the above report was opposed; and, I allowed its introduction with a *caveat* that its value hinged on the ruling in *Nairobi High Court Petition 244 of 2013.* The proceedings of the Board were pursuant to a consent dated 15th July 2013 which required the complaint to *"be referred to the Board's Professional Conduct Committee within 100 days"*. That consent was *set aside* by Majanja J in the above petition on 19th December 2013.

48. In my view, it meant that the foundation of the proceedings and findings of the Board of 6th November 2013 became moot. Doubt is removed by the learned judge's holding at paragraph 24-

[24] the consent order particularly order No. 2 directing an inquiry into the affairs of the 2nd Interested Party [Kiriaini Hospital], to the extent that it was made in the absence of the interested parties [Dr. Kirii and Kiriaini Hospital], cannot stand. It must be set aside ex debito justitiae. [underlining added.]

49. Bereft of the findings of the Board and in the absence of expert medical evidence by the plaintiff, his sole testimony fails to prove some elements of medical negligence surrounding the *availability* of transfusion blood. DW1 and DW2 said that the blood was available; that a group and cross match of blood was done; and, that the 1st defendant called for it from the lab.

50. The plaintiff has thus not discharged his burden to demonstrate that blood reserves for transfusion were unavailable. But what is not disputed is that *no* blood was transfused during the birth or in the ambulance on the trip to Nyeri town. The defendant's nurse said that the patient was put on a substitute, *hestar plasma expander*, which the Board in the impugned report had taken issues with. In the absence of professional evidence, I am unable to say categorically whether the substitute was appropriate or not.

51. When DW2 was cross examined by *Prof. Kiama*, she conceded that giving the patient more than ¼ *cycotec* could rapture the uterus. From the *Cardex*, her colleague had administered ½ *cycotec* at 2:40 p.m. The point to be made is that in the absence of expert evidence on the matter, I cannot say for certain that it is the drug that led to uterine atony.

52. DW1 said the that the hospital has a *"comprehensive obstetric emergency care facility with fully equipped laboratory and transfusion services [and] that all protocols were followed in this particular case"*. But she admitted that the 1st defendant was a medical officer and not an obstetrician/gynaecologist. The hospital did not also have a pediatrician and that role was being performed by the medical officer.

53. It is thus clear that the hospital was ill equipped to deal with the nature of the emergency and the foetus had little or no chance of survival. The baby did not cry at birth. He was resuscitated but died a few hours later. From the death certificate (exhibit 2) the infant died from *"asphyxia due to birth asphyxia"*. However, the plaintiff failed to prove that the nursery had poor conditions. I say so because the Maternity Unit file (Defence exhibit 1) shows that at 12:45 a.m., the mother delivered *"a live female infant scored 4/1, 5/5, 5/10. Resuscitated for about 45 min. Infant left with O2 and in incubator"*.

54. The plaintiff did not also lead cogent evidence to demonstrate that the staff at the hospital including the nurses and the doctor were "incompetent". Like I stated earlier, when the foetus suffered distress, the doctor asked for group and cross match of blood and asked the patient to be prepared for an emergency caesarian section. He reviewed the patient next after 12:45 a.m. But every minute counted, and I blame him for the delays.

55. Regarding the claim of late referral, the *Cardex* shows that the deceased gave birth at 12:45 and was bleeding heavily. At around 1:50 a.m., and when the condition of the mother *"rapidly deteriorated post-partum"*, the Medical Officer summoned an ambulance to transfer the patient to Nyeri PGH Hospital. From the timelines and the contested evidence, I am unable to state conclusively that the referral took an unreasonable time.

56. In the end analysis, the evidence supports the plaintiff's assertions that the hospital was ill-equipped to handle the rapidly deteriorating post-partum condition of the patient and that Dr. Kirii dragged his feet in a matter of life and death. But I remain alive to the fact that the patient was under the watch of a nurse throughout.

57. I stated earlier that not every misadventure amounts to medical negligence and not every death of a patient is a consequence of negligence. ***Pope John Paul's Hospital & Another v. Baby Kasosi*** [1974] EA 221. In the instant case, telling signs of distress were first noted at about 11:30 p.m. when the patient's meconium turned into stained liquor grade. The doctor asked for group and cross match of blood and asked the patient to be prepared for an emergency caesarian section.

58. It is uncontroverted that no blood was transfused during the birth or in the ambulance on the way to Nyeri. The defendant's nurse said that the patient was put on a substitute of hestar plasma expander. However, Dr. Kirii who was residing at the hospital did not review the patient until 12:45 a.m. and a referral made at 2:00 a.m. The patient was put into an ambulance to Nyeri but died before admission into Nyeri PGH Hospital. The ambulance turned around with the body to Kiriaini. I thus readily find that the defendants failed to use diligence, care, skills and caution in handling the patient.

59. I am alive to the fact that an earlier decision of the board dated 16th December 2011 (defence exhibit 8) had absolved the hospital and Dr. Kirii of negligence. But it is also true that the matter was referred to the full tribunal of the Board that led to the decision of 6th November 2013 and whose foundation was impeached by the ruling of *Majanja J* on 19th December 2013. I am not thus persuaded by the submission of the 2nd defendant that the first report of the Board should be accepted as the *"authentic and uncontroverted position on the issue of liability"*.

60. My answer to issue number (i) framed above is thus in the *affirmative*.

61. I will now briefly turn to the issue of legal capacity of the 2nd defendant. In paragraph 2 of the amended plaint, the plaintiff pleaded that the hospital *"is a limited liability company duly registered under the companies Act and having its registered office at Nairobi within the Republic of Kenya and carrying on the business of Medical Health Care service facility…."*.

62. That allegation was specifically denied in paragraph 3 of the amended defence. There was thus a joinder of issues under Rule 10 of the ***Civil Procedure Rules***. It thus behooved the plaintiff to lead evidence on the legal capacity of the 2nd defendant. He did not do so. On the other hand, none of the 2nd defendant's witnesses led evidence on the matter. Instead, its learned counsel submitted that the 2nd defendant is a medical facility *"owned by the Catholic Diocese of Murang'a Registered Trustees, a body corporate registered under the Trustees (Perpetual Succession) Act"*.

63. The submissions by parties are *not* pleadings or evidence. But the amended plaint refers to the 2nd defendant only as *Kiriaini Mission Hospital*. In view of the joinder of issues and failure by the plaintiff to prove its legal capacity, I find that *Kiriaini Mission Hospital* is not a legal entity capable of being sued in its name. That answers issue number (ii) above in the negative.

64. I will next deal with damages. This claim is brought under both the **Law Reform Act** and the **Fatal Accidents Act**. I accept the wisdom of Waki, Kiage and Mohammed JJA in ***Koigi Wamwere v Attorney General,*** Nairobi, Court of Appeal, Civil Appeal 86 of 2013 [2015] eKLR that an *award of damages is not an exact science; and, no monetary sum can really erase the scarring of the soul.*

65. The deceased did *not* die immediately. I make an award Kshs 200,000 for *pain and suffering*. I am of the opinion that a sum of Kshs 500,000 is suitable for *loss of expectation of life*. See ***LWW (suing as the administrator of the estate of the estate of BMN) v Dr. Charles Githinji***, Nairobi HCCC 34 of 2012 [2019] eKLR.

66. With regard to the infant GNM *[particulars withheld]*, she died of *"asphyxia due to birth asphyxia"*. She did not cry at birth. From the Maternity Unit file (Defence exhibit 1), at 12:45 a.m., the mother delivered *"a live female infant scored 4/1, 5/5, 5/10. Resuscitated for about 45 min. Infant left with O2 and in incubator"*. The foetus had fully matured. The new born suffered distress and died at 10:55 a.m. as per the *Cardex* (exhibit 4). I would have awarded her Kshs 20,000 for pain and suffering. No evidence was laid for any further award of damages for the infant. However, the plaintiff did not obtain or produce at the trial any grant for the estate of the infant *GNM* and the claim in that respect fails.

67. I am however satisfied that the plaintiff obtained a limited grant of letters of administration in respect of his deceased wife in the High Court at Nairobi in *Probate & Administration Cause 1842 of 2011* on 19th October 2011 (Plaintiff's exhibit 3).

68. In assessing damages under the **Fatal Accidents Act**, the court must be guided by the age of the deceased, life expected, vicissitudes of life and the acceleration of the lump sum payment. See ***Kemfro v Lubia*** [1982-88] KAR 727. Learned counsel for the plaintiff, *Prof. Kiama*, submitted for an award for loss of dependency of Kshs 9,240,000 based on a salary of Kshs 35,000 and life expectancy of 60 years. He also sought other unspecified general damages of Kshs 4,000,000. The 2nd defendants retort was that there was no proof of earnings or dependency. Without prejudice, its learned counsel submitted that the multiplicand should be pegged on the minimum wage of Kshs 5,000 with a multiplier of 7 years only.

69. It is common ground that the deceased was 38 years. Damages for lost years fall in the realm of *special damages*. It is trite that special damages *must* be *specifically* pleaded; and, *strictly* proved. See ***Kampala City Council v Nakaye*** [1972] E.A 446. The degree of *certainty* and *particularity* of proof depends on the circumstances and nature of the acts themselves. See ***Hahn v Singh*** [1985] KLR 716.

70. The plaintiff did not *specifically* plead for these damages. Paragraph 15 of the amended plaint simply stated: <u>*Special damages (a) to be ascertained*</u>. Paragraphs 11 and 12 of the amended plaint just listed the dependents and the age of the deceased. There were *no* particulars of her employment or earnings. A belated attempt to amend the plaint orally long after the cross-examination and in the middle of re-examination of the plaintiff was denied for reasons on the record. The pay slip (exhibit 4) referred to by the plaintiff cannot be relied upon. In the end no sufficient evidence of dependency was led and the claim for damages under that head fails.

71. The plaintiff also prayed for aggravated damages. The plaintiff did not demonstrate that the defendants acted with malice. I am unable to say that the defendants callously or purposely left the deceased to die. As I discussed earlier, mistakes occurred which were the basis of my findings on negligence. But I am not persuaded to grant aggravated or punitive damages. See generally, ***Obongo & another v Municipal Council of Kisumu*** [1971] E.A. 91; ***Bank of Baroda (Kenya Limited) v Timwood Products Limited*** [2008] KLR 236 at 250.

72. In the end, I award the plaintiff a total of Kshs 700,000 under the heads of pain and suffering; and, loss of expectation of life. The claim for dependency, special and aggravated damages is dismissed. I award interest on the sums from the date of this decree until full payment. However, the sums shall be paid by the 1st defendant only. I held earlier that the legal capacity of the 2nd defendant, who was sued as *Kiriaini Mission Hospital*, remained in doubt and was never established by the plaintiff. In paragraphs 4, 5 and 6 of this judgment, I explained that the 1st defendant was left with no formal statement of defence when the pleadings were amended and he appointed a new lawyer. He did not defend the proceedings either. Furthermore, DW1's evidence, which remained uncontroverted, was that the 1st defendant

was not an employee of the 2nd defendant but seconded to the facility.

73. For the avoidance of doubt, and as detailed in paragraphs 61, 62 and 63 of this judgment, the suit against the 2nd defendant is incompetent for want of capacity. The suit against it is dismissed but with no order on costs. That answers issue number (iii) as framed earlier.

74. The last issue relates to costs. Costs generally follow the event and are at the discretion of the court. I grant the plaintiff costs and interest thereon to be paid by the 1st defendant.

It is so ordered.

DATED, SIGNED and **DELIVERED** at **MURANG'A** this 13th day of April 2021.

KANYI KIMONDO

JUDGE

Judgment read in open Court in the presence of-

Prof. Wangai for the plaintiff instructed by Prof. Kiama Wangai & Company Advocates.

No appearance for the 1st defendant.

No appearance by counsel for the 2nd defendant instructed by Wanyonyi & Muhia Advocates.

Ms. Dorcas Waichuuhi & Ms. Susan Waiganjo, Court Assistants.