



REPUBLIC OF KENYA

IN THE HIGH COURT OF KENYA

AT NAIROBI

CIVIL DIVISION

HIGH COURT CIVIL APPEAL NO. 686 OF 2019

DR. FRANK KIBET ENDERE.....APPELLANT

VERSUS

JOHN KENYATTA ONCHIRI (legal and personal Representative of estate of

PAULINE KASESYA MWINZI).....RESPONDENT

AND THE CROSS-APPEAL

BETWEEN

JOHN KENYATTA ONCHIRI (legal and personal Representative of estate of

PAULINE KASESYA MWINZI).....APPELLANT

DR. FRANK KIBET ENDERE.....1ST RESPONDENT

ST MARY'S MISSION HOSPITAL LANGATA.....2ND RESPONDENT

KENYA MEDICAL PRACTITIONERS AND DENTISTS COUNCIL....3RD RESPONDENT

JUDGMENT

- 1.The Appeal herein and the Cross-Appeal are from the ruling on an inquiry by the Disciplinary and Ethics Committee of the Medical Practitioners and Dentists Council (Prof. Alice Mutungi, Chairperson) dated 30th October, 2019 in PIC Case No.31 of 2014.)
2. John Kenyatta Onchiri (hereinafter the complainant) lodged a complaint before the Medical Practitioners and Dentists Board (Now known as Council) pursuant to Section 3 of the Medical Practitioners and Dentists (Amendment) Act 2019. The complaint was on behalf of the late Pauline Kasesya Mwinzi who was stated to have died as a result of medical negligence.
3. The Council served Dr. Frank Kibet Endere (Appellant) and St Mary's Mission Hospital, Langata with the copies of the complaint and the supporting documents and requested for their responses. The responses were filed and forwarded to the complainant for his response. A report was also requested from Kenyatta National Hospital.
4. The matter was referred by the Council to its Preliminary Inquiry Committee (PIC) which considered the complaint and the documents before it and did not call for *viva voce* evidence. The PIC found the doctor culpable. The doctor was dissatisfied with the decision and applied for Judicial Review on the basis of lack of an oral hearing. The suit was compromised by the parties and the decision of PIC quashed and a fresh inquiry conducted under the Councils Disciplinary & Ethics Committee case No. 31 of 2014.
5. The Committee in it's ruling found the Appellant delayed in referring the patient to a facility which was appropriately equipped to manage the patient's condition. The Committee found the complaint against the Hospital not proved. The Committee then proceeded to make the following orders:

“(i) The 1st Respondent, Dr. Frank Kibet Endere be admonished for failing timely to refer the patient to a facility appropriately equipped to manage the complications.

(ii) The 1st Respondent, Dr. Frank Kibet Endere practicing license be suspended for a period of six months from the date hereof.

(iii) The 1st Respondent, Dr. Frank Kibet Endere shall for a period of six (6) months be place on probation at the Kenyatta National Hospital, Department of Obstetrics and Gynaecology, under the direct supervision of the head of the said department.

(iv) The Head of the Department of Obstetrics and Gynaecology shall submit a progress report to the Kenya Medical practitioners and Dentists Council every two months and a final report at the end of the problem.

(v) The 1st Respondent, Dr. Frank Kibet Endere do pay a fine of Ksh.250,000/= to the Kenya Medical Practitioners and Dentists Council within fourteen (14) from the date hereof.

(vi) The 1st Respondent, Dr. Frank Kibet Endere mediate with the Estate of the Late Pauline Kasesya Mwinzi, with a view of compensation and thereafter submit a report to the Chair of the Kenya Medical practitioners and Dentists Council within sixty (60) days from the date hereof.

(vii) The Complaint against the 2nd Respondent is hereby dismissed.”

6. The Appellant was dissatisfied with the said ruling and appealed on the following grounds:

“1. That the Committee erred in law by proceeding with the hearing and then delivered a ruling on a mere complaint without (a) formal charge (s) being formulated contrary to the express provisions of the governing law.

2. That the Committee erred in law by proceeding with the hearing without (a) formal charge (s) being served upon the appellant to enable him prepare his defence thereto contrary to the governing law as well as the principles of natural justice.

3. That the Committee erred in law by relying upon documents and reports that had never been supplied to the appellant.

4. That the Committee erred in law by convicting the appellant of acts that had not been classified as offences under the governing law.

5. That the Committee erred in law by delivering a legally incompetent ruling.”

7. It was prayed that the Appeal herein be allowed and the ruling appealed from be set aside and replaced with an order declaring the proceedings before the Committee null and void and discharging the Appellant forthwith.

8. The Complainant filed a Cross-Appeal against the Dr. Frank Endere as the 1st Respondent and St Mary’s Mission Hospital Langa’ta as the 2nd Respondent on the following grounds:

“1. That the Disciplinary and Ethics Committee of the Kenya Medical Practitioners and Dentists council (the Committee) erred in law and fact by failing to take into consideration the gravity of the matter and the evidence on record and thereafter proceeded to give the 1st respondent a lenient sentence in the circumstances despite finding that the complaint against the 1st Respondent alleging professional negligence.

2. That the Committee erred in law and fact by failing to find the 2nd Respondent liable despite having overwhelming evidence on record showing that the chronology of events leading to the death of the deceased started at the 2nd Respondent premises.

3. That the Committee erred in law and fact by failing to find that the 2nd Respondent was vicariously liable for the acts of the 1st Respondent.”

9. The Cross- Appellant sought the following orders:

1. The main appeal herein be dismissed with costs.

2. The cross-appeal herein be allowed by substituting the findings/orders complained of in the decision of the Disciplinary and Ethics Committee of the Kenya Medical Practitioners and Dentists Council (Prof. Alice Mutungi, Chairperson) dated October, 30, 2019 in PIC Case No.31 of 2014 with the following orders:

(a) The Interested Party be ordered to permanently remove the name of the 1st Respondent name from the register of

medical and dental practitioners.

(b) In the event that prayer 1(a) above is not granted, the Interested Party be ordered to suspend, withdraw or cancel the practicing license of the 1st Respondent for a period equal to 12 months.

(c) The Appellant John Kenyatta Onchiri (Legal and Personal Representative of the Estate of Pauline Kasesya Mwinzi) be awarded the costs in the proceedings before the Council and the same to be paid by the Respondents.

(d) A declaration that the 2nd Respondent is vicariously liable for the acts/professional negligence of the 1st Respondent.

(e) A declaration that the 2nd Respondent is liable for the death of the deceased, Ms Pauline Kasesya Mwinzi.

(f) The Interested party be ordered to suspend, withdraw or cancel the license of the 2nd Respondent for a period equal to 12 months.

(g) The 2nd Respondent be admonished for both its negligence and that of the 1st Respondent.

3. The costs of the cross-appeal be awarded to the Appellant, John Kenyatta Onchiri (Legal and personal representative of the Estate of Pauline Kasesya Mwinzi).

10. The Appeal and the Cross-Appeal were canvassed together by way of written submissions by the Appellant and Cross-Appellant. The Interested Party, the Kenya Medical Practitioners and Dentists Council did not participate in the proceedings herein.

11. This being a first appeal, this court is duty bound to re-evaluate the facts afresh and come to its own independent findings and conclusions. See for example the case of **Selle v Associated motor Boat Co. & others [1968] E.A. 123** where it was stated as follows:

“An appeal to this Court from a trial by the High Court is by way of retrial and the principles upon which this Court acts in such an appeal are well settled. Briefly put they are that this Court must reconsider the evidence, evaluate it itself and draw its own conclusions though it should always bear in mind that it has neither seen nor heard the witnesses and should make due allowance in this respect. In particular this court is not bound necessarily to follow the trial judge’s findings of fact if it appears either that he has clearly failed on some point to take account of particular circumstances or probabilities materially to estimate the evidence or if the impression based on the demeanor of a witness is inconsistent with the evidence in the case generally (Abdul Hameed Saif v Ali Mohamed Sholan (1955), 22 E.A.C.A. 270)”.

12. The complainant’s complaint was among the documents Dr. Endere and the Hospital were served with prior to the hearing before the Committee. The brief nature of the complaint was stated as **“Deceased due to negligence from the hospital and doctor thereby causing massive intra abdominal haemorage due to high vsad fesia vascular injury (procedure related –caeserian Section and left behind the twin girls at birth and one daughter (5) years old. “**

13. The documents attached were:

- (i) Post Mortem form dated 22nd May, 2014.
- (ii) Patient hospitalization account summary (St Mary’s)
- (iii) Permit for burial plus a receipt
- (iv) Interim invoice from Kenyatta National Hospital and patient release form.
- (v) Hospitalization discharge summary
- (vi) Hospital payment receipts from (St Mary’s Mission Hospital – Children Notification Form of Birth.

14. The Appellant and the Hospital filed a response vide letter dated 9th October, 2014. The following documents were enclosed:

“A comprehensive report (item no a) on the management of patient Pauling Kasyesya Mwinzi that also serves as statement (part of item no c) of Dr. Frank K. Endere.

A certified copy of the patient file (item no b) Statement from the medical personnel who managed the patient (item no c) that is, Dr. Frank K Endere, Michael L. Chimika, Lucy Kimondo, Eric Mutuma, Julita Seenoi Teeka, Standley M. Marete, Fredrick Willis Migunde Aruwa and George N. Njenga. We sincerely apologize for not being able to supply any other information due to the short notice (item c) and lack of documents on the care given while at Kenyatta National Hospital, Nairobi where we referred the patient for further case.”

15. The complainant John Kenyatta Onchiri gave evidence that when he arrived at the Hospital at about 8.00 a.m. on 20th May, 2014 he was

taken to the theater where Dr. Endere the Appellant informed him of the complications the patient had developed after the delivery of twin babies. He testified that the complications included heavy bleeding and swelling leading to four operations being carried out, blood transfusion and transfer of the patient to Kenyatta National Hospital where the patient passed away the same day.

16. Dr. I.S.O Maraga the Acting Head of Department Obstetrics and Gynaecology at Kenyatta National Hospital produced the patient's medical report from Kenyatta National Hospital. His evidence was that the patient was registered at Kenyatta National Hospital at 2.44.47 p.m. and received in the ward at 3.00 p.m. He gave a history of the patient as indicated in the referral notes. It was his testimony that the referral note from St. Mary's Hospital was not as detailed may be due to the acute nature of the patient. He stated that there is chronology which was indicated in the referral note that stated the patient had been admitted at St Mary's Hospital for elective caesarean section due to two previous scars and twin gestation. That the first twin was breach and the second twin cephalic presentation. That the patient was taken to theatre for laparotomy three hours after the caesarean section. That at 5 a.m. the patient was noted to be in shock and was resuscitated and taken back to theatre, was re-opened and subtotal hysterectomy done. That at around 9 a.m. on the same date, that is about 4 hours after the previous laparotomy, the abdomen was found to be distended and at paracentesis it was positive so they re-opened the abdomen again. That at the time the urine was about 100 ml and they found small bleeders which they ligated and put surgical and a large drain left in place. He stated that the patient had four operations with the last being done at 9 a.m.

17. That by the time the patient arrived at Kenyatta National Hospital the pressures were low with labored breathing. That there was no urine in the urine bag, an impression of hypovolemic shock, acute kidney injury and possible disseminated intravascular coagulopathy (DIC). That the patient was started on treatment which entailed normal saline, oxygen by nasal prongs, fresh frozen plasma (on packed red cells), tranexamic acid. That the renal team reviewed the patient and they requested for various tests including preparation for dialysis. That at 5 p.m. the patient was reviewed by the ICU team and they advised to have the patient transferred to ICU once a bed was available. It was his evidence that the hospital did the best they could under the circumstances.

18. Dr. Bernard Midia (Dr. Midia) a pathologist at Kenyatta National Hospital in his evidence stated that he performed the post-mortem on the body of the deceased. His findings were that the cause of death was massive intra-abdominal haemorage due to right ileac fosa vascular injury which was procedure related.

19. Dr. Frank Endere (Dr. Endere) the Appellate testified that he was the Obstetrician Gynaecologist who attended to the deceased at St. Mary's Hospital. He relied on his report and documents as per his response to the complaint. He stated that the patient was operated on at night and that he proceeded with the other surgeries to stem the bleeding and carried out blood transfusion followed by the referral to Kenyatta National Hospital due to DIC. That the patient was handed over to the ambulance at 11,00 a.m. and released to go to Kenyatta National Hospital for management by senior colleagues. During cross-examination he pointed out the patient's pre-conditions which could lead to poor outcome as low blood levels, the previous surgeries and going into labour during the night while the elective surgery had been planned for the morning. That during the surgery the patient was noted to have abruption placenta. He explained that the first operation was for delivery, that he was capable of proceeding with the second operation and the third was sub-total hysterectomy and the fourth followed consultation.

20. On cross examination by the Committee it was his testimony that "the best approach for management of coagulopathy was blood and blood products. He clarified that during the second surgery there was an element of uterine atony. He stated that the oozing was noted in the 3rd surgery. It was his evidence that the actual oozing was in the 3rd surgery where they did sub-total hysterectomy. He stated that the referral to Kenyatta National Hospital was for dialysis and secondly they did not have the requisite blood products. It was the evidence of Dr. Endere that in a similar situation he would ensure that there is a team ready together with adequate blood products and medicine and also have an ambulance at the Hospital for ease of transfer. He stated that where the facility does not have needed equipment, he would refer the patient. He re-stated that Dr. Okemwa called him and informed him that the postmortem had started. From his indication it was as if he arrived after the postmortem had started. He stated that he did not discuss the postmortem results with Dr. Okemwa. He confirmed Dr. Okemwa was representing the Hospital at the postmortem. He also clarified that the accompanying person was a member of staff from the Hospital. He stated that ordinarily the person accompanying would be a nurse or a clinical officer. He confirmed that there was no documentation of the transfer and handing over of the patient at Kenyatta National Hospital.

Dr. Endere disputed that there was any vascular injury. He confirmed that there was bleeding and that was why they transfused the blood. He also confirmed that there were sources of bleeding necessitating the laparotomy and also the sub-total hysterectomy and other interventions. He confirmed that he would refer the patient after the second surgery. On re-examination he stated that it was during the 4th surgery that he noted he was dealing with a case of DIC. It was his evidence that the events were happening very fast and he tried to manage the bleeding. It was his testimony that he did not refer the patient after the second surgery because the patient was markedly stable. He stated that the practice at the Hospital was that any patient being referred would be accompanied by the staff and a report handed over. He stated that it would not be possible to get a copy of the hand over report due to change in management. He opined that if the patient had a vascular injury she would not have made it out of St. Mary's Hospital. It was his further opinion that with all the staff at Kenyatta National Hospital attending to the patient she would have had a decent chance of survival "

21. The findings of the Committee were as follows:

(i) From the outset, Pauline is categorized as a high risk obstetric patient as evidenced by two previous caesarean section scars, twin gestation and placenta abruption.

(ii) The decision to carry out the caesarean section was appropriate the decision carry out the second surgery was appropriate under the circumstances.

(iii) Dr. Endere having noted the feature of disseminated intravascular coagulopathy and being aware that the hospital did not have the requisite facilities to manage the patient in that condition, failed to execute a timely referral of the patient to an institution with the facilities.

(iv) It is noted that the mainstay of management of DIC is transfusion of specific blood products including fresh frozen plasma, packed red blood cells and platelets. The 1st Respondent confirmed during cross-examination by the Committee, that St. Mary's Mission Hospital had a blood bank that was able to avail whole blood but did not have the capacity to prepare these blood products.

(v) Dr. Frank Endere is culpable of mismanaging the patient Pauline Kasesya Mwinzi.

(vi) The complaint against the 2nd Respondent has no merit.

22. The Recommendations of the Committee were that:

(i) Dr. Frank Endere is admonished for failing to refer the patient in a timely manner as her condition was deteriorating in view of the fact that

(ii) Dr. Frank Kibet Endere practice license be suspended for a period of 6 months from the date of the ruling.

(iii) Dr. Frank Kibet Endere shall for a period of six (6) months do rotations in the Department of Obstetrics and Gynaecology at the Kenyatta National Hospital under the direct supervision of the Head of the said Department. Thereafter the supervisor shall submit a report at the completion of rotation.

(iv) Dr. Frank Endere do pay the Kenya Medical Practitioners and Dentists Council the sum of Ksh.150,000/= as part cost of the Committee sitting within 30 days from the date of the ruling.

(v) Dr. Frank Endere does mediate with the Estate of Pauline Kasesya Mwinzi with the view to compensate and there after confirm compliance with the Chair of the Council within sixty (60) days from the date of the ruling.

(vi) The complaint against the 2nd Respondent be dismissed.

23. Mr. Okeke Counsel for the Appellant (Dr. Endere) argued grounds 1 and 2 of the Appeal together. That is whether the Committee erred for want of formal charge(s) against the Appellant. It was submitted that no charges were formulated against the Appellant as required by rule 5 of the Medical Practitioners and Dentists Act (Disciplinary Proceedings Procedures Rules) which states:

“5. Submission of complaint or information

(1) Whenever a complaint or information is received by the Chairman from a body or person and it appears to him that-

(a) a medical practitioner or dentist has been convicted of an offence under this Act or under the penal Code; or

(b) that a question arises whether the conduct of a medical practitioner or dentist constitutes serious professional misconduct

(2) When the preliminary Inquiry Committee refers the complaint to the board under rule 4 (2) (b), the Chairman shall send to the medical practitioner or dentist to whom the complaint relates a notice of inquiry which shall-

(a) be in Form 1 in the Schedule and shall, unless the Board otherwise directs, require the party to whom it is addressed to furnish the Chairman and every other party a notice of all the documents which he intends to rely on at the hearing.

(b) set out, in general terms, the charge or charges of professional misconduct made against the medical practitioner or dentist and

(c) specify the date and time of and the place at which the inquiry is proposed to be held.

(3) The notice of inquiry be sent to the medical practitioner or dentist by registered post addressed to his last known address as notified to the Registrar or by any other means approved by the Board.

(4) In any case where there is a complainant, a copy of the notice of inquiry shall be sent to him.”

24. It was further submitted that in the premises there was nothing for the Council to inquire into and that therefore the proceedings were null and void *ab initio*. It was further submitted the Cross-Appeal was filed out of time.

25. On the other hand, the complainant's counsel, Mr. Omoke submitted that both the Appellant and the Hospital were informed of the complaint lodged against them through a letter dated 15th September, 2014 which required them to respond to the complaint and forward to the Council the patient's file, statements of medical personnel who handled the patient and any other relevant documents. That the Appellant and the Hospital were aware of the complaint and responded accordingly and were thereafter given a fair hearing. That the Appellant alleged lack of service of the complaint and documents prior to the hearing and was supplied again with the same and appeared at the hearing with his advocates and the same documents were served on the Advocates.

26. It was further submitted that the Appeal was time barred as it was not filed within the period of 30 days stipulated under Section 20(9) of the Medical Practitioners and Dentists Act.

27. The ruling of the Committee was delivered on 30th October, 2019. The Appeal herein was filed on 26th November, 2019. The Appeal was filed within the timeframe of 30 days provided by the law. The filing of a Cross-Appeal is provided for under Order 42 rule 32 Civil Procedure Rule which gives this court the power to hear a Cross-Appeal. The Cross-Appeal was filed on 2nd December, 2019 which is within six days of the filing of the Appeal. Consequently, I hold that the Cross-Appeal was filed within time.

28. Going back to the genesis of the case herein, this court finds that the complaint started with the filing of the application form for lodging of a complaint which gives amongst others, the details of the Applicant, the details of the complainant, the details of the practitioner in respect of which complaint is lodged, the details of the institution, brief nature of the complaint and a list of the documents attached.

29. The issue of the formal charges was raised at a preliminary stage before the proceedings of the Committee. The Committee held as follows:

(i) The Council informed Dr. Endere and the Hospital on 15th September, 2014 about the complaint.

(ii) The 1st Respondent wrote to the Council on 13th October, 2014 with a substantive response to the complaint.

(iii) Following the decision of the preliminary Inquiry Committee dated 11th March, 2016 the 1st Respondent went to Court seeking to quash the said decision and a consent was entered into on the following terms:

(a) That the Board (Council) will undertake a fresh inquiry. The Council has opted to have a fresh inquiry.

(iv) On 10th July, 2019 the Council wrote to the parties herein notably the first Respondent and his advocate on record.

(v) On 19th July, 2019 the 1st Respondent appeared in person and sought for a further mention to allow his advocate to appear on his behalf. On 24th July, 2019 appeared with an advocate by the name Mr. Korir acting on his behalf and he indicated verbally that he would be ready to proceed today.

(vi) The 1st Respondent and his counsel can therefore not state that they are not aware of the complaint they are answering to today.

(vii) This Committee therefore rules that the inquiry proceeds as scheduled.

30. I have gone through the proceedings herein and I am satisfied that all the steps aforesaid were undertaken by the Committee. Indeed, the court's finding is that the Appellant was aware of the charges that he faced to enable him prepare for his defence.

31. It was submitted by the Appellant's Counsel that the Appellant was not supplied with the medical report prepared by Kenyatta National Hospital yet the Council relied on the said report. The complainant's side took the position that the Appellant was served with the complaint and all the documents.

32. It is noteworthy that the Committee found that there was undue delay in referring the patient to a facility that was appropriately equipped for the patient's condition. It was the Committee's view that the St Mary's Hospital did not have the capacity to prepare the blood products required to manage the patient. The Committee further held that the chronology of events leading to the death of the patient started at St. Mary's Hospital. I find no blame visited by the Committee on the Appellant in respect of the events that happened at Kenyatta National Hospital.

33. The Committee's aforesaid findings led to the orders made under Section 20(6) of the Medical Practitioners and Dentists Act and the Committee proceeded to make orders accordingly. The submission by the Appellant's Counsel that the Committee did not find the Appellant guilty of professional misconduct have no merits.

34. In the Cross-Appeal, the issue of the gravity of the matter herein *viz-a-viz* the sentence was raised. It was submitted that the sentence meted out to the Appellant was lenient. Taking into account the findings of the Committee, the sentence is reasonable and this court is not inclined to enhance with the same.

35. On whether St. Mary's Hospital is liable and also vicariously liable for the acts of the Appellant, it was submitted by the complainant's Counsel that the Appellant had handled the patient at the Hospital, that there was evidence of no proper record keeping, that there was failure to file a report of the accompanying nurse, not having an ambulance or have an easily accessible ambulance, failure to refer the patient though not being well equipped but left it to the family to call an ambulance and insisted on payment of Hospital bills before the patient could be referred.

36. It was submitted on behalf of the St Mary's Hospital that there was no proof of any acts of negligence against the said Hospital and that no witness from Kenyatta National Hospital testified on what transpired after the patient was transferred there. The court was urged to dismiss the Cross-Appeal against the St Mary's Hospital.

37. Turning to the evidence adduced before the Committee, the complainant who blamed both the doctor and the St Mary's Hospital for

negligence testified that the Clinical Officer at the said hospital at around 9.00 a.m. asked him to look for funds to transfer the patient to Kenyatta National Hospital and to also look for blood donors. That the Hospital Matron then at round 11.00 a.m. asked him to clear the Hospital bill so that they could refer. That the accounts office could not give the bill as the patient's file was still in the theater. Then at around noon after clearing the bill he was told that the hospital had no ambulance and he was given a number to call for an ambulance then paid Ksh.1,000/= for the nurse who was to accompany the patient and eventually started the journey to Kenyatta National Hospital at around 1.00 p.m. and arrived at Kenyatta National Hospital at around 2.00 p.m.

38. The chronology of events as narrated by the complainant is not controverted by any other credible evidence. The evidence of Dr. Endere was that the last surgery stopped at 10.30 a.m. and then he wrote the referral letter and the Hospital mobilized and called the ambulance and that the patient was handed over to the ambulance management by 11.00 a.m. and released to go to Kenyatta National Hospital. There is no evidence from any of the other officials from the Hospital to corroborate the time indications given by Dr. Endere or to shed light on how they called for the ambulance.

39. Based on the foregoing, it is impossible to entirely separate the actions of Dr. Endere and St. Mary's Hospital. The referral by the doctor was delayed but the Hospital's other members of staff were involved in further delay after the decision to refer the patient was made. Dr. Endere's evidence was that he was the Obstetrician Gynecologist who attended to the patient at St. Mary's Mission Hospital. The Hospital was therefore liable and also vicariously liable of negligence.

40. **On vicarious liability, the court in the case of Ricarda Njoki Wahome (suing as an administrator of the estate of the late Wahome Mutahi (deceased) v Attorney General & 2 others (2015) eKLR held thus:**

"A duty of care arises once a doctor or other health care professional agrees to diagnose or treat a patient. That professional assumes a duty of care towards that patient. On the other hand, a hospital is vicariously liable for the negligence of the member of staff including the nurse and the doctors. A medical man who is employed part-time at a hospital is a member of a staff, for whose negligence the hospital is liable..... (emphasis added)

See Charlesworth & Percing on negligence"

41. *The Court of Appeal in M (a Minor) v Amulega & Another [2001] KLR 420*, as cited by the Respondent in the main appeal observed as follows:

"Authorities who own a hospital are in law under the self-same duty as the humblest doctor. Whenever they accept a patient for treatment, they must use reasonable care and skill to cure him of his ailment. The hospital authorities cannot of course do it by themselves. They must do it by the staff whom they employ and if their staff are negligent in giving the treatment, they are just as liable for that negligence as is anyone else who employs others to do his duties for him ... It is established that those conducting a hospital are under a direct duty of care to those admitted as patients to the hospital. They are liable for the negligent acts of a member of the hospital staff, which constitutes a breach of that duty of care owed by him to the Plaintiff thus there has been acceptance from the courts that hospital authorities are in fact liable for breach of duty by its members of staff It is trite law that a medical practitioner owes a duty of care to his patients to take all due care, caution and diligence in the treatment."

42. With the foregoing, the upshot is that the Appeal fails save for adjusting of the fine of Ksh.250,000/= to Ksh.150,000/=. The Cross-Appeal succeeds to the extent that St Mary's Mission Hospital, Langata is held liable and also vicariously liable for the acts of Dr. Endere, the 1st Respondent in the Cross-Appeal.

43. The orders of the Committee remain save as follows:

(a) Order (v) is set aside and substituted with a similar order for the 1st Respondent, Dr. Frank Kibet Endere to pay a fine of Ksh.150,000/= to the Kenya Medical Practitioners and Dentists Council within 14 days from the date hereof.

(b) Order (vii) is set aside and substituted with an order that the 2nd Respondent, St Mary's Mission Hospital Langata, is liable and vicarious liable and is to pay a fine of Ksh.150,000/= to the Kenya Medical Practitioners and Dentists Council within 14 days from the date hereof.

(c) The 2nd Respondent, St Mary's Mission Hospital Langata to mediate with the Estate of the Late Pauline Kasesya Mwinzi, with a view of compensation and thereafter submit a report to the Chair of the Kenya Medical Practitioners and Dentists Council within (60) days from the date hereof.

(d) The 1st Respondent, Dr. Frank Kibet Endere and 2nd Respondent, St Mary's Mission Hospital, Langata to meet the complainant's (John Kenyatta Ochiri) costs of the Appeal, the Cross Appeal and the costs of the proceedings before the Committee.

DATED, SIGNED AND DELIVERED AT NAIROBI THIS 3RD DAY OF NOVEMBER, 2021

B. THURANIRA JADEN

JUDGE