REPUBLIC OF KENYA

IN THE HIGH COURT OF KENYA

AT NAIROBI

MILIMANI LAW COURTS

HIGH COURT CIVIL SUIT NO. 257 OF 2013

LOISE WAMBUI KARIUKI (suing on behalf of the estate of

ELIUD KIMARU MUTURI (deceased).....PLAINTIFF

VERSUS

NATHAN KAGASI KEIZA.....1ST DEFENDANT

RADIANT GROUP OF HOSPITAL LIMITED.....2ND DEFENDANT

JUDGMENT

The plaintiff herein moved this court vide a plaint dated the 24th day of June, 2013, in which, she has sued the defendants claiming special damages in the sum of Kshs 219,625, general damages for pain and suffering under both the Law Reform and Fatal Accidents Acts, costs of the suit plus interest.

She avers that on or about the 11th day of August 2011, Eliud Kimari Muturi (deceased) was admitted to the 2nd defendant's hospital at Pangani for an operation to remove tumor in his stomach. That he was discharged on the 18th August, 2011, but was later re-admitted on the 24th day of August, 2011, discharged on 27th August, 2011 then re-admitted on 31st August, 2011, but passed away on the 4th September, 2011 while in the 2nd defendant's hospital.

The plaintiff contends that the said death was solely caused by the professional negligence of the 1st defendant under whose personal care the deceased was. The particulars of negligence and those of special damages are set out in paragraph 8 of the plaint. She has prayed for judgment as set out in the plaint.

The defendant filed a statement of defence and a counter-claim, on the 8th August, 2013, denying the plaintiff's claim.

They aver that if any death occurred, but which is denied, the same was not caused by any professional negligence on the part of the 1st defendant as alleged or at all. The particulars of negligence are denied. Further and without prejudice, they contended that such death as the plaintiff may prove, was solely caused by natural causes. They denied the particulars of pain and suffering, loss of amenities and special damages set out in paragraph 8 (a) (c) of the plaint.

In the counter-claim, the 2nd defendant claims a sum of kshs. 140,717/= from the estate of Eliud Kimaru Muturi (deceased) on account of outstanding medical bills incurred by the deceased while under its care and treatment. The defendants have urged the court to dismiss the suit with costs and have prayed for judgment for the sum of Kshs. 140,717/= aforesaid and the costs of the counter claim.

The plaintiff filed a reply to the counter claim on the 30th August, 2013, in which she has denied averments contained in the defence and the counter-claim. she has urged the court to offset the amounts claimed by the defendants from the judgment sum to be awarded to the plaintiff, if any is found owing.

At the hearing, Jamlick Githaiga Muturi testified as PW1. He adopted his witness statement dated the 21st June, 2013, as his evidence in chief. In his evidence, he reiterated the contents of the plaint and told the court that his late brother was admitted at the 2nd defendant's hospital on 11th August, 2011, for an operation in his stomach which operation was carried out by the 1st defendant. He stated that after the operation, he started experiencing stomach upsets and would vomit very often after eating every meal and after taking any fluids which made

him very weak. He told the court that he was discharged on 18th August, 2011, but the vomiting continued and on 24th August, 2011, he was re-admitted in the same facility and was discharged on 27th August 2011 but later re-admitted on 31st August 2011, but died on 4th September, 2011, while still admitted at the 2nd defendant's hospital.

The wife to the deceased, Loise Wambui Kariuki, testified as PW2. She adopted her witness statement dated the 21st June, 2013 as her evidence in chief. She reiterated the evidence adduced by PW1 on how the deceased was taken to the 2nd defendant and the events leading to his death. She produced the plaintiffs list of documents filed on the 2nd July, 2013 as exhibits in the case.

Dr. Oduor Johansen, a pathologist, carried out post-mortem on the body of the deceased. His external findings were that there was a mid-line surgical scar, which was extending from the xypisternum to the umbilicus. There were also venepuncture marks on the radial area of the wrists.

On opening the body, the cardiovascular system was normal. On the respiratory system, there was a blackish fluid within the lumen of the trachea, down the bronchi into the lungs and the lungs were congested. The liver was fatty. On the stomach, his observation was that there was a stitched wound on the anterior wall of the greater curvature of the stomach, using catgut suture. There was also another site at the pylorus of the stomach that had been stitched and this led to reduction in the size of the pyloric orifice. He also noted that there were thrombi that were obstructing the deep vessels in the calf muscles on the left leg.

He further stated that there were features of congestion in the lungs and also thromboemboli within the lung substance. There were also features of chronic gastritis in the stomach. His conclusion was that the deceased died as a result of pulmonary thrombo-embolism.

On their part, the defendants called two witnesses. The 1st defendant who testified as DW1 adopted his witness statement dated 25th July 2013, as his evidence in chief.

It was his evidence that he treated the deceased in July 2011, when he went to consult him and was complaining of vomiting food and fresh blood. He carried out a surgery on the deceased on the 11th August, 2011, to remove a tumor on his lower part of the stomach which was touching on the pylorus. The surgery involved the removal of the part of his stomach to ensure that no remnant will remain and grow back.

He stated that he repaired the wound that had remained after removing the tumor and there was no obstruction of the pylorus. He was discharged after 3 days but he was re-admitted after six days and later was discharged on the 27th August, 2011, was re-admitted on 31st August but died on 4th September, 2011.

It was his further evidence that on the 3rd re-admission, he complained about pain on the left leg and upon review, he found that the deceased had a clot in the left lower leg which in medical terms, he referred to, as vein thrombosis. He prescribed two types of drugs namely Heparin and Wafarin with strict bed rest. He stated that the deceased did not have complications but he died on the 4th September, 2013, while still in hospital and on treatment. According to him, the lungs were congested because of the clot, a piece of which broke off from the main clot and went to the lung thus causing the death of the deceased.

Doctor Mucheru Wang'ombe gave evidence as DW2. She holds a Degree in Medicine and a Master's Degree in Psychiatry. She stated that she saw the deceased on the 1st September, 2011 after the surgery. At the time, the deceased complained of vomiting and that he was forced to take four glasses of water to induce vomiting and would also use a tooth brush to induce the same. That she talked to the deceased who told her that he was disappointed that, he had driven himself to hospital but by then he could not walk on his own.

It was her further evidence that on examining the deceased, he had a low mood and also hallucinations. She concluded that the patient had a mood disorder otherwise known as Bipolar. She also diagnosed him with factitious disorder which is a condition where a patient induces a condition to continue enjoying the sick role so that he/she can continue remaining in hospital. She prescribed an injection called fluanxol and an appetite stimulant called Trimetabol. According to her, the deceased had a psychiatrist problem which was caused by his deteriorating health, the fact that he had no phone and yet he wanted to communicate with his girl friend. The other cause was that he claimed he had closed his multi-million business following post violence clashes.

Parties filed written submissions in support of their respective positions which this court has considered together with the pleadings, the evidence on record and the authorities relied on.

In my considered view, the following are the issues for determination;

1. *Whether the defendants owed the deceased a duty of care in the course of his treatment.*

2. *Whether the defendants breached that duty of care*

3. *Whether the plaintiffs suffered any damage or loss as a result of the breach of that duty*

4. *Whether the plaintiffs are entitled to damages and if so the quantum of such damages.*

5. *Who should bear the costs of the suit?*

From the evidence on record, it is not denied that the deceased and the 1st defendant had a patient doctor relationship. It is also not denied

that the deceased was admitted at the Radiant Hospital at Pangani (the 2nd defendant) on different occasions between 11th July, 2011 and 4th September, 2011 when he passed on. The first defendant has admitted having carried out surgery on the deceased on the 11th July, 2011, at the 2nd defendant's facility where he had been booked to undergo a surgery to remove a tumor from his stomach. It therefore follows that a duty of care arose once the first defendant agreed to diagnose and treat the deceased. In the case of ***Ricarda Njoki Wahome*** (***suing as the administrator of the estate of the late Wahome Mutahi (deceased) Vs. Attorney General & 2 others (2015) eKLR*** the court had this to say about the duty of care;

> ***""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 members of staff including the nurses and doctors. A medical man who is employed part-time at a hospital is a member of staff, for whose negligence the hospital is liable..... see ***Charles worth & Percing*** on negligence)

The duty of care expected of a medical person was explained in the case of ***R, Vs. Bateman (1925) 94LJKB791*** as follows;

> *"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 the 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."*

Further in the case of ***Jimmy Paul Semenya vs. Aga Khan Hospital & 2 others (2006) eKLR*** the court held that;

> *There exists a duty of care between the patient and the doctor, hospital or health provider. Once this relationship has been established, the doctor is taken to;*
>
> *a. Possess the medical knowledge required of a reasonably competent medical practitioner engaged in the same specialty.*
>
> *b. Possess the skills required of a reasonable competent health care practitioner engaged in the same specialty.*
>
> *c. Exercise the care in the application of the knowledge and skill to be expected of a reasonably competent health care practitioner in the same specialty and;*
>
> *d. Use the medical judgment in the exercise of that care required of a reasonably competent practitioner in the same medical or health care specialty.*

On whether the defendants breached that duty of care, the plaintiff has to proof negligence on the part of the medical practitioner. In the case ***Blyth Vs. Birmingham Co. (1856) 11 exch 784*** negligence was defined as follows;

> *"An omission to do something which a reasonable man, guided upon those considerations which regulate the conduct of human affairs would do, or doing something which a prudent and reasonable man would not do. in strict legal analysis, negligence means more than needless or careless conduct, whether in omission or commission, it properly connotes the complex concept of duty, breach and damage thereby suffered by the person to whom the duty was owing. 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 the patient."*

In ***Bolan Vs. Friern Hospital Management committee (1957)2 AIIER 118, MC Nair J.*** summed up the law on medical negligence as follows;

> *"The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill. It is well established law that, it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art. In the case of a medical man, negligence means failure to act in accordance with the standards of a reasonably competent medical man at the time there may be one or more perfectly proper standards, and if he conforms with one of these proper standards then he is not negligent"*

With regard to this issue, the plaintiff's counsel submitted that the first defendant was negligent for failing to reopen the defendant's stomach particularly after the 2nd and 3rd readmission. They have argued that had he done so, the shrinkage of the pyloric orifice would have been detected and corrected in good time. They have further submitted that, had the defendants considered addressing the Deep Vein Thrombosis (DVT) ailment via an alternative method of treatment instead of oral medication, chances are that the deceased would have survived the DVT attack. They also blamed the 1st defendant for failing to remove the stitches after the operation.

On their part, the defendants contended that the stitches used by the 1st defendant were absorbable sutures which are never removed but get absorbed by the body. On failure to administer appropriate treatment following diagnosis of DVT, it was submitted that proper treatment was given and the first defendant also prescribed strict bed rest to minimize the chances of the clot breaking off and migrating to the sensitive organs such as the lungs, brain and the heart.

In his evidence PW1 stated that he was present when the postmortem was done and he saw the stitches when the body was opened and the pathologist said they ought to have been removed. In cross examination, it was his evidence that the stomach had features of chronic

gastritis. He also referred to the pathologist report and the conclusion made by the pathologist to the effect that the persistent vomiting could have been caused by narrowing of pylorus.

According to Dr. Johansen Oduor, (PW1), the body of the deceased was dehydrated and in the stomach at the great curve there was a stitch wound using catgut. It was also his evidence that between the stomach and the beginning of the intestines (Pylorus) there was a stitch which was leading to the reduction of the hole that led to the intestine. There were blood clots on the left leg and the stomach had features of gastritis. He formed the opinion that the cause of death was pulmonary thrombo-embolism.

He further stated that he found some clots in the deep muscles of the left leg and he concluded that, that was the source of the clots that went to the lungs and caused the death of the deceased. He also opined that the stitches that had formed in the stomach could have been the cause of the vomiting and that the cause of dehydration was as a result of stitches that were narrowing the hole between the stomach and the intestine as a consequence of which food and fluid could not pass. According to him, if a person is vomiting, the stitches ought to be removed.

On the other hand, Dr. Nathan Keiza stated that the tumor was on the lower part of the stomach touching on the pylorus and that after the operation, he repaired the defect using absorbable sutures. It was his further evidence that the surgery involved removal of the tumor and part of the stomach to ensure that no remnant will remain and grow back. He denied that there was obstruction of the pylorus.

In addressing this issue, it is important for the court to consider the following aspects of the treatment that was administered on the deceased.

1. *What was the nature of the sutures that were used?*

2. *What was the cause of vomiting*

3. *At what point was DVT discovered, what treatment was given and was it the correct and effective treatment.*

In his evidence, DW1 told the court that the stitches that were used were absorbable sutures and were expected to dissolve as the wound healed. This was corroborated by PW3, in his postmortem report who confirmed that the stitches that DW1 used are catgut sutures and the same dissolves when the wound heals and they are supposed to take 14 days. It is not therefore true as alleged by the plaintiff that the stitches that were used were supposed to be removed after the surgical operation.

On the cause of vomiting, in his report, PW3 noted that the body of the deceased looked dehydrated and was not pale or cyanosed. He was of the view that the vomiting and dehydration could have been caused by the stitches in the stomach that were narrowing the hole between the stomach and the intestine as a result of which fluids and food could not pass.

On his part, DW1 stated that there was no obstruction of the pylorus. He denied that the vomiting had anything to do with gastritis. According to him, the cause of dehydration observed during the post mortem was because it was done a few days after the death of the deceased and he was not able to drink water like a normal person.

According to DW1, the cause of vomiting was psychological and that the deceased used to induce the same. The defendants' witness who testified as DW2 corroborated this evidence. She produced a psychiatric review report that she prepared after she saw the deceased upon being requested to do so by DW1. In the said report, she noted that the deceased could induce vomiting using a toothbrush and that he had developed a mood disorder called Bipolar. After talking to the deceased and his wife, she formed the opinion that the vomiting was psychological and not medical as it was self induced, the problem being that his health was deteriorating and he had no phone to communicate with his girl friend. He also claimed he had a multi-million business with the armed forces which was doubtful as he had already closed down his business following the post violence clashes.

In his reaction to that assertion, counsel for the plaintiff suggested that the evidence of DW2 was an afterthought because her report was filed much later during the hearing of the case. The court has perused the report that was produced by DW2. It shows that it was prepared in the year 2011 when the deceased was still admitted at the 2nd defendant. Her evidence corroborates that of DW1. In his report, PW3 has noted that the doctor who was sent from the 2nd defendant reported to him that the deceased had developed a neuropsychiatric disorder which he was being treated for by DW2 as shown in her report. The court notes that the pathologist report was prepared hardly a month after the death of the deceased. The demand letter was done on 22nd March, 2013 which was long after the said report had been prepared. This therefore means that the issue of psychological disorder was not an afterthought.

In any event, DW2 in her evidence stated that she interviewed the wife of the deceased who confirmed that the deceased was going through stress. Though her counsel denied that she was interviewed, she was not recalled to deny the same under oath.

On PW3's opinion on the cause of vomiting, as stated in his report, the court notes that it was his suggestion and the word used is "**may**" meaning that his opinion was not conclusive. In any case, there is no evidence that the vomiting had anything to do with the death of the deceased.

The court is alive to the evidence of the pathologist (PW3) in which he stated that between the stomach and the intestines (pylorus) there is a stitch which was leading to the reduction of the hole that leads to the intestine. However, DW1 in his evidence stated that the surgery involved removal of the tumor and part of the stomach to ensure that no remnant will remain and grow back. It was his evidence that the loss of tissue could have caused narrowing of the pylorus but there was no obstruction of the same.

On the issue of DVT, the evidence available to the court from DW1 is that the deceased started complaining of pain on the left leg when he was admitted for the 3rd time. That was on the 31st August 2011. On review, he was found to have a clot in the said leg otherwise referred to

as deep thrombosis. DW1 prescribed some drugs to the deceased namely; Heparin and Wafarin.

In his report, PW3 stated that the lungs were congested that there was thrombo-embolism within the lungs. There was thrombi that was obstructing the deep vessels in the calf muscles on the left leg.

In his conclusion, the deceased died as a result of pulmonary thrombo-embolism. He described the same as a condition whereby there is migration of blood clots from a distant area into the lungs causing sudden death. According to him the clots originated in the vessels on the left calf muscles as seen during the post mortem.

In cross examination, DW1 stated that there are many causes of blood clots which include tumor and immobility. In this case, he did tell the court that the deceased was on medication for the clot and had put him on heparin and Wafarin. Both DW1 and PW3 were in agreement that the treatment for DVT takes time for results to be seen.

The plaintiff has alleged that the treatment that was administered on the deceased was not proper due to the fact that he was vomiting and not in a position to take it orally.

In his evidence, DW1 stated that one of those drugs he prescribed and in particular Heparin is injectable and works fast and it prevents more clots from forming. It was his further evidence that the clot may break even when a patient is under treatment. This evidence was not challenged. In his report, PW3 stated that he could not tell if the deceased had been given medication for the clot but he admitted that medication for clots requires a lot of monitoring.

In view of PW3's opinion on the cause of death and the evidence available, this court finds that the first defendant was not negligent in administering treatment to the deceased.

In the plaintiff's submissions, counsel sought to rely on the doctrine of Res Ipsa Loquitur and asked the court to invoke the same should it find that the plaintiff has failed to discharge the burden of proof. On this doctrine, I wish to say this;

1. *The doctrine is not pleaded in the plaint and was only invoked at the submissions stage.*

2. *Secondly, in my view, I don't think the doctrine would have aided the plaintiff's* case.

The cause of death as opined by PW3 who was the plaintiff's witness is clear. As rightly submitted by counsel for the plaintiff, there are many causes of DVT which include; being overweight, immobility, recent surgeries, hereditary conditions, cancer and injuries.

In his submissions, counsel has argued that it is possible that the surgical operation could have caused the DVT. He also suggested that the DVT could have been as a result of prolonged stay in hospital (immobility). In this regard, the court notes that these suggested causes of DVT were brought up at the submissions stage by counsel for the plaintiff. There is no medical evidence that was adduced to connect the suggested causes with the death of the deceased. This is notwithstanding the fact that PW3 is a doctor and he could have guided the court on the nextus (causal connection), if at all, between immobility or the surgery to the DVT that caused the death. It is trite law that a party cannot argue his/her cause by way of submissions. Actual evidence is needed. This is not there.

With regard to the 2nd defendant and whether it is vicariously liable for the negligence of the 1st defendant, this court agrees with the holding in the case of ***Ricarda Njoki Wahome Vs. Attorney General & 2 others*** which cited the case of ***M. (a minor) vs. Amulega & Another (2001) KLR 420*** where the court held;

> "*Authorities who own a hospital are in law under a 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 is negligent in giving 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 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"*

The court has considered the evidence on record, there is no negligence attributed to the 2nd defendant as an institution. Infact, paragraph 8 of the plaint sets out the cause of action against the 2nd defendant as that of vicarious liability. The court having made a finding that the 1st defendant was not negligent, it therefore follows that the 2nd defendant cannot be held liable as well.

Having made a finding that the defendants are not liable, this court is enjoined to assess the quantum of damages that it could have awarded the plaintiff had she succeeded in her claim.

In this regard, the court of appeal in the case of ***SJ vs. Francessco D. Nello & Another (2015) eKLR*** referring to several authorities on the issue of assessment of damages stated;

> "*The guiding principle in the assessment of damages has been the subject of numerous authorities. For the purposes of this case,* we refer to the ***Ossuman Mohammed & Another vs. Saluro Bundi Mohamud, CA 30/1997 (unreported)*** wherein the following passage, in the case of ***Kigaragari vs. Aya (1982 – 1988), KAR 768*** is employed***;***

> *"Damages must be within limits set out by decided cases and also within limits the Kenyan economy can afford. Large awards are inevitably passed on the members of the public, the vast majority of whom cannot afford the burden in the form of increased costs of insurance or increased fees. Over time, courts have held that damages should not be so inordinately low or so inordinately high as to be a wholly erroneous estimate of damage"*

On general damages, a claim was made under both Fatal Accident and Law Reform Acts. The plaintiff also claimed damages for pain and suffering and loss of amenities.

On pain and suffering and bearing in mind that the deceased was in pain for 20 days, kshs. 100,000/= would have been reasonable.

On loss of expectation of life, I find Kshs. 150,000/= to be reasonable in this case.

In awarding damages under the head of pain and suffering and that of loss of expectation of life, the ***court is guided by the case of Francis Nzivo Munguti vs. Agnes Nechesa Preston*** *(suing as an administrator of the estate of* ***Preston Juma (deceased)*** High Court of Kenya at Eldoret Civil case No. 155/2010 and that of ***Paul Kioko*** (*suing as the legal representative of the estate of* ***Mary Mwikali Kioko (deceased) vs. Samuel G. Karinga*** High Court of Kenya at Nairobi civil case No. 140/1999 where similar amounts were awarded.

On loss of dependency, this court notes and with a lot of concern that the plaintiff did not adduce any evidence to proof whether the deceased was in any gainful employment. Infact, there is no mention of what he was doing for a living. This court is greatly at a loss as to the multiplicand it can employ. On the other hand, minimum wages is applicable where there is evidence of gainful employment. It is very unfortunate that the plaintiff left out this very crucial evidence. The court has not even been told if the deceased let behind any dependants and/or their ages. This was not even pleaded in the plaint.

Consequently, this court could not have made any award under this head but as already stated the plaintiff failed to proof her case on a balance of probability.

With regard to the counter claim, the 2nd defendant has proven its case on a balance of probability. The cheques of Kshs. 140,717 issued to it were stopped by the brother to the deceased. This fact was not denied.

I do enter judgment for the 2nd defendant in the sum of kshs. 140,717 as pleaded and proven.

Due to the nature of this case, each party shall bear its own costs of the suit.

Dated, Signed and Delivered at NAIROBI this 13TH Day of FEBRUARY 2020.

……

L. NJUGUNA

JUDGE

In the Presence of

.....For the Plaintiff

.....For the Defendants