REPUBLIC OF KENYA

IN THE HIGH COURT OF KENYA

AT NAIROBI

CIVIL CASE NO. 360 OF 2009

JAMES ODUNDO.....PLAINTIFF

VERSUS

CHARLES OPONDO.....1ST DEFENDANT

GERTRUDES CHILDREN HOSPITAL.....2ND DEFENDANT

JUDGMENT

The plaintiff herein, JAMES ODUNDO, is the father to the late Master LRO (a minor). He filed the plaint dated the 2nd day of July 2009, as the next of kin and on behalf of the late L, against the defendants Dr. Charles Opondo and Gertrude's Children's Hospital in which, he has claimed General damages for negligence and recklessness under the Law Reform Act and Fatal Accidents Act, Special damages in the sum of Kshs.761,169.00cts, interest and costs of the suit.

It is pleaded that on or about the 29th day of August 2008, the late L developed a fever and was treated at the Hospital's clinic situated along Othaya Road but did not improve and on the 30th August, 2008, he was admitted at the 2nd Defendant's main hospital in Muthaiga after he started displaying symptoms of malaria after a family excursion.

The late L stayed in hospital as an in-patient from 30th August 2008 until the 6th September 2008 when he was transferred to Aga Khan Hospital after his condition worsened and he was admitted at the Intensive Care Unit where he succumbed to illness on the 7th September, 2008.

The plaintiff avers that the first defendant, as the late L's pediatrician owed him a duty of care expected of his professional skills and knowledge in providing appropriate medical care and attention towards his recovery. The plaintiff also avers that the aforesaid fatal condition suffered by the late L was as a result of the first defendant's failure to use due diligence, care, caution, professional knowledge and skill in providing medical care and treatment to the late L.

The plaintiff contended that the first Defendant was negligent in his treatment of the late L resulting in deterioration of his health and eventual death. The particulars of negligence on the part of the defendants are particularized in paragraph 14 of the plaint. The 2nd Defendant is alleged to have misrepresented itself in holding itself out to be an institution equipped with the requisite capacity to offer and be contracted to provide proper medical care to the general paying public and it was on that belief that the late L sought and was entrusted to the care of the 2nd Defendant only for the 2nd defendant to breach the contract and the trust bestowed upon it by the late L. The particulars of the 2nd Defendant's breach of contract are set out in paragraph 15 of the plaint.

That as a result of the defendants' negligence, the plaintiff has suffered loss and damage which is particularized in paragraph 16 and 19 of the plaint. The plaintiff sought for the reliefs set out in paragraph 1 of this judgment.

The first defendant filed his statement of Defence dated 26th August, 2009 on 27th August 2009, whereas the 2nd defendant filed a further amended statement of defence on the 7th December, 2009. Both defendants denied the plaintiff's claim.

The plaintiff gave evidence as PW1 and told the court that his family, which included the late L had travelled to Siaya county on the 14th August 2008, and came back to Nairobi on the 17th August, 2008. The deceased fell sick on the 29th August 2008 and was taken to the 2nd defendant's clinic, along Othaya road, where the doctor diagonized him as having a throat infection. He was given some medication and went home with them.

That on the 30th August, 2008 while on a family gathering at Karen, he noticed the deceased was not feeling well and he took him to Othaya branch of Gertudes and he was referred to the main hospital at Muthaiga where he was admitted under the care of the first defendant. In the course of treatment, he told the 1st defendant that the deceased could be suffering from malaria as his two nephews with whom he had travelled to Siaya, had been diagonized with malaria and had been admitted in Nairobi and Getrudes hospital and the 1st Defendant had treated the two of them.

He testified that, after the admission, the 1st Defendant told him he was suspecting the deceased was suffering from Hepatitis B and though he took malaria test, it turned out to be negative. The test for hepatitis also turned negative. That the 1st Defendant carried out a repeat test for malaria on the 3rd day of September 2008 which showed the presence of malaria plus 4 level. That the first defendant requested for quinine but the 2nd defendant did not have it and the deceased was put on palther and upon taking the drug, the deceased's eyes started turning yellow. That on the 5th September 2008, the deceased was seen by Dr. Kamenwa who carried out tests at the request of Dr. Opondo and among the tests that she took, is the one for the liver and the samples were taken to the laboratory, by this time, the deceased had become aggressive and was not himself.

That by 6th September 2009 the deceased's condition had worsened and the plaintiff was called to the hospital by his wife and he drove there at 5a.m. in the morning and since there was no doctor attending to the deceased he tried to reach the 1st defendant but he could not reach him. He tried to reach Dr. Kamenwa but she could also not be reached. On failing to reach the two of them, the brother to the plaintiff called Doctors Were and Akide who attended to the deceased and recommended dialysis and transfer of the patient to Aga Khan hospital as the 2nd defendant did not have the dialysis machine. He testified that the 1st defendant never called him back but Dr. Kamenwa went to see the deceased at Aga Khan. That, both doctors Kamenwa and the first defendant did not give advice on transfer of the deceased to Aga Khan hospital.

On cross-examination, it was his evidence that the deceased was tested twice for malaria and the first defendant kept assuring him that the deceased was doing well. He stated that the first defendant had informed them that he would be travelling out of Nairobi and was leaving Dr. Kamenwa to check on the deceased's liver but he did not tell them she would be in-charge of the patient.

It was his evidence that when he took the deceased to the hospital he was given a list of consultants to choose from and he chose the 1st defendant but the 2nd defendant did not disclose to him how they relate with the consultants that attend to patients in their hospital. He said he was also not made aware of the process of handovers between doctors and it was his evidence that though Doctors Were and Akida are also doctors at Getrudes, they were called by the family members to attend to the deceased after they failed to reach the first defendant and Dr. Kamenwa.

The first defendant testified as DW1. He stated that he knew the deceased since he was nine months old. He was called on the 30th day of August 2008 by the doctor on duty at the 2nd defendant who told him that the deceased was admitted under his care. On asking about his condition, he was informed that the deceased had throat infection and that he had been tested for malaria the previous day but had tested negative. He saw the deceased on the 31st August 2008 and was sick looking and had jaundice and fever. He was told that the child had travelled to Western Kenya and he asked for full malaria test, urine examination and culture and blood culture to rule out bacterial infection. He also ordered for liver function test because of jaundice, kidney function and stool examination including stool culture to rule out salmonella.

That, he went back in the evening on the 31st August, 2008 to see the patient by which time, some of the results were ready which showed that the kidney function was normal. Report on malaria was negative but the liver function was not normal in that, there was presence of bilirubin but the blood count was normal. He suspected hepatitis, salmonella, infection of the bladder and malaria. He asked for tests for three types of hepatitis. He stated that when he saw him again on 1st September, 2008 the results of the blood test showed that there was no blood infection, the urine was normal and the tests were negative for salmonella. He ordered for ultra sound in the evening on 1st September, 2008 which showed features of hepatitis and cholicystitis but the fever had come down. He saw him again on 2nd September 2008 and though the fever had gone down, there were no signs of bacteria growth and no signs of infection. On the same day, he held a discussion with the father of L and told him that he was suspecting hepatitis. He briefed him on the results though some of them were not yet out and had to be waited for.

That, he saw him again on 2nd September 2008 in the evening and the infection had settled but he added another dose of antibiotic to cater for the infection. On the 3rd September 2008 the patient looked better but jaundice had increased and he decided to do a third test of malaria which now turned out to be positive and there was also Hepatitis A.

He put him on palther, a malaria treatment after he consulted the pharmacy. He saw him on 4th September 2008 in the morning and the patient had a fair night and the fever had gone down. He stated that he had not started him on treatment earlier, because he did not have evidence of sickness.

Because of the deteriorating liver function, he decided to consult Dr. Kamenwa on 4th September 2008 who was not available to see the patient on that day but on 5th September 2008 when she went for ward rounds, the nurses forgot to show them the patient, though it had been noted. She later saw the patient and she reported to him that the patient was doing well during which discussion, he informed her that he will be away and they agreed that she will stand in for him. On 6th September, 2008 while at the Airport he was called and was told the child was not doing well and that the 2nd defendant was trying to reach Dr. Kamenwa in vain. He called her and she said she was on her way to see the patient and he left for Kisumu. When he reached Kisumu, he was called by Dr. Akide who informed him that the patient had been taken to Aga Khan hospital after he developed kidney and liver problem and required haemo-dialysis which was not available at Getrudes. On the 6th September 2008 he called Dr. Akide and requested him to go and see the patient and tell him about his condition but Dr. Akide did not call him back but in the evening of the same day, an Uncle to the patient called him and they agreed he would change his flight to travel the

following morning but was called later in the evening and was informed that the patient had passed on that evening.

In cross-examination, he stated that he was aware that the patient had travelled to Western Kenya which is a high malaria epidemic area and there was high chances that he could have contacted malaria. He had been given that information on 31st August 2008. He told the court that similar symptoms had been noted in one of the cousins of the deceased who had travelled with him but he stated that he could not have treated him earlier for malaria as it had not been found. He, however, admitted that early detection of malaria is important because a delay in diagnosis could lead to severe malaria which is a medical emergency. He said that he recommended palther as it was the only available drug at the pharmacy of the (2nd defendant). He stated that though he was scheduled to travel on the 5th September 2008, he changed the travel plans to 6th September 2008 as he had to make alternative arrangements and get a consultant to leave the patient in care of. He saw the child on 5th September 2008 by which time, he had improved but he did not see him on 6th September 2008 but he was told he had deteriorated.

On further cross-examination, he stated that the malaria test was done on 29th August 2008 and not on 30th August 2008 – as he did not see the patient on the 30th August 2008. That as at 2nd September, 2008 some results were still not out and on enquiring, he was told some of the hepatitis tests were taken outside the hospital. He stated that there was no procedure of handing over a patient to another doctor but in this case, he left the patient in the hands of Doctor Kamenwa through discussion and there was no formal hand over. That when the patient was transferred to Aga Khan he was not involved but he was informed of the decision to transfer him – the reason being that there was no dialysis machine at Getrudes (2nd defendant)

On his relationship with the 2nd defendant, it was his evidence that he is a consultant only and he visit there when admitting patients, he takes a separate cover for his work but he is bound by the Doctor's admission rules of the 2nd defendant. He stated that he was the primary doctor and as a primary doctor, his work was to assess the patient, order tests, institute treatment and call other colleagues to help manage the patient if need be. It was his evidence that the primary doctor makes major decisions on the patient as far as treatment is concerned. That in the case at hand, Artemether and palther were the best drugs he could give as he was informed there was no quinine and he gave an alternative of what was available and the next best. That he handed over the patient on 5th September 2008 and he informed the parents but he did not inform the clinician at the 2nd defendant and the management because it was to be for a short time.

He stated that he was aware of the proceedings before the medical practitioners and Dentist Board in which the 2nd defendant and himself were found guilty but the 2nd defendant filed an Appeal against that decision and the same was successful.

Thomas Ngwire gave evidence as DW2 on behalf of himself and the 2nd defendant. He was/is the head of clinical services at the 2nd defendant having worked in that capacity for 6 years from February 2010. His role is to ensure the clinical services availed to the patients is of best quality. He was not personally involved in the treatment but the matter was handed to him by Dr. Mukhwana who headed the clinical services. In his testimony, he relied on documentation with regard to the patient (L). He stated that in the case at hand, the 1st defendant is a serving doctor with the 2nd defendant with admitting privileges and he was the primary doctor and was responsible for directing management of the patient. That the 1st defendant was not on call but was the family's choice. He stated that once a patient is admitted, care is given by a team of doctors with the primary doctor as the lead Doctor, nurses are also included, laboratory staff, radiology, physiotherapy or any other area as required. That the primary doctor directs what services the patient will require from any departments that are available in the hospital. It is also the responsibility of the family doctor to communicate with the family and update them.

According to him, everything requested for, by the primary doctor was provided and all tests were done. He stated that there is a form for handing over a patient which states the reasons for the hand over i.e. if the condition of the patient is outside his area, if one is travelling or at the request of the family. The other alternative is for the information to be entered in the patient's treatment notes which is still an acceptable way of hand over. In this case, there was no formal hand over and the responsibility remained with the primary doctor. That there was no formal complaint from the 1st defendant about any issue. That even in cases where the patients are admitted under care of their consultants, the hospital has a resident doctor who is available to attend to the patient in the event of an emergency.

He admitted that the 2nd defendant does not have a haemo- dialysis machine and the medical board was unhappy about lack of facilities and made an order directing them to put in place the necessary facilities for a centre providing high quality pediatrics health care services including haemo-dialysis machine. He stated that they have not yet installed those machines as most of the patients that they admit do not need them. That there is no evidence that the first defendant requested for quinine and that the same was not available. He told the court that it is not standard practice for a doctor employed by the 2nd defendant to see a patient admitted by a consultant, in their normal ward rounds unless the patient is deteriorating and the hospital cannot reach the consultant. He participated in the proceedings before the Board and in Appeal the High Court held that the 2nd defendant was not a party to the case.

In his submissions, counsel for the plaintiff submitted that the plaintiff has established liability against both the defendants. As against the first defendant, because he did not take a proper history of the patient and more particularly the fact that the patient had travelled to Siaya which is a malaria pandemic area, he is young and that another patient they were with, had been diagonized with malaria. That the 1st defendant did not order for a malaria test himself but he instead relied on tests done by a clinician and by the time he asked for the test, it was too late and the patient was suffering from severe malaria. That the first defendant did not administer the 1st line of treatment and when the condition of the patient deteriorated he abandoned the patient.

It was submitted that a complaint was lodged before the Board and it found the 1st defendant guilty of failing to assess the patient's needs properly and the hospital guilty of practicing medicine on a facility that lacks drugs and equipments and though there was an Appeal against that decision, the same was allowed on a technicality and not on merits as the 2nd defendant argued that it was not a party to the proceedings before the board. The other argument was that the plaintiff was not made a party to that Appeal and only got to know about the same after the judgment was served upon him in these proceedings.

On behalf of the 1st defendant it was submitted that the plaintiff did not make a case on liability against him. It was argued that he conducted several tests on the patient including those of malaria and hepatitis but both turned out negative. That all through the patient's treatment, the 1st defendant exercised professionalism as informed by the tests and he did not commit any fault in the treatment and care of the patient.

On his part, counsel for the 2nd defendant fully adopted the submissions made by Counsel for the 1st defendant and added that, in medical negligence cases, it has been established that not everything that goes wrong in the treatment of a patient amounts to negligence. That the plaintiff was not able to establish liability against the 2nd defendant. That the role played by the 2nd defendant was satisfactory and that the 1st defendant was not an employee of the 2nd defendant and therefore not vicariously liable for the acts and omission on the part of the 1st defendant. That everything was availed to the 1st defendant to attend to the patient and if the court is to find the 2nd defendant liable, not to make any award under the Law Reform Act as no letters of administration were produced in evidence.

In a brief rejoinder, Counsel for the plaintiff submitted that the 2nd defendant has not been sued because it is vicariously liable but because it had a duty of care to the patient and not a responsibility to assist the 1st defendant and hence has a direct responsibility to the patient.

The court has carefully considered the pleadings, the evidence on record, the submissions by the learned counsel for the respective parties and the authorities relied on.

After the above analysis, the court sets out the following issues for determination:

> ***(1) Was the deceased owed a duty of care by the defendants?***
>
> ***(2) Did the defendants breach that duty of care***
>
> ***(3) Did the plaintiff suffer any damages or loss as a result of the breach of that duty?***
>
> ***(4) If the answer to the 3rd issue is in the affirmative is the plaintiff entitled to damages and what is the quantum***
>
> ***(5) Who should bear the costs of the suit?***

On the first issue, though the first defendant denies that he was entrusted with the care of the late Master L and the second defendant denies that the late L was admitted at their hospital, the evidence on record is clear without a doubt that the late L was admitted at the 2nd defendant under the case of the first defendant. It therefore follows that a patient–doctor relationship existed between the 1st defendant and the late L. This was well enunciated in the case of **Ricarda Njoki Wahome (suing as administrator of the estate of the late Wahome Mutahi (deceased) Vs. the Attorney General and 2 others (2015 eKLR)** where the court held as follows;

> **"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 the doctors. A medical man who is employed part time at a hospital is a member of staff, for whose negligence the hospital is reasonable – See Charlesworth & Percing on negligence".**

In the case of a hospital, the existence of the duty of care of a hospital towards a patient it admits, is asserted in the following words quoted from Charlesworth and Percy on Negligence.

> ***……..the law is that hospitals are liable vicariously for the negligence of the members of its staff, including nurses and doctors. A medical man who is employed part time at a hospital is a member of the staff for whose negligence the hospital is responsible similarly in the English Court of Appeal case of Cassidy Vs. Ministry of Health (1954) 2 KB 343) the court remarked thus;***
>
> ***…….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……."***

In addition to the vicarious liability, a hospital also owes patients a direct duty of care, quite apart from the vicarious liability that would arise following the negligence of its staff.

This position in law is also captured in the case of **M (a minor) Vs. Amulega & Another (2001) KLR at 426** where Muluka J. quoted the case of **Gold Vs. Essex County Council (1942) 2 KB 293** where Lord Greene Stated as follows:

> ***"When a patient seeking free advice and treatment knocks at the door of the defendant hospital, what is he entitled to expect? He will find an organization which comprises consulting physicians and surgeons, a staff of nurses, equipment – radiographers etc."***

He went further to state;

> ***"…. If they (hospital authorities) exercise that power (of treating patients) the obligation which they undertake is an obligation to treat, and they are liable if the person employed by them to perform the obligation on their behalf act without due care."***

From the aforegoing, its clear beyond paradventure, that the defendants owed a duty of care to the deceased.

Did the defendants breach that duty?

That a doctor owes a patient a duty to exercise reasonable care and skill is well established in our legal system.

If a doctor does not act with reasonable care and skill in dealing with a patient, that would be negligence. The nature of this duty and the test for its breach have received extensive and authoritative judicial and academic commentary over the years. In the case of **R V. Bateman (1925) 94, L.J.K.B. 791** the court had this to say about the duty of care;

> ***"If a person holds himself out as possessing a special skill and knowledge and he is consulted, as possessing such skill and knowledge….he owes a duty to the patient to use due caution in undertaking the treatment. The law requires a fair and reasonable standard of care and competence.***

In **Charles Worth & percy on negligence (8th Edition**), it is noted that;

> ***"The doctor's relationship with the patient that gives rise to the normal duty to exercise his skill and judgment to improve the latter's health in any particular respect, in which the patient has consulted him, is to be treated as a single comprehensive duty: it covers all the ways in which a doctor is called upon to exercise his skill and judgment in the improvement of the patient's physical or mental condition and in respect of which his services were engaged (Emphasis added)***

When can a doctor be said to be negligent? A doctor can only be held guilty of medical negligence when he falls short of the standard of reasonable medical care and not because in a matter of opinion, he made an error of judgment. For negligence to arise there must have been a breach of duty and breach of duty must have been the direct or proximate cause of the loss, injury or damage. By proximate, is meant a cause which in a natural and continuous chain, unbroken by any intervening event, produces injury and without which injury would not have occurred. The breach of duty is one equal to the Level of a reasonable and competent health worker.

In the case of **Pope John Paul's Hospital & Another Vs. Baby Kosozi (1974) E.A. 221** the East Arica Court of Appeal held;

> ***"…….but the standard of care, which the law requires, is not insurance against accidental slips. It is such a degree of care as normally skilful member of the profession may reasonably be expected to exercise in the actual circumstances of the case, and, in applying the duty of care to the care of a surgeon, it is peculiarly necessary to have regard to the different kinds of circumstances that may present themselves for urgent attention...A charge of professional negligence against a medical man was serious. It stood on a different footing to a charge of negligence against the driver of a motorcar. The consequences were far more serious. It affected his professional status and reputation. The burden of proof was correspondingly greater...The practitioner must bring to his task a reasonable degree of skill and knowledge, and must exercise a reasonable degree of care...In cases charging medical negligence, a court should be careful not to construe everything that goes wrong in the course of medical treatment as amounting to negligence. The courts would be doing a disservice to the community at large if they were to impose liability on hospitals and doctors for everything that happens to go wrong".***

In the course of treatment, some discretion must be left to the judgment of the doctor on the spot so that he uses his common sense, his experience and judgment as far as it suits to the situation of the case. One cannot be guided by what has been written in the text books because statements in the text books are mere opinions, cannot substitute for the judgment of the surgeon who handles the situation at the spot. Nor can negligence be inferred when a surgeon of higher education, higher experience and higher degree of skill had adopted a different mode of treatment. The court further views that the general practitioner should not be criticized just because some experts disagree. It is important to view the treatment and see matters with the eyes of the attending physician. No medical practitioner was insurer for effecting a cure nor should the court condemn an honest exercise of judgment even though the other practitioner disagree with that judgment.

The above position was adopted by the Court of Appeal in the **Administrator, H.H. The Aga Khan Platinum Jubilee Hospital V. Munyambu (1985) eKLR** where the court quoted with approval the case of **Maynard Vs. West Midlands Regional Health Authority (1983)** thus;

> ***"Differences of opinion and practice exist and will always exist in the medical as in other professionals. There is seldom any one answer exclusively of all others to problems of professional judgment. A court may prefer one body of opinion to the other, but that is no basis for a conclusion of negligence"***

In the case of **Bolam V. Friern Hospital Management Committee (1957) 2 AII E.R,** McNair J. explained the law on liability in medical negligence as follows;-

> ***"……the test whether there has been negligence or not is not the test of the man on the clapham, Omnibus, because he has not this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill"***

Having the foregoing in mind, can the defendants herein be said to have breached the duty of care towards the plaintiff?

On the part of the first defendant, he is accused of failure to take proper medical history and diagnosis; improper treatment and abandoning the patient while the 2nd defendant is accused of failure to provide essential equipment and drugs and inadequate systems of work. The basis of the allegations of failure to take proper medical history and diagnosis was that the doctor failed to take precautionary measures such as putting the child on anti-malarial treatment in view of the obvious risks associated with child mortality due to malaria in Kenya having been informed that the child had travelled to Siaya two weeks before seeking treatment and the 1st Defendant having treated one K O with whom, the child had travelled to Siaya and had been diagnonised with malaria. That, given the age of the child and his non-immune system, the risk of the child succumbing to malaria was easily avoidable if the doctor had undertaken the necessary anti-malaria treatment.

According to the first defendant, when the admitting doctor examined the patient, he formed the opinion that that child was suffering from tonsillitis and dehydration. He was admitted under the first defendant's care and the admitting doctor briefed the 1st defendant of the initial observations and diagnosis whereafter the 1st defendant suggested the tests to be carried out and started the child on treatment. Though the first defendant contends that the course of treatment he adopted was informed by the medical tests that had been carried out, it is noted that with all the information that was within his knowledge, he took time to carry out proper medical history and diagnosis. Being the doctor under whose care the child was admitted, he cannot be heard to say that he initially relied on the tests that had been done when the child was first admitted. As a prudent doctor, he ought to have carried out his own independent tests on the patient with the history he had about the child. During cross-examination, the first defendant was at pains to explain when he first carried out malaria test on the child. He stated that he had not started the child on malaria treatment because the tests that had been taken had turned out negative, his explanation being that the treatment for malaria involves medicine and a doctor should be careful in giving medicine before the results are out. According to the medical report dated 16th April 2009 by Gertrudes Hospital prepared by Dr. Benson O. Mukhwana, only two malaria tests were done on the child on 30th August 2008 and 3rd September 2008 by which time, malaria was severe. Dr. Rose Kamwenwa who attended to the child at the request of the first defendant prepared a medical report dated the 22nd February, 2010 in which, she stated that "Earlier intervention noting that jaundice was noted on the 31st August 2008 might have assisted"

It is on record that the family of the deceased complained against both the defendants before the medical practitioners and Dentists Board and six charges were preferred against the first defendant out of which he was found guilty on the following;

> "*That you being a medical practitioner registered under the medical practitioners and Dentists Act having attended to L O failed to make proper assessment on what kind of medical attention the patient needed as a matter of priority leading to inappropriate decisions hereby contributing and/or hastening his death"*

In finding the first defendant guilty, the Board noted the sentiments of Dr. Kamenwa and the fact that the first defendant had prior knowledge that the child had travelled to Siaya District with other family members who presented with similar symptoms and were treated for malaria and they improved. The Board further noted that in the report by Dr. Kamenwa, the patient had been on treatment for malaria and Hepatitis A infection but, when she looked at the laboratory tests, her interpretation was that the patient did not have acute hepatitis A infection. When she had the opportunity to review the history of the patient at that time, there was possible symptoms of malaria and in her opinion, she would have recommended that malaria treatment be started earlier.

The first defendant has also been accused of inappropriate treatment in that he was treating the child for hepatitis and not malaria. I have already dealt with this complaint as hereinabove. The plaintiff also contended that even after the first defendant diagnosed the child with malaria, the first defendant did not administer the correct drug in that the doctor did not administer quinine which is the first line of treatment for malaria but he instead administered palther. This, it was submitted, is against the guidelines by Getrudes hospital which characterize malaria as a medical emergency. The said guidelines provide that palther is an alternative only if quinine and IV Artesunate are not available. In his response, the first defendant stated that he could not prescribe quinine because he was told it was not available in the 2nd defendant's pharmacy.

The first defendant was also accused of abandoning the patient in that he travelled out of Nairobi with the knowledge that the condition of the patient had deteriorated on 6th September 2008 a fact that was brought to the first defendant before he travelled.

Further, he was informed that Dr. Kamenwa, in whose care he left the patient could not be reached but despite being informed of this, he proceeded to leave town for a family visit. The plaintiff averred that the reason for his leaving was not compelling nor urgent and that at the time he left, he was fully aware of the deteriorating condition of the child. Further to this, the plaintiff contended that the first defendant did not hand over the patient to another doctor.

The first defendant on his part contends that he handed over the patient to Dr. Kamenwa and he informed her that he was travelling out of Nairobi. The 2nd defendant through its witness DW1 testified that there was no formal handover while Dr. Kamenwa, though she admitted that the 1st defendant requested her to see the patient for him, she agreed but it was subject to her patients. In my view, the first defendant cannot be said to have abandoned the patient, in that, he had informed the parents of the patient that he was travelling out of Nairobi and he had left him in the hands of Dr. Kamenwa.

On the part of the 2nd defendant, the plaintiff avers that it failed to provide essential equipment and drugs and adequate systems of work. The basis of this allegation is that it did not have a facility for testing Hepatitis and that it did not have a haemo dialysis machine. That the testing of Hepatitis is outsourced with the resultant four days delay, which, would have taken shorter had the machine been available. This delay, it was submitted, was detrimental as it was only when the results arrived that the doctor considered an alternative diagnosis of malaria at which point, the malaria had reached the severe level. The plaintiff further averred that the 2nd defendant did not have a haemo dialysis machine and that made it necessary for the child to be transferred to Aga Khan for further treatment.

As regards inadequate systems of work, the plaintiff averred that the 2nd defendant's system of treating and caring for the patients who are admitted under consulting pediatricians is lacking in that, the 2nd defendant exercises indirect control of those patients as it happened on 5th September 2008, when the patient needed urgent intervention and there was nobody to attend to him and the parents had to look for an

alternative doctor for the patient. The plaintiff also cited the events of 4th September 2008 when the nurses forgot to remind Dr. Kamenwa to see the patient when she went for the ward rounds. Coupled with this, was also the system of handing over a patient by a Doctor to a colleague which, the plaintiff submitted, was unsupervised, in that there is no record to show that the first defendant handed over the patient to Dr. Kamenwa.

According to DW1 Dr. Thomas Ngwiri, everything that was asked for by the first defendant was provided for and he is not aware of any test that was ordered and it was not done by the hospital. His evidence was that there is a procedure of handing over and a doctor has to fill a prescribed form stating the reasons for the handing over and the condition of the patient. That alternatively, the same information can be entered on the patient's notes, which is still an acceptable form of handing over a patient.

He stated that haemodialysis is not commonly used procedure and there is an alternative method called peritoneal dialysis which is more safer in children but if a doctor providing care recommends haemodialysis they outsource the same at Aga Khan and Kenyatta Hospitals.

As I had pointed out earlier, a complaint was lodged against the defendants by the parents of the patient. The charges preferred against the 2nd defendant were that they admitted and treated patients in an institution that lacks appropriate facilities and drugs. The other charge related to putting in place inappropriate systems of work that contributed to the death of Master L R O. The board found the 2nd defendant guilty but it appealed against that decision in Civil Appeal No. 382/2011 in the High Court at Nairobi. The Judge allowed the Appeal and set aside the sentence against Gertrude's hospital. The plaintiff argued that the Appeal was allowed on technicality in that the Judge found that the 2nd defendant was not a party to the proceedings before the Board as it had not legally been charged with the offence and was thus not given an opportunity to appear and defend itself. The Judge found that the proceedings were defective as against the 2nd defendant and that the same amounted to a mistrial and therefore void. The court went further to state that the sentence was unlawful and invalid.

As rightly submitted by the plaintiff, the Appeal was allowed on a technicality and the proceedings before the Board were declared null and void meaning they do not have any legal effect. In my view, granting of the Appeal by the High Court did not exonerate the 2nd defendant from negligence in the circumstances of this case, the proceedings before the board and the subsequent Appeal and the reasons why the Appeal was allowed.

The evidence on record is that on the 4th September, Dr. Kamenwa was called to review the patient at the request of the first defendant, but when she went to the hospital, the nurses did not remind her to see the patient. DW1 confirmed that the request had been formally made and there was a problem on the part of the nurses for failing to remind the doctor to see the patient. He is also on record as having stated that by this time the condition of the patient had deteriorated and had been diagnosed as a medical emergency which calls for high alertness and in those circumstances one would not expect somebody to forget to remind a doctor to see such a patient. This then, means that for the whole day, the patient was not seen by a doctor, which was very unfortunate taking into account his condition at the material time. One would have expected that after the nurses realized that they did not remind the doctor to see the patient, they could either have called the doctor later or requested their doctor to attend to the patient, which did not happen. It is noted that even after the 2nd defendant learnt what had happened, it did not take any steps to reprimand the nurses so that there would be no repeat of a similar omission.

DW2 also admitted that the test for Hepatitis requested by the first defendant had to be outsourced as the 2nd defendant did not have the facilities to test for hepatitis. It emerged from his evidence that when the test is done it takes a few hours to get the results but when they took the samples to Aga Khan, it took four days to have the results obtained yet, when admitting patients they do not disclose this information to enable them make informed decisions.

He also admitted that the 2nd defendant does not have a haemo dialysis machine and that is why the patient had to be transferred to Aga Khan Hospital. He also confirmed that quinine was not available and the 1st defendant had to use the 2nd line of treatment for malaria.

In my view, there is overwhelming evidence to prove that the 2nd defendant was also negligent in this matter. Considering the evidence on record, I find that both defendants were to blame and I proceed to apportion liability in the ratio of 60%: 40%. The first defendant to bear 60% while the 2nd defendant should bear 40%.

I now proceed to consider the quantum of damages to be awarded to the plaintiff.

On special damages a sum of Kshs.761,169.00 was claimed but the receipts that were produced in evidence totals to Kshs.685,552.08 cents which I hereby award.

I wish to note that the plaintiffs did not produce a grant of letters of administration and as such no general damages can be awarded under the Law Reform Act. This was rightly observed by counsel for the 2nd defendant and I fully concur with him to that extent. The Plaintiff is, however, entitled to damages under the fatal accidents Act in the head of loss of dependancy. The plaintiff on his part has urged the court to award a total sum of Kshs.36,000,000 and has relied on the case of **Hassan Vs. Nathan Mwangi Kamau Transporters & 5 others (1986) KLR 457**. The figure was arrived at using a multiplier of 30 years and a multiplicand of 100,000. The case of **P I v Zena Roses Ltd & Another (2015) eKLR** was relied on in which the court held that;

> **"For the case of minors, it is my view that the tabulation for damages for loss of future earnings and lost years can be gauged depending on what evidence is brought before the court. For instance, a good case can be argued where evidence is shown that the minor is in school, well performing and that it is hoped, based on his or her performance, would engage himself or herself in this or that occupation".**

On their part the 2nd defendant urged the court to award a global sum of Kshs. 1,000,000 and have cited the case of DMM (suing as the administrator and legal representative of the estate of **LKM Vs. Stephen Johana & Another (2016) eKLR** and that of **Oshivji Kuvenji &**

Another Vs. James Mohammed Ongenge (2012) eKLR.

The first defendant submitted that a sum of Kshs.700,000 is reasonable and have relied on the case of **P I v Zena Roses Ltd & Another (2015) eKLR** where a sum of Kshs.300,000 was awarded.

The court has considered the submissions on quantum. Though it has been submitted that the deceased was a student at **[particulars withheld]** School and had aspired to be a neurosurgeon, no evidence was produced in support of that assertion. As the court rightly observed in the case of **P I v Zena Roses (supra)** no evidence was placed before the court to show how the deceased was performing and what he had hoped to become, based on his or her performance. I do concur with the defendants that the best formula to apply in the circumstances of this case is that of global sum. I hereby award Kshs.1,500,000 being guided by the case of **LKM Vs. Stephen Johana** and taking into account the fact that it was decided more than two years ago.

In the end, the court enters judgment for the plaintiff against the defendants as follows:

(A) Liability 60%: 40%

(B) Loss of dependancy – 1,500,000

(C) Special damages – 685,552.08

Special damages shall earn interest from the date of filing of the plaint and general damages from the date of the Judgment.

The plaintiff shall also get the costs of the suit.

Dated, signed and delivered at NAIROBI this 13th day of December, 2018.

L. NJUGUNA

JUDGE