REPUBLIC OF KENYA

IN THE HIGH COURT OF KENYA AT ELDORET

CIVIL CASE NO. 136 OF 2012

ANTONY LUNGAYA MURUMBUTSA ....PLAINTIFF

VERSUS

MOI TEACHING & REFERRAL HOSPITAL …...................... DEFENDANT

JUDGMENT

The Plaintiff's claim against the Defendant is for;

(a) Ksh. 185,000/= as special damages.

(b) General damages.

(c) Costs of the suit with interests on (a) and (b) at court rates.

The Plaintiff averred that on the 10th September, 2008, he was attended to at the Defendant's hospital with symptoms of nose bleeding and was given five (5) tablets to take. He averred that the Defendant's staff and professional personnel were negligent in attending to him as a result of which he suffered irreparale loss and damage as he lost his eye sight. He outlined the particulars of negligence in paragraph 4 of the plaint as follows:-

(a) Failing to diagnose the illness suffered.

(b) Administering a drug that he reacted to adversely.

(c) Failing to solicit information about allergic medical reactions.

It is the Plaintiff's further case that before the illness, he was an electronic technician. He cannot now carry on with his occupation/profession, hence the claim for special damages. The special damages are outlined in paragraph 5 of the plaint as follows:-

(a) Monthly earnings – Ksh. 15,000/=

(b) Farming income - Ksh. 120,000/= per year

(c) Treatment costs Ksh 50,000/=

Under paragraph 6 of the Plaint, he further claims a sum of Ksh. 1.5 million as costs of training in the use of braille and electronic sign language in order to engage with a new trade or profession.

He also avers that he is married to two wives and has seven (7) children. He is the sole bread winner of the family. However, due to the visual impairment, he can no longer provide for the family needs.

He states that he has made several demands to the Defendant which has declined to accept liability.

The Defendant filed a statement of defence on 1st December, 2011 in which it denied liability. In addition, it admitted that the Plaintiff visited its facility on 10th September, 2008 and was admitted into the hospital until the 29th September, 2008. He presented himself with sponteneous nose bleeding, headache and blurred vision. He was managed and treated at the hospital in accordance with acceptable professional standards. It thus denies that its staff or professional staff were negligent in attending to the Plaintiff and cannot therefore be held liable for the Plaintiff's blindness.

The Defendant also denied liability for special damages particularized in paragraph 5 of the Plaint. It also denies that any demand of intention to sue was issued to it. The Defendant also averred that the suit was time barred by virtue of Section 4 of the Limitation of Actions Act, Cap 22, Laws of Kenya.

Before I dwelve into the evidence adduced, it is important to note that the Defendant filed a Preliminary Objection dated 20/12/2011, stating that the suit was time barred under Section 4 of the Limitation of Actions Act, Cap 22, Laws of Kenya and also that this court had no jurisdiction to entertain the suit.

This Preliminary Objection was heard on 9th February, 2012 and a ruling delivered on 11th April, 2012, in which the same was dismissed with no orders as to costs.

PLAINTIFF'S CASE

The Plaintiff called a total of six (6) witnesses. He testified as PW1.

At the time the Plaintiff testified, he was studying at Machakos Institute for the Blind. He testified that on 10/9/2008 he had a problem of bleeding from his private parts (penis). He went for treatment at the Defendant's hospital at about 7.00 p.m. and by 2.00 a.m. he had not been treated. In the period between 7.00 p.m. and 2.00 a.m. he would be moved from one room to another but no doctor attended to him. Finally, two young men attended to him. When he explained his problem to them, they concluded that he was suffering from diabetes and they gave him five (5) tablets to swallow. Immediately he swallowed the tablets, he started vomiting. He then fell unconscious. The doctor then told him that he would be admitted.

It was the Plaintiff's evidence that his sight started failing while he was in the ward. He informed a nurse and a doctor. On the following day, he was given three (3) tablets without any examination. Thereafter he was informed that he had high blood pressure and that it is the pressure that had caused the loss of sight. The medication was then reduced to half (½) tablet twice a day.

He testified that on the second week, he was not given any medication.

He further testified that he underwent a CT scan. During the X-ray, he was given intravenous medicine that affected his heart. He was also informed that the CT scan rays were directed to his eyes without protection. He stated that he was admitted in the hospital for 27 days. Before his discharge, a nurse told him that he lost his sight because he was not properly treated. He thereafter visited Kikuyu eye hospital as well as the Lion of Kenya Eye Hospital where he was informed that his optical nerves had been damaged. He sought a medical report from a doctor Mengich of the Moi Teaching & Referral Hospital who declined to give him.

It was the Plaintiff's further testimony that on 6th August, 2010 he was taken to the theatre but was

not operated on. Instead, the doctors told him that he had become blind due to the negligence of the hospital. The particulars of negligence were however not disclosed to him. He was referred to see an eye specialist.

He stated that he continued to visit the specialist clinic for treatment of high blood pressure, which condition he developed after he became blind.

He then reported the matter to human rights activists. After that, his hospital file went missing. He stated that he was supposed to be seen by Doctor Fraiser but the hospital refused him to see the doctor. The hospital also failed to recommend a special diet for him when he presented himself with nose bleeding. Instead he was treated for diabetes. He stated that he visited another hospital which informed him that he did not suffer from diabetes or hypertension.

PW1 also testified that the Defendant hospital prescribed for him medicine known as carpimazole for diabetes. He took it for six (6) days. He was later told to stop taking it. He then learnt that the medicine was used by people with mental illness, which information he obtained from a doctor at Huruma District Hospital.

PW1 stated that before he became blind, he worked as a mason and blacksmith. He made bricks and jikos. He no longer can do the work. He produced as P. Exhibit No. 1 a letter dated 10/4/2013 from the District Commisioner, Likuyani District, confirming that he (PW1) hailed from this district and was appealing to well wishers to assist him tend to his family, meet medication cost for his ailment and educate his children.

In cross-examiantion, he said he presented himself at the Defendant's hospital suffering from nose bleeding and the hospital gave him medicine for diabetes. He stated that blood pressure examination was done after three (3) days of his admission. He was not able to tell which doctor treated him but he knew that a doctor Fraiser was from the said Defendant hospital.

He further stated that after the CT scans were done at the Lumakanda District and Kikuyu Hospitals, he was informed that his kidneys were not functioning well and that he had completely lost his eye sight. He said a doctor Abusakala of Moi Teaching & Referral Hospital told him that he did not suffer from blood pressure. He said that he learnt that the carpimazole drug was for mentally sick patients from a doctor at Huruma District Hospital. According to him, the information by the defendant hospital that the nose bleeding was caused by high blood pressure was untrue because no examination was done to ascertain that position.

PW2, Milka Musanga and a wife to PW1 testified that on 10th September, 2008, the Plaintiff began the day with good health. He went to town to buy his business wares. He returned home at 2.00 p.m. when he informed her that he could not continue working because he was nose bleeding. She made him to lie under a shadow but the bleeding continued. She called his sister who advised her to take him to hospital. At 6.00 p.m. she looked for a vehicle that drove them to Moi Teaching & Referral Hospital. They arrived in hospital after 7.00 p.m.

She testified that, at the hospital, there was a delay of referral to a doctor. But when he was finally seen by a doctor, he was informed that he was sufering from diabetes. He was given medicine to take and 15 minutes later, he started vomiting. Nothing was done to stop the nose bleeding. After 30 minutes, he could not stand or walk. It is then that he was informed that he would be admitted – she signed the admission form and left for home.

PW2 testified that on the following day when she visited PW1, he had lost his sight. She stated that the first examination on PW1 was done three (3) days of his admission when it was found that he did not suffer from diabetes.

She stated that after PW1's discharge, he was advised to follow up treatment at specialist clinic but every time he took medicine from the hospital he would be more sick. It was at Kikuyu Hospital

where he was informed that he would not see again. They asked for his treatment file from Moi Teaching & Referral Hospital but were informed that the file was missing. That is when he enrolled at the Machakos School for the Blind.

In cross-examination, PW2 said that she accompanied PW1 to hospital in the first instance. At this time PW1 did not give his medical history but the doctors complained that he did not go for medical check-ups. She confirmed that PW1 was taken to the theatre. She said he was not examined but was asked to return to hospital after three (3) days. She stated that PW1 was told at Sabatia hospital that he had no eye problems.

PW3, Habel Gilbert Alubokho testified that he knew the Plaintiff as a person who used to repair radios in Eldoret town near the bus stop way back in 1998. He met him again in the year 2009 and was surprised that he could not see. He was informed by PW1 that the blindness was occasioned by medication he received from Moi Teaching & Referral Hospital sometime in September, 2008.

In cross-examination, PW3 stated that PW1 had a repair shop in Eldoret town and that he knew him between the years 1990s and 2003.

PW4, John Moi testified that he was a jua kali artisan in Eldoret town. He stated that he knew the Plaintif in the year 2004 when he was running a radio and television repair shop at Maili Nne. He was surprised to see him blind later on. PW1 told him he became blind after taking medicine.

PW5, John Nundu Awich said he hailed from Maili Nne in Eldoret. He stated that he knew PW1 as a person who repaired radios and both served as school Committee members at Kabiemei Primary School. When he later met him, he informed him that he became blind after he fell ill.

PW6, Amos Wekesa Wamalwa said that he was a matatu driver in Eldoret. He stated that on 10/9/2008 at about 7.30 p.m. he was called by PW1's wife to take PW1 to hospital. He went and collected PW1 from his house. He was nose-bleeding. He took him to Moi Teaching & Referral Hospital in the company of his wife. PW1 told him that he had been bleeding the whole afternoon of that day. He waited for PW1 to be treated but at 12.00 midnight he was informed that PW1 would be admitted. He accompanied him to the ward and left for home. On the following day, he was informed by people who had visited him that he had lost his sight. He returned to hospital after he was discharged to take him back home.

In cross-examination, PW6 stated that he was not present when PW1 was receiving treatment and could not also tell what complaint he made to the doctor.

<u>DEFENCE CASE</u>

The defence called only one witness, doctor Paul Kipkorir Rono. He practised medicine at Moi Teaching & Referral Hospital and testified on behalf of the Director of Moi Teaching & Referral Hospital in respect of the treatment PW1 received in the Defendant's hospital on 10th September, 2008.

DW1 testified that PW1 had a problem with nose bleeding. His pressure was also high at 220/120 while the normal blood pressure ought to read at 140/80 for his age which was then 34 years. PW1 was fairly sick and had to be admitted. At the ward he was given medicine to bring down the pressure. An Ear, Nose and Throat (ENT) specialist was also called in due to the nose bleeding. PW1 was also found to be anaemic. He also had poor sight. An Orphalmologist was called in and he found out that PW1's eyes could not respond to light. His heart was also enlarged due to hypertension. Examination of the kidneys showed acute renal failure. He was treated and discharged on 29th September, 2009.

DW1 testified that an occupational therapist was also called to help PW1 walk without sight. He thereafter attended treatment as an outpatient.

He testified that the blood pressure was treated with Lasix 40 mg (which is the lowest dose), Adanat 20 mg to be taken once a day. He honoured the outpatient treatments and by the year 2011, the blood pressure had lowered.

DW1 stated that the hospital was thereafter served with a letter from Human Rights and Democracy (referring to Centre for Human Rights and Democracy), an NGO, complaining that the hospital did not treat PW1 properly. He responded to the letter indicating that there was no negligence on the part of the hospital (see D. Exhibit 2).

Later, the hospital was served with another complaint letter from the Kenya Medical Practitioners and Dentists Board dated 10th August, 2011 (D. Exhibit 3). A reply by the hospital dated 30th August, 2011 was done denying any negligence on the part of the hospital and also outlining that PW1 had a history of malignant hypertension with poor drug compliance since 2008. The letter further stated that blindness was a well documented medical complication of End Organ Disease secondary to severe hypertension. DW1 stated that the medical board did not react to their response. He said that PW1 had no known allergy and that the drugs given to him were drugs used by all other patients. He also produced PW1's discharge summary as D. Exhibit 1.

According to DW1, PW1 lost the sight due to a complication of hypertension. He said that other complications of hypertension include nose bleeding, heart problem and kidney failure. He said that the hospital managed PW1 properly but unfortunately he lost his sight.

In cross-examiantion, DW1 stated that the Plaintiff's kidney problem was confirmed upon tests whose results he showed to the court. Moreover, he reiterated that the hospital did its part and taught him how to walk without his eye sight. He said that he wrote the discharge summary but did not recall recommending any special diet for him, but that all hypertension patients are advised to reduce on salt, fat and being angry. He stated that no drugs for diabetes were administered on the Plaintiff. There was first the need to establish the cause of the nose-bleeding before dealing with the nose bleeding itself. He stated that he met PW1 on two occassions and he never advised him to take traditional medicine. He added that PW1's kidney failure did not require dialysis.

SUBMISSIONS

The Plaintiff made oral submissions as follows. First, that the medication he was given was without any pre-examination of what he was suffering from. Second, when he arrived at the hospital, it took upto four hours for him to be treated. Third, the hospital refered him for a scan so that he could lose his life. Four, on 6th August, 2010, the hospital decided to take him to the theatre without a justifiable cause for an operation. However, a doctor proposed that he should be seen by a specialist as a result of which he was not operated. Five, a Mr. Chepkonga advocate had proposed to the hospital that it should compensate him, but the hospital hid the letter containing the proposal. Six, he was given medicine for a disease he was not suffering from. Seven, Dr. Imbenzi of the hospital told him that he was treated for an illness he was not suffering from. Eight, his blindness is due to medical negligence. Nine, the hospital failed to give him full-length medication but instead prescribed short-term medication, say for three (3) weeks which caused him to develop the hypertension.

Finally, PW1 submitted that a Doctor Omar conceded that it was the outpatient doctors who were negligent. He submitted that currently, he spends Ksh. 4,500/= for treatment of the hypertension.

The law firm of Kalya & Company Advocates filed written submissions on behalf of the Plaintiff. They are dated 4th February, 2014 and are as follows;

The Plaintiff was treated in accordance with the acceptable professional standards and the hospital cannot be held liable for his blindness. The Plaintiff did not call any evidence on the issue of medical negligence and all the witnesses he called testified as to how they knew him prior to 10th September, 2008 when he was allegedly treated and lost his eye sight. The Plaintiff did not also

prove that the drugs that were administered to him by the Defendant hospital caused his blindness.

Further, tests conducted on the Plaintiff revealed that he suffered from malignant hypertension – grade four hypertension with chronic renal failure. Malignant hypertension is defined in the medical journals as follows:-

"Malignant hypertension is a rare but very serious form of high blood pressure. Officially, malignant hypertension is defined as severe hypertension that occurs along with internal bleeding of the retinas in both eyes and swelling of optic nerves behind the retinas. Overtime, untreated high blood pressure can damage organs such as the heart, kidneys or eyes leading to complications such as heart attack, stroke, kidney failure, peripheral arterial disease and retinopathy (eye damage)."

As such, the high blood pressure the Plaintiff was suffering from was the cause of his blindness. Furthermore, DW1 had testified that PW1 was the author of his own misfortune due to poor compliance with medication. The immediate treatment administered upon presentation was reasonable, necessary and life saving and the blindness suffered was not due to medication. And since blindness was a compliacation of blood pressure, the Defendant was ultimately absolved from liability.

Counsel for the Defendant cited the case of **HERMAN NYANGALA TSUMA -VS- KENYA HOSPITAL ASSOCIATION T/A THE NAIROBI HOSPITAL AND 2 OTHERS (2012) e KLR** in which the case of **PAYREMALU VEEPAN -VS- DR. AMARJEET KAUR (2001) HIGH COURT OF MALAYA** was cited in which it was held:-

"A doctor cannot be held negligent simply because something goes wrong. A doctor can be found guilty only if he falls short of standards of reasonable skilful medical practice. The true text, therefore, to hold a medical practitioner guilty of negligence is to have a positive finding of such failure on his part as no doctor of ordinary skill would be guilty of acting with reasonable and ordinary care."

and further that,

"...... the mere fact that something has gone wrong is itself not sufficient to sustain a tort of professional negligence."

ANALYSIS OF EVIDENCE AND DETERMINATION

Having analysed the evidence on record as well as the submissions by the respective parties, I formulate the issue for determination to be whether the Defendant should be held negligent for the Plaintiff's blindness. To address this question it is important to determine what constitutes negligence.

The Black's Law Dictionary, Eighth Edition at page 1061 defines *"negligence'* as,

"The failure to exercise the standard of care that a reasonably prudent person would have exercised in a similar situation; any conduct that falls below the legal standard established to protect others against unreasonable risk of harm, except for conduct that is intentionally, wantonly, or wilfully disregardful of others' rights. The term denotes culpable carelessness."

Under the explainantion notes, *"negligence in law ranges from inadvertence that is hardly more than accidental to – sinful disregard of the safety of others"*.

From the above definition, negligence would only arise when one owes the duty of care to another

person. In the case of a patient/doctor relationship, the duty of care can only be established when the patient visits the doctor and the doctor agrees to treat the patient.

So then, did this duty of care exist between the Plaintiff and the Defendant?

The Plaintiff visited the hospital on 10th September, 2008. He testified that he informed the medical personnel who received him that he had previously visited the hospital and they needed to check his records so that they would ascertain what they were treating him for. This testimony cannot be far-fetched as DW1 did also state that PW1 was a patient in the hospital with a known history of blood pressure. This notwithstanding, the hospital personnel commenced treatment on PW1, thereby establishing its duty of care over the Plaintiff. From then on, it was presumed that the Defendant personnel were possessed of the medical knowledge required of a reasonable competent medical practitioner to treat the medical condition the Plaintiff was suffering from. It was also expected that the medical practitioner who would treat the Plaintiff was skilled in that area of medicine which he/she would apply competently to treat the Plaintiff.

Therefore, neglience would only arise if the said medical practitioner failed to reasonably apply his knowledge and skill competently as would be expected of him in a situation that confronted the Plaintiff. Further, he/she would be held negligent if his application of his knowledge and skill fell below the standards established in the medical practice. That medical practitioner, if found negligent, his conduct holds the Defendant vicariously liable.

Having established the duty of care between the Plaintiff and the Defendant, the next step is to establish whether there was negligence in the manner in which the Plaintiff was handled by the Defendant personnel.

A further definition of the word negligence was given in the case of **BLYTH -VS- BIRMINGHAM CO. (1856) 11 EXCH. 781.784** as cited in **JIMMY PAUL SEMENYE -VS- AGA KHAN HEALTH SERVICE, KENYA T/A THE AGA KHAN HOSPITAL & 2 OTHERS (2006) e KLR,** in the following words:-

"The 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 provident and reasonable man would not do. In strick legal analysis, negligence means more than needless or careless conduct, whether in ommission or commission, it properly connotes the complext concept of duty, breach and damage thereby suffered by the person to whom the duty was owing."

When the Plaintiff was checked in to the Defendant Hospital, he had been nose-bleeding profusely. His testimony in this respect was corroborated by that of his wife PW2. He stated that at the time of admission, he was experiencing blurred vision. It is worthy of note that both PW1 and PW2 stated that the Plaintiff had been fit on the morning before he was taken to the hospital and even went about his usual businesses. He later went back to his house and complained of a headache and non-stop nose-bleeding. At this stage, there was no indication that the Plaintiff had stepped into the Defendant hospital in the recent past. The symptoms had presented themselves without any administration of drugs from any hospital. According to a letter dated 30th August, 2011 addressed to the Medical Practitioners and Dentists Board and the Plaintiff's testimony before the Court, the Plaintiff had been receiving medication from the Defendant hospital. The letter however stated that the Plaintiff had poor drug compliance, an assertion the Plaintiff did not rebut. The letter stated that the Plaintiff had a long-standing history of Malignant Hypertension which was defined and explained by the learned Counsel for the Defendant in their submissions. It was noted that if hypertension goes untreated, it can become more severe and lead to renal failure, heart disease and blindness of which the Plaintiff presented. Poor drug compliance on the part of the Plaintiff directly alludes to negligent behaviour as defined in the case of **JIMMY PAUL SEMENYE -VS- AGA KHAN HEALTH SERVICE T/A AGA KHAN HOSPITAL** (Supra), being ***"..... omission to do something which a reasonable man, guilded upon those considerations which regulate the***

conduct of human affairs would do, or doing something which a provident and reasonable man would not do."

This fact is vindicated by the evidence of PW2 who on cross-examination admitted that when they arrived at the hospital, the doctor complained that PW1 did not adhere to medical check-ups and treatment. This was a clear indication that he was required to make follow ups on treatment for the hypertension but had blantantly declined to do so.

It was also the Plaintiff's evidence, that when he visited the hospital with a problem of nose-bleeding, he was instead treated for diabetes. In self-contradiction, he stated that a drug called carpimazole was given to him. That when he visited Huruma District Hospital he was informed that this drug was used to treat the mentally sick. Unfortunately, he did not avail any specialist to prove that the said drug was for the mentally ill. Besides, he did not tender any documentation, particularly in the form of a prescription in prove that this drug or any other that was not meant to treat his condition was administered to him. He neither called the medical personnel who gave this information.

Moreso, it was also imparative upon him to demonstrate that the drug that was prescribed to him did infact cause the blindness. This evidence could only be proved by a medical practitioner who the Plaintiff did not call to buttress his case.

It is also worthwhile noting that the Plaintiff went to other hospitals, ostensibly for second medical opinions. He said that it is these other hospitals which informed him that the medicines that was prescribed by the Defendant hospital were not suitable. The hospitals also told him that he did not suffer from hypertension and diabetes. He however did not provide any evidence of such medical advise. His testimony thus remained a theory which this court cannot take as truth.

The fact that the Plaintiff chose to follow other advise concerning the state of his health did not imply negligence on the part of the Defendant. He had the right to seek a second, third or fourth medical opinions. However, the other medical opinions given to him, despite the fact that they were not presented to court, did not demonstrate that the Defendant was negligent in the manner it handled him. They also ought not to have hindered him to follow the doctor's instructions in so far as he did not opt to take other paths of treatment other than was prescribed by the Defendant.

In any event, DW1 was categorical that the Defendant did not prescribe any medicine for treatment of diabetes. And this fact was not dislodged by the Plaintiff himself as he never showed any one diabetes drug that he took or was prescribed to him. Again, DW1 did also come to court with the original treatment record of the Plaintiff and it did emerge that at no time was he required to take drugs meant to treat diabetes. Records of treatment exhibited by DW1 indicated that he presented himself with nose bleeding and nothing could be done until the cause of the nose bleeding had been established. It was then established it was caused by high blood pressure and appropriate drugs were prescribed and administered.

And as noted in the case of **HERMAN NYANGALA TSUMA -VS- KENYA HOSPITAL ASSOCIATION T/A THE NAIROBI HOSPITAL** (Supra) ***"as long as the doctor does not go outside the well known medical procedures, it is acceptable that there may be variation in approaches to particular cases. It is only where a doctor decides for reasons only known to himself to deviate from well-known procedures that in the event that deviation leads to injury to a patient, that the court will find fault with the doctor."***

In the case at hand, there is no iota of evidence that the medical personnel who handled the Plaintiff deviated from the known procedures of treating the case at hand. There was also no indication of incompatibility with the professional skills expected of the said personnel which led to the Plaintiff's condition.

In this court's view, given the evidence on record, the doctors exercised reasonable skills and care

within the time and perimeters they were expected to do so. Owing to the malignant hypertension the Plaintiff suffered, the resultant condition could not have been avoided through any other or further action taken by the doctors. As such, the Defendant cannot be held liable due to lack of concrete evidence to support the Plaintiff's claim. It is my view that had the Plaintiff been adhering to the strict medication hitherto prescribed to him, the malignant hypertention would not have ensued – and so the blindness would not have resulted.

It is not disputed that PW3 – 6 knew the Plaintiff before he became blind, but the burden lay on him (Plaintiff) to prove that the blindness was specifically caused by the negligent treatment accorded to him at the Defendant hospital. That is to say that the doctors' actions or omissions led to his blindness together with the renal failure and the heart problem. He failed to discharge this noble burden, reasons wherefore his claim must fail.

In the same spirit, the claim on special damages must also fail as the same accrues from the claim on liability. Needless to say though, the Plaintiff did not provide any evidence on how he arrived at the sum claimed while it is trite law that special damages must be specifically pleaded and specifically proved.

May I also note that the Defendant took forth a noble task of providing the Plaintiff with occupational therapy to help him to function, particularly walk, as a visually impaired person. The Plaintiff's situation is indeed pathetic but it is hoped that with the additional skill in braille at the Machakos School for the blind, he will be able to live a more fulfilling life.

In the end, I dismiss the suit in its entirety. Costs follow the event. But noting the circumstances under which this suit was filed, I order that each party bears its own costs.

DATED and **DELIVERED** at **ELDORET** this 10th day of July, 2014.

G. W. NGENYE - MACHARIA

JUDGE

In the presence of:

The Plaintiff in person

Mr. Mkabane holding brief for Maritim for the Defendant