REPUBLIC OF KENYA

IN THE HIGH COURT OF KENYA AT NAIROBI

CIVIL APPEAL NO. E195 (consolidated with CIVIL APPEAL NO. E190 OF 2021

UNIVERSITY OF NAIROBI ----------.--------
APPELLANT

-VERSUS-

OCHIENG G. MBEO (Suing on Behalf of the Estate of the Late PETRONILLA OKINYO MBEO) ----------.- 1ST RESPONDENT

AGA KHAN UNIVERSITY HOSPITAL ---------- 2ND RESPONDENT

DR. CAROLINE ODULA ---------- 3RD RESPONDENT

DR. SAMSON MIYORO ----------.- 4TH RESPONDENT

(Being an Appeal from the Judgment and Decree of Nairobi CMCC No. 919 of 2018 delivered by the Hon. G.A. Mmasi, Senior Principal Magistrate dated 15th March 2021)

CONSOLIDATED JUDGMENT

INTRODUCTION

1. Two appeals were filed by the parties in CMCC No. 919 of 2018. Appeal No. 190 of 2021 was lodged on 13th April

2021. The Appellant is the Aga Khan University Hospital, whilst the respondents are Ochieng G. Mbeo (1st Respondent), Dr Caroline Odula (2nd Respondent), Dr Samson Miyoro (3rd Respondent), and the University of Nairobi (4th Respondent). On 14th April 2021, Civil Appeal No. 195 of 2021 was submitted by the University of Nairobi, the Appellant. The respondents include Ochieng G. Mbeo (suing on behalf of the estate of the late Petronila Okinyo Mbeo), Aga Khan University Hospital (2nd Respondent), Dr Caroline Odula (3rd Respondent), and Dr Samson Miyoro (4th Respondent). The Appellant in HCCA No. 190 of 2021 seeks to have the appeal allowed, the judgment of the Trial Magistrate against it overturned, and the suit in the lower court dismissed with costs. The Appellant also requests that it be awarded costs of the appeal to be paid by the 1st Respondent. In HCCA No. 195 of 2021, the Appellant seeks the following orders: that the appeal be allowed, the judgment of the lower court be set aside with costs, that the court substitute the lower court's judgment with an appropriate one against the Respondents, and that the costs of the appeal be awarded. Appeal No. 195 of 2021 was filed a day after Appeal No. 190 of 2021. The two appeals challenge the Trial Magistrate's findings in CMCC No. 919 of 2018. When I took over the matter, the parties did not agree that the appeals had been consolidated. I have reviewed the court proceedings and find that although the parties mentioned that the appeals should be consolidated, neither party filed a consent, nor is there a

court order on the same. The last order I issued in the matter was that the court would deliver judgments in HCCA No. 190 of 2021 and 195 of 2021. However, after considering the issues in each appeal, I find that the appellants, who were defendants in CMCC No. 919 of 2018, have raised essentially the same issues in their appeals, which I will later specify. I also note that most of the handwritten proceedings are in HCCA 195 of 2021. When I issued the order in HCCA No. 195 of 2021, I had not yet reviewed the Memoranda of Appeal in each case. Having now done so, I believe that a consolidated judgment is appropriate since the issues in both appeals concern the findings of the Trial Magistrate relating to liability and quantum. Therefore, this judgment will be in HCCA 195 of 2021, where all parties involved in HCCA 190 of 2021 are also parties. No prejudice will be caused to any party, as I will consider the issues raised in a manner I believe each will understand as stemming from CMCC No. 919 of 2018.

2. The Appeal before this Court emanates from a civil suit filed by the 1st Respondent vide his plaint dated 15th February 2018 seeking the following reliefs: -

(1) General Damages under the Law Reform Act and Fatal Accident Act;

(2) Aggravated Damages;

(3) Special Damages to be ascertained;

(4) Interest on (1) and (2) above;

(5) The costs of the suit;

(6) Any other relief that the court deems just to grant.

3. The plaintiff's case was that the late Petronilla Okinyo Mbeo, who was his deceased wife, died around 15th June 2017. He attributed her death to negligence by the Appellant as well as the 2nd, 3rd, and 4th Respondents in how they managed and/or treated her while she was under their care. Specifically, the doctors involved in the care of the deceased from 30th July 2016 to December 2016 failed to inform her and/or her relatives that they had discovered she was suffering from a terminal illness. As a result, the deceased's life was put at risk because she did not receive timely treatment, including but not limited to the start of chemotherapy that could have saved her.

BACKGROUND/PLEADINGS

4. The 1st Respondent stated that the deceased underwent a hysterectomy carried out by the 3rd Respondent, Dr. Odula, who was employed by the appellant. This procedure took place on 1st August 2016 at the 2nd Respondent's health facility. The operation was intended to remove the deceased's uterus for diagnostic reasons.

5. Following that procedure, follow-up management was conducted by the 4th Respondent, who was employed by the appellant. It was argued that the first surgical procedure performed by the 3rd Respondent was

negligently carried out, resulting in perforation of the deceased's intestines. This necessitated a series of subsequent surgeries performed by Prof. Saidi Hasssan (now deceased), an employee of the 2nd Respondent. The said doctor aimed to correct the deceased's intestines. However, her condition did not improve.

6. Thus, the deceased was attended to by Dr. Gladwell Kiarie in January 2017. Upon examination, the doctor confirmed that the deceased had undergone a hysterectomy in August 2016. However, no post-operative follow-up was performed. During histological examination, the doctor identified an endometrial tumour in the deceased's body. This diagnosis concerning the deceased's uterus was received by the 3rd Respondent on 8th October 2016.

7. The 1st Respondent stated that they were never informed either by the 3rd Respondent or the late Prof. Saidi Hassan that the deceased had an endometrial tumour requiring post-operative follow-up. This information was only revealed to them when the deceased was examined by Dr. Kairie while requesting the deceased's histology report for August 2016 from the 2nd Respondent's Surgical Department on 22nd February 2017.

8. It was his case that the management provided by Dr. Kiarie could not save the deceased's life because it was initiated too late when her condition had already worsened. The

deterioration of her health was attributable to the failure of the appellant, the 2nd, 3rd, and 4th Respondents to provide timely post-operative follow-up, which led to her death on 15th June 2017.

9. It was the 1st Respondent's further case that a post-mortem conducted on 3rd July 2017 on the body of the deceased confirmed that the deceased died due to endometrial carcinoma. He accused the 3rd and 4th Respondents of negligently mismanaging the deceased, leading to her premature death. He also faulted the 2nd Respondent for negligently neglecting to observe due care of the deceased at its facility during admission on 30th July 2016. He averred that this was based on the fact that these parties owed a duty of care and an implied contractual obligation to the deceased.

10. The 1st Respondent outlined the details of negligence in paragraph 23 of the plaint. He explained that since the deceased was 61 years old at the time of her death, employed as a permanent and pensionable worker for the appellant, and earning a monthly salary of Kshs. 280,000/=. with nine years remaining until retirement, the deceased's estate should be awarded compensation for her wrongful death.

11. The 3rd Respondent, Dr. Caroline Odula, filed her statement of defence dated 28th March 2018. She denied

the contents of the plaint. In particular, she denied being negligent in treating and diagnosing the deceased. She also denied failing to report that the deceased was suffering from a terminal illness that endangered her life. She admitted that she carried out the surgery on the deceased on 1st August 2016 at the 2nd Respondent's facility, in the presence of Dr. Wanjohi, a colleague from the appellant's institution, and anaesthetist Dr. Devi Mong'are.

12. The 3rd Respondent stated that she examined the deceased daily until the 6th post-operative day after the surgery, when the deceased was discharged. She stated that she advised the deceased to continue with wound dressing on alternate days at a facility of her choice.

13. The 3rd Respondent stated that her call week concluded on 8th August 2016 at 0800 hrs when she handed over the patient to her gynaecology colleagues. She went on her annual leave from 19th August 2016 to 9th September 2016.

14. She further stated that the deceased was a general patient at the University of Nairobi Health Services, and whenever readmitted for care under different specialities, she was neither on call nor informed. She denied receiving the results and/or diagnosis made on the deceased's uterus on 8th October 2016 as alleged, stating that she was only informed of this in mid-February 2017 by Dr Doreen

Asimba, the Deputy Chief Medical Officer of the appellant. That was when she was told that the uterus and ovary samples of the deceased revealed adenocarcinoma of the uterus. At that point, the deceased was under the care of radiotherapists and oncologists.

15. The 3rd Respondent denied any mismanagement of the deceased, lack of post-operative follow-up, or failure to institute such follow-up in a timely manner. Acknowledging her duty of care towards the deceased, she asserted that she had fulfilled this obligation by providing professional care of high standards and exercising all reasonable skills when attending to the deceased.
16. The 4th Respondent filed his statement of defence dated 18th November 2019. He denied the contents of the plaint. He averred that he was not the deceased's primary doctor or surgeon who attended to her, as the deceased chose the 3rd Respondent as her primary obstetrician and gynaecologist. He stated that it was the 3rd Respondent who recommended a hysterectomy for the deceased, and affirmed that he was not part of the team that performed the surgery.

17. He stated that the deceased was never handed over to him and that he was only called upon by the then Chief Medical Officer – University of Nairobi, the late Dr. M.R.B. Otieno, who informed him of the deceased's re-admission to the 2nd Respondent's facility on 10th August 2016. It was then

that he was asked to check on her progress, and he observed that her wound had sepsis, prompting him to commence treatment.

18. The 4th Respondent stated that following discussions with Dr. Otieno, it was advised that a General Surgeon should attend to the wound. It was at this point that Professor Hassan Saidi, a General Surgeon, assumed responsibility for the treatment of the wound sepsis. The 4th Respondent further stated that, at this stage, the mentioned Professor remained a consultant while the primary treatment was conducted by the 2nd Respondent's surgical team.

19. The 4th Respondent denied that the treatment initiated on 10th August 2016 was related to the deceased's intestines. Instead, he explained that it was intended to treat the developed wound sepsis at the surgical site. He also denied being aware of the histology report or the results of the hysterectomy procedure, as these had never been uploaded to the 2nd Respondent's system or the deceased's file. Consequently, he was unaware that the deceased had endometrial adenocarcinoma. He expressed the view that, as a standard practice, disclosure of the histology report—when it was positive or conclusive—should only be made to the patient's primary doctor or next of kin.

20. He further stated that even if they had received the results from the hysterectomy, treating the wound sepsis was an emergency and a priority because it would have impacted any subsequent treatment for the deceased's alleged condition. He recalled that the deceased was discharged in good condition on 5th September 2016 and denied ever having any contact with the deceased after the discharge.

21. He also stated that any allegations of negligence are unrelated to the cause of the deceased's death. He argued that the progression of her condition was not caused by the issues raised in the plaint. In his view, the deceased died from fluid loss due to vomiting and diarrhoea, which resulted in hypovolemic shock. He asserted that he was never negligent in any way that could have caused injury to the deceased from the treatment he provided for the wound sepsis.

22. The 4th Respondent attributed negligence to the deceased, the 1st Respondent, and the 2nd Respondent for failing to exercise reasonable care and skill to prevent the death. He detailed the instances of negligence as outlined in the plaint and pleaded the defence of *novus actus interveniens*.

23. The 2nd Respondent filed its statement of defence dated 7th September 2018. It denied the contents of the plaint and put the plaintiff to strict proof. It averred that, although

the post mortem was conducted on 3rd July 2018, and although the 3rd and 4th Respondents were highly qualified doctors, they were not its employees. Finally, it denied the particulars of negligence set out in the plaint.

24. The appellant filed its statement of defence dated 15th October 2019, denying the contents of the plaint and putting the 1st Respondent to strict proof. It was its case that although the 3rd and 4th Respondents were its employees, they were not negligent in any way. Therefore, the appellant was not vicariously liable. It also stated that the deceased was successfully operated on by the 1st Defendant, together with Dr Wanjohi, on 1st August 2016. Subsequently, samples of the removed tissues were sent to the 2nd Respondent's laboratory for analysis and a pathology report.

25. It was stated that the deceased was discharged on 7th August 2016. The surgery performed was to manage menopausal bleeding. It denied that the deceased suffered any perforation of the intestines during the operation, as alleged, or that any corrective surgery was carried out. Instead, further post-operative procedures were performed on the deceased's wound by the 2nd Respondent's surgical team led by Dr. Hassan Saidi, due to the fact that the appellant did not have general surgeons.

26. The appellant stated that the 2nd Respondent provided in-patient services to the deceased unless consultation with its doctors was necessary. At the time of the deceased's review by the 4th Respondent and the 2nd Respondent's surgical team, the histology report was not available for their review and advice. As a result, they were unaware that the deceased had endometrial adenocarcinoma; this information was only known to the 2nd Respondent.

27. It stated that it could not reasonably be expected to obtain the said information since the deceased's pathology results were neither posted on the 2nd Respondent's internal system nor issued to the appellant, the 3rd, and 4th Respondents.

28. It was further alleged that the pathology results were only brought to their attention on 16th February 2017. That was when the acting Chief Medical Officer, Dr. Doreen Asimba, reviewed the deceased's MRI pelvic report from the 2nd Respondent and noted that the deceased suffered from endometrial adenocarcinoma, upon which she immediately initiated curative and management procedures.

29. It was their argument that by the time the deceased was operated on 1st August 2016, she was already suffering from the said disease, which, despite being at an advanced and rapidly progressing stage, was being well managed by

the appellant's team together with the 4th Respondent; that the deceased was successfully treated and attended to at the appellant's hospital on different dates until 15th June 2021.

30. The appellant argued that the doctors of the 2nd Respondent, to the exclusion of the appellant, failed and wilfully neglected to take adequate measures to provide life-saving medical care to the deceased. It stated that the deceased died due to hypovolemic shock caused by fluid loss from vomiting and diarrhoea over the course of a week. It was not foreseeable that the deceased would die as a result of the endometrial carcinoma, and the defence of novus actus interveniens was applicable.

31. It was averred that the alleged negligence was not related to the cause of death, as the development of the deceased's condition was never caused by the matters alleged. It was stated that the deceased did not suffer any injuries from the medical treatment provided and that the appellant did everything medically possible to discharge its duty. Instead, it attributed any negligence to the deceased, the 1st and 2nd Respondents, and specified this in paragraph 5 of its Defence. It further sought indemnity from the other Defendants.

JUDGMENT OF THE TRIAL COURT

32. The matter was set down for hearing, and at its conclusion, the trial court entered judgment in favour of the 1st Respondent as follows:

> ***"Liability at 100% against the Defendants with the 4th Respondent being vicariously liable for the 1st and 2nd Defendants who were its employees.***
>
> ***a) General Damages for Injury – Kshs. 11,720,000/=***
>
> ***b) Loss of life expectancy – Kshs. 100,000/=***
>
> ***c) Aggravated Damages against the 1st and 3rd Defendants – Kshs. 1,000,000/=***
>
> ***TOTAL – Kshs. 12,820,000/=***
>
> ***d) Costs of the Suit."***

THE APPEAL

33. Aggrieved by the above decision, the appellant in HCCA No.195 of 2021 filed the present appeal via its memorandum of appeal dated 14th April 2021. The appellant sought to set aside the judgment of the trial court with costs and to have it replaced with an order entering judgment against the Respondent with costs of the appeal. I have already indicated the relief sought by the Appellant in HCCA No. 190 of 2021. Appeal No. 195 of 2021 raises

twelve (12) grounds of appeal, which are reproduced as follows: -

GROUNDS OF APPEAL IN HCCA NO. 190 OF 2021

1. **That the Learned Trial Magistrate erred in law by making an improper analysis of the pleadings and evidence adduced in support of the Appellant's and the Respondents' averments, leading to an erroneous decision in the matter.**
2. **That the Learned Magistrate erred in law and in fact in failing to take into account material aspects of the evidence in support of the Appellant's defence and eventually arriving at the finding that the Appellant was negligent in not informing the 1st Respondent of the lab results.**
3. **That the Learned Trial Magistrate erred in finding against the weight of evidence that the Appellant was negligent.**
4. **That the Learned trial Magistrate erred in fact and in law in making an award for general damages amounting to Kshs.11,720,000/- which was manifestly excessive as to represent an entirely erroneous estimate.**
5. **That the Learned Trial Magistrate erred in law in awarding aggravated damages of KShs. 500,000/-.**
6. **That the Learned Trial Magistrate's Judgment in the assessment of the available evidence in proof of the**

Appellant's defense is erroneous and based on wrong principles.

7. **That the Learned Trial Magistrate misdirected herself, misapprehended and misconstrued the legal principles in the case before her and by reason thereof came to a wrong conclusion**

GROUNDS OF APPEAL IN HCCA NO. 195 OF 2021

(1) **The Learned Trial Magistrate erred in law and in fact in dismissing the Appellant's defence notwithstanding the evidence on record in support of its case.**

(2) **The Learned Trial Magistrate erred in law and in fact in failing to consider the issues raised by the Appellant in its Statement of Defence, cross-examination by its advocates and submissions filed.**

(3) **The Learned Trial Magistrate erred in law and in fact in misunderstanding the evidence tendered by the parties at the trial thereby arriving at wrong findings.**

(4) **The Learned Trial Magistrate erred in law and in fact in wholly dismissing the Appellant's defence despite the same being supported by the evidence of the 4th Respondent.**

(5) **The Learned Trial Magistrate erred in law and in fact in finding that the Appellant was 100%**

liable to the 1st Respondent despite finding that Prof. Saidi Hassan, an employee of the 2nd Respondent liable for negligence.

(6) The Learned Trial Magistrate erred in law and in fact in holding that the deceased's death was as a result of cancer and/or that the same was by reason of lack of post-operation follow up in spite of contradictory evidence in the post-mortem report and certificate of death.

(7) The Learned Trial Magistrate erred in law and in fact I failing to find that the deceased and the Plaintiff were in any even guilty of contributory negligence despite abundant evidence of the same.

(8) The Learned Trial Magistrate erred in law and in fact in failing to find that the Appellant had afforded the deceased adequate medical care and was not liable.

(9) The Learned Trial Magistrate erred in law and in fact in finding that the Appellant was vicariously liable for the actions of the 3rd and 4th Respondent s.

(10) The Learned Trial Magistrate erred in law and in fact in awarding the 1st Respondent General Damages of Kshs. 11,720,000/= without any proof and/or justification therefore which damages were excessive in the circumstances.

(11) The Learned Trial Magistrate erred in law and in fact in failing to find that the 2nd Respondent wholly liable for the deceased's death.

(12) The Learned Trial Magistrate erred in law and in fact in delivering a judgment that was contradictory.

34. The appeal was admitted for hearing and the parties took directions to canvass it by way of written submissions which are now on record.

SUBMISSIONS

APPELLANT'S SUBMISSIONS

35. The appellant filed written submissions along with a list of authorities dated 21st September 2023. Counsel submitted on behalf of the appellant that the judgment was contradictory and baseless, as it was found liable in negligence for causing the death of the deceased. They opined that it was actually the 2nd, 3rd, and 4th Respondents who mismanaged the deceased, leading to her death. Counsel also accused the deceased of negligence for not following her prescriptions as advised medically.

36. Looking at the evidence of Dr. Caroline Odula and Dr. Samson Miyoro, it was the appellant's submission that they provided the deceased with adequate medical care. It

argued that the evidence on record proved that its employees exercised reasonable care and skill throughout the management of the deceased, particularly on the 15th day of June 2017 when she passed on.

37. It pointed out that several reasons were presented to the court attributing the cause of the deceased's death. As there were multiple speculative opinions about the cause of death, it argued that it could not be held responsible. This is because the death certificate stated that the deceased died from endometrial carcinoma due to cardiopulmonary arrest on 15th June 2017.

38. Learned Counsel further stated that the deceased died while waiting for emergency lifesaving medical intervention at the 2nd Respondent's premises, which lacked a vacant High Dependency Unit bed to accommodate her. It submitted that the 2nd Respondent failed to implement timely emergency procedures upon receiving the deceased in a life-threatening condition on that fateful day. It urged this court to note that this was admitted by the 2nd Respondent and that it ultimately led to the deceased's death.

39. The appellant then submitted that when the 4th Respondent took over management of the deceased, he did not have the password to access the 2nd Respondent's

digital records. Accordingly, it was not brought to his attention that the deceased suffered a terminal illness. That the trial court properly found that the late Professor Hassan did not disclose such crucial information to the 4th Respondent.

40. Submitting on contributory negligence, the appellant attributed blame to the deceased, the 1st Respondent, and the 2nd Respondent for their alleged negligent contributions to the deceased's death. It explained that the 1st Respondent resided with the deceased as her husband and primary carer. Therefore, he owed her a duty of care to ensure she was properly nourished, adhered to her medication, and attended laboratory tests.
41. It blamed him for failing to take the deceased to the appellant’s facility for medical attention and for only waiting until she was severely deteriorated. The appellant submitted that she had been vomiting and suffering from diarrhoea for one week. It further blamed the 1st Respondent for not taking quicker action to have the deceased undergo a pap smear when she was due in January 2016, and submitted that he was not even aware of its necessity. Therefore, it proposed that negligence be attributed to the deceased and the 1st Respondent at 70% and to the 2nd Respondent at 30%.

42. The appellant argued that, given the circumstances, it was not responsible and therefore should not compensate the deceased's estate. It objected to the 1st Respondent's submission of the deceased's net earnings, which was introduced outside the hearing, and pointed out that there was no basis for the award of Kshs. 11,720,000.00. The learned counsel contended that the award was excessively high and failed to consider the deceased's medical history, which diminished her chances of survival until retirement age. It requested that the appeal be allowed.

43. 1ST RESPONDENT'S SUBMISSIONS

The 1st Respondent did not file any written submissions

2ND RESPONDENT 'S WRITTEN SUBMISSIONS

44. The 2nd Respondent filed written submissions and a list of authorities, both dated 22nd September 2023. It argued that it was undisputed that whenever a post-menopausal woman presented with spotting, it was indicative to any obstetrics and gynaecology practitioner that such spotting was most often due to a cancerous invasion. This understanding led the 3rd Respondent to conduct a biopsy on the deceased.

45. The 2nd Respondent outlined the chronology of the deceased's treatment to demonstrate that Dr. Gakinya posted the results of the deceased's biopsy, which were uploaded onto the electronic platform on 11th August 2016.

It was stated that these could be accessed by both the 3rd and 4th Respondents, as they had clinical and admission privileges permitting them to do so. The submission was that the 2nd Respondent only tested the specimen, did so promptly, and submitted the results in a professional manner.

46. According to the 2nd Respondent, the appellant, the 3rd and 4th Respondents failed to follow up on the results. As such, they were negligent and callous, as their actions fell below the standard expected of a reasonably competent medical practitioner. It was submitted that a positive diagnosis of cancer ought to be disclosed to a patient by his or her primary caregiver and not by any other person or entity. Therefore, it was incumbent on the 3rd and 4th Respondents to follow up on the biopsy results; practitioners who had clinical and admission privileges at its facility.

47. The 2nd Respondent reaffirmed that the results were posted rapidly. The responsibility of accessing results therefore rested with the primary caregiver. It argued that since pathologists perform hundreds of tests daily, it would not be practical to inform each doctor and/or patient about the results. In its view, it was not the obligation of the 2nd Respondent to bring the deceased's disputed histology report to the attention of the 4th Respondent. In any event,

Professor Saidi Hassan only offered expertise in the management of wound sepsis, which she did adequately.

48. It highlighted the fact that the results were pending, as indicated in the discharge summary and during the patient's second admission. In its view, this demonstrated that the 4th Respondent was aware. It is argued that the 3rd and 4th Respondents never requested physical copies of the results, yet they were aware of this requirement.

49. Regarding the entitlement to awards by the 1st Respondent, the 2nd Respondent contended that the damages awarded by the trial court were excessively high. Moreover, the deceased's earnings were not sufficiently proved on a balance of probabilities. It argued that the deceased's estate should be awarded Kshs. 1,646,400.00, calculated as follows: 280,000 × 12 × 1 × 1/3 (for taxes) × 1/3 (for dependents). Concerning pain and suffering, the 2nd Respondent submitted that it was not proven that the deceased experienced pain prior to her death, as indicated by the medical records of 15th June 2017. It agreed with the trial court's findings regarding the loss of expectancy of life.

4TH RESPONDENT 'S WRITTEN SUBMISSIONS

50. The 4th Respondent filed written submissions dated 3rd March 2024. The 4th Respondent submitted that the

deceased was already ill when she visited the appellant's facility. The 4th Respondent recommended a hysterectomy, which was performed by the 3rd Respondent. During the procedure, complications arose, requiring her admission to the 2nd Respondent. The 4th Respondent then summarised the evidence at trial, concluding that the 2nd Respondent was negligent in failing to provide the deceased's report, either physically or in the digital system.

51. The 4th Respondent reaffirmed that it was not disputed the deceased was admitted and treated at the 2nd Respondent's facility. A duty of care therefore arose. The Respondent argued that there was no connection between the cause of death and the consultation services provided by the 4th Respondent. However, the cause of death was attributed to the 2nd Respondent, where the deceased died. The 4th Respondent noted that the 2nd Respondent's staff did not adequately manage her.

52. The 4th Respondent argued that the 3rd and 4th Respondents were not liable because they exercised the reasonable diligence and skill expected of them as professionals in managing the deceased. They maintained that there was no basis for awarding general damages against the 4th Respondent. Therefore, they asked this court to find that the 1st and 2nd Respondents were liable

and to set aside the liability findings against the appellant, the 3rd Respondent, and themselves.

ANALYSIS AND DETERMINATION

53. The duty of this court as a first appellate court is to re-evaluate, re-assess, and re-analyse the evidence on record, bearing in mind that this court did not have the benefit of hearing and seeing the witnesses. It is also important to note that the court's responsibility is to decide on the evidence presented, without introducing extraneous matters not addressed by the parties in their evidence (***see Kenya Ports Authority vs. Kuston (Kenya) Limited (2009) 2 EA 212).*** I have carefully considered the written submissions of the parties, taking into account all the evidence and the relevant law.

54. This court is also mindful of the well-established principle by Kneller JA and Hancox Ag. JJA in Mkube v. Nyamuro [1983] KLR at 403, where it was held as follows: -

"A Court on appeal will not normally interfere with the finding of fact by a trial court unless it is based on no evidence, or on a misapprehension of the evidence, or the judge is shown

demonstrably to have acted on wrong principles in reaching his conclusion."

55. Having said that, in my view, the only two issues that need to be determined centre around the questions of liability and quantum. In other words, did the trial court reach the correct or incorrect decision in its analysis of the facts, the evidence on record, and the law?

LIABILITY

56. Liability in civil claims arises from a duty of care, an obligation, a debt, or a responsibility that originates from a contract, tort, or statute. To determine whether a party is liable in a civil case, the court must review the facts and decide if a duty of care was owed by the defendant to the injured party. Essentially, it involves a failure to meet a reasonably expected standard of behaviour owed to others. This breach of duty forms the basis of the tort of negligence.
57. The term 'medical negligence', which is central to this appeal, was defined in the case of JPS vs. Aga Khan Health Service, Kenya t/a The Aga Khan Hospital & 2 others [2006] KEHC 2134 (KLR) as follows:

"When a physician or other medical staff member does not treat a patient with the proper amount

of quality care, resulting in serious injury or death they commit medical negligence."

58. Seeking to clarify the definition of that term as outlined in the cited decision, this court is tasked with determining whether a duty of care was owed to the wife of the deceased of the 1st Respondent by the Appellant and the 2nd to 4th Respondents. In this regard, the court will refer to the principles established in the Bolam test, which was derived from the landmark case of Bolam v. Friern Hospital Management Committee [1957] 1 WLR 582; 2 All ER 118. The Queen's Bench held thus: -

"A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art."

59. The Supreme Court of India outlined the threshold for establishing negligence by a doctor in the case of M.A. Biviji v. Sunita, Civil Appeal No. 3975 of 2018, consolidated with Nos. 4847 of 2018 and 6917 of 2023, as follows:

"36. As can be culled out from above, the three essential ingredients in determining an act of medical negligence are: (1.) a duty of care extended to the complainant, (2.) breach of that duty of care, and (3.) resulting damage, injury or harm caused to the complainant attributable to the said breach of

duty. However, a medical practitioner will be held liable for negligence only in circumstances when their conduct falls below the standards of a reasonably competent practitioner."

60. Back in our jurisdiction, in the case of Ricarda Njoki Wahome (suing as administrator of the estate of the late Wahome Mutahi (Deceased)) vs. Attorney General & 2 others [2015] KEHC 4929 (KLR), this court stated: -

"A doctor can be held guilty of medical negligence only 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 the 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."

61. Lastly, in the case of Magil v Royal Group Hospital & Another [2010] N.I QB 1, the High Court of Northern Ireland held: -

> ***"The general principles of law applicable in clinical negligence cases are rarely in dispute in modern cases…. To all the defendants in this case, there is to be applied the standard of the ordinary skills of a consultant, doctor or nurse as the case may be. They must act in accordance with the practice accepted at the relevant time as preferred by a responsible body of medical and nursing opinion, (see also Sidaway v. Bethlem Royal Hospital Governors [1985] 1 All ER 643 at 649.) The standard of care must reflect clinical practice which stands up to analysis and is not unreasonable. It is for the court, after considering the expert evidence whether the standard of care afforded the deceased put him at risk."***

62. The significance of this is that a court of law cannot hold a medical practitioner liable if their actions were backed by responsible medical opinion, even if other professionals might have acted differently. In other words, the actions of the Appellant and 2nd – 4th Respondents in this case will not amount to medical negligence, provided that their actions and decisions were based on sound medical

reasoning and did not fall outside the bounds of best practise.

63. The standard of care is therefore that which members of a professional body are reasonably expected to perform in a specific situation. In this context, not every wrongful act can be regarded as negligence. If the courts were to hold hospitals and all doctors liable for every issue that arises when caring for patients, it would result in a flood of frivolous and vexatious legal claims with no end in sight. Therefore, the test should be a fair and reasonable standard of care and competence.

64. In this case, the 1st Respondent blamed the Appellant and the 2nd to 4th Respondents. He alleged that they negligently mismanaged his deceased wife through the way they administered, or failed to administer, healthcare services to her. During his trial evidence, the 1st Respondent revealed that the deceased was diagnosed with endometrial adenocarcinoma, a type of cancer. This diagnosis came from tests conducted on samples taken after the deceased underwent a hysterectomy. According to the 1st Respondent, this information was not communicated promptly. As a result, it was difficult for his deceased wife to access medical treatment.

65. In his evidence-in-chief, the 1st Respondent recalled that by the time Dr. Gladwel Kiarie administered chemotherapy to the deceased in February 2017, the cancer had already advanced significantly. He stated that the hysterectomy procedure took place in August 2016. It was at this point, in his view, that she should have been diagnosed with and informed of the disease. At that stage, it was only at stage 2. He argued that since the disease was in its early stages, the deceased could have benefited from early treatment. He further stated that Dr. Kiarie raised a red flag, questioning why treatment was not commenced as soon as the histology results were provided to the 3rd Respondent on 10th August 2016.

66. A brief review of the record before this court indicates that the deceased's histology report was first uploaded on 11th August 2016. It is also noteworthy that the 1st Respondent and his deceased wife only became aware of the report in February 2017 when Dr. Gladwel Kiarie informed them of it. Based on the above, were the appellant, and the 2nd, 3rd, and 4th Respondents liable for medical negligence? I will analyse each of the parties mentioned sequentially as outlined below.

(a) THE 3RD RESPONDENT - DR. CAROLINE ODULA

67. The 3rd Respondent was the deceased's primary doctor. In her evidence-in-chief, the 3rd Respondent stated that after

the hysterectomy, she attended to the patient regularly and reviewed her daily until her discharge on 7th August 2016. She then proceeded on her annual leave. She mentioned that one Dr. Kakinya signed the surgical report of 11th August 2016.

68. During her cross-examination, it was revealed that she requested a histopathological examination to determine whether the deceased needed any further medical attention. As the lead surgeon, she stated that she was only aware of the patient's results in February 2017. She added that she did not know whether any of the other doctors at the facility where she worked followed up on the report. In her view, although the report was in the 2nd Respondent's system, it should have been printed and physically placed in the file.

69. She admitted that she did not carry out any follow-up when she went on leave and acknowledged that she and her team could access the 2nd Respondent's system if they logged in. It was her concession that, had the histology report been provided, the deceased would have begun chemotherapy within six weeks after the hysterectomy.

70. On further cross-examination, the 3rd Respondent admitted that it was necessary for the doctors attending to the deceased after the initial surgery to have the histology

report, as they carried out the debridement on the surgical wound. She also acknowledged that the patient's condition was not properly managed. Furthermore, she testified that it had not been established what the link was between the first and subsequent surgeries.

71. Additionally, the 3rd Respondent denied being able to access the 2nd Respondent's system, as it was only accessible to staff members. She also argued that any doctor would have managed the discharge summary while she was away. While accepting that the deceased was her responsibility and that, in normal circumstances, she would have followed up regardless of being referred to the 2nd Respondent's facility, she suggested that blame should be attributed to the pathologist for not informing her of the outcome of the histology report.

72. Finally, she explained that she expected the results within a week but never received them, even after two months. She argued that the deceased was not responsible enough, as she delayed in providing the results of the histology examination.

73. My analysis of the evidence above is that the 3rd Respondent demonstrated a lack of understanding of the urgency and importance of obtaining the results from the histopathology examination, despite being the one who

requested it. In her own evidence, she revealed that her reason for requesting the histopathological examination was to determine whether the deceased required any further care. This alone indicated a pressing need to rule out any underlying issues that could have caused the ongoing spotting leading to the procedure performed on the deceased.

74. In my view, a responsible medical practitioner in her position was obliged, as the patient's primary doctor, to diligently follow up and uncover the results of the histology examination. Instead, the 3rd Respondent conveniently hid behind the excuse of her annual leave to absolve herself of responsibility for the deceased; yet she was her primary doctor and was expected to determine the nature of the deceased's health issues, which she failed to do. The 3rd Respondent, as the deceased's primary doctor, owed a higher duty of care and was responsible for obtaining feedback from the tests conducted after her hysterectomy.

75. The court is surprised by the 3rd Respondent's actions or inactions. She was the one who ordered a histopathological examination but then showed a lacklustre attitude towards the matter. By ordering that examination, the 3rd Respondent understood the importance, nature, and significance of the results and was fully aware of any delays

in relaying information due to delayed treatment. She could not, therefore, seek refuge under her annual leave.

76. It is even more troubling that the 3rd Respondent, a seasoned medical practitioner, chose to blame the pathologist and her colleagues in charge when she went on leave, as well as the deceased herself. In my view, this was not only an admission that there was some negligence or a breach of duty owed to the deceased, but also a revelation that she was aware more could have been done to improve the deceased's urgent and severe condition.

77. In other words, the 3rd Respondent neglected the deceased by failing to attend to or follow up on her medical tests, even long after she returned from her annual leave. She stated that she only became aware of the histology report six (6) months later. If her lackadaisical conduct in following up on the report while away on leave was not enough to find her culpable, then her failure to follow up after returning from leave was a more compelling reason to conclude she was partly at fault.

78. My findings above are further supported by the fact that DW4 stated that although the 3rd Respondent was not a doctor at the 2nd Respondent's facility, she had accessed privileges to retrieve the results from the system. Her argument that she was unable to access the system lacks

probative value and is unpersuasive. The results were properly uploaded onto the portal on 11th August 2016. Even though she had already gone on her annual leave by this time, nothing prevented her from accessing the system upon her return on 16th September 2016 to verify the diagnosis made by DW3.

79. There was also no evidence that she attempted to follow up on the results in vain. She also stated that it was the pathologist who was supposed to call her. However, wasn't she the one who requested the report? Even if that was the case, it was her responsibility to make the necessary follow-ups. That did not happen.

80. It can safely be concluded that her negligent acts and conduct arose the moment she left for her leave and became even more evident upon her return. As the deceased's primary doctor, she had an unquestionable duty to establish the results of the histology, whether she was on active duty or not. She was consequently negligent for failing to do so, as would be expected of a reasonable doctor. I base these findings on the excerpt from Charles Worth & Percy on Negligence (8th Edition), where it is stated 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."

81. As the deceased's primary doctor, the 3rd Respondent's duties and responsibilities did not cease when she took leave. She was expected to exercise due diligence in following up on the report before and after her annual leave or upon her return. It is my conclusion that she cannot be absolved from responsibility for the death and negligent management of the deceased after her hysterectomy procedure and is therefore liable.

4TH RESPONDENT – DR. SAMSON MIYORO

82. The 4th Respondent testified that while attending to the deceased at the 2nd Respondent's facility, he accessed her confidential notes and patient file. He also stated that all medical staff, including nurses and doctors, had access to these notes. He further explained that they had different levels of access to various documents, with some being restricted. These restrictions applied to results related to HIV or cancer. He stated that he first learned of the deceased's cancer diagnosis when the matter was filed in

court and reiterated that he only treated her for the septic surgical wound.

83. During his cross-examination, he testified that tissue samples were removed from the deceased for histology examination. Generally, these results would be presented to the doctor who took the tissues or uploaded to the system. He stated that his role was primarily consultative since the wound was not healing properly. He also mentioned that whenever he reviewed the patient, he neither saw nor was given the histology report.

84. He continued that in 2016, he could not access the 2nd Respondent's system because he needed a PIN number. He sought assistance from Dr. Saidi Hassan to check the results on his behalf. He stated that the primary doctor was the one who accessed the report and refuted the 3rd Respondent's assertion that the patient's entire history was available digitally for any doctor to access. He added that during the 10 years he worked at the 2nd Respondent's facility, he had never accessed their system. However, he later contradicted himself by stating that he could only access the system when he was employed by the 2nd Respondent.

85. The 4th Respondent strongly denied that it was his duty to follow up on the report. He stated he was unaware that the

deceased's primary doctor was on leave. He argued that he was not responsible for the deceased's cancer and maintained that it was the responsibility of the deceased and her family to ensure that the histopathology results were provided to them.

86. He further stated that the deceased's family was slow to take her to the hospital when she experienced vomiting and diarrhoea. He blamed negligence on the part of the 2nd Respondent, stating they delayed in admitting the deceased to the High Dependency Unit (HDU) due to a lack of available beds. In his view, the 2nd Respondent should have referred her to another facility. He clarified that the deceased did not die from cancer and reaffirmed that there is no link between her cause of death and the missing histology results.

87. Initially, I must emphasise that it was never disputed that the 4th Respondent was also an obstetrician and gynaecologist at the Appellant's facility alongside the 3rd Respondent. Although he was not directly involved in the first hysterectomy carried out by the 3rd Respondent, it was clear that the patient was under his care after the procedure. He stated that he had previously seen the deceased and provided her with a second opinion on whether she should undergo the hysterectomy. He added

that the purpose of the procedure was to conduct laboratory tests for a potential diagnosis.

88. The evidence of the 4th Respondent indicates that it was crucial for any medical doctor attending to the deceased after the hysterectomy to follow up and produce a report from the examination. This duty was assigned to all the medical practitioners involved before, during, and after the procedure. It was not sufficient for the 4th Respondent to absolve himself of this responsibility simply because he neither performed the surgery nor was her primary doctor.

89. My finding is further supported by the fact that, from the discharge summary, the histopathological results were recorded as 'pending'. In fact, in the deceased's discharge report, the 3rd Respondent explicitly indicated that a histopathology was to follow. She also testified that any doctor was to conduct a follow-up on it. It follows, then, that whoever was responsible for the care of the deceased had an obligation to follow up and determine whether any diagnosis could be made from the hysterectomy, which was in any case the purpose for which it was originally intended.

90. I also hold the view that the 4th Respondent should not have casually dismissed the seriousness of the tests ordered by the 3rd Respondent. As an obstetrician and gynaecologist, he fully understood the purpose of the

procedure and the rationale for requesting a histology. Therefore, it was his duty to obtain the report and determine the cause of the deceased's illness. In fact, when the deceased was under his care, he noted that tissue samples had been taken for histology. He was well aware of its importance, as he stated:

> *"The report is important as it would assist the team to know the best way for management."*

91. Moreover, it was insufficient to simply state that he asked a few colleagues to check the Respondent's portal on his behalf. Claiming that these colleagues never responded was negligent. His account of the events indicates that he could not escape or evade responsibility. Inevitably, he must be held accountable.

92. I also hold the view that when the deceased returned to him for a wound review and dressing, he assumed the role of the primary doctor, as the 3rd Respondent was on leave. He should have initiated the discussion on the test results immediately. DW4 testified that even if the deceased had returned to the hospital due to a sprained ankle, the report would still have been accessed, especially when reviewing the patient's history. Therefore, it was insufficient for the 4th Respondent to claim that he was unaware the 3rd Respondent had gone on her annual leave, or that he could

not access the system, or that he was not the primary doctor.

93. Even if his assertions that he was not the primary doctor were credible, it still does not negate the fact that he was still a medical practitioner. Therefore, a standard of care was imposed on him from the moment the deceased was brought into his care. The histology report had been promptly made available. It was his responsibility to build on the work of the primary doctor and establish a further diagnosis and/or prognosis.

94. On one hand, the 4th Respondent testified that it was not his responsibility to pursue the report. On the other hand, he stated that he did not have the PIN to access the patient's report. Wasn't the 4th Respondent contradicting himself? What did he want the court to believe? If, indeed, it was not his responsibility to pursue the report, then he had no reason to claim that he had no access to the 2nd Respondent's portal. In fact, he would then not have sought the assistance of his colleagues. He ought to have done better than that.

95. This court also finds it disheartening that, like the 3rd Respondent, the 4th Respondent acknowledged that if the histopathology results had been followed up and provided to the deceased sooner, cancer treatment could have

commenced immediately after the wound sepsis was treated. It is expected of a prudent medical practitioner that, in a critical situation such as this, such an important report should not be ignored. Although he attributed the cause of death to other factors, this did not negate or invalidate the fact that the deceased was under his care after the hysterectomy, and therefore, he had a duty to disclose the diagnosis results in the absence of the primary doctor.

96. In **Pope John Paul's Hospital & Another vs. Baby Kosozi** [1974] EA. 221, the East Africa Court of Appeal held: -

> ***"If a professional man professes an art, he must reasonably be skilled in it. He must also be careful, but the standard of care, which the law requires, is not insurance against accidental slips……. The professional 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 construe everything that goes wrong in the cause of medical treatment as amounting to negligence. … They must insist on due care for the patient at every point, but must not condemn as negligence that which is only a misadventure. To the extent of not confusing***

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

97. From the above, it is clear that the 4th Respondent's failure to follow up on the results and communicate them to the primary doctor or the deceased and her family leads this court to conclude that he was negligent in fulfilling his professional duty. It was inappropriate for the 4th Respondent to restrict his role solely to wound dressing and wound sepsis. He took on the responsibility of the deceased's professional medical care and management after the 3rd Respondent went on leave. Just as he noted that her wound was septic, he should have also followed up on the histology for further diagnosis. This omission on his part formed the basis of his negligent actions.

98. Based on the contradictions highlighted in this judgment and his evidence, I find that the 4th Respondent had proper access to the 2nd Respondent's system. He could therefore not shift goalposts as he attempted, pretending that he was

making follow-ups when they had already been uploaded on 11th August 2016. Notably, by that time, the deceased had returned for her services with her septic wound.

99. Furthermore, I note that the evidence of DW4 Majid Swahun, the Chief of Staff at the 2nd Respondent's hospital, indicated that consultants such as the 3rd and 4th Respondents had privileges to admit patients and access their systems. I therefore also dismiss the 4th Respondent's assertions that he had no access at all to the system. The 4th Respondent owed a duty of care to the deceased after the hysterectomy procedure. He failed to uphold the standard of care expected of him.

100. Turning to the Appellant and the 2nd Respondent, the issue for the court's determination is whether vicarious liability applies to them as employers or principals of the 3rd and 4th Respondents and any other parties who negligently attended to the deceased herein.

101. Vicarious liability originates from the phrase, '*Respondeat Superior*', which is translated as "Let the Master Answer". Black's Law Dictionary, 9th Edition, at page 998, defines vicarious liability as follows: -

"Liability that a supervisory party (such as an employer) bears for the actionable conduct of a subordinate or associate (such as an employee)

based on the relationship between the two parties."

102. The Court of Appeal in ***Samson Kairu Chacha vs. Isaac Kiiru King'ori*** [2016] KECA 818 (KLR) expounded on the doctrine in the following terms: -

> ***"This Court differently constituted in the case of Tabitha Nduhi Kinyua versus Francis Mbuvi and Another Nakuru Civil Appeal No. 186 of 2009 explored and also expounded on the parameters for the application of the doctrine of vicarious liability from various case law. We reflect a few on the record by way of illustration. The case of Kenya Bus Services Ltd versus Kawira Civil Appeal No. 295 of 2000 and Messina association Carriers versus Kleinhaus [2001] 3 All SA 285 (SCA) for the proposition that an employer will be held to be vicariously liable if its employee was acting within the course and scope of employment at the time the delict was committed. The case of Pritoo versus West Nile District Administration [1968 EA 428 for the proposition that liability placed upon an employer/master due to a master/servant relationship is not absolute. It can only arise where there is demonstration that the tort feasor was a person whose negligence the owner is***

responsible. The case of Joseph Cosmas Khayigila versus Gigi & Co Ltd & Another Civil Appeal No. 119 of 1986 for the proposition that vicarious liability will arise where there is demonstration that the tort feasor was at the time of the occurrence of the delict a servant or an agent of the principal. Lastly, the case of Minister of Police versus Rabie [1986] (1) SA 117 (A) for the proposition that a master may be liable even for acts which he has not authorized provided that they are so connected with an act which he had authorized."

103. To establish whether a party is vicariously liable for someone else's tort, the following must be proven:

(a) The relationship of the parties either as employer and employee or principal and agent;

(b) That the wrongful act was committed within the scope of that relationship; and

(c) That there was no actual or personal fault committed by the party in a senior position, i.e. principal or employer.

104. The facts of this case reveal a specialised arrangement between the Appellant and the 2nd Respondent. Given the nature of the Appellant's facilities (mainly outpatient services), they established a partnership for surgical

procedures and inpatient care available at the 2nd Respondent's facility.

THE 2ND RESPONDENT – THE AGA KHAN UNIVERSITY HOSPITAL

105. The 2nd Respondent asserted that it did not supply the deceased with her primary doctors. It maintained that its responsibility was limited to performing laboratory examinations and promptly recording the results in the system, which it did. It further claimed that the cause of death could not be attributed to any procedure carried out by their own general surgeon, who merely performed a further operation to clean the septic wound.

106. It was undisputed that when the deceased's wound became septic, the 4th Respondent reviewed her and referred her to Prof. Saidi Hassan (now deceased), a professor and general surgeon at the 2nd Respondent's facility. He attended to her and discharged her. The general surgeon only performed debridement and vacuum procedures on the wound. At no point was the issue of her pending histology report raised.

107. This court takes judicial notice that when a patient is attended to by healthcare providers in a hospital such as the 2nd Respondent's facility, their health history must be

accurately and comprehensively documented and available to all other medical staff.

108. In this case, it was demonstrated that the deceased's medical records could be accessed from the 2nd Respondent's system. Having already established that DW3 duly conducted the required examinations, prepared a histology report, and uploaded it to the system on 11th August 2016, I therefore conclude that the said report should have come to the attention of any doctor who attended the deceased subsequently, including Prof. Saidi Hassan.

109. In this regard, I find that Dr. Saidi Hassan should have reviewed and noted the report, which was accessible on their system. This is because he treated the deceased's septic wound just days after the hysterectomy. Although he was not the primary doctor and was involved only with the septic wound, he was still a medical practitioner. Therefore, there was an expectation that he should have communicated the information from the deceased's histology report to her.

110. My view is that although DW3, an employee of the 2nd Respondent, conducted the histology, prepared a report promptly, and duly uploaded it into the system, thereby making it accessible to any doctor attending to the patient,

the 2nd Respondent was vicariously liable for the acts committed by Dr. Saidi for failing to inform the deceased of the outcome of her histology. He could not isolate himself and limit his duties solely to those of a general surgeon. As a reasonable doctor, it was expected that upon coming across the said report, he had a duty to communicate its contents to the deceased when she was being discharged or to the 4th Respondent who referred the deceased.3, an employee of the 2nd Respondent testified that should he diagnose a patient with cancer, the standard procedure was to disclose the same to the doctor, and not the patient, who would require some counselling. It is not gainsaid that the pathologist DW3's report uploaded on 11th August 2016 revealed that she had cancer. Going by DW3's statement, it is clear from the proceedings that he electively failed to call the 3rd Respondent and inform her of the deceased's diagnosis.

111. Having stated that, DW3 was duty-bound to inform the doctor. From the record, it was not demonstrated that he contacted that said doctor. I find that DW3 was medically negligent to this extent. Although he tried to mitigate this fact by stating that only life-threatening situations would warrant a call to the doctors, I find that DW4 should have acted promptly to contact the 2nd Respondent. After all, cancer is a life-threatening disease and that was clearly demonstrated in these proceedings; a life was lost.

112. Having failed in his duty to inform the deceased of her status, I find that Dr. Saidi, as an employee of the 2nd Respondent, rendered the 2nd Respondent vicariously liable. Additionally, based on DW3's conduct, the 2nd Respondent was also vicariously negligent for DW3's inaction.

THE APPELLANT - UNIVERSITY OF NAIROBI

113. Turning to the Appellant, it argued that no vicarious liability could be assigned to it for the negligent death of the deceased because there were several speculative reasons for her cause of death. It stated that it should be absolved of any responsibility in the matter because the deceased was under the care of the 2nd Respondent, and her husband also failed to provide proper aftercare and nutrition. It further contended that the Appellant and its doctors could not access the results from the 2nd Respondent's system because they did not have access.

114. I have already established that the Appellant's doctors, the 3rd and 4th Respondent, not only had admission rights to the 2nd Respondent's facility but also access to the system. DW5 testified that the two doctors gained access to the facility's system after being successfully vetted. He further stated that it was their responsibility to follow up on the results called for and to coordinate any additional care.

115. Alongside the above, it was not disputed that the 3rd and 4th Respondents were employees of the Appellant. Since this court has already established the existence of an employer-employee relationship and has also proven negligence on the part of the two doctors, it is my finding that the Appellant was vicariously liable for the negligent actions and inactions of the 3rd and 4th Respondents, who were its employees. I base my findings on the case Ricarda Njoki Wahome (suing as an administrator of the estate of the late Wahome Mutahi (deceased)) vs. Attorney General & 2 others (supra), where the court held thus: -

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

116. I therefore uphold the trial court's finding regarding the liability of the Appellant, the 2nd, 3rd, and 4th Respondents for the reasons outlined above, and **I see no reason to disturb the trial court's conclusions. Accordingly, the**

appeal against liability lacks merit and is hereby dismissed.

QUANTUM

117. The well-known principle that this court shall not disturb the findings on quantum unless it can be shown that the learned judge acted on wrong principles was considered by the Court of Appeal in the celebrated case of Gitobu Imanyara & 2 others vs. Attorney General [2016] KECA 557 (KLR), wherein it held as follows:-

> ***"Further, it is firmly established that this Court will be disinclined to disturb the finding of a trial Judge as to the amount of damages merely because they think that if they had tried the case in the first instance they would have given a larger sum. In order to justify reversing the trial Judge on the question of the amount of damages it will generally be necessary that this Court should be convinced either that the Judge acted upon some wrong principle of law, or that the amount awarded was so extremely high or so very low as to make it, in the judgment of this Court, an entirely erroneous estimate of the damage to which the plaintiff is entitled. This is the principle enunciated in Rook v Rairrie [1941] 1 ALL E.R. 297. It was echoed with approval by this Court in Butt v.***

***Khan** [1981] KLR 349 when it held as per Law, J.A that:*

> ***"An appellate court will not disturb an award of damages unless it is so inordinately high or low as to represent an entirely erroneous estimate. It must be shown that the Judge proceeded on wrong principles, or that he misapprehended the evidence in some material respect, and so arrived at a figure which was either inordinately high or low."***

In Kemfro Africa Limited t/a Meru Express Service Gathogo Kanini v. A.m. Lubia and Olive Lubia (1982 –88) 1 KAR 727 at p. 730 Kneller J.A. said: -

> ***"The principles to be observed by an appellate court in deciding whether it is justified in disturbing the quantum of damages awarded by a trial judge were held by the former Court of Appeal of Eastern Africa to be that it must be satisfied that either that the judge, in assessing the damages, took into account an irrelevant factor, or left out of account a relevant one, or that; short of this, the amount is so inordinately low or so inordinately high that it must be a wholly***

erroneous estimate of the damage. See ILANGO V. MANYOKA [1961] E.A. 705, 709, 713; LUKENYA RANCHING AND FARMING CO-OPERATIVES SOCIETY LTD V. KAVOLOTO [1970] E.A., 414, 418, 419. This Court follows the same principles."

And in Gicheru V Morton and Another (2005) 2 KLR 333 this Court stated:

> ***"In order to justify reversing the trial judge on the question of the amount of damages it was generally necessary that the Court of Appeal should be convinced either that the judge acted upon some wrong principle of law, or that the amount awarded was so extremely high or so very small as to make it, in the judgment of the Court, an entirely erroneous estimate of the damage to which the Appellant was entitled."***

See also Major General Peter M. Kariuki v Attorney General- Civil Appeal No. 79 of 2012. The foregoing sets out the law and the guiding principles which we are bound to apply in the determination of this appeal."

118. In finding the Appellant, 2nd, 3rd, and 4th Respondents liable in medical negligence for the death of the deceased, the court awarded general damages of Kshs.

11,720,000.00; Kshs. 100,000.00 for loss of expectancy of life; and Kshs. 1,000,000.00 against the 2nd and 3rd Respondents. In his plaint, the 1st Respondent sought general damages under the Law Reform Act and Fatal Accident Act, aggravated damages, specific damages to be ascertained, interest, and costs of the suit.

119. Regarding damages under the Law Reform Act, the award of damages is categorised under the headings: Pain and Suffering and Loss of Expectation of Life. The court, in the case of Mercy Muriuki & Another v Samuel Mwangi Nduati & Another (Suing as the legal Administrator of the Estate of the late Robert Mwangi), [2019] eKLR, held the following regarding the determination of damages under this statute:-

> ***"The generally accepted principle therefore is that very nominal damages will be awarded on these two heads of damages if the death followed immediately after the accident. The conventional award for loss of expectation of life is Ksh 100,000/- while for pain and suffering the awards range from Ksh 10,000 to Ksh 100.000/= with higher damages being awarded if the pain and suffering was Prolonged before death."***

120. In this case, the trial court awarded only Loss of Expectation of Life and was silent on the award for Pain and Suffering. From the facts gathered here, the deceased died from endometrial carcinoma caused by cardiopulmonary arrest on 15th June 2017. This information is from the death certificate. Although the Appellant attempted to suggest that the deceased died from other causes, no evidence was presented to support a different view. I therefore find that the death of the deceased is conclusively proven by her death certificate.

121. The trial court record shows that the deceased was poorly managed by the Appellant and the 2nd, 3rd, and 4th Respondents, particularly due to their failure to promptly inform her and subsequently administer the necessary treatment for her diagnosis. It has also been established that the deceased's diagnosis was first uploaded to the 2nd Respondent's portal on 11th August 2016. It was accessible to the 3rd and 4th Respondents, the appellant's employees.

122. I have also established from the record that if the deceased's diagnosis had been disclosed earlier, she might have begun treatment, possibly leading to a different outcome. According to the evidence, when the disease was identified in August 2016, the deceased was at stage 2. However, by February 2017, it had significantly progressed to stage 4.

123. Dr. Kiarie informed the 1st Respondent that she could not save the deceased's life because chemotherapy was started very late, after the condition had significantly deteriorated. She explained that the health decline was due to the failure of the Appellant, the 2nd, 3rd, and 4th Respondents, to provide timely post-operative follow-up, which ultimately led to her death on 15th June 2017. In fact, the doctor questioned why she was not treated immediately after the results were available on 11th August 2016.

124. Based on the foregoing, it is my considered opinion that the deceased experienced prolonged pain. In fact, her suffering was intensified by the distressing realisation that her cancer was in an advanced stage. Taking all these factors into account, I conclude **that the deceased should be awarded Kshs. 160,000.00 for pain and suffering.**

125. Regarding the loss of expectation of life, given that the Appellant and the 2nd, 3rd, and 4th Respondents possessed this crucial information, I find that the 1st Respondent was indeed entitled to general damages for loss of expectation of life. The trial court awarded Kshs. 100,000.00 under this category, explaining that had it not been for the deceased's death, she would have led a happy

and meaningful life. **I will therefore not disturb those findings**.

126. Considering the damages awarded under the Law Reform Act, I will now address the damages granted under the Fatal Accidents Act. The damages under this statute pertain to loss of dependency. Lord Scarman, in the case of Gammel v. Wilson (1981) 1 ALL ER 578, established the following guiding principle that this court will adopt when assessing damages under this head:

> ***"The correct approach in law to the assessment of damages in these cases presents, my Lords, no difficulty, though the assessment itself often will. The principle must be that the damages should be fair compensation for the loss suffered by the deceased in his lifetime. The appellants in Gammell's case were disposed to argue, by analogy with damages for loss of expectation of life, that, in the absence of cogent evidence of loss, the award should be a modest conventional sum. There is no room for a 'conventional' award in a case of alleged loss of earnings for the lost years. The loss is pecuniary. As such, it must be shown, on the facts found, to be at least capable of being estimated. If sufficient facts are established to***

enable the court to avoid the fancies of speculation, even though not enabling it to reach a mathematical certainty, the court must make the best estimate it can. In civil litigation it is the balance of probabilities which matters. In the case of a young child, the lost years of earning capacity will ordinarily be so distant that assessment is mere speculation. No estimate being possible, no award, not even a 'conventional' award should ordinarily be made. Even so, there will be exceptions: a child television star, cut short in her prime age of five, might have a claim; it would depend on the evidence. A teenage boy or girl, however, as in Gammell's case may well be able to show either actual employment or real prospects, in either of which situation there will be an assessable claim. In the case of a young man, already in employment (as was young Mr Furness), one would expect to find evidence on which a fair estimate of loss can be made. A man well established in life, like Mr Picket, will have no difficulty. But in all cases, it is a matter of evidence and a reasonable estimate based on it. (see page 593)."

127. In this case, it was established on a balance of probabilities that the deceased earned Kshs. 280,000.00 as a lecturer and pharmacist. She was 61 years old at the time of her death. Evidence presented before the trial court indicated that she left behind five dependants. These facts were never contested. The court adopted a 9-year multiplier on the basis that the deceased would have worked for a further 9 years. I find that multiplier reasonable given the circumstances. However, the trial magistrate erred when she pronounced herself as follows:

> ***"I shall adopt a 9-year multiplier with a third of the same going to taxes, a third of the remainder going to food and other expenses on the dependents."*** (underline mine)

128. The trial court erred in that conclusion. This is because, firstly, the deduction of taxes on the award of general damages is not solely within the court's authority. It is important to note that taxes are not fixed and can change over time. Any payable taxes can only be determined by the Kenya Revenue Authority once an amount is paid. Secondly, it was also incorrect for the trial court to assign a 1/3 dependency ratio after it had already established that the deceased left five dependents. Mathematically, this would imply that the deceased had a 2/3 dependency ratio.

129. Taking the above into account, this court shall interfere with the findings of quantum**. I set aside the sum of Kshs. 11,720,000.00 and replace the award with a sum of Kshs. 20,160,000.00 that is calculated as follows: Kshs. 280,000.00 × 12 × 2/3 × 9.**

130. On aggravated damages, the trial court held: -

> ***"Aggravated damages are meant to punish conduct (sic) a defendant's part if their conduct was such that it calls for sanction (sic) I take special note of the manner in which the 1st and 3rd Defendant (sic) herein treated the deceased, it was in a manner that calls for sanctioning which this Court does in the form of an award of Kshs. 500,00/= from each."***

131. In establishing whether a party is entitled to aggravated damages, this court is invited to establish whether the principles were satisfied as set out in ***GATLEY ON LIBEL AND SLANDER 12th Edition para 9.18 at page 353*** *as follows: -*

> ***"The conduct of the defendant, his conduct of the case, and his state of mind are all matters which the claimant may rely on as aggravating the damages in so far as they bear on the injury to him.***

It is very well established that in cases where the damages are at large the judge can take into account the motives and conduct of the defendant, where they aggravate the injury done to the Plaintiff. There may be malevolence or spite or the manner of committing the wrong may be such as to injure the plaintiff's proper feelings of dignity and pride. These are matters which the jury can take into account in assessing appropriate compensation."

132. The court in ***Abdulhamid Ebrahim Ahmed vs. Municipal Council of Mombasa*** [2004] eKLR held thus: -

"Aggravated damages are awarded in actions where the damages are at large, that is to say where the damages are not limited to the pecuniary loss that can be specifically proved. They are normally awarded in actions of defamation, intimidation, false imprisonment, malicious prosecution, trespass to land, persons or goods, conspiracy and infringement of copy right. Such damages are part of, or included in, the sum awarded as general damages and are therefore at large. As such they need not be specifically pleaded or included in the prayer for relief."

133. Looking at the facts of this case, it is clear that the 3rd Respondent was the deceased's primary doctor. She was subsequently seen by the 4th Respondent while the 3rd Respondent was on leave. During their medical care for the deceased, it has been shown that they did not inform her that she had been diagnosed with cancer by DW3. From Dr. Kiarie's perspective, it was concerning that the deceased was not told the test results when they became available in August 2016.

134. Certainly, the trial court was correct in awarding aggravated damages against the two Respondents for the reasons I have outlined. It was exceptionally incumbent upon them to take necessary action. They failed in the discharge of that duty. I consequently see no reason to interfere with those findings.

135. Finally, regarding special damages, it is well-established law that such damages must be specifically pleaded before they can be awarded. See Provincial Insurance Co East Africa Ltd v Nandwa [1995-1998] 2 EA 288. In the reliefs sought in the plaint, the 1st Respondent requested that special damages be ascertained. However, these were not pleaded with the required specificity as set out in law. Therefore, I find that the trial court correctly dismissed the relief sought on that ground.

136. The upshot of my above analysis is that the appeal on liability lacks merit and is hereby dismissed. On quantum, this court sets aside the award of damages under the Law Reform Act of Kshs. 100,000.00 and substitutes the same with an award of **Kshs. 160,000.00**. On damages under the Fatal Accidents Act, this court sets aside the award of the trial court in the sum of Kshs. 11,720,000.00 and substitutes the same with the sum of **Kshs. 20,160,000.00**

137. Since the appeal is in favour of the 1st Respondent, who did not participate in these proceedings, I direct that each party shall bear its own costs of this appeal. It is so ordered. As I conclude, I thank the parties for their patience in awaiting the delivery of this judgment; the delay was caused by my heavy workload in Bungoma Law Courts. It was not intentional to delay this judgment, and I sincerely apologise to each party.

Dated, signed and delivered at Bungoma on the 30th September 2025.

R.E. OUGO

JUDGE

In the presence:

Mr . Lutta -For the Appellant/ 4th Respondent (HCCA E190/ 2021)

1st Respondent-Absent

Mr. Kenneth Murithi h/b for Mr. J Okeyo for 2nd Respondent/ (Appellant in HCCA E190/2021)

Mr. Mwihuri -For the 3rd Respondent/ 2nd Respondent (HCCA E190/2021)

For the 4th Respondent/ 3rd Respondent in HCCA 190/2021)

For the 4th Respondent

Wilkister C/A