

**IN THE COURT OF APPEAL
AT NYERI**

(CORAM: LESIIT, OCHIENG & ALI-ARONI,

JJ.A.) CIVIL APPEAL NO. E064 OF 2021

BETWEEN

DR. SARAH GICHUKI NYAGA.....APPELLANT

AND

SEKUNDU MURIIRA IBAYA 1ST

**RESPONDENT PERMANENT SECRETARY
MINISTRY OF MEDICAL 2ND**

RESPONDENT THE HONOURABLE ATTORNEY GENERAL

3RD RESPONDENT DR. JUSTUS

NGATIA 4TH RESPONDENT

(Being an appeal from the Judgment and Decree of the High Court of Kenya at Meru (Chitembwe, J.) delivered on 14th April 2020

in

***HCCA No. 101 & 102 of
2017)***

JUDGMENT OF THE COURT

1. The deceased **Christine Mwari Nteere** (“the deceased”) passed away on 20th September 2008, while delivering her third-born child at the Meru General Hospital (“The Hospital”). The 1st respondent, the husband of the deceased, initially moved the court by filing a plaint dated 15th December 2011 in the High Court, seeking compensation for the wrongful death of his deceased wife and unborn child, pain and suffering, lost years, loss of companionship and loss of expectation of life.

2. The High Court transferred the matter to the Chief Magistrate's Court on 16th June 2016 and it was given the number **C.M.C.C. 190 of 2016**. The decision in **C.M.C.C. 190 of 2016** triggered

the appeal at the High Court, being **HCCA Nos. 101 & 102 of 2017** (Meru), whose judgment (Chitembwe, J.) was delivered on 14th April 2020, and which in turn triggered this second appeal before us.

3. This being a second appeal, we are restricted to determination of only points of law and not of fact as set out under **Section 72(1) of the Civil Procedure Act**, and as further explained by this Court in the case of **Stanley N. Muriithi & Another vs. Bernard Munene Ithiga [2016] KECA 821 (KLR)**, where the court quoted with approval the case of **Kenya Breweries Limited vs. Godfrey Odoyo [2010] eKLR (Civil Appeal No. 127 of 2007)** (Onyango Otieno, J.A.) put it succinctly in the following words:

“...In a second appeal however, such as this one before us, we have to resist the temptation of delving into matters of facts. This Court, on second appeal, confines itself to matters of law unless it is shown that the two courts below considered matters they should not have considered or failed to consider matters they should have considered or looking at the entire decision, it is perverse.

We hasten to observe, however, that failure on the part of the first appellate court to re-evaluate the evidence tendered before the trial court and as a result, arriving at the wrong conclusion is a point of law.”

4. A brief background of the matter is that on or about 20th September 2008, the deceased lost her life while delivering a child who also died in the process. The appellant and the 4th respondent, who were both employed by the Government of Kenya at the Meru General Hospital (“The Hospital”), and

being under the supervision of the 2nd respondent, handled
the

deceased, the appellant was the doctor on call on the material day and she briefly interacted with the deceased just before she died, while the 2nd respondent attended to the deceased during her ante-natal clinics. Both were accused of negligently handling the deceased, leading to her death and that of the unborn baby girl.

5. In a joint defence dated 2nd February 2012, the appellant, 2nd and 3rd respondents denied every allegation put forth by the 1st respondent, particularly any negligence or unprofessional conduct in the services provided to the deceased. The appellant claimed that she acted with utmost professionalism and without any negligence.
6. The 4th respondent filed a separate defence, also denying any negligence on his part and urging that he had been exonerated from any form of negligence by the Kenya Medical Practitioners and Dentists Board (“The Board”).
7. The trial was heard by way of *viva voce* evidence. The **1st respondent (PW1)** informed the court that on 20th September 2008, while at his place of work at Michii-Mikuru Tea Company, he received a call at 7:15 am from the deceased, who was pregnant, that she needed to be taken to the hospital as her membrane had ruptured. The 1st respondent contacted their neighbour, Robert Kinyua (PW3), and requested him to rush home and take the deceased to the hospital. He also called the deceased brother, Alex Mureithi (PW2), a Clinical Officer working at Kangeta Sub-County Hospital and residing at Makutano and asked him to accompany the deceased to the hospital.

8. PW1 drove from his place of work to the hospital, arriving at around 9:30 am, when he learned that the deceased had been taken to the hospital by a mason, one Odongo. The 1st respondent, who was accompanied by his sister-in-law, Isabela, found the deceased already admitted. He spoke with the deceased, who informed her that she had tried to call her pre- natal doctor, the 4th respondent, but he had not answered her calls. He learned from the nurses that they had reached the 4th respondent, who directed that the appellant would attend to the deceased as it was an emergency.
9. He also learned that the appellant was at her private clinic, and decided to go to the appellant's private clinic, accompanied by PW2. On arrival, they were informed that she was attending to another patient. After waiting for a while, he called the appellant on her phone, introduced himself as the husband of the deceased, and in a short time, she invited him in, wanting to discuss payment. This incident occurred approximately 45 minutes after the witness arrived at the clinic, which was located about 1 km from the hospital. He assured the appellant that he would pay her fees, after which they left together, PW2 driving them back to the hospital.
10. Upon the appellant's arrival at the hospital, the deceased was taken to the theatre. Thirty minutes later, they were informed that both his wife and their unborn baby had died. He blamed the appellant and the 4th respondent for the death of his wife and child. He believed that if the appellant had immediately acted, his wife and unborn child might have

survived.

11. **Alexander Murithi Nteere (PW2)**, a Clinical Officer working at Kangeta Sub-County Hospital and a brother-in-law of the 1st respondent, testified that on 20th September 2008, he received a request from the 1st respondent to assist in taking the deceased, who was in labour, to the hospital. On their way to the hospital, the deceased attempted to call the 4th respondent, but he did not pick up or return her calls. Upon arriving at the hospital, they went to the amenity ward, where PW2 explained the condition of the deceased to a nurse. The deceased was then wheeled to the ward. PW2 requested to see a doctor and was informed that the appellant, who was to attend to the deceased, was not at the hospital. The deceased was put on a drip as they waited for the doctor. The 1st respondent arrived after 30 minutes and left to look for the appellant, returning more than half an hour later. The appellant attempted to insert an IV line but was unsuccessful. She then instructed the patient to be taken to the theatre while they waited in the bay area. After approximately 45 minutes, a nurse, whom PW2 knew, called him, and the 1st respondent followed him when they were informed that the deceased had passed away.
12. **Robert Kinyua (PW3)**, a neighbour, testified that on 20th September 2008 at about 8:20 am, he received a call from the 1st respondent asking him to take his wife to the hospital because she had experienced a rupture. On getting to the 1st respondent's house, he was to learn that one Odongo had already taken the deceased to the hospital, and he followed them. Upon arrival, he found the deceased on a stretcher. There were no doctors present.

13. Shortly after, the 1st respondent arrived and asked to accompany him to Twiga Plaza to look for the appellant. Upon arrival at the appellant's private clinic, they were informed that the appellant was attending to another patient. They waited for over 45 minutes, after which more time was spent negotiating the appellant's charges. The 1st respondent assured the appellant that he would pay her charges and they left for the hospital. Minutes later, he learned that the 1st respondent's wife had died.
14. **Isabella Nkoyai (PW4)**, a sister-in-law of the deceased, testified that on 20th September 2008, she received a phone call from the deceased, who informed her that she was in labour. She went to the deceased's house and instructed a worker named Odongo to take them to the hospital using the 1st respondent's car. Enroute, the deceased called the 4th respondent, but he did not answer. They picked up PW2 at Blue Towers and then continued to the hospital. Upon arriving at the hospital, they found two nurses who placed the deceased on a stretcher. Shortly after, PW3 arrived, followed by the 1st respondent, and the two left to look for the appellant, returning after 45 minutes. Later, they learned that the 1st respondent's wife had died after being taken to the theatre.
15. **Dr. Moses Njue Gachuki (PW5)** performed the post-mortem on the deceased. He testified that the deceased died while those attending to her tried to resuscitate her. She was 38 - 40 weeks pregnant and was pale due to loss of blood. Her spleen was shrivelled, which was evidence of massive loss of blood. She experienced hyperbolic shock.

Her uterus was 43 cm with a

dead baby measuring 46 cm. The placenta was sitting on the cervix. There was a big blood clot between the placenta and the uterine wall, which had caused the bleeding. The placenta had tears and lacerations, meaning she was in labour. She had a complete placenta previa - the placenta, partially detached from the uterine wall, thus the massive bleeding, and this was probably the cause of death and had she survived, she would have had enormous problems.

16. In his defence, **Dr. Justus Ngatia (DW1)**, the 4th respondent/cross-appellant (“cross-appellant”), confirmed that he attended to the deceased at her pre-natal stage. She primarily complained of back pain and bleeding. He last saw her on 9th September 2008, when she was 31 weeks pregnant. Furthermore, he testified that on 19th September 2008, he had called the appellant to inform her that he would be away and she would be in charge of the obstetrical care for the patient in the amenity ward. Upon the death of the deceased, the 1st respondent called him requesting a transfer of the body at 8:00 pm; he advised removal the next day, as the hospital policy prohibited the release of bodies after 6:00 pm.
17. The appellant (DW2), **Dr. Sarah Gichuki Nyaga**, testified that on 20th September 2008, the 1st respondent came to her private clinic while she was attending to another patient. Before that, the hospital had called to inform her that the relatives of a patient of the 4th respondent were there and that the patient was experiencing vaginal bleeding. She instructed that the patient be admitted while she spoke to the relatives. She then proceeded to her private clinic,

where a patient was waiting.

She confirmed that the 1st respondent, upon arriving at her clinic, had to wait as she attended to another patient. She also confirmed that they discussed her fees, after which they left for the hospital. The appellant asserted that both the 1st respondent's wife and the unborn baby could not be saved, without elaborating further.

18. She further testified that a complaint was subsequently filed against her by the 1st respondent with the Medical Board, and that she had been found guilty of practising in a private clinic without a license, while she was the doctor on call in her department on the material day. She was initially put on suspension for 15 months, which she appealed against and the suspension reduced to 6 months.
19. In a judgment delivered on 30th October 2017, the court concluded that the 4th respondent, although an employee of the 2nd respondent, attended to the deceased in his private clinic, thus had personal responsibility for the deceased, which was against the general guidelines and ethical standards in place at that time. By doing so, he must have understood and willingly accepted a duty of care towards the deceased during her pregnancy. In this regard, no duty was placed on the 2nd and 3rd respondents. As a qualified doctor in the relevant field, he was expected to recognise the special attention required for an expectant mother in her third trimester. The court determined that he was negligent for failing to respond to or return calls from his client, the deceased.
20. Regarding the appellant, the court found that although she

had not been specifically assigned the deceased, she was on duty

and in charge as the Obstetrician-Gynecologist at the hospital at the material time. Instead, she was at her private clinic attending to her own patients. Furthermore, the time she spent negotiating her fees with the 1st respondent seemed excessive in the circumstances, and she further took steps only upon assurance from the 1st respondent that he would pay whatever amount was necessary. Of particular concern was the fact that these negotiations were taking place after a nurse from the hospital had called her much earlier to inform her of the obstetric emergency.

21. The court found that the time lost in reaching the hospital significantly contributed to the tragic outcome involving the deceased, and held that the particulars of negligence attributed to the appellant and the 4th respondent had been fully proved on a balance of probability. The two were found to have been wholly to blame for the demise of the mother and child, and although they were public servants, they prioritized their own interests, which ultimately led to the 1st respondent losing his wife and unborn child.
22. In awarding damages under the Law Reform Act, the trial court found that the deceased had endured excruciating four hours of pain, suffering a slow death. For this, the court awarded Kshs. 300,000, for loss of expectation of life, the court gave Kshs. 200,000. In awarding damages under the Fatal Accidents Act, the trial court applied a multiplier of 24 years, taking into account the vicissitudes of life, and a multiplicand of Kshs. 34,000, along with a dependency ratio of 2/3, resulting in an award of damages of Kshs. 6,528,000. Additionally, the court

awarded loss of consortium in the amount of KShs. 50,000 and funeral expenses at Kshs. 80,000, along with costs and interest. To avoid double compensation from the two Acts, the court ordered that Kshs. 200,000 will be deducted from the overall award.

23. Dissatisfied with the trial court's decision, the appellant and the cross-appellant appealed to the High Court and in a judgment dated 14th April 2020, the High Court affirmed the trial court's decision that the appellant and the 4th respondent were jointly and severally liable for the 1st respondent's wife's death and that of their unborn baby. The awarded damages were deemed not excessive, and the appeal was dismissed for lacking merit.
24. The decision of the High Court precipitated the appeal by the appellant and the 4th respondent's cross-appeal. The appellant raised nine grounds of appeal in a memorandum of appeal dated 29th June 2021, where she contended that the learned Judge erred in law by: finding that the 1st respondent proved his case to the required standard; awarding the 1st respondent Kshs. 6,965,000, which included special damages of Kshs. 60,000 not strictly proved; relying on incomplete evidence; passing judgment and decree in favour of the 1st respondent without calling an expert witness to determine whether the actions of the appellant contributed to the deceased's death; by relying on documents produced by the 1st respondent without calling their authors to testify; failing to appreciate adequately or ignoring the *Bolam test*; disregarding the principle that parties are bound by their pleadings; in misdirecting himself against the weight of the

evidence on record. She prayed for the

appeal to be allowed and the judgment of the trial court and the High Court to be set aside.

25. The 4th respondent filed a cross-appeal dated 5th August 2021 on the grounds that the learned Judge erred in law; in failing to consider relevant facts, and relied on extraneous matters in arriving at conclusions that were not supported by the available evidence, and failure to interfere with the quantum of damages. The 4th respondent prays that the court sets aside the judgment and decree of the High Court.
26. Learned counsel for the appellant filed submissions, a list of authorities and a digest of authorities, all dated 27th January 2022. Counsel submitted that special damages must not only be specifically pleaded but strictly proved. To prove the alleged special damages, the 1st respondent ought to have provided documentation, such as receipts detailing the costs incurred. He referred to the case of **Ryce Motors Limited & Another & Another vs. Elias Muroki [1996] KECA 30 (KLR), Capital Fish Kenya Limited vs. The Kenya Power and Lighting Company Limited [2016] eKLR,** and **David Bagine vs. Martin Bundi [1977] eKLR,** in support of the proposition that special damages must be pleaded and proved by way of evidence.
27. Counsel further submitted that medical negligence cannot be inferred, and that there is need for expert evidence to be availed. He urged further that it is only the testimony of a qualified professional which would have shed light on whether the appellant ought to have done something differently or whether the procedure was botched, or give

sufficient particulars of the procedure that ought to have been conducted. Further, this

case does not invoke the doctrine of *res ipsa loquitur*, as it was not sufficient to merely prove that the 1st respondent suffered as a result of the action undertaken by the appellant. He urged that the law placed a burden on the 1st respondent to prove that the appellant acted outside the standards expected of a skilled professional. Additionally, it is crucial to prove that there was indeed negligence on the part of the appellant. He contended that the evidence placed before the court failed to establish the standard of care in medical negligence. Counsel further asserted that the cause of death was not ascertained, as the patient had a pre-existing condition.

28. Counsel further asserted that the two courts below erred in holding that the appellant was liable, and for failing to apply the accepted standard of care required as encapsulated in the *Bolam test*, named after the famous English Case of ***Bolam vs. Friern Hospital Management Committee [1957] 1 WLR 583***, where the court stated that the standard to be applied in a claim of professional negligence is that of an ordinary skilled man exercising and professing the special skill and need not possess the highest skill.

Nearer home, he cited ***Pope John Paul's Hospital & Another vs. Baby Kasozi [1974] EA 221***, where the East African Court of Appeal held inter alia that the law requires the standard of proof to be to a degree of care as a normal skilled member of the profession would be expected to exercise, and this does not include care against accidental slips. Counsel equally referred to the home-grown case of ***Wishaminy vs. Kenyatta National Hospital Board***

[2004] 2 EA 351, where the court

stated ***“the true test of establishing negligence and treatment on the part of the doctor is whether he has been proved to have been guilty of such failure as no doctor of ordinary skill would be guilty of it acting within ordinary care”***.

29. On ground that the provisions of **Section 35 of the Evidence Act** was violated, counsel argued that the two courts below erred when they both disregarded the general rule on the production of documents, which requires that documents should be produced in court by their authors. Counsel took issue with the production of the report from the Medical Board by the 1st respondent without calling the maker. In support of the contention, counsel cited the Case of **Kenneth Nyaga Mwige vs. Austin Kiguta & 2 Others [2015] KECA 334 (KLR)**, where the court was of the view that documents ought to be produced in evidence by the maker or a competent witness. Furthermore, the board's proceedings were not made available, which would have shed light on how the board's decision was arrived at.
- 30.** Learned counsel for the 4th respondent filed submissions dated 23rd June 2022. It is submitted that the learned Judge arrived at a wrong conclusion. That while it is true that a doctor can be held liable for professional negligence resulting from his action or inaction, such negligence must be related to the doctor's professional responsibilities. Failure to answer a patient's call or to be available for consultations when the doctor is off duty does not constitute professional negligence. Counsel cited the case of **John Gachanja Mundia vs. Francis**

Muriira & Another [2017] eKLR, in arguing that medical negligence is distinct from other forms of negligence. He also cited the case of **Pope John Paul's Hospital & Another vs. Baby Kasosi (supra), Ricarda Njoki Wahome vs. Attorney General & 2 Others [2015] eKLR**, where the court held that for a doctor to be found to be negligent, there has to be established that there was a breach of duty and the breach must have been the direct or proximate cause of the loss, injury or damage.

31. To exonerate his client from the claim of negligence during his engagement with the deceased which may have led to the emergency, counsel cited the case of **Hunter vs. Harley [1955] Sc 2000**, which was referred to with approval the case in **The Agha Khan Platinum Jubilee Hospital vs. Busan Munyambu [1985] e KLR**, where the court appreciated that in the field of medicine there are varied opinions in diagnosis and treatment and the test of negligence is whether the doctor is guilty of such failure as no doctor of ordinary skill would be guilty with ordinary care.
32. Counsel further contended that the learned Judge erred in dismissing the Medical Board's findings without seeking additional professional opinion that could otherwise have informed the court's decision. In support he cited the case **Fox vs. General Medical Council [1960] 3 All ER 225**, where the Privy Council was of the view that a medical tribunal is entitled to make findings before it, and it would be impossible for an appellate court to reverse the finding of fact by such a tribunal.

33. Regarding the breach of the duty of care, counsel argued that there is evidence that the 4th respondent properly provided professional advice and care during the antenatal stage, that he was not on duty when the emergency arose, and that he assigned his responsibilities on the day to the appellant as the doctor on call.
34. Furthermore, counsel contended that the High Court erred in law by finding that the 4th respondent was personally liable. Yet, the evidence presented to the court indicated that the 4th respondent was employed by the 2nd respondent and had only interacted with the deceased during the antenatal care. Once the deceased was admitted to the hospital, she ceased being a patient of the 4th respondent/cross appellant's private clinic. He cited **Article 236(a) of the Constitution**, which states that a public officer should not be victimized or discriminated against for performing their duties in accordance with the Constitution or any other law.
35. On the part of the 1st respondent learned counsel filed submissions dated 15th November 2021, where he submitted that the learned Judge did not err in concluding that both the appellant and the cross-appellant were negligent and professionally liable. It is contended that the cross-appellant failed to make proper arrangements for his patient while he was away. The appellant, on the other hand, is liable for having been away from her duty station at the hospital while the cross- appellant was away. In the testimony of the cross-appellant, he informed the court that when the nurse in the amenity called him, he directed her to call the appellant, as he had left her in

charge, and that she admitted to having been at her private clinic at the time.

36. Counsel further submitted that the learned Judge considered the general guidelines, as well as the ethical and professional standards that were in effect at the time and arrived at the conclusion that the appellant and the 4th respondent did not adhere to these standards, thereby failing in their duty of care towards the deceased during her pregnancy. Thus, the learned Judge correctly determined that both the appellant and the cross-appellant contributed to the death of the 1st respondent's wife and found them culpable.
- 37.** Counsel further submitted that the damages awarded to the 1st respondent were not excessive as the Judge appropriately considered all relevant facts. He cited the case of **PBS & Another vs. Archdiocese of Nairobi, Kenya Registered Trustees & 2 Others [2016] KEHC 3468 (KLR)**, where the court awarded the sum of Kshs. 5,045,879, which included general damages for pain and suffering, loss of expectation of life, loss of dependency, loss of consortium and special damages. Similarly, he cited **Silas Mugendi Nguru vs. Nairobi Women's Hospital [2014] eKLR, KEHC 7761 (KLR)**, where the court awarded the plaintiff the sum of Kshs. 9,358,485 for pain and suffering, loss of expectation of life, lost years and special damages.
38. We have considered the facts of the case, the submissions by counsel appearing for the parties, case law cited and the

law applicable, and we are of the view that the issues for consideration are; whether the Judge erred in law by failing to

consider the appropriate standard of professional care required in determining a doctor's professional negligence and by finding the appellant and 4th respondent/cross-appellant were jointly and severally liable for the death of the deceased and the unborn child.

39. In his plaint before the Chief Magistrate's Court, the 1st respondent complained against both the appellant and the 4th respondent/cross-appellant for dealing with the deceased "negligently and unprofessionally". As regards the 4th respondent/cross-appellant, he claimed that he was negligent for not professionally and adequately advising the deceased: mishandling the deceased and failing to take regard in the circumstances; putting off his cell phone when informed of the deceased problems; not acting with speed as expected of a doctor; deceiving the deceased that he had a right to practice privately; failing to give proper instructions.

The appellant was blamed for: acting unprofessionally and against medical ethics and profession; not acting with speed; failing to exercise due care and skill in handling the deceased; practicing illegally and asking for money; negligently causing the death of the deceased; and causing the death of the unborn child.

40. The facts of the case are extensively explained in the summary of witnesses, and we need not rehash them, save to briefly state that the cross-appellant/4th respondent attended to the deceased during her antenatal clinics as a private patient in his private clinic. On the day she met her death, she went into labour, tried to contact the cross-

appellant/4th respondent, but

failed to reach him. She was then taken to the amenity ward of the hospital, where she gave the name of the cross-appellant/4th respondent as her doctor and when the hospital reached out to the cross-appellant/4th respondent, who was one of their doctors, he directed the nurses to reach out to the appellant, who was the doctor on call at the time. The appellant was not at the hospital. The nurses called her and she advised them to admit the deceased. On arriving at the hospital minutes later, the 1st respondent, in a state of despair, drove to the appellant's private clinic to look for her. On arrival, he found the appellant attending to another patient. When he eventually met her, the appellant wanted assurance of payment of her fees, after which they proceeded to the hospital. According to the appellant's statement upon arrival at the hospital, at 10:15 a.m., she went straight to the amenities ward, where she found the patient in bed with an oxygen mask. She found the patient restless and sweating, with dry blood on her legs, no blood on the bedsheet and the perennial pad had little blood. The deceased was taken to the theatre but passed away together with her unborn child at 10:45 a.m.

41. The 1st respondent's complaint to the Medical Board was that the appellant and the cross-appellant/4th respondent were careless in the handling of the deceased. He blamed the appellant for taking time before attending to the deceased and the cross-appellant/4th respondent for failing to pick up his calls, yet he was aware of the deceased's condition.

The Medical Board found no wrongdoing on the part of the cross-appellant/4th respondent in failing to answer the

deceased's calls or in not handing over the patient to the appellant. It found him guilty of how he handled the aftermath of the deceased's death. On the part of the appellant, the Medical Board found her culpable for having delayed in attending to the patient, which led to "a chain of events" that led to the patient's death, and for failing to prevent the featal death by way of post-partum caesarean section and for practicing privately in violation of the provisions of the Medical Board.

42. The trial magistrate inter alia found the cross-appellant guilty of taking a road trip; failing to answer or call back the deceased; and failing to hand over his patient while he was away. The Judge on first appeal agreed with the trial court that the cross- appellant was negligent for failing to answer the deceased's call and to hand over the deceased as his private patient. The appellant was faulted for failing to call the cross-appellant to know the medical condition of the deceased; going for a private patient, yet there was an emergency, and only went upon the 1st appellant's intervention; failing to be at the hospital as she could have saved a life.
43. Against the above narration, we pause the question whether the appellant and the cross-appellant were jointly or severally negligent in the way they handled the deceased. It is not disputed that the cross-appellant attended to the deceased severally in his private clinic for her antenatal care. In one of the exhibits produced in court, a letter dated 6th November 2008, written by the cross-appellant to the Medical Board, stated, inter alia, that the antenatal profile of

the deceased was

within normal. An ultrasound done on 6th July 2008 had shown a normal intrauterine pregnancy with a low-lying placenta. He attended to her last on 9th September 2008, and the deceased complained of mild backache and fatigue, and had no history of bleeding. This he reiterated in his evidence and stated further that he had put her on medication, placed her on bed rest, and that she was in a fair condition. The 4th respondent is blamed for failing to take phone calls from a patient with a previous condition and for not handing over the patient, having in mind her delicate condition.

44. The appellant seems to bear the brunt of the blame. She was the one on call at the hospital on the material day; the nurses at the hospital called and told her that the cross-appellant had directed them to her to attend to the patient. She is blamed for the delay in attending to the deceased and not being at the hospital as she ought to have been. It is unclear when the patient arrived at the hospital. PW2 stated that he arrived at the hospital an hour after receiving the call from the 1st respondent, which would have been approximately 9:30 am. Indeed, the 1st respondent says he arrived at 9:30. a.m., spoke to the deceased and the nurses, etc. According to the appellant, she received a call from the hospital at about 10 a.m. as she headed to her private clinic, informing her that the cross- appellant's patient was at the hospital and that the nurses had not yet assessed her condition, as they were speaking to her relative at the time. The nurse who called provided little information, as the patient was still in the car. She directed the nurse to admit

the patient and asked the patient's relative to speak with her. She went to the clinic to attend to another

patient. The 1st respondent went to her private clinic and found her attending to a client. They later spoke and left for the hospital at 10:15 am. The patient was pronounced dead at 10:45 a.m. On the issue of the time, between the time the appellant received the call and when they left her private clinic, and how long the 1st respondent waited to see the appellant, it is the word of one witness against the word of the other. It seems fair from the chronology of things to have taken 30-40 minutes.

45. In ordinary cases of negligence, the standard of care to be considered is that of an ordinary man in the street. It is whether the ordinary man would do or refrain from doing some act. In allegations of medical negligence, the standard to be considered cannot be that of a reasonable man on the street. The standard to be applied is that of an averagely skilled practitioner in the field of medicine. The standard set for medical practitioners is now settled in our jurisdiction; the courts continue to apply the *Bolam test* as encapsulated in the notable case of **Bolam vs. Friern Hospital Management Committee [1957] 1 WLR 583**, where the court stated:

“The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill... it is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art... In the case of a medical man, negligence means failure to act in accordance with the standard of reasonably competent

medical man at that time.... There may be one or more perfectly proper standards, and if a

medical man conforms to one of these proper standards, then he is not negligent.”

46. There is consensus that the cross-appellant attended to the deceased for her antenatal clinics; the last visit she had with him, she had complained of fatigue and back pain, and he had put her on bed rest. He believed that was the best for her. There was no evidence presented to the court to suggest that the treatment and advice given to the deceased were negligent. Regarding the fateful day, the cross-appellant was attending to his personal matters, was off duty from the hospital, and had handed over his responsibilities to the on-call doctor, who happened to be the appellant. Regarding his private patient, his evidence is that when he received a call from the amenities ward, he redirected his private patient to his colleague. His evidence was that the last attendance with the patient on 9th September 2008 was normal, with mild backache. There was no peculiar condition.
47. In considering this matter, we have taken heed of the words of the predecessor to this Court in **Pope John Paul’s Hospital & Another vs. Baby Kasozi [1974] EA 221**, that:

“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. It is such a degree of care as normally skilful member of the profession may reasonably be expected to exercise in the actual circumstances of the case, and, in applying the duty of care to the care of a surgeon, it is peculiarly necessary

to have regard to the different kinds of circumstances that may present themselves for urgent attention...A

charge of professional negligence against a medical man was serious. It stood on a different footing to a charge of negligence against the driver of a motorcar. The consequences were far more serious. It affected his professional status and reputation. The burden of proof was correspondingly greater...The practitioner must bring to his task a reasonable degree of skill and knowledge, and must exercise a reasonable degree of care... (Emphasis ours)

48. We ask whether the action taken by the cross-appellant of asking the nurse in charge to contact the appellant, as the patient was at the hospital, is that not what any other reasonable doctor would have done, being away, attending to a personal matter? The Medical Board, consisting of men and women of his profession, found that he had acted reasonably. Attending to a dentist by a doctor cannot be said to be a 'road trip'. Doctors, too, are human and have medical needs that require attention. It is bad that he did not answer the calls from the deceased or return them, but can that fact alone amount to medical negligence? Was refusal or neglect to pick up a call an approximate cause of death? Since the deceased had a normal pregnancy at the last point of examination, there was nothing for him to have handed over in any event. From the patient's history provided by the cross-appellant, we do not believe that even if he had personally contacted the appellant, it would have added any value. Further See ***Ricarda Njoki Wahome vs. Attorney General & 2 Others [2015] eKLR.***

49. As relates to the appellant, her evidence is that she had left the hospital and was at the petrol station heading to her

private clinic. She is accused of failing to act within good time to attend

to the patient and of attending to her in a negligent and unprofessional manner. We take cognizance that the appellant was already punished for practicing privately when the Doctors' Rules of Procedure and Regulations did not permit her and was punished by the board for the misconduct.

50. There is no dispute on the chronology of events:

- 8:15 a.m. The 1st respondent received a call from the deceased.
- 8:20 a.m. The 1st respondent calls PW2 & PW3.
- 9:20 a.m. PW3 arrives at the hospital (see PW3's evidence)
- 9:30 a.m. 1st respondent arrives at the hospital (see 1st respondent's evidence).
- 10:00 a.m. The appellant receives a call, having just left the hospital, on her way to attend to a client at her private clinic.
- 10:15 a.m. The appellant and 1st respondent arrive at the hospital. (see appellant's evidence).
- 10:30 a.m. The deceased is wheeled to the theatre.
- 10:45 a.m. The deceased and unborn child are pronounced dead.

51. In a statement we believe to the Medical Board dated the 30th of September 2008, the 1st respondent confirmed that in an examination of the deceased two weeks before her death, she had complained of a backache. He arrived at the hospital at

9.30 a.m. and found the deceased bleeding profusely with no sign of a doctor. The nurses informed her that the cross-petitioner had referred them to the appellant, although none of those present had been informed. He called the appellant's clinic and was told she was attending to a client.

On finishing with the client, he met the appellant and explained the emergency, and the appellant inquired about her fees. The

appellant called the hospital and directed the patient to be prepared for theatre. The appellant, on the other hand, states that the nurses initially said the patient was bleeding, but in the car, based on the relative's information. She asked the relative to get in touch. Further, no history was relayed to her of the patient's condition until the 1st respondent met her at her clinic. The appellant, in her own words described the situation at the hospital on arrival thus; -

***“The blood pressure was not readable. I tried to fix an intravenous line, but failed as the patient's veins had collapsed. I tried to get a femoral tap grouping and cross matching but it was difficult. I made an impression of severe antepartum hemorrhage in shock. I instructed the nurses to wheel the patient to the theatre immediately so that the anesthetist could assist in resuscitation. We wheeled the patient ... We arrived at the theatre at 10:30 am. And the patient was received by the staff. I changed into theatre clothes and went to fix the intravenous line again. This time I succeeded but didn't get enough sample of blood to submit to the lab for examination. We started infusing normal Saline very fast and there were no plasma expanders and called the lab technician to the theatre to come and assist in grouping the patient with the small sample of blood I got. He came immediately and grouped her. She was blood group O+ and informed us there was no Group O+ blood in the hospital. Fixing another intravenous line was impossible and meanwhile I did an obstetric examination and the fundal height was 34/40 but I didn't pick fetal heart rate. A nurse who accompanied us to the theatre from amenity remembered there was one pint of blood in the fridge that was kept for a*”**

patient who had since been operated on and a supportive staff was sent to go pick it and drop it to the lab so that it could be given to the patient.

At 10.40 am, the anesthetist arrived at the theatre and the patient was wheeled to the operating table. The anesthetist took charge of the patient, and I went to the scrub with a male nurse. The anesthetist noticed the patient had no heartbeat. He did a cardiac massage and also gave the patient atropine and adrenaline, but resuscitation was unsuccessful, and she was confirmed dead at 10:45 am. By the time the patient died, we had not received one unit of blood promised from the amenity ward.
(Emphasis ours)

52. She went on to say she did not think she could have done anything else to save the lives. In our view, upon arrival at the hospital, the appellant did all she could as a doctor in an attempt to save the lives of the deceased and the unborn child. She was blamed for not carrying out a post-partum feotal caesarean section to save the child's life, overlooking the fact that she had done an obstetric examination and failed to get the feotal heartbeat, meaning the child was already dead at the time.
53. The issue then is whether the appellant lost time. Dr Ngatia, in his response to the Medical Board, stated that the deceased had bled profusely before being taken to the hospital. This statement was not controverted, neither the statement by the appellant that she was called at 10:00 a.m., arrived at the hospital and was at the theatre at 10:30 a.m. controverted. The time element was not well articulated; it remains a grey area. How do we assess the time? was the delay of 30 minutes or an hour, what was 'a long time' in the circumstances of the case? The "chain of

events” referenced by the Medical Board, which was said to have been triggered by the lateness of the appellant, was not

explained either. The evidence of a representative of the Medical Board would have shed light on what the board meant by 'chain of event', additionally the evidence of a doctor skilled in the field practiced by the appellant and the cross-appellant would have explained whether the delay of 30 minutes or so, attributed to the appellant contributed to the fate of the deceased and the unborn child or whether the action she took when she got to the hospital was a direct consequence of death. In **Pope John Paul's Hospital & Another vs. Baby Kasozi** (*supra*) the court stated as follows:

"In cases charging medical negligence, a court should be careful not to construe everything that goes wrong in the course of medical treatment as amounting to negligence. The courts would be doing a disservice to the community at large if they were to impose liability on hospitals and doctors for everything that happens to go wrong. Doctors would be led to think more of their safety than of the good of their patients. Initiative would be stifled and confidence shaken. A proper sense of proportion requires the courts to have regard to the conditions in which hospitals and doctors work. 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. 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...In medical cases the fact that something has gone wrong is not in itself any evidence of negligence”

54. It is regrettable that the deceased, a young woman lost her life and that of her unborn child in the course of childbirth. The 1st respondent and his family must have suffered emotional and material loss. However, it is not in all situations where death occur that doctors ought to be blamed for death. As stated in

Pope John Paul's Hospital & Another vs. Baby Kasozi

(supra), we have to be careful not to confuse medical negligence with misadventure. The 4th respondent/cross-appellant did not answer his phone and did not directly call the appellant to refer the patient to her. There is evidence that when he last saw the deceased, she had no complications. The appellant was called and informed that a patient had been referred to her by the cross-appellant, but with no details regarding the patient's medical condition. She was on her way to her private clinic, which she ought not to have been operating (that is not an issue before us; indeed, the relevant body dealt with the issue and punished her for the misconduct). The appellant asked to be paid as the patient was a private patient in the amenities ward of the hospital, and proceeded to the hospital after about 30 minutes. There are situations where doctors, being human, may not be readily available due to other contingencies. In such situations, fate must be left to take its course. This case in our view, is such a situation. Looking at the totality of evidence and circumstances surrounding the case, we are not satisfied that the alleged medical negligence against the appellant and the cross-appellant/4th respondent was proved to the required standard. As a consequence, we set aside the

judgment of the

**H.C.C.A. Nos. 101 & 102 of 2017 and C.M.C.C. No. 190
of 2016.**

55. We order that each party bears its own costs.

56. Following the untimely death of the **Hon. Mr. Justice Fred Ochieng** prior to delivery of this judgment, and there being concurrence by the remaining members of the bench, this judgment is delivered under **Rule 34(4) of the Court of Appeal Rules.**

Dated and delivered at Nyeri this 28th day of November, 2025.

J. LESIIT

.....
**JUDGE OF
APPEAL ALI-
ARONI**

.....
JUDGE OF APPEAL

*I certify that this is
a true copy of the
original.*

Signed
DEPUTY REGISTRAR