THE REPUBLIC OF UGANDA

IN THE HIGH COURT OF UGANDA AT KAMPALA

CIVIL SUIT NO. 111 OF 2012

1. THE CENTER FOR HEALTH HUMAN RIGHTS AND DEVELOPMENT
2. MUGERWA DAVID
3. NANTONGO GLORIA}
4. NALUKWAGO SUSAN}
5. NAMUGERWA GRACE} SUING THROUGH THEIR NEXT FRIEND MUGERWA DAVID.....PLAINTIFFS

VERSUS

NAKASEKE DISTRICT LOCAL ADMINISTRATION.....DEFENDANT

BEFORE: HON JUSTICE BENJAMIN KABIITO.

JUDGMENT

The first plaintiff is a company limited by guarantee that works towards full realiasation of the right to health and the promotion of human rights in health and practices.

The second plaintiff is the husband to the deceased Nanteza Irene. The third, fourth and fifth plaintiffs are minors and daughters of the deceased Nanteza Irene and are suing through their next friend Mugerwa David their father.

The defendant is a Local Government with administrative oversight over Nakaseke hospital, that is situate, in the District of Nakaseke.

It is the plaintiff's case that one Nanteza Irene, hereinafter referred to as the deceased, was brought to Nakaseke Hospital, a local referral hospital in the area, for obstetric care and management, to deliver a child.

It is contended that from admission, at the hospital, the deceased who had an obstructed labour condition, did not receive the appropriate medical care and attention owing to the absence of the assigned doctor on duty for the day to attend to her and manage her condition and the birth of her child.

It is on account of this neglect of duty of the deceased as a patient in critical need of care and management, that this action is brought for damages against the defendant that has oversight responsibility over Nakaseke Hospital.

The plaintiffs claim is set out as hereunder;

a) A declaratory judgment that Nanteza Irene's (deceased) right to life, to health, freedom from inhuman and degrading treatment and equality and that of her children were violated.
b) General damages.
c) Punitive damages
d) Interest at a court rate from the date of the cause of action till payment in full.
e) Costs of the suit.

In its written statement of defense, the defendant denied the plaintiff's claim and maintained that;

a) Nanteza Irene (deceased) was admitted at 1:30 pm, reviewed and received all the necessary examinations and checks.
b) There was a doctor on duty at the hospital.
c) The deceased never sought to be transferred to Kiwoko.
d) There was no negligence in the care of the deceased and it contends that the patient was properly, adequately and professionally managed from the time she entered the hospital upto the time of her untimely and unfortunate demise.
e) There was no violation of the patient's constitutional rights at all.

For the defendant, it is generally, denied that the deceased was neglected and did not receive any care and attention from the onset of her admission at the hospital till the time of her death. The defendant insists that the staff and the hospital administration gave the appropriate medical care to the deceased in the circumstances of her medical condition.

JOINT SCHEDULING MEMORANDUM

The parties both filed a joint scheduling memorandum that guided the scheduling conference held with the parties and counsel.

The parties agreed to the fact of death of Nanteza Irene.

The issues for resolution were framed as follows;

1. Whether the deceased's human and health rights were violated by the defendant.
2. Whether the children's rights were violated by the defendant upon the death of the deceased as a wife and a mother.
3. Whether the defendant is liable.
4. What are the available remedies?

EVALUATION AND REVIEW OF EVIDENCE ADDUCED.

It is important from the onset, to review the evidence of both the plaintiff and the defendant witnesses critically, in order to establish a credible time line for the fact of admission of the deceased, into the hospital and the time of her death.

ARRIVAL AT HOSPITAL

On the 5th day of May 2011, the deceased Nanteza Irene had labour pains while at her home. She was taken to Nakaseke Hospital, by, her husband, **Mugerwa David, PW1**, for delivery at around 12:00pm.On arrival, the deceased was taken to the maternity ward and admitted by 1:35pm.

Nyasuna Florence, DW1, noted that upon arrival that;

> *"Her clothes were soiled as her membrane had already ruptured. There was water and blood. I gave her a bed in order to examine her as I suspected that the baby may be near".*
>
> *While examining her, she informed me that labour had started whilst she was in the garden. It would appear that the onset of labour had long started before she arrived at Hospital given that she was 8cm dilation. Normally at 10cm dilation, a baby is born.*
>
> *According to my experience, an expectant mother dilates at one cm per hour. For an expectant mother who is at 8cm at 1:35 pm dilation, I would expect, delivery by about 5pm, bearing other interferences such as the baby turning. At 3:30 pm the dilation was about 9cmand everything looked normal."*

DW1's testimony is in conformity with the Labour Progress Chart (Partogram) which indicates that at 3:35pm the deceased was 9cm dilated and that at a dilate of 1cm per hour, her expected time of delivery was between 4:35pm and 5:00pm.

MANAGEMENT UPON ARRIVAL

DW1 testified in respect to the management approach that she undertook for the deceased.

> *"I put her on IV drip to give her strength for the delivery of the baby given the state she was in. The IV drip is just to support her in a normal delivery. I asked her whether she had taken any drugs and she told me that she had taken mumbwa, a native drug, commonly taken. Such a drug can help but there can be other negative consequences such as a rupture. I handed over the deceased at 3:30pm.*

Nanfuka Esther, DW2 testified on this on this point as follows;

> *"I found the deceased in the second stage of her labour at about 4pm.She was in stable condition. After some 30 minutes, I detected that the deceased condition had changed.*
>
> *The deceased was handed over to me at 4pm by Dw1. I examined her and then explained to the husband that the patient would not deliver normally, because her membrane had already ruptured by the time she came to the hospital. With an early rupture of the membrane, is a bad sign or indicator of the labour condition.*
>
> *On account of this situation, you are advised that such a patient had to be taken to the theatre.Even the fetal heart of the baby was beating fast. This was an indication of an emergency for the deceased. This was an indication that I could not handle the deceased myself. I confirmed that this was a sign of obstructed labour of the deceased. In an obstructed labour, the patient feels pain and tiredness. Obstructed labour, if not attended to, could result in death.*
>
> *In case of an emergency, I am required to call the doctor. I called the doctor four times.*

DW4, Dr Mubeezi, conceded to the following matters generally in his testimony to the court.

> ***"In the case of an obstructed labour, the nurses are required to handle the case as an emergency. The nurses ought to consult a senior doctor. Death by ruptured uterus is a terrible way for a woman to die.***

PW1 was compelled in the absence of the duty doctor to call his mother in law when he realized that the deceased's situation had aggravated. PW1's mother in law came to the hospital at around 8:00pm as per her testimony.

Although the deceased did receive IV fluids as part of the management of her condition, she did not receive the appropriate expected obstetric care to aid safe delivery of her child arising from a condition of obstructed labour that she was entitled to and for which, DW4, as doctor on duty, was required to give as a health professional.

DOCTOR ON DUTY.

Pw1 testified as follows on this point.

> ***"It was the nurse that told me that there was no doctor in the hospital. I was told that the doctor had left the Hospital at 11am.***
>
> ***By the time, I filled the form and left, it was about 8:30 pm.It was the nurse that informed me that the doctor was about to get to Wobulenzi.The nurse was communicating to me and the doctor in Luganda.***
>
> ***The form was for my consent to the operation.***
>
> ***It was the guards who informed me that the doctor had come. This was at about 9pm."***

Nabantanzi Joyce, PW2, the mother of the deceased testified as follows on this point;

> ***"I got to the Hospital at about 8pm.I found the deceased to be in bad shape. She was wailing out loud that the child was kicking.***
>
> ***There was a nurse. She was dressed in white. I did not see any other medical worker. It was a nurse who was attending to my daughter. It was***

the doctor who was to carry out the operation. It was confirmed that the doctor was coming to do the operation."

DW1testified that; according to the duty rota of the day, as prepared by Dr Mukwaya, the medical superintendent of the hospital at the time, it was Dr Mubeezi, who was on duty on the day in question.

DW1, testified thus on this matter;

"Dr Mubeezi was present in the morning of that day. I saw him between 8 to 9 am that morning. I do not know whether Dr Mubeezi was still in the Hospital as at 1:35pm.As at 3:30 pm, I cannot confirm whether Dr Mubeezi, was at the Hospital. The numbers on the duty rota are to enable one to call a doctor during an emergency. The HIV section is about 10 meters away from the maternity ward. At about 3:30pm, when I was leaving the hospital, I noticed that the medical superintendent, Dr Mukwaya, was present in his office. I did not see any other doctor.

DW2 testified as follows in respect to her frenetic efforts to call Dr Mubeezi, to respond to the emergency at hand on the day in question.

"I went to the main operating theatre and informed the staff there that there was an emergency and that they should be prepared.Thereafter,I took a chart, which has details of the patient, to a guard, at the main gate , to help call the doctor who was on duty at the time. I informed the guard to help me call the doctor as there were emergencies on the ward. The guard took the chart to the doctor's mess where they sleep. This was about 4:30 pm.

The guard returned after about 10 minutes and notified me that there was no doctor at the doctor's mess. My colleagues namely Dw1,Nabisiya Sarah, Sister Ejakieti Agnes ,informed me that Dr Mubeezi, had been around that morning and was the one on call.

If a doctor is within the hospital, it would have taken about 10 to 20 minutes to get to the theatre.If there is no doctor within the hospital, we can refer the patient to another hospital."

DW2 gave the following timeline in her attempt to locate the doctor on duty.

4:15PM. she took the patient to the theatre together with Dw3, Dora Ssengendo.

4:30pm made first call to Dr Mubeezi.

4:45 pm made second call to Dr Mubeezi.

The third call, in between the second and last call.

5:30 pm made last call to Dr Mubeezi.

DW2 continued on this point as follows;

> *"I informed Dr Mubeezi, that there was an emergency in the theater was instructed to take the patient up. I told him that the patient was already up. The doctor told me that he was coming."*
>
> *I do not know when Dr Mubeezi came. I know that Dr Mubeezi was not on station.*
>
> *The doctor was required to sign the chart indicating that he was aware and that he was coming. The chart was not signed when it was returned. This prompted me to make a call. I made a call on the basis that the doctor was not around.*

Ssengendo Dora, DW3, a nursing assistant, who worked under DW2, supervision gave evidence that generally corroborates the evidence of DW2, except in one respect.

She testified that;

> **"We were in the waiting room with the patient, Dw2, until the Doctor came in. This was approaching 7pm when Dr Mubeezi came in. I was with Dr Mubeezi when the doctor came in. When we were about to enter the main theatre, the patient died. I believe she died between 7pm and 7:30pm."**
>
> **"I can't tell where Dr Mubeezi was as he is my boss. I do not know where he was coming from. I only know that he came in after 15 -20 minutes.**

Yet DW2 was quite emphatic that she did not know when the doctor came in.

The other difference is in respect to the calls that DW2 made to the doctor on duty.

DW3 testified thus;

"I do not know whether Dw2, called the doctor four times. I only knew of the call made at 6:30pm."

Yet DW2's timeline for the calls is from 4:30 PM to 5:30pm.

DW4 testifies as follows in respect to being at the hospital and the calls made.

"At about 4; 30pm, I was attending the HIV Clinic at the hospitals. I left the hospital after 5pm went through the main gate to my home for lunch. I returned to the hospital by 5:30 pm and went to the data section, HIV.I left the data section at 6pm. I returned home through the main gate. From 6pm to 6:30pm, when I received the call from Dw2, I was at home.

"I received a call from Dw2. It was one call. I received the call at around 6:30pm.The information was that there were patients that needed a doctor's attention. One of whom was suspected to have obstructed labour.I was at my residence when I received the call. I was within the hospital quarters at the hospital.

I responded immediately within 5 to 10 minutes after getting the call. The deceased died between 7:00pm and 7:30 pm.

TIME OF DEATH AND CAUSE.

Upon being questioned by the court in respect to the entries made on Maternal Death Notification Form No 10053 that had been filled out by the defendant upon the death of the deceased as is required by the Ministry of Health, DW4, conceded that the form indicated the duration of stay of the deceased before death, as being 8 hours and the cause of death as Ruptured uterus secondary to Anemia on 5th May 2011.

The eight hours of labour puts the time of death at 9:30 pm.

RESOLUTION OF ISSUES.

ISSUE ONE AND TWO

I will consider both these issues concurrently as they are related.

Whether the deceased's human rights were violated by the defendants and whether the children's rights were violated by the defendant upon the death of the deceased as a wife and a mother.

Essentially the main issue for resolution in this case, is whether the deceased received the appropriate obstetric care and management that she was entitled to for a pregnancy that presented a condition of "obstructed labour".

It is evident that by the time of admission at the defendant facility, the deceased was in urgent need for immediate and urgent obstetric care, as her waters had broken and she was in advanced stages of labour.

The evidence of DW1/DW2 indicates that upon admission the deceased at 1:35pm on the day in question was at 8cm dilation and due for birth by 5pm.

Before then, a review of the deceased condition at about 4:30pm, by DW2 detected a condition that suggested "obstructed labour".

There is a preponderance of evidence especially by DW4 and DW2, that such a condition of "obstructed labour", would lead to death of a mother and child, unless attended to with urgency and dispatch and that her condition needed the attendance, management and intervention of a senior doctor.

DW2's evidence indicates her understanding of the seriousness of the deceased's situation and the need for an emergency intervention of a doctor, as early as 4:30pm, of that day, which tallies with the evidence of DW1, that the deceased would get to 10cm dilation by about 4:30pm.

It is thus no wonder, that DW2, having fully taken cognizance of the deceased situation, by virtue of her training and experience, frenetically began to look for the doctor on duty, for the day who was DW4 (Dr. Mubeezi), from within and at the doctors mess.

There is considerable convergence of both the plaintiff's and the defendant's case regarding the absence of DW4, who was to be on duty on the day in question.

PW1/PW2 and DW1/DW2 and DW3 all testified to the fact that DW4 was absent from hospital from 11:00am that morning and only returned to the hospital, in the late evening of that day.

It is only DW4 who claims to have been at the hospital, at about 4:30pm, at the HIV clinic, just a few meters away from the theater and the maternity ward.

I had occasion to visit the hospital at Nakaseke in order to acquaint myself with the various locations, such as the theatre, maternity ward, gate, HIV clinic and the doctor's mess, that were mentioned in the evidence of various witnesses in this case.

For DW4 to claim that he was at the HIV clinic from 4:30pm till after 5:00pm, when he left, is quite startling considering that the HIV clinic is a mere 10 minutes walk to the maternity wing/ theatre where the deceased was admitted and DW2, was making frenetic efforts to locate him, within the hospital itself and at the doctors mess, situate about 100 meters from the main hospital gate, the only gate into and out of the hospital precincts.

If DW4 was indeed at the HIV clinic as he claims, he would have been traced by DW2 as at 4:30pm in order for the emergency condition of the deceased to be attended to.

It is my finding that the preponderance of evidence of PW1/PW2, /DW1/DW2/ DW3 that DW4 was not at the hospital from midmorning of that day till late.

DW4 was not even at the doctor's mess as at 4:30pm, when the guard was sent by DW2 to alert him of the emergency situation that had ensured at the maternity ward.

The chart that had been sent by DW2 was returned unsigned which indicated that DW4 was not at the mess either.

There has been an attempt by DW4 to move the time of notification indicated in his statement, from 7:30pm to 6:30pm, on grounds that this was a typing error.

I am not convinced that this attempt by DW4 at manipulating the time line to his convenience is but an innocent error. These attempt smacks of a deliberate, well calculated attempt by DW4, to place himself, at the hospital about 6:30pm

to 7:30pm of that evening, in order to avoid a charge of being absent from duty.

There is a claim by DW3, a junior nursing assistant, who confessed that DW4 was her "Boss", to state that DW4 came at the theatre at about 6:30pm while DW2 was present. DW2 denied this and categorically insisted that she did not know when DW4 come to the theatre on the day in question.

It is evident from DW3's demeanor, that she was under the influence of DW4 as her boss to offer a fovourable time line in order for DW4 to escape blame, from being absent from duty.

Considering the evidence of PW1 who testified to have waited for the doctor in the compound of the hospital, near the gate, it is clear that DW4, returned at the hospital at about 9:00pm, which is almost 8 hours after the deceased had been admitted at the hospital from 1:35pm, of that day.PW1, was able to detect when the doctor came in.

DW3's evidence that the deceased died before the onset of the operation, is consistent with a series of events, right from the time of admission, of the deceased, to about 4:30pm- 5:00pm when, the condition of obstructed labour became manifest to DW2.

By the time the doctor came in at 9:00pm, with labour having gone on for some 8 hours already, it was probably too late for any medical intervention to reverse the heamorrhage that had arisen from uterus rapture

The maternity Death Notification Form, No. 10053 which DW4, acknowledges is prepared and filled by an official of the hospital, after a death has occurred, confirms that the deceased had stayed at the hospital for 8 hours before her death. This form corroborates in a material particular the time line given by PW1, as at 1:35pm at admission and 9:30pm as time of death of the deceased.

The medical certificate of death PEX No. 2 itself confirms the time of death as at 21:30 hours, 9:30pm as being due to hemorrhage and ruptured uterus.

It is quiet significant that DW4 admits that the time of death was not indicated in the clinical notes for the deceased and further still that the entries that he made

were made much later after the death of the deceased, given the emergency situation that DW4 found himself in.

It is clear that, the clinical notes in respect to the deceased's file that were recorded by DW4 after the death of the deceased, do not reflect the correct findings in relation to the time of death and appear entered to fit the DW4, version of events and to be in accord with his attempt to alter the time line in his own witness statement given under oath.

It is with astonishing audacity that DW4 could claim the that he was present at the hospital at 4:30pm at the HIV clinic, which was barely ten minutes away from the maternity ward in the emergency condition she was in.

It was even with greater astonishment that DW4 could even claim, without remorse, that he walked around the hospital out of the gate to his residence and back, when DW2 and the hospital guards were looking for him to attend to an emergency that had arisen as early as 4:30pm.

It is understandable, for DW4 to strenuously strive to place himself within the precincts of the hospital, from 4:30pm onwards, in order to avoid the charge of neglect of duty, and ultimate responsibility for the death of the deceased and her child, as doctor who went missing while on duty.

Paragraph 4.3 of the Code of Conduct and Ethics for the Uganda Public Service provides;

> ***"A public officer shall seek and obtain permission from his or her supervisor to be absent from duty. Permission shall not be unreasonably denied or granted."***
>
> ***"A public officer shall, during official working hours, report his or her absence from office to his or her immediate supervisor or relevant persons."***

In the result, by absence of DW4 from duty from about 11:00am in the mid morning till late in the evening, when he was the doctor on duty, the deceased did not receive the timely, immediate and emergency obstetric care that she needed to overcome the "obstructed labour" condition she was in.

DW4 confirmed that no postmortem was conducted at Nakaseke hospital following the death of the deceased.

DW4 explained that owing to the angry outburst and reaction of the relatives of the deceased, and the taking away of the body, the post mortem could not be conducted.

The angry outburst of the relatives of the deceased merely confirms their outrage at how the deceased had been treated and neglected at the hospital for a period of 8 hours.

DW4 had by the time of the trial been promoted to the Medical Superintendent of Nakaseke Hospital.

No doubt, this elevation, gave DW4, considerable influence on most of the defendant witnesses that testified in this case, such as DW3.

It is quite shocking, that a person such as a DW4 who bore the most responsibility for the death of the deceased and her child, and who as a consummate liar, as tried to cover it up the unfortunate death out of negligence of duty, was able to secure promotion to the position of Medical Superintendent. In respect to the circumstances of this case, DW4, ought not, in my opinion, hold any position of responsibility in any hospital.

The deceased did not receive the care and protection she was entitled to under the constitution as a result of a flagrant act of neglect of duty of DW4.

Article 33(3) provides;

> ***"The state shall protect women and their rights, taking into account their unique status and natural maternal functions in society."***

The deceased children, plaintiffs, 3 4 and 5 and the Pw1, have been denied the care and companionship of their mother and wife, that is recognized under the constitution, by a flagrant act of neglect of duty by DW4.

Article 34(1) of the Constitution states;

> **"Subject to the laws enacted in their best interests, children shall have the right to know and be cared for by their parents or those entitled by law to bring them up."**

In the result, the human and maternal rights of the deceased and the rights of the children and spouse, arising under the constitution, were violated.

ISSUE THREE

Whether the defendant is liable.

Having found as I have that the deceased's right to basic medical care were violated, I will now consider whether the defendant is liable.

Section 30 of the Local Government Act Cap 24, provides for the functions, powers and services of a council. Section 30(2) refers us to the part 2 of the second schedule to the Act for the services and functions of the council.

Part 2 of the second schedule to the Act has other functions of the District Council among which it has to provide medical and health services including; hospitals, health centers, dispensaries, sub dispensaries, maternal and child welfare among others..

Article 176 2(g) of the Constitution provides;

> ***"the local government shall oversee the performance of persons employed by the Government to provide services in their areas and to monitor the provision of Government services or the implementation of projects in their areas."***

Ssentongo Badru, DW5, the Chief Administrative Officer of Nakaseke District Local Government testified that the defendant is responsible for the operations and management of Nakaseke Hospital and for its employee's such as, doctors, nursing and other staff.

The defendant as part of its oversight responsibility over the defendant appoints a Hospital administrator to oversee the management and provision of medical services at Nakaseke hospital on behalf of the district. The district is meant to supervise and appraise the said staff, from time to time.

It is on account of this responsibility, that the Hospital superintendent, one Semakula David filed a report on the death of the deceased to the Chief Administrative Officer, Nakaseke District, on the 6th May 2011. (DEX 4).

The report reads thus;

> *"Nanteza Irene (deceased) came to Nakaseke Hospital on 5th may 2011, in established labour at 1:35pm.She was aged 34 years, married, Ugandan and coming from Mifunya village, Nakeseke Sub-county, Nakaseke District. On arrival, she was examined by staff on duty, who established that she was holding a 4th pregnancy and had 3 other siblings who were alive. She was in 1st stage labour.*
>
> *Nanteza Irene was admitted in labour ward assessed progressely in normal labour by midwives on duty. Her condition changed..Doctor on duty reviewed the patient and made a diagnosis of obstructed labour.*
>
> *The patient was resuscitated and taken to theatre but died before operation in theater.*
>
> *Cause of death was bleeding following ruptured uterus."*

There is evidence to show that the hospital administrator one "Semakula" was present on the fateful day and was notified of the condition of the deceased by DW2.

DW2 testified that;

> *"I also informed Mr. Semakula the administrator of the of the hospital of the condition of the patient."*

Upon notification of the condition of the deceased to the hospital administrator, there was no indication at all of any efforts that were made to have the deceased transferred to another hospital in the absence of the doctor on duty at the hospital to attend to the emergency that had arisen.

Yet, in his report, Semakula David does not report that the doctor on duty was absent for most of the day, falsely represents that it was the doctor on duty who diagnosed the condition of obstructed labour , when it was DW2 that had detected the anomaly first, falsely represents that the patient was resuscitated and then taken to the theatre when it was the case that the deceased died during resuscitation attempted when DW4 ,finally showed up, the report did not state the time of death, just as the clinical notes.

A defendant is vicariously liable for the negligent, acts and or omissions of its servants committed within the scope of the employee's employment.

Christopher Yiki Agatre V Yumbe District Local Government HCCS No. 22 of 2004, it was held;

> ***"The latter will still be held vicariously liable even if the acts of the servant are negligent, deliberate, wanton, criminal or for the benefit of the servant. The acid test of deciding vicarious liability is whether the acts were done or committed within the scope of the servant's employment. It is irrelevant if the act was done contrary to the instructions of the matter."***

In the circumstances, the defendant, charged with administrative and supervisory oversight over the Nakaseke Hospital, for which an administrator is deployed to monitor the observance of adequate health care and services to patients in need, for failing to ensure that the necessary obstetric care that the deceased urgently required was provided, and for failing to ensure that DW4 a doctor deployed to offer such professional health care and services, was present on duty on the day in question, is vicariously liable for the death of the deceased and her child, in such circumstances.

I therefore find that the defendant is vicariously liable in damages, for the violation of the human and maternal rights of the deceased and that of her children.

ISSUE FOUR

Remedies available to the parties.

PUNITIVE DAMAGES

The plaintiffs prayed for punitive damages for the death of the deceased arising out of negligence of a doctor subject to the supervision of the defendant.

Rookes Versus Barnard [1964] AC 1129, at page 1220 Lord Devlin laid down three considerations for the grant and award of exemplary damages among which is;

> ***"the means of the parties are material in the assessment of exemplary damages."***

The defendant being Local District Council has means and resources that go principally toward the operations and management of the defendant. I must take judicial notice that such means and recourses, are often in short supply and barely adequate to cover the intended services.

For this reason therefore, I make no award of punitive damages that could affect the operations and management of the defendant.

GENERAL DAMAGES.

General damages are awarded at courts discretion and are intended to place the injured party in the same position in monetary terms as he would have been had the act complained of not taken place. **See Phillips versus Ward [1965] I AU ER 874.**

I have considered the following matters in respect to a claim under this head.

1) The violation of the deceased right to access appropriate medical and health services.

2) The deprivation of the children of their right to be cared for by their mother, in this case.

3) The terrible agony that the deceased was subjected to in her 8 hours of obstructed labour.

4) The suffering and mental anguish that the 2nd to 5th plaintiffs have had to go through as a result of the loss of life of their wife and mother.

5) The need to ensure that the damages awarded do not cripple the operation, supervision and management of the defendant as a district referral hospital.

Basing on the above, I will therefore award a sum of **Ugx 35,000,000/= (Thirty five Million Shillings Only).**

INTEREST

I award interest of 6% per annum on the award of general damages, from the date of judgment till payment in full.

COSTS

I have considered the fact that the defendant is local government entity and awarding costs could cripple the District operations. I have also considered the fact that the defendant provides health services to very many patients within and outside the District and making an award of costs against it is not in the public interest.

I have also put into consideration the fact that the 1st plaintiff receives sponsorship for the conduct of cases such as this.

For those reasons, each party to bear its own costs.

Before I take leave of this matter, I must express my concern at why the 1st plaintiff being an activist in respect to health matters, did not consider it appropriate to have joined as defendants, Dr Mubeezi, who bore the greatest responsibility for the death of the deceased and the Hospital administrator, one Semakula, who did not detect, or merely ignored, the absence of a duty doctor at the hospital for an appreciable length of time on the day in question in order to take remedial action in good time to avert a situation of neglect to patients in need.

It is the case that it is a plaintiff who names a defendant in an action if there is a reasonable appreciation that a defendant has a case to answer and liable in damages for loss occasioned to the plaintiff, in any matter.

By omitting to join the said officials, the 1st plaintiff has denied to the 2nd, 3rd, 4th and 5th plaintiffs an award of aggravated or exemplary damages that would have been awarded against the said individuals, in the circumstances of this case.

Notwithstanding the said situation, on the basis of this judgment of this court, the 2nd, 3rd, 4th and 5th plaintiff can cause criminal proceedings to be instituted, against Dr Mubeezi and Ssmakula, for neglect of duty, resulting in a death of a mother and child, under section 114 of the Penal Code Act, for deterrence purposes.

The other matter of concern is the poor standard of the plaint which did not succinctly particularize the acts and omission of negligence of the defendant.

The third matter is the very poor level of advocacy exhibited by the counsel for the plaintiff. On a number of instances, in the conduct of this case, counsel for

the plaintiff, apologized to the court, for not being prepared to discharge his responsibilities to this clients and to the court.

Another matter of concern is that, I note as well that DW2, who was the most candid and forthright of the defendant's witness, notwithstanding the influence of DW4, who appeared to be in considerable distress, when I last saw her at Nakaseke Hospital, during the visit to the hospital has since been transferred away from the said hospital.

This transfer must be investigated by the medical council or appropriate body to ensure that it was not punitive in nature at the hands of any person on account of the evidence that she gave to the court, in respect to this case.

It is also my expectation that the Hospital administrator must enforce the Code of Conduct and Ethics of the Uganda Public Service , without reservation, that require , notification to be made and permission to be sought for a public servant ,such as a doctor , but more importantly, a doctor who knows that he is on duty and the fact is known by the other health workers, to seek permission before leaving his or her watch, for any reason or to alert a suitable and competent stand in to handle any emergencies that may arise.

Finally, I must reprimand, counsel for the plaintiff, who without ledve of court, invited a horde of photographers and video recorders, to capture the state of the hospital at Nakaseke Hospital during the court's visit in a manner that disrupted the operations of the hospital during the visit.

BENJAMIN KABIITO

JUDGE

30/04/2015