THE REPUBLIC OF UGANDA

IN THE HIGH COURT OF UGANDA SITTING AT ARUA

CIVIL SUIT No. 0020 OF 2016

1.	**FREDA KASAIRA**	**}**	
2.	**AJILI PETER**	**}**	
3.	**HARRIET MANZONI**	**}**	
4.	**NANCY AKUJE**	**}**	**…… PLAINTIFFS**
5.	**JOAN MASINDA**	**}**	
6.	**FIONA ASIMBA (6th plaintiff a minor suing through next friend ONZIMA NYAKUNI)**	**}**	

VERSUS

THE REGISTERED TRUSTEES OF NEBBI CATHOLIC DIOCESE …… DEFENDANT

Before: Hon Justice Stephen Mubiru.

JUDGMENT

The plaintiffs jointly and severally sued the defendants for the recovery of general and special damages for the wrongful death of Ms. Angucia Lucy which occurred on 12th September 2015 at Angal St. Luke Hospital alleged to have been caused by employees of the defendant who were at all material time acting in the scope of their duty and course of their employment as medical workers at a medical facility founded and operated by the defendants. The plaintiffs are children and dependants of the deceased. Their case is that the deceased was on 8th September 2015 admitted at the defendant's said hospital complaining of appendicitis. The deceased underwent surgery for that condition on 10th September 2015 during which a number of negligent acts occurred including; failure to properly administer anesthesia, to ensure an effective and constant supply of oxygen to the patient during the operation, failure to monitor the vital signs of the patient during the operation, failure to install the monitoring equipment of those signs during the operation, lapses in handing over the patient to the ward staff and generally failure to exercise professional care and skill to the required standard. As a result, the deceased never regained consciousness and eventually died at the said hospital on 12th September 2015.

In their written statement of defence, the defendants refuted the claim that the death of the deceased was a result of any negligence on their employees' part. Contrary to the advice of the doctor, the deceased left the hospital premises after admission and being informed that her condition required surgery. Complications arose while she was being operated upon in the hospital theatre including difficulty with intubation resulting in cardiac arrest and all efforts made to revive her brain function were unsuccessful such that she was in a vegetative state at the time she was taken out of the hospital theatre. In the circumstances, her death was the inevitable result of a series of medical complications that the medical team could not reverse despite their exercise of professional care and skill to the required standard. the deceased was properly advised of the possibility of those complications and she willingly gave her informed consent to the surgical operation.

P.W.1 Driciru Salome, a sister in law of the deceased, testified that her husband advised the deceased to seek medical attention at Angal St. Luke Hospital after she complained of stomach pains. On 8th September 2015, upon being examined by a doctor at the hospital, her condition was diagnosed as appendicitis and it was suggested to her that she needed to undergo a surgical operation. She was taken into the surgical theatre on 10th September 2015 at around 8.00 am and was brought out of the theatre at around midday. She was unconscious and still had two tubes inserted in her mouth and on drip. At around 2.00 pm concerned that the patient was not regaining consciousness, she alerted the nurses. The nurse, upon looking at the patient said there was a problem. She replaced the intravenous drip with another unit and returned after about twenty minutes to check on the patient and re-connected oxygen supply. By 4.00 pm she still had not regained consciousness and monitoring by the nurses had intensified. At around 5.00 pm the doctor who conducted the surgery checked on the patient but did not explain what was wrong with her. The plaintiff's brother returned at around 6.00 pm and upon seeing the patient began to shed tears and told the witness that the doctor who had conducted the operation had called him earlier and told him that something had gone wrong during the operation. he told her the patient was already dead. The deceased was kept on oxygen supply overnight and the following day the nurses came and removed all the tubes and began preparing her body. The hospital staff took the body to church for a requiem mass and later helped the family return it to her home and she was buried the following day.

P.W.2 Ocokuru Zena, a business associate of the deceased, testified that the deceased was a trader dealing in silver fish and was a member of the Arua Women Business Enterprise Uganda Limited, an association of dealers in fish. Their trade involved buying dried silver fish from fishermen on Lake Victoria at Buikwe landing site in Buikwe District. The traders would hire a truck jointly and each would load their merchandise onto it at the cost of shs. 30,000/= per sack full, at the total cost of shs. 1.8 - 2 million for a return journey. On return to Arua, each of them would re-sell their fish on wholesale and retail basis. Each trader ordinarily made a profit of shs. 165,000/= per sack full of fish. The average volume of sales was 6 to 7 sacks per week when business is at its peak and about 4 to 5 sacks per week when business was low. Their major customers are from South Sudan and the Democratic Republic of Congo although some traders would come from the towns, Districts and counties neighbouring Arua such as Terego and Odramacaku. Each member pays an annual subscription fee of shs. 50,000/= to their association but the land on which they operate was bought by the company and thus they do not pay monthly rent but a charge of shs. 7,000/= per bag. The deceased's business turnover averaged 30 sacks full per month.

P.W.3 Candiru Grace testified that she has been in the fish trade for over eighteen years. The deceased was her employer and she was responsible for selling off the fish delivered by the deceased. A sack full would cost shs. 700,000/=, all expenses included, at the point of delivery in Arua. The deceased had a business turnover that averaged at 30 sacks full per month, give or take two sacks full. A sack full would be sold at the whole sale price of shs. 1,100,000/= for customers from South Sudan and at a retail price of shs. 865,000/= to other customers. the average profit per bag was shs. 165,000/= at retail price and shs. 200,000/= at wholesale price.

P.W.4 Onzima Nyakuni Ben, a brother of the deceased, testified that upon receiving the sad news of the passing of his sister, he left his duty station in Kampala and travelled back to Arua. He met the management of Angal St. Luke Hospital seeking to find out what had caused his sister's death. The medical Superintendent of the hospital Dr. Odaga told him the anesthetist could have committed an error during the surgery. He made arrangements for the burial and was in charge of all necessary purchases of such items as the coffin, foodstuffs for the mourners, hire of a public address system and so on.

The deceased was a single mother who lived together with her children at Ediofe in a house provided by him. Occasionally, her brothers would provide her with financial assistance, especially with school fees for her children, but she largely met all her financial needs and those of her children. The first plaintiff Kasaira Freda now 32 years old was at the time undertaking a secretarial course, the second plaintiff Ajili peter now 28 years old was undertaking a plumbing course, the third plaintiff is now aged 26 years, the fourth plaintiff Nancy Akuje now aged about 23 years was in her third year. The fifth plaintiff Joan Masinda is about 21 years old. The last born, Fiona Asimba was in Senior Four at the time. The deceased also had two dependant nieces; Brenda aged 24 years and Asia aged about 11- 12 years and is now in primary seven. None of her children had been able to find gainful employment and this they all depended on her. Having been a sole proprietor, her business collapsed following her death after all her stock had been sold off.

P.W.5 Ajili Peter, the second plaintiff and son of the deceased testified that his mother died in September 2015 at Angal Hospital. She had gone for treatment but she never came back alive. She had six biological children. She was also looking after two dependants. At the time of her death five of her children were above eighteen and one of her dependants was below eighteen years. She was doing everything for them. She used to provide school fess, clothing, feeding, medication, parental guidance, and so on. She also provided accommodation by the house his uncle had built her. She was doing her business of selling Mukene (silver fish) in Arua Market. He is holder of a certificate in Craft 1, plumbing. Four of his siblings were still in school. Two are still in school. One is in primary seven, the dependant Asianzu Harriet. the sixth plaintiff Asimba Fiona is in senior six. After her death there is no one to provide for them anymore. She was spending about two million shillings per month her children and dependants. I still feel the pain up to now because of all that she was doing for us. Although five of them were above eighteen and she had sponsored their education, they had not found jobs yet. They were still searching for employment but in vain. When his mother died, he felt the world had ended for them. He holds the hospital responsible because it is where she lost her life. He prayed court to help them secure compensation for her death and suggested seven hundred million shillings.

P.W.6 Wikole Simon Bob, the brother of the deceased was the Hospital Administrator of Angal St. Luke Hospital at the time of his sister's death. As hospital administrator he facilitated the work of the medical team through provision of supplies and the rest. He is a Health services manager at Masters Level with a degree from Uganda Martyrs University Nkozi. He also oversaw employee performance. He stated that the defendants are the legal owners of the hospital. His sister was admitted and operated for appendicitis and she never woke up. Being the next of kin, it is him who signed her consent form. The content was explained to him as acceptance of the outcome if everything is done very well. It is for acceptance for risks but not negligence. If the patient came with a pre-existing medical condition it would be covered. After the operation the doctor who performed it, Dr. Dan Okello, went to him and informed him that "I have operated your sister but the outcome is bad. This was after two or three hours after she had left the theatre. He then went to see her for the first time after she came out of the theatre, and found she was convulsing. The doctor had already told him that there was no hope of resuscitation. The doctor had told him that during the operation he realised dark blood on the operation site. He immediately alerted the anesthetic officer and he then realised there was no monitor connected to the deceased. The oxygen was connected but it was not being monitored and when he checked on her eyes, he found the pupil dilated and fixed meaning brain death. The cause of death is indicated on the death certificate is Hypoxia with brain esecma due to cardio-pulmonary arrest. It was issued on 25th September 2015. As a next of kin he was part of the committee that made arrangements for her burial. the coffin cost, shs. 500,000/= while hire of public address system cost 250,000/=

He asked Dr. Odaga to convene a clinical audit into the death. The Audit team was convened. All the doctors in the hospital participated. There were four doctors. Augustine, Tugume, Justin and Ondaga. He too participated as the next of kin. The doctor who handled the operation presented what he did and what happened before, during and after the operation. It was attended by the doctor and the operating team; the doctor, nurses (theatre attendants- four or five of them) and the anesthetic officer (he is the only one who did not say anything though he was asked). The nursing team was asked to speak and they agreed with the doctor. After the open discussion, Mr. Onzima was called for briefing. The conclusions and recommendations reached were contained in a report and he was given a copy of the report. No post mortem examination was done on the

body since they did not request for it. I was requested to sign on the consent form as next of kin. The Doctor who conducted the operation did not tell him whether the appendix was successfully removed. They requested for an apology but it was not forthcoming. There was need to reprimand the staff and the board convened the disciplinary council.

P.W.7 Dr. Odaga Jimmy, testified that he is a surgeon in general surgery. He qualified in 2005 from Mbarara University of Science and Technology and did internship from Lacor Hospital. He practiced in Apac for one year and in December 2007 joined St. Luke Angal Hospital until August 2012 when he left to undertake a Masters programme at Makerere University. In 2015 June he returned to the hospital where he worked up to July 2016 Muni University as a lecturer. He also practices medicine at Arua Regional Referral Hospital as a honorary Surgeon seconded by the University.

In June 2009 he was the Acting Medical Superintendent up to 2012. In 2014, that appointment was terminated when another medical officer was substantively appointed in that position. He resumed as a medical officer on return. He signed the death certificate in respect of the deceased Angucia Lucy based on clinical diagnosis. The cause of death was heart and lung failure due to brain death for lack of oxygen. Since the patient was given anesthesia, she was supposed to be put on oxygen supply. During surgery the pulse oxymeter measures the amount of oxygen in the blood. It is attached to the fingers. If no oxygen is detected, the remedy is to re-insert the tube because it could be blocked. The oxygen source, the connectors and monitors should be checked. This is work of the anesthetist but the doctor supervises. The doctor made most of the explanation at the death audit meeting. The anesthetist did not say anything at that meeting. The meeting relied on the doctor for information regarding what transpired during the surgery. The monitors would have helped to detect the problem early if they had been connected.

When they realised the patient had suffered a cardiac arrest, they started compressions to the chest or resuscitation drugs. They were supposed to record major occurrences but there were no records. The doctors were in the doctors' room but they were not invited. There was no follow up in the ward. The tube was left in the patient up to the ward and neither the anesthetist nor any of the surgical team made a follow up. There was no transition through the recovery room. The

tube should have been removed at the table after reversing the anesthesia the drugs are short acting. In the ward the nurses should have continued to monitor using the available monitors. The nurses did not know how critical the patient was. The information on the chart was only the doctor's treatment. There were many but avoidable errors. The team did not meet the medical standards right from the start. There were three attempts at intubation and the difficulty could be a result of the expertise or anatomy of the patient. The alternative would be spinal anesthesia. The monitors were not in place. It is standard practice to have the monitors. She should not have been taken her off oxygen support. Lack of oxygen caused the brain death. The information contained in the report was from the surgical team; the doctor, the anesthetist and the theatre staff. The operating Doctor was the only one who gave the meeting this information. The others contributed in the discussions. The anesthetist was requested to make a submission but he did not. A post mortem is done by a pathologist. A certificate of death is proof of a probable death. The post-mortem states the cause as established.

The purpose of a consent form means the doctor has explained the procedure, how it will be done, possible complications, and the patient has understood. Only adults sign such a form. It is routine as a matter of procedure. Complications during anesthesia may arise. A doctor should explain how it will be mitigated. There could be pre-op or intra-op complications. The anesthetic agents are drugs that can affect all organs hence the monitors to pick e.g. heart failure. If they occur intra-op, the anesthetist is the first person to detect the complication. The anesthetist is not on the surgeon side but on the anesthetic side. They are trained to inform the surgeon who is the lead person. He should stop the procedure and join the anesthetist in the resuscitation process. The anesthetist did not record the major occurrences. When complications occur, the primary thing is to save life. One of the importance of records is for continuity of care. After the life is saved, there has to be records of what was done. The next team therefore did not know what to do and what could have happened because there was no record. At the bottom of exhibit P. Ex. 3 of the first page are directive to the ward. The Audit Committee noted the absence of vitals recorded. The vitals include the pulse and blood pressure. Indication of respiratory arrest did not make sense in absence of an indicator of satisfactory condition at leaving the ward. The tube was left in the patient and thus indicated that the patient had not maintained breathing. If the

recording is not done in the theatre it should be done in the recover. The columns in the form represent the intervals.

Clinical death Audit is mandatory in the event of every death that occurs in the hospital. Some hospitals do it monthly and others quarterly. The Committee interviewed the team involved which included the surgeon the other surgical staff and reviewed the medical forms from the theatre after surgery. In doing all this, they were guided by clinical standards which are policy statements by the Ministry of Health. They are the Uganda Clinical Guidelines and they also referred to medical text books. The anesthetist was part of the surgical team but he did not say anything. Most of the information the Committee relied on was from the operating doctor. He told the Committee how he detected lack of oxygen. Intubation is done in the presence of the doctor. That is why he was able to relate the difficulty that was experienced at that stage.

The death report should be issued by the attending Doctor, the one who was present when the patient died. This doctor may or may not be the surgeon. This was a clinical diagnosis and not a post mortem report. A post mortem report is not required by the guidelines. Where the cause of death cannot be explained by the clinician, a post mortem is mandatory. Recording on a patient chart is mandatory upon each review by a doctor. According to exhibit P. Ex. 1, on 8th September the admitting doctor omitted a full examination of the patient. The next entry was on 10th September. There is no entry for 9th September and the witness did not know why. If the patient was not in the ward then it should have been indicated. The audit team did not look at the pre-op period for that relied on what the doctor said. Entries of the day before surgery should have been indicated on that form. It is unacceptable for a patient to leave the ward and go home and from home and go straight to theatre, save in emergencies. The nurses said they did not know what to do because the patient came with a tube from the theatre. The nurses too did not perform their work fully for they should have detected. She was brain dead in the theatre. After that point whatever is done thereafter would be pointless.

The doctor realised cardio and respiratory arrest. Resuscitation was attempted. They did chest compresses and gave drugs. The methods were not documented but they said they performed CPR. The patient was not supposed to be given to the nurses. The patient did not recover from

the cardiopulmonary arrest. It is a patient who has recovered after CPR that is placed in intensive care. During the surgery, the doctor expressed his dissatisfaction with the anesthetist on account of; difficulty in intubation, not using the monitors and the anesthetist was not monitoring. It is the doctor who detected the cardio-respiratory arrest. He made those statements in the presence of the anesthetist before the audit team. The anesthetist was persuaded by the staff and management team to say something but he elected to keep quiet. The brain death resulted from negligence. If the brain is deprived of oxygen 3 -5 minutes a person would be dead. That was the close of the plaintiffs' case.

D.W.1 Dr. Daniel Okello, testified that he has practiced since 2009. He did internship training for one year and has worked for seven years. He graduated in June 2009 and stared working on 3rd or 4th July 2010. Before that he was on internship at Gulu Regional Referral Hospital as a general practitioner. He recalled that it was a Tuesday in August 2015, at around 4.00 pm while he was at the Trading Centre where he had gone to fix my shoes when the then Hospital Administrator Mr. Simon Wikole called him on phone saying he had a sick sister. I had briefly left my work station and went to the. He went straight to the female ward where he found a lady, Angucia Lucy, waiting in the duty room with an attendant. He asked her what the problem was, and took her history, she had a pile of medical forms. She pointed to the lower right side of the abdomen. He proceeded to do a full clerkship on that day.

He got to know her demography, the name age around 51 -52, she said she came from Arua and the next of kin was Simon Wikole, the then Hospital Administrator. He asked her why she came to the hospital and she said she had been brought by her brother for treatment. He took her history, did the examination and it revealed she had appendicitis. He placed her on intravenous antibiotics because she was running a fever from what appeared to be an infection from the appendicitis. She had had that problem for over a month. She was produced because she was refusing to get care. He admitted her and they preferred to be in a private ward. This meant they were to be attended to by the doctor in charge of the female ward. They instead went home.

He went to the ward in the night and she was not there. The attendant told him she had returned home. The attendant said there was no space yet it was there and there were no bed sheets. He

was not unhappy with the attendant. There was a break in the continuity of care because the drugs had to be administered intravenously before, during and after the operation. He passed the information to Dr. Odaga Jimmy who was in charge of the female ward and the private wing. The next time he saw the patient was on Thursday morning the day she was to undergo surgery.

He had scheduled the surgery in consultation with the doctor in charge of the private wing. He admitted her on Tuesday and she spent a good part of Wednesday at home. Ideally there should have been a re-scheduling but they were under pressure from the patient and the Hospital Administrator to perform the surgery. He reviewed the patient in theatre but she was not on the table. She was fit and ready for the operation and the fever she had had before had gone down. He was no longer under pressure from the patient or the administration. He handed her over to the anesthetist and he did his test and gave a go ahead. They then went through the procedures leading to surgery.

After washing the hands with antiseptic he waited to start putting on the gown. The aesthetic stared the procedure of endo-trachea intubation, i.e. through the mouth. She would then be put on endo-ventilation (breathing through the machine). He was observing the intubation. It was done according to procedure except that the anesthetist had difficulty at intubation. He made three attempts. At first attempt he connected but the air was not going in. On second attempt it went to one lung. The third time he said we can go ahead. He could not establish what the problem was. Sometimes the airway gets constrained as a reaction to the tube. There was a monitor that was attached to the arm. It is was this witnesses' obligation to ensure that all vitals were ok. He admitted it was an oversight on his part not to check the vital readings. The anesthetist told him to go ahead with the surgery. He draped and asked the anesthetist whether he could make the incision and he if it could be done. When he cut, the blood had a dark colour. He asked the anesthetist what the circulation was. It was then that he put the machine on and circulation was established. The ventilator was on, the tube was in place but when the monitor was turned on the circulation of oxygen was low and that meant that the tube was probably not in the right place.

The time lag from the moment the tube was inserted to the time the monitor was turned on was about three minutes during which he was putting on the apparel as the anesthetist was preparing

his side. When the blood indicated a lack of oxygen, he asked the anesthetist to check whether the lungs were getting oxygen and he found the patient was not breathing and the heart had stopped beating. He asked the anesthetist to remove the tube and re-intubate but at that time the airway had gone into spasms, it had already constricted and it was more difficult to re-intubate. He did CPR for about five minutes. He was trying something out of desperation. the patient was given adrenalin and she started breathing again but at a very low rate and the heart had started beating gain. He asked the nurse to open the eyes and the pupils were fixed and dilated and that is a sign of brain death. Even if some recovery of other vital functions was achieved, they would not support life again.

The team had come to the point where it had to all it could in the hope that something good would result, akin to a miracle. They finished the surgery although the patient was in a critical state. The patient was put in the recovery area on oxygen. She was then transferred back to the private ward. She was in the recovery room for about two hours. The nurses were instructed to monitor vital signs every fifteen minutes and to report to a doctor in case of complications. Two hours after the operation he was called back by the attending nurse and he was told the patient was twitchy. The oxygen circulation was again going low, fever had come in and there were no signs of recovery. He instructed that she gets back to oxygen and the airway should not be removed. He tried calling his supervisor but he had gone with the Administrator to Purongo. They said they were on the way back and the team should continue with the management.

He later explained to Dr. Odaga and the Administrator what had happened in the theatre and the condition of the patient and they went and saw the patient together. Dr. Odaga examined and recorded his findings on the medical form and recommended some strategies. He re-adjusted the tube and added more anti-biotics and the oxygen was to continue. The patient never improved. The central nervous system was not functioning and she was on brain stem functioning; breathing was erratic and rolling of the pupils. The cognitive function was non-operative. Two days after the surgery at about 4.00 or 5.00 pm she succumbed.

Under cross-examination, he stated that he appeared at the clinical audit. The deceased had been receiving treatment in other clinics in Arua and she had medical forms. She did not have a

referral notes and medical forms from other hospitals are not kept in their records except referral notes. He would have kept that record had he known that litigation was likely. There were no bed-sheets at the time she was admitted. There was a breakdown in care. Ms. Salome Wikole was the attendant and she is wife to the hospital administrator and she was working in the pharmacy as a storekeeper. The attendant in the ward had several of the medications he had prescribed, which is contrary to standard practice since drugs should be kept and administered by nurses. On 8th September one gm of Ampicilin and Gentocymin was administered at her home by Zako Scovia. They could have disqualified the patient from surgery because of this break in treatment but she was fit.

Before intubation some drug is injected to paralyse the airway so that the tube can go in without resistance. It remains effective for a few minutes within which there should be a successful insertion. If it fails you put a face mask and bag the patient. That would be sustained for as long as the surgery goes on and the patient wakes up. He was faced with a personality clash in the theatre. The anesthetist was a retired Principal Anesthetist who had worked in Arua Hospital for many years but was recruited by Angal hospital to work on contract. But he had a big personality problem which all staff had learnt to tolerate. He would not readily respond to instructions. For the time he worked with him he was efficient save for that personality problem..

The surgeon is the head of the operating team. The anesthetist would supposedly be subordinate to him. The tube was not in the right place because the blood was dark coloured. He attended the death audit although he never saw the minutes afterwards. The team made findings but he has never seen the report. If all that he testified to in court is in the audit report, he would though acknowledge the contents. The anesthetist was in the room but he refused to speak. The rest of the surgical team corroborated his version.

D.W.2 Tugume Bernard the Medical Superintendent of Angal St. Luke Hospital premises since July 2017 testified that he knew Angucia Lucy as a sister to the then Hospital Administrator Mr. Simon Wikole. She passed on at the hospital but he could not remember the year. He was involved in the audit meeting that was carried out after her death as a member in attendance. It was chaired by the then Medical Superintendent Dr. Odaga Jimmy. The purpose was to identify

gaps if at all they existed in the service delivery system that led to her death. His role was to listen to the events that led to the death and discern whether there were any gaps that existed and derive solutions to prevent reoccurrence.

He only attended the meeting which took approximately two hours. He was not assigned any other tasks prior to that meeting. He was not aware whether any other member was assigned any other task. He reviewed the report of the Audit, exhibit P. Ex. 9 and Minute 04/26/09/2015 is about the findings. There were no other steps taken after the meeting. He was aware of two meetings in relation to this death. The first one was informing them of the audit meeting and deriving the people who would attend and the second was the one he attended. The documents were presented to the meeting by Dr. Daniel who was the one operating. The members looked at the admission Chart and the anesthetic monitoring chart. Everyone who was involved was present at the meeting. The meeting obtained all the information required from the personnel and the documents except the anesthetist who declined to say anything. The report is not disputed. It was brought out that the intubation had difficulty and the monitors had not been turned on at the commencement of the operation. that was the close of the defence case.

In their joint memorandum of scheduling, the parties agreed on the following issues for the determination of this court;

1. Whether the defendant's agents were negligent in conducting the medical operation or procedure on the deceased.
2. What remedies are available to the parties in the circumstances?

In his final submissions, counsel for the plaintiffs Mr. Renato Kania argued that the plaintiffs had proved that the defendants agents were negligent in that the cause of death was heart and lung failure caused by brain death due to lack of oxygen. This was primarily because the deceased was placed under anesthesia without external oxygen supply. Although the ventilator machine had been installed, the medical team did not attach a pulse oxymeter and was therefore unable to detect in time that there was no oxygen supply to the patient, most probably as a result of a faulty intubation. Having found that intubation was difficult after three attempts, they failed to devise alternative methods that were readily available. The testimony of P.W.7 on this errors was

corroborated by that of D.W.1 and D.W.2. He cited the case of *Bolam v. Friern Hospital Management Committee, [1957] 2 All ER 118 at 121* regarding the standard of care required of medical practitioners and concluded that the medical team in the instant case had failed to meet that standard and were therefore negligent. As regards remedies, citing *Cuossens v. Attorney General [1999] 1 EA 40 at 46* and *Benham v Gambling [1941] 1 ALL ER 7 at 10*, he submitted that the plaintiffs should be awarded general damages for loss of expectation of life in the sunm of shs. 250,000,000/=. Citing *Gulbanu Rajabali Kassa v. Kampala Aerated Water Co. Limited [1965] EA 587* and *Jane Gaffa v. Francis X. S. Hatega, H.C.C.S No. 1158 of 1975*, he submitted that the plaintiffs should be awarded damages for loss of dependency using a multiplier of eight based on their respective age at the time of the death of the deceased, hence a sum of shs. 192,000,000/=. They should also be awarded special damages of shs. 6,781,000/=, interest on the decretal sum and costs.

In reply, counsel for the defendants Mr. Peter Rukwiya Nyero submitted that the cause of death was incorrect since the method used, clinical observation, did not take into account the fact that the deceased spent two post surgery days in the ward. The possibility of intervening causes was never ruled out and the procedure used in the death Audit was very unreliable considering that it focused only on the pre-op and intra-op procedures and not the post-op management and by reason of the fact that the Chairperson of the Committee Dr. Odaga was never called as a witness. The post surgical management of the patient involved her being put on oxygen and lack of oxygen supply to the brain therefore could not have been the cause of her death. The death audit team did not take into account that the deceased avoided monitoring after admission when she returned home and continued with self-medication. Lack of continuous monitoring before the surgical operations creates the possibility of death resulting from other complications which were never ruled out by a conclusive post mortem examination since none was done. All surgical operations involve a degree of risk and this was explained to the deceased prior to giving her consent (exhibit P. Ex. 2). When they realised the patient had developed complications, the team did all it could to resuscitate her. Citing *Sarah Watsemwa Goseltine and another v. Attorney General, H.C.C.S. No. 675 of 2006*, he argued that not every error of judgment made by a doctor may be classified as negligence. It must be proved that the health worker adopted a practice that no professional or ordinary person would have taken, which the plaintiffs have failed to prove.

As regards the claim for the various heads of relief, he submitted that St. Luke Angal Hospital is a charity based hospital offering low cost medical care and solely relies on donations. The sums demanded by the plaintiffs are not supported by any cogent evidence and are exorbitant. Citing *Lusiya v. K.C.C. [1972] EA 240*, he submitted that contrary to established judicial practice, the dependants were never produced in court and their age was not ascertained. With regard to special damages, receipts proving a sum of only shs. 750,000/= were produced. He concluded that in the event of the defendants being found liable, the plaintiffs should be awarded only that sum as special damages, otherwise the suit should be dismissed with costs to the defendants.

First issue: Whether the defendant's agents were negligent in conducting the medical operation or procedure on the deceased.

Medical negligence is constituted by an act or omission by a medical professional that deviates from the accepted medical standard of care. Medical negligence occurs when a doctor, dentist, nurse, surgeon or any other medical professional performs their job in a way that deviates from this accepted medical standard of care. Medical professionals are required to conduct themselves at least in accordance with the standard of their professional peers, but they are not expected to guarantee the success of their procedures or the perfect safety of their patients. The test was articulated in *Bolam v. Friern Hospital Management Committee, [1957] 1 WLR 582, [1957] 2 All ER 118*, thus;

> Where some special skill is exercised, the test for negligence is not the test of the man on the Clapham omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising or professing to have that special skill. It is the duty of a professional man to exercise reasonable skill and care in the light of his actual knowledge and whether he exercised reasonable care cannot be answered by reference to a lesser degree of knowledge than he had, on the grounds that the ordinary competent practitioner would only have had that lesser degree of knowledge. This is not a gloss upon the test of negligence as applied to a professional man. That test is only to be applied where the professional man causes damage because he lacks some knowledge or awareness. The test establishes the degree of knowledge or awareness which he ought to have in that context. Where, however, a professional man has knowledge, and acts or fails to act in way which, having that knowledge he ought reasonably to foresee would cause damage, then, if the other aspects of duty are present, he would be liable in negligence by virtue of

> the direct application of Lord Atkins' original test in *Donoghue v Stevenson*. 'it is not enough to show that another expert would have given a different answer . . the issue is . . whether [the defendant] has acted in accordance with practices which are regarded as acceptable by a respectable body of opinion in his profession' and 'How do you test whether this act or failure is negligent? In an ordinary case it is generally said you judge it by the action of the man in the street. He is the ordinary man . . But where you get a situation which involves some special skill or competence, then the test of whether there has been negligence or not is not the test of the man on the top of the Clapham omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill.

Not every error of judgment made by medical professionals constitutes negligence (see *Sarah Watsemwa Goseltine and another v. Attorney General, H.C.C.S. No. 675 of 2006*). The test of professional negligence is the standard of the ordinary skilled man exercising and professing to have that special skill (see *Maynard v. West Midlands Regional Health Authority, [1985] 1 WLR 685, [1985] 1 All ER 635*). Doctors and other medical professionals have a duty to their patients, to provide treatment that is in line with the "medical standard of care," defined as the level and type of care that a reasonably competent and skilled health care professional, with a similar background and in the same medical community, would have provided under the circumstances that led to the alleged malpractice. A doctor who professes to exercise a special skill must exercise the ordinary skill of his specialty. The true test for establishing negligence in diagnosis or treatment on the part of the doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of, if acting with ordinary care.

It is well settled that medical professionals have a duty to conduct their practice in accordance with the conduct of a prudent and diligent medical professional in the same circumstances. In the case of a specialist, such as a surgeon, the surgeon's behaviour must be assessed in light of the conduct of other ordinary specialists, who possess a reasonable level of knowledge, competence and skill expected of professionals in that field. While conformity with common practice will generally exonerate medical professionals of any complaint of negligence, there are certain situations where the standard practice itself may be found to be negligent. However, this will only be so where the standard practice is fraught with obvious risks such that anyone is

capable of finding it negligent, without the necessity of judging matters requiring diagnostic or clinical expertise.

For the plaintiffs to succeed in an action of this nature, they must therefore prove that; (a) a doctor-patient relationship existed, (b) the medical professionals were negligent, (c) the medical professionals' negligence caused the death. It would be necessary for the court to be satisfied that the defendants vicariously failed to have or to exercise the knowledge, skill and understanding expected in accordance with the standards of the medical profession as would be provided by reasonably competent and skilled health care professionals, with a similar background and in the same medical community, under the circumstances.

a) Existence of the doctor / patient relationship.

It is common ground between the parties that the deceased went to St. Luke Angal Hospital on 8th September, 2015 complaining of stomach pains in the lower right side of the abdomen. She was attended to by D.W.1 Dr. Daniel Okello, who took her history, reviewed the pile of medical forms she had in her possession. He proceeded to do a full clerkship and diagnosed appendicitis thereby recommending surgery. He placed her on intravenous antibiotics to stem a fever from what appeared to be an infection from the appendicitis. He admitted her to a private ward in the hospital. He undertook a surgical operation on her on 10th September, 2015 at the hospital theatre. I am therefore satisfied that the plaintiffs have proved to the required standard that a doctor / patient relationship existed between the deceased and D.W.1 Dr. Daniel Okello.

b) Negligence of the medical professionals.

It is common ground between the parties that St. Luke Angal Hospital is a facility under the stewardship of the defendants and it is not disputed that all staff employed at that health facility are in law agents of the defendants. According to the decision in *Muwonge v. Attorney General [1967] EA 17*, an act may be done in the course of employment so as to make the master liable even though it is done contrary to the orders of the master, and even if the servant is acting deliberately, wantonly, negligently, or criminally, or for his own behalf, nevertheless if what he

did is merely a manner of carrying out what he was employed to carry out, then his master is liable. For the defendant's to be found vicariously liable, it must be established that the medical professionals at the hospital failed to have or to exercise the knowledge, skill and understanding expected in accordance with the standards of the medical profession as would be provided by reasonably competent and skilled health care professionals, with a similar background and in the same medical community, under the circumstances.

Most medical procedures, treatments or tests involve some risk. However, except in cases of emergency or necessity, all medical treatment is preceded by the patient's choice to undergo such. It is the medical professionals' responsibility to give the patient information about a particular treatment or procedure so that the patient can decide whether to undergo the treatment, procedure, or test. Risks that are statistically likely enough to make disclosure worthwhile should be disclosed. In legal terms, the patient's consent to the treatment may be valid once he or she is informed in broad terms of the nature of the procedure which is intended. But the choice is, in reality, meaningless unless it is made on the basis of relevant information and advice. One of the factors relevant to, but not decisive of, the question of what a reasonable medical practitioner ought to have foreseen is the state of medical knowledge at the time when the duty should have been performed. A reasonable medical practitioner cannot be expected to have foreseen an event wholly un-comprehended by medical knowledge at the time. The law demands no more than what was reasonable in all the circumstances of the case.

In the instant case, the plaintiffs tendered in evidence exhibit P. Ex. 2 titled "Pre-operative Preparation and Consent form." It is a standard from that has provision by way of blank spaces for inserting information such as; the patient's demographic data, diagnosis, pre-operative procedures done, pre-operative medication and two options towards the bottom requiring only a tick to the statement "Consent for procedure Obtained (Yes / No)." Under the space reserved for "Pre-operative Procedures Done," were inserted the following handwritten remarks; "Consent gained from the patient. IV line passed *in situ*. Catheter *in situ*." There is no indication anywhere on the form as to any information given to the patient relating to the nature and range of the more or any significant risks involved in the suggested surgical procedure for which her consent was

being sought. The information on this form does not meet the requirement of proof that the deceased gave her informed consent to the surgical procedure.

If a patient is to undergo a surgical procedure it is necessary for such patient to receive information from the medical team about the benefits and the risks of the procedure prior to the procedure being carried out. After having heard the possible risks and benefits, if the patient deems that they wish to go ahead with the surgical procedure they must sign a consent form, outlining the nature and range of the more or all significant risks involved in the suggested surgical procedure of which they have been fully advised, whereby their signature would then signify that they have understood and accepted the potential risks "inherent" in the procedure. This is what informed consent requires. Failure to fully brief a patient about the possible ill effects of the procedure prior to the surgery and thereby depriving the patient of the ability to give his or her full informed consent, could of its own be a basis for a claim of medical negligence.

Common law imposes a duty on a medical practitioner to warn a patient of material risks inherent in the proposed surgical procedure; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it. This standard does not deal with the foreseeability of the risk in question, save to the extent that the risk must be "inherent" in the procedure. In this respect the general law of negligence still applies. Once there is a risk which is generally known to the profession, there is a duty to warn. In the circumstances of this case, in the absence of any evidence, written or oral as to the nature and range of the inherent risks involved in the surgical procedure of which the deceased is alleged to have been advised, there is no basis for the finding suggested by counsel for the defendants that by signing exhibit P. Ex. 2, she gave her informed consent to the surgical process or that she accepted the potential risks involved.

Moreover, even though the patient's informed consent dictates that the patient is aware that certain complications can occur, it does not mean that this covers negligent techniques or

mistakes that occur during the surgery, that are not inherent in the procedure itself. The conduct of medical professionals must be judged in the light of the knowledge that ought to have been reasonably possessed at the time of the alleged act of negligence. The conduct of the procedure must reflect the current state of knowledge as to the risks involved in the use of that procedure. However, the standard to be observed by medical practitioners is not to be determined solely or even primarily by medical practice. Rather, it is for the courts to judge what standard should be expected from the medical profession (see *Maynard v. West Midlands Regional Health Authority, [1985] 1 WLR 685, [1985] 1 All ER 635*).

In his own admission, D.W.1 Dr. Daniel Okello as head of the surgical team in the theatre at the material time did not take the trouble to ascertain and record readings of the vital signs before making the first incision. Had he done so, he would have discovered that although the ventilator machine had been installed, the anesthetist had not attached the pulse oxymeter and would therefore be unable to detect in time that there was no oxygen supply to the patient and advise him accordingly during the operation. He chose instead to rely on the anesthetist verbal confirmation for commencement of the surgical procedure and by the crude method only of placing his ear near the chest of the patient to detect breathing.

I do not find this omission to be inherent in the surgical process. In any event, it is inconceivable that in signing exhibit P. Ex. 2, the deceased was advised that the risk of not attaching the pulse oxymeter before commencement of the surgery was so inextricably involved with that procedure and that when she was so advised, she did not attach significance to it. The more reasonable conclusion to draw is that she was either not advised so since a reasonable person in her position, if warned of such a risk, would be likely to attach significance to it or that it was not one of the inherent risks involved in the procedure. Either way, it was not one of the risks understood and accepted by her as a potential risk when she signed exhibit P. Ex. 2.

The factors according to which a court determines whether a medical practitioner is in breach of the requisite standard of care will vary according to whether it is a case involving diagnosis, treatment or the provision of information or advice. In diagnosis and treatment, the patient's contribution is limited to the narration of symptoms and relevant history; the medical practitioner

provides diagnosis and treatment according to his or her level of skill. I have considered the fact that as a result of the anesthetist's' failure to attach a pulse oxymeter, he was unable to detect in time that there was no oxygen supply to the patient, most probably as a result of a faulty intubation. Having found that intubation was difficult after three attempts, the team failed to devise alternative methods that were readily available for conduct of the surgical operation in a safer manner. The team not only had the necessary equipment in place within their reach and failed to use it appropriately, but also had the knowledge and skill to adopt alternative methods which they inexplicably never did.

I do not find this to be consistent with exercise of standard of knowledge, skill and understanding expected in accordance with the standards of the medical profession as would be provided by reasonably competent and skilled health care professionals, with a similar background and in the same medical community, under the circumstances. Their efforts to resuscitate the patient later were the proverbial too little too late. The omissions that occurred in the recovery room and the private ward were insignificant since at that time the deceased was already brain dead. I am therefore satisfied that the plaintiffs have proved to the required standard that two of the key defendant's medical professionals involved in the surgical procedure, D.W.1 Dr. Daniel Okello and the anesthetist, were negligent.

c) <u>The medical professionals' negligence caused the death</u>.

The surgical operation was performed on 10th September, 2015 yet the deceased died on 12th September, 2015, two days after the surgery. In circumstances such as this, where there is a significant degree of remoteness between the negligent act or omission and the result, in this case death, where the eventual result may be the product of additional factors which are more directly connected than is the conduct of the tortfeasor, the function of the law of causation is to identify the conditions under which the result may nevertheless be attributed to the tortfeasor. An intervening cause will break the chain of causation if it is independent of the acts of the tortfeasor and so potent in causing the death, but a tortfeasor will be held responsible for the final outcome if it is a substantial and operating result of what the tortfeasor did.

The common law has always recognised that there are two fundamental questions involved in the determination of causation in tort: the first relates to the factual aspect of causation, namely, the aspect that is concerned with whether the negligent conduct in question played a part in bringing about the harm, the subject of the claim. The second aspect concerns the appropriate scope of liability for the consequences of tortious conduct. In other words, the ultimate question to be answered when addressing the second aspect is a normative one, namely, whether the defendant ought to be held liable to pay damages for that harm. Causation will be established if, on the balance of probabilities, the harm would not have occurred "but for" the defendant's breach of his or her duty of care.

At common law, if it is an established fact that conduct of a particular kind creates a risk that injury will be caused to another or increases an existing risk that injury will ensue; and if the two parties stand in such a relationship that the one party owes a duty not to conduct himself or herself in that way; and if the first party does conduct himself or herself in that way; and if the other party does suffer injury of the kind to which the risk related; then the first party is taken to have caused the injury by his or her breach of duty, even though the existence and extent of the contribution made by the breach cannot be ascertained (see *McGhee v. National Coal Board [1973] 1 WLR 1*). The precise and particular character of the injury or the precise sequence of events leading to the injury need not be foreseeable. It is sufficient if the kind or type of injury was foreseeable, even if the extent of the injury was greater than expected.

If at the time of death, effects of the original act or omission are still an operating and substantial cause, then the death can properly be said to be the result of the act or omission, albeit that some other cause of death is also operating. Only if it can be said that the original act or omission is merely the setting in which another cause operates, can it be said that the death does not result from the act or omission. In other words, only if the second cause is so overwhelming as to make the original act or omission merely part of the history can it be said that the death does not flow from the act or omission (see for example *R v. Smith [1959] 2 QB 35; Cheshire v R. [1991] 3 All ER 670*and *People v. Lewis 57 Pac 470 (1899) (Cal SC*).

In the instant case, according to the Medical Certificate of Cause of Death, exhibit P. Ex. 4, the deceased died of cardiopulmonary arrest with brain ischema as a result of prolonged hypoxia. It was the testimony of both P.W.7 and D.W.1 that the deceased was confirmed brain dead even before she was taken off the operation table in the theatre. She remained in this irreversible vegetative state for the next two days until her death. She became brain dead as a result of the defendants' negligence. That there could have been some other intervening cause remains a remote, fanciful but not in any way probable possibility, in light of the evidence before court. There certainly is no evidence of a supervening cause of such a nature as was capable of breaking the chain of causation. I am therefore satisfied that the plaintiffs have proved to the required standard that the defendants' negligence during the surgical operation was an operating and substantial cause of the deceased's death. Therefore, even if some other cause of death could also have been operating, which has not been proved, her death can properly be said to be the result of the negligent acts and omissions of the defendants' agents while she was in the operation theatre undergoing the surgical operation.

Second issue: What remedies are available to the parties in the circumstances?

In their plaint, the plaintiffs seek an award of general and special damages for loss of expectation of life, loss of dependency, bereavement, interest on the ward and costs. The principles upon which court must assess general damages for loss of dependency were well laid down in *Gulbanu Rajabali v. Kampala Aerated Water Co. Ltd [1965] E.A. 587* and in *Jane Gaffa v. Francis X.S. Hategа, H. C. Civil Suit No. 1150 of 1975*. These principles generally require that:- the court takes the last earnings of the deceased person as the starting point. The Court may consider the deceased's earnings at the time of death, the last known earnings if unemployed, and potential future earnings. Out of those earnings is assessed the pecuniary benefit regularly accruing to the defendants; court then determines the appropriate multiplier. This is the number of years during which the benefit of the dependency would have continued to be available to the dependants if the deceased had lived beyond the date of death and continued making earnings; the determination of the multiplier is guided by the age at which the deceased died and what his or her working life expectancy would have been had he or she not met his or her demise in the fatal accident; the total lost dependency or benefit is obtained by multiplying the annual lost

benefit by the multiplier; the total lost dependency benefit is then apportioned among the dependants. If the deceased was the husband, the widow is entitled to a more substantial share of the damages in recognition of the fact that her dependency upon her husband's support would ordinarily continue longer than that of the children. If the wife was the bread winner in the family and she is the one who met her death, the surviving dependant husband would be treated in a similar manner. In apportioning the damages court would award the younger children relatively larger portions in recognition of the fact that their dependency, upon the deceased, would have lasted longer than that of older children.

General damages for loss of dependency include loss of wages and future earnings, loss of consortium, loss of support, and loss of companionship. A child might be entitled to compensation for the personal loss of a parent as well as the amount of financial support the child would have received from the deceased parent while a minor, a wife would recover damages for loss of her husband's love and companionship and a lifetime of expected support, while a parent would be limited to damages for loss of companionship but not support. may recover medical and funeral expenses in addition to the amount of economic support they could have received if the decedent had lived and, in some instances, a sum of money to compensate for grief or loss of services or companionship.

Determining the amount of damages in a wrongful death action requires taking into account of many variables. To compute compensation, the income that the deceased could have earned may be multiplied by the number of years he or she most likely would have lived and can be adjusted for various factors, including inflation and other imponderables of life. The court may be guided by the life expectancy of particular groups identified by age or gender. The decedent's mental and physical health, along with the nature of his or her work, may also be taken into consideration.

In the instant case, it was the testimony of P.W.2 Ocokoru Zena, P.W.3 Candiru Grace, P.W.4 Onzima Nyakuni Ben and P.W.5 Ajili Peter, the deceased was a sole proprietor in the silver fish trade. Her monthly turn over averaged at 30 sacks full per month out of which she earned an average of shs. 165,000/= per sack hence a total of shs. 4,950,000/= as her gross income per

month. In the absence of any records verifying this to have been her average income over any considerable period of time, I consider this to be a mere estimate of her income. I have as well taken into account the testimony of her brother P.W.4 Onzima Nyakuni Ben, her income was inadequate to meet the school fees requirements of her school going children and from time to time her brothers would give her financial support. The said gross monthly income is therefore is on the higher side. A sum of shs. 3,000,000/= appears to be a more reasonable estimate of her average gross monthly income.

According to the Medical Certificate of the Cause of Death, exhibit P. Ex. 4, the deceased was 51 years old at the time of her death. It is generally accepted that a person in Uganda would work up to 60 years both in the formal and informal sector (see *Awino and four others v. Luwaga and another, H. C. Civil Suit No. 139 of 2006*). Therefore, all things being equal, she would have had another nine or so years of active self employment. However, considering the imponderables of life, the exigencies of her trade that required her to travel long distances to the landing site and back to Arua frequently and the toll such physical exertion would have had on her life, the fragility of her business as a sole proprietor that was demonstrated by the more or less instant collapse following her death, the multiplier of eight years suggested by counsel for the plaintiffs is on the higher side. I am inclined instead to apply a multiplier of five years. Consequently, with an annual gross income estimated at shs 36,000,000/= her gross income in the five year period would be shs. 180,000,000/=

It was the testimony of P.W.4 Onzima Nyakuni Ben that at the time of her death, she was in the process of constructing her own house. She was therefore spending a considerable part of her income on that project. She also employed P.W.3 Candiru Grace and must have been paying her salary from that income. Her other business overheads as well would be drawn on that income. She would also use it for her own needs and sustenance, including medication as evidenced by the medical forms she presented to D.W.1 Dr. Daniel Okello on 8th September 2015 when he examined her and diagnosed appendicitis. In light of all that, it would seem that she was spending only a half of her income on the sustenance of the plaintiffs and her other defendants.

No amount of money can ever compensate for a life lost in the circumstances of this case. No amount of money can ever console the family of the deceased for their bereavement and deep sense of loss. The court can only determine a sum appropriate to ease some of the financial hardships that befell the family as a result of the sudden loss of life of their bread winner and to assuage, to the extent reasonably possible under the peculiar facts of the case, their deep sense of loss. Therefore, bearing in mind and all the principles set out earlier, the loss of dependency and expectation of life proved by the plaintiffs is shs. 90,000,000/= and that sum is accordingly awarded as general damages.

As regards special damages, not only must they be specifically pleaded but they must also be strictly proved (see *Borham-Carter v. Hyde Park Hotel [1948] 64 TLR*; *Masaka Municipal Council v. Semogerere [1998-2000] HCB 23* and *Musoke David v. Departed Asians Property Custodian Board [1990-1994] E.A. 219*). The plaintiffs pleaded expenditure of shs. 6,781,000/= as funeral expenses but produced receipts for only a total of shs. 750,000/=. It is trite law though that strict proof does not necessarily always require documentary evidence (see *Kyambadde v. Mpigi District Administration, [1983] HCB 44; Haji Asuman Mutekanga v. Equator Growers (U) Ltd, S.C. Civil Appeal No.7 of 1995* and *Gapco (U) Ltd v. A.S. Transporters (U) Ltd C. A. Civil Appeal No. 18 of 2004*). I have scrutinized exhibit P. Ex. 5 which is a tabulation of the various items on which expenditure is said to have been incurred. None of the items listed is can be categorized as unnecessary. The majority of the items are not of the nature which in the ordinary conduct of affairs of this nature, receipts or other documentary proof of expenditure would be expected. The amounts do not appear to be exaggerated in any way. I am therefore satisfied the evidence before court is cogent and sufficiently proves to the required standard that the plaintiffs incurred that expense. The plaintiffs are accordingly awarded shs. 6,781,000/= as special damages.

It was the testimony of P,W,4 that the first plaintiff Kasaira Freda now 32 years old was at the time undertaking a secretarial course, the second plaintiff Ajili peter is now 28 years old was undertaking a plumbing course, the third plaintiff is now aged 26 years, the fourth plaintiff Nancy Akuje is now aged about 23 years was in her third year of tertiary education. The fifth plaintiff Joan Masinda is about 21 years old. The last born, Fiona Asimba was in Senior Four at

the time. The deceased also had two dependant nieces; Brenda aged 24 years and Asia aged about 11- 12 years and is now in primary seven. None of her children had been able to find gainful employment and this they all depended on her. In his final submissions, counsel for the defendant contended that since only the second plaintiff testified in court and court did not have the opportunity to see and verify the age of the rest of the plaintiffs, they do not merit any award.

I have considered the authority cited by counsel. The decision appears to have been based on the peculiar facts of that particular case and cannot be said to have laid down a principle of law of general application. During the cross-examination of all the plaintiffs' witnesses, the authenticity of the stated ages was never brought in issue as to require specific proof. In any case, the existence in fact and age of the various family members and dependants named does not go to the quantum of general damages to be awarded by court but only to the apportionment of the award among them. I have not been presented with any evidence suggesting that the named plaintiffs and dependants do not exist in fact or that their respective ages were misstated. To find to the contrary would be against the weight of the evidence before me.

Following the decision in *Jane Gaffa v. Francis X.S. Hatega, H. C. Civil Suit No. 1150 of 1975*, the court is required to apportion the award of Shs. 90,000,000/= among the plaintiffs guided by the principle that in apportioning the damages, court should award the younger children relatively larger portions in recognition of the fact that their dependency, upon the deceased, would have lasted longer than that of older children. The general damages awarded to the plaintiffs are accordingly apportioned as follows: the minor will take 60% of the award, the adult dependants will take 30% of the award to be shared equally among them and the dependants and 10% of the award is to be shared between the dependant relatives, the minor taking two thirds of that and the adult one third, hence;- Plaintiff No. 1. Kasaira Freda: she was 32 years old at the time undertaking a secretarial course, was unemployed and still fully dependent upon support from her mother. She is awarded Shs. 5,400,000/=.

Plaintiff No. 2, Ajili peter; he is 28 years old and had completed a course in plumbing but was unemployed and still fully dependent upon support from her mother. He is awarded Shs. 5,400,000/=.

Plaintiff No. 3, Harriet Nanzoni; she was aged about 26 years, unemployed and fully dependent upon support from her mother. She is awarded shs. 5,400,000/=.

Plaintiff No. 4, Nancy Akuje; she was aged about 23 years and in her third year of tertiary education. She fully dependent upon support from her mother. She is awarded shs. 5,400,000/=.

Plaintiff No. 5, Joan Masinda; she was aged about 21 years old, unemployed and fully dependent upon support from her mother. She is awarded Shs. 5,400,000/=.

Plaintiff No. 6, Fiona Asimba; was the youngest of the deceased's children at 15 years of age and still in school in Senior Four at the time, dependent entirely upon the deceased. She is awarded shs. 54,000,000/=.

Dependant No. 1, Brenda.

She is aged 24 years and was fully dependant on the deceased. Being an adult dependant relative, she is awarded Shs. 3,000,000/=

Dependant No. 2, Asia

She is aged about 11- 12 years and is now in primary seven. Being a minor dependant on her deceased Aunt, she is awarded Shs. 6,000,000/=

In summary, the court makes the following awards;-

a) General damages of shs. 90,000,000/=
b) Special damages of shs. 6,781,000/=
c) Interest on the awards in (a) and (b) above at the rate of 8% per annum from the date of judgment until payment in full.
d) The costs of the suit

Dated at Arua this 26th day of October, 2017

……..
Stephen Mubiru
Judge,
26th October, 2017.