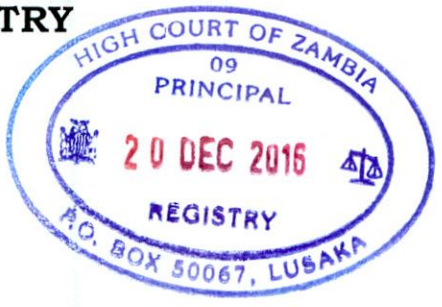
IN THE HIGH COURT FOR ZAMBIA **2011/HP/497**
AT THE PRINCIPAL REGISTRY
HOLDEN AT LUSAKA
(Civil Jurisdiction)



BETWEEN:

CHILUBA DAKA **(Suing as Administrator of the Estate of the late Tamara Yambayamba)** **PLAINTIFF**

AND

THE UNIVERSITY TEACHING HOSPITAL **1st DEFENDANT**

THE ATTORNEY GENERAL **2nd DEFENDANT**

THE LUSAKA CITY COUNCIL **3rd DEFENDANT**

Before the Hon. Mrs Justice J.Z Mulongoti in Open Court on the 20th day of December,2016

For the plaintiff: Mr A. Musukwa and Mr S. Kaonga of Musukwa and Company
For the 1st and 2nd Defendants: Mrs S. Sakala, Senior State Advocate, Attorney General's Chambers
For the 3rd Defendant: Mr M. Moono, Director Legal Services, Lusaka City Council

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JUDGMENT

Cases referred to:

1. Lindsey C.C Marshall (1937) AC 97
2. Attorney General v Rosemary Mulenga SCZ Judgment No. 52 of 2014
3. Ndola Central Hospital Board of Management v Alfred Kaluba and Priscilla Kaluba SCZ 1997 SJ 38
4. Robertson Kalonga v The People (1988 – 1989) ZR 90 (SC)

5. John Nyambe Lubinda v The People (1988 – 1989) ZR 110 SC
6. Bolam v Friern Hospital Management Committee (1957) I W.L.R 582
7. Cicuto v Davidson and Oliver (1968) ZR 149
8. Moy v Pettman Smith (a firm) and Another (2005) UKHL 7
9. Kopa Kopa (suing as Next Friend and Administrator of the estate of Chuubo Kopa Kopa) v University Teaching Hospital board of Management
10. Nyasulu v Attorney General (1983) ZR 105 (HC)
11. Rosemary Bwalya v Zambia Consolidated Copper Mines Limited and Others (2005) ZR 1
12. Mohamed v The Attorney General (1982) ZR 49
13. Zulu v Avondale Housing Project Ltd (1982) ZR 172
14. Thacke v Maurice (1986) 1ALL ER 497
15. Lupupa v The People 1977 ZR 38

Works referred to:

1. Halsburry Laws of English vol. 33 4th edition (reissue)
2. Clerk & Lindsell on Torts, 11th edition, London; Sweet & Maxwell

This is an action arising out of the alleged negligent treatment and death of Tamara Yambayamba, the deceased, while she was hospitalised at University Teaching Hospital (UTH) the first defendant herein. The action is brought by the deceased's sister as the administrator of her estate, for aggravated damages and damages as a result of the defendants' alleged negligence towards the deceased. The deceased was on 14th December, 2009 referred to the first defendant hospital after she delivered a still born baby at her mother's home in garden compound. She was initially taken to chipata clinic in Lusaka but the clinic referred her to the first defendant hospital. The plaintiff alleges that the first defendant's agents failed to diagnose the deceased's condition as she was left unattended to from 15:30 hours to 18:00 hours. No decent care was extended to her until her death around 22:30 hours. Her relatives were informed of her death the following day around 05:00 hours by a cleaner as the doctors kept lying to them that she was recuperating and receiving treatment. The plaintiff further alleges that the deceased was negligently buried by the third

defendant without the involvement of her relatives. It was only after the involvement of the Human Rights Commission (HRC) that the third defendant admitted liability over the burial of the deceased without her family being informed and mistaking her illness as cholera when it was not.

The particulars of negligence of the first defendant are stated as follows:

1. Failure to conduct a proper examination on the deceased who was its patient.
2. Failure to observe and analyse the signs and symptoms of the deceased's condition.
3. Failure to heed the deceased's history, in particular, the failure to realize that the deceased was referred from a cholera centre which would have treated the disease if it had been cholera and that during her puberty whenever she had her menstruation periods she always suffered from vomiting and diarrhoea, which history should have been taken into consideration
4. Wrongly concluding that the deceased was suffering from cholera without any medical tests conducted to ascertain that conclusion
5. Failure to give adequate care to the patient/deceased as she was left on a bench from 15 hours when she arrived at the hospital up to 18 hours when her relatives were told to leave the hospital. However, the care was never extended to her as she died on a bench later that night at around 22:30 hours.
6. Failure to inform the relatives of the deceased about her fate. Even when she died, the defendants lied that she was still alive receiving treatment causing the plaintiff pain and anguish when she discovered through a cleaner in the hospital.

The particulars of negligence of the second defendant were the same as against the first defendant as stated at paragraphs 1 to 6 above.

The particulars of negligence against the third defendant were as follows:

1. Burying the deceased in a pauper's grave without informing the plaintiff and her relatives, causing them panic and anguish.
2. Failure to invite the plaintiff or any member of the family to witness the burial of the deceased contrary to normal practice and procedure.

The plaintiff avers that by reason of the defendants' negligence, she underwent pain and suffering. The deceased's death was greatly aggravated and the consequences prolonged causing the plaintiff severe trauma and pain and thereby loss and damage.

The first and second defendants admit that the deceased was admitted at the hospital but averred that it was due to suspected cholera. That she was in labour at the time of admission and later delivered a still born male right at the hospital. They admitted that the third defendant was called by the first defendant's public health department, to bury the deceased. The deceased died as her condition continued to deteriorate despite sufficient resuscitation by the first defendant. The first and second defendants deny being negligent and aver that the plaintiff will be put to strict proof thereof. That the plaintiff is not entitled to the reliefs claimed.

The third defendant admits that it buried the plaintiff in a single grave and not a mass grave. It denied that she was buried in a pauper's grave. It averred that it was mandated under the Public Health Act to bury

infectious bodies and it is under no duty to inform the relatives of the deceased as this would have been done by the first defendant.

At the trial all the parties adduced oral evidence. The plaintiff testified as PW1. It was her testimony that on 14th December, 2009 the deceased delivered a still born baby boy at their mother's home in garden compound. The deceased was taken to garden on the 13th of December, 2009 after she fell sick. During the night of the 13th the deceased continued being sick. The still born baby was only discovered the following morning. The deceased and the still born were taken to the clinic at chipata compound by their mother but they were referred to the first defendant (UTH).

According to PW1 around 17 hours her mother returned home and told her that she was not allowed to remain with the deceased at UTH. At 22:00 hours PW1 called the deceased on her phone but got no response. The following morning her mother and she went to see the deceased at UTH. They found a cleaner who referred them to the ward downstairs where her mother was told that the deceased had passed on. They asked for the body but they were told it was in the mortuary. They went back home and held a funeral and lots of people gathered at their home. Around 11:00 hours her mother and brother went back to UTH for a burial permit but were asked to go back in the morning. When her brother went back, he was told that the deceased had been buried.

The family lodged a complaint with the HRC which wrote to the first defendant per letter at page 2 of the plaintiff's bundle of documents, dated 31st May, 2010. The first defendant responded via letter dated 18th August, at page 5 of the plaintiff's bundle of documents.

In conclusion PW1 testified that the first defendant refused to release the deceased's lab results and told them that she did not suffer from cholera. The Court also heard that though the deceased had diarrhoea she was able to move on her own. Furthermore, that no one had cholera at home or among the people who had gathered at their home for the funeral. Even their mother who cleaned the deceased's vomit did not suffer from cholera.

In cross examination by the first and second defendant's counsel she testified that the deceased constantly vomited and had diarrhoea especially when she was menstruating. She admitted that chipata clinic was used as a cholera centre whenever there was an outbreak of cholera. She stated that she would not know if there was an outbreak of cholera in December, 2009. She admitted that according to the doctor's notes at page 5 of the defendant's bundle of documents, the deceased was suspected to have cholera from which she died.

During cross examination by the third defendant she testified that the deceased was her blood sister and she was her next of kin because she was staying with her. It was her testimony further that the deceased's grave was pointed to the family but they do not know if she was buried in the mass grave. She disclosed that the 1st defendant informed them that the deceased had been buried a day after which was on the 15th of December, 2009. Then on the 16th they were shown the grave.

In re examination she testified that chipata clinic was a cholera centre at the time of the deceased's death.

PW2 Mabvuto Daka testified that on 14th December, 2009 his sister, the deceased, delivered a still born at home. She was taken to chipata clinic where they were advised to bury the still born but the deceased was

admitted. After the burial they went back to the clinic to check on the deceased. The doctor referred her to UTH. They took her to UTH around 15 hours and she was admitted. They left UTH around 18 hours and returned in the morning only to be informed that the deceased died in the night. They went and held a funeral but he returned to UTH later in the day for a burial permit as advised. He was given a piece of paper with the name "Julu" written on it and a phone number. He called the number and found out that Julu was working at Leopards Hill Cemetery. They met him there and he showed them the grave where he had buried the person who was put in a plastic bag by UTH.

He too testified that the deceased had a chronic problem of the stomach for years from the time she became of age.

In cross examination, PW2 testified that he was a resident of garden compound at the time of the deceased's death and there was no outbreak of cholera then. It was his testimony that he did not see the deceased vomit or purge on the night of 13th December, 2009 though PW1 stated so. Furthermore, that PW1 lied when she testified that the deceased went to garden from kuku compound on 13th December, 2009 after she fell sick. It was PW2's testimony that the deceased and he moved from kuku to garden compound two months before her demise. He also disclosed that when his mother and he took the deceased to UTH she was okay and was only taken there for her womb to be cleaned. He stated that she was not sick as stated by the doctor in his notes and that their mother would have stayed by her bed side if she was sick. He maintained that if the deceased had cholera their house would have been sprayed by the public health department as is normally done whenever there was an outbreak of cholera.

In answer to a question from the third defendant's counsel, he stated that Julu showed them a single grave.

PW3 Phaless Daka (mother to the deceased) testified that on 12th December, 2009 PW1 phoned her and told her that the deceased, who was pregnant at the time, was vomiting and having diarrhoea. She asked them to come to her house in garden compound from kuku where they stayed. When the deceased and PW1 arrived in garden, she noticed that the deceased's problem of vomiting and diarrhoea persisted. It was her testimony that the deceased had had the problem from the time she reached puberty. That night she vomited twice and had diarrhoea twice.

In the morning the deceased delivered a still born as they were preparing to take her to the hospital. She took the deceased and the still born baby boy to chipata clinic. The deceased was admitted and she was advised to go and bury the still born. After burial she returned to chipata clinic where she found the deceased vomiting. The nurse decided to refer her to UTH because of the vomiting and diarrhoea. They went back home.

Then they got to UTH around 15 hours and went to the maternity ward. They waited up to 16 hours without being attended to. She complained to the nurses who told her to wait for the doctor, as the deceased continued vomiting on a bench where she sat. Around 18 hours the nurse advised her to go home due to her advanced age and assured her that the doctors would take care of the deceased.

The following morning she went back in the company of her children PW1, PW2 and Mannaseh. They asked a cleaner where the deceased was and she told them to wait. After a long while she returned and told her to wait for the doctor. The doctor came but failed to speak to her. Then the nurses

and the cleaner told her that her daughter had died and her body was in the mortuary. PW2 and she went to check in the mortuary to no avail until they learnt that the deceased had been buried by the third defendant because she was suspected to have been suffering from cholera.

Later she met Dr. Vwalika who told her that the deceased was HIV positive which she admitted but insisted that she should not have been buried without her relative's involvement. They were then referred to the third defendant and Julu. Julu said he was also surprised that he was told to pick up a cholera body from maternity and that he was doing so for the first time. PW1 asked him if he did not pick the body from the mortuary because she was told it had been taken there but Julu repeated that he got it from maternity. She demanded for a shovel so she could go and exhume the body but Julu told her it was an offence as only the third defendant could do so.

She decided to lodge a complaint with the HRC. An investigation was instituted, starting with the nurse at chipata clinic who confirmed that she referred the deceased to UTH because of vomiting and diarrhoea. She also confirmed that the clinic had a cholera center and that where necessary they sometimes referred cholera cases to chingwere not UTH. After that the HRC and she went to see Dr. Kasoka the Director at UTH, who asked for time to investigate. After many months they went back to UTH and Dr. Kasoka showed them a document from the lab which stated that the deceased did not have cholera. However, he refused to give them a copy.

In cross examination, PW3 testified that the deceased had problems of stomach aches periodically and according to her that is why she had a still

born. She clarified that the stomach aches did not come during her periods only because sometimes she would have periods without the stomach aches. Further, that sometimes she suffered the stomach aches plus vomiting and diarrhoea once in a year. She reiterated that no doctor attended to the deceased at 15 hours or before 16 hours. When referred to page 3 of the first and second defendants' bundle of documents, she stated that it was not true that the deceased was seen by a doctor before 16 hours.

When cross examined by Mr. Moono for the third defendant, she testified that two council employees showed her a grave site of a single person at Leopards Hill Cemetery. It was her testimony that after delivery the deceased was not very sick and was able to walk unaided. She was taken to UTH because they were referred there by the chipata clinic. She reiterated that the deceased was not attended to for a long time and was made to sit on a bench, waiting for a doctor.

That was the evidence on behalf of the plaintiff.

The first defendant called one witness (DW1) Dr. Gertrude Gundumure Tshuma, an Obstetrician Gynaecologist at UTH. She informed the Court that she has been a doctor for twenty three years with seventeen years as a specialist. She has worked for UTH maternity ward since 2006. She stated that the maternity ward is an emergency ward and patients are attended to immediately. She testified that she studied the deceased's record card. The deceased was first seen by Dr. Ngalamika and later by Dr. Shanzi. She drew the Court's attention to page 1 of the first and second defendants' bundle of documents and identified the deceased's card dated 14th December, 2009 as date of arrival and the same date at

22:30 hours as date of death. The cause of death was indicated as; *"post natal anaemia, retroviral disease and query cholera".*

DW1 further testified that the document at page 3 of the first and second defendants' bundle indicates "U/A unbooked firm A" which meant that the patient (deceased) had just arrived in the maternity emergency ward at UTH although antenatal was not done at UTH. She arrived on 14th December, 2009 at 15:30 hours. She reported to ward B12 where her BP was checked and it was 118/79 (normal), her temperature was 37.2 C (normal). Her haemoglobin was as taken on 28th September, 2009; CD4 count was very low at 6 as taken on 5th October, 2009 an average human being has 700 to 1500. The record also revealed that the deceased had delivered a macerated still born (MSB), bleeding was minimal, she was on Anti Retroviral (ARV) drugs for two months, she had shortness of breath, pain in the left ear, fever, vomiting and diarrhoea five days prior and occasional headache.

When she was examined by Dr. Ngalamika he found that she was *"ill for some time not sudden, not hot to touch, breathing not smooth a bit fast, not pale, pulse normal, chest clear and that the uterus showed that she had just given birth*". The doctor ordered malaria slide, Full Blood Count (FBC), kidney and liver test, chest X-ray, and christerpen injection. He also stated that she continues with treatment of septrine, ARVs and transferred her to ward B11. At 21 hours the deceased was seen by Dr. Shanzi, he observed that *"she had diarrhoea and received three litres of drips. He also stated that she was very ill, not hot to touch, temperature was normal, pulse not felt, BP was unrecordable as he could not pick it*". He confirmed that she had just given birth and noted that she was not bleeding from the vagina. He also noticed a dish of white stool which he

diagnosed as *"shock secondary to cholera in retroviral disease"*. According to DW1 it was ordinary cholera. Dr. Shanzi also ordered two drips plus ringers lactate fluid to run fast and prescribed cyperfloxacin an antibiotic. Also a swab of stool and that vital signs be monitored. He also recommended for the patient to be transferred to the filter clinic due to severe dehydration and shock in cholera. The filter clinic wrote *"on the way prepare patient for transfer"*. Later at 22:30 hours Dr. Shanzi attended to the deceased only to certify her dead. He observed no pulmonary activity. He stated the cause of death as shock hypovoleamic in cholera which according to DW1 meant she had drained out the fluids with cholera. It was her testimony that the deceased was given fluids as shown on the fluids chart at page 7.

It was her testimony that there was no negligence by UTH. She opined that the only thing UTH could have done differently perhaps was to give the deceased the cholera drugs such as tetracycline. However, this was not done because the cholera drugs are not kept at the maternity ward as it is not a cholera ward and tetracycline is not given to pregnant or breast feeding women. In conclusion she reiterated that white stool is a strong suspicion for cholera and treatment can be done without lab tests. She also stated that the nurses usually inform relatives of the deceased patient in cases of death.

In cross examination, she stated that she could not recall if she was on duty when the deceased was admitted. She agreed that she never attended to the deceased. It was her testimony that when a patient is brought in their details including the time are recorded in a register. She conceded that the register was not before court and that she did not know if the deceased's file before court was complete. She agreed that the drug chart

and Pulse Respiratory Monitoring (TPR) chart should have been part of the file together with the lab results if tests were done.

Under further cross examination, she testified that the main clinical manifestation of cholera is diarrhoea, that is, white water stew in large volumes with diarrhoea or not and vomiting or not. Then as time goes on the BP goes down because the blood vessels collapse. She admitted that cholera was a highly contagious disease and that an infected person is quarantined. She said the drugs for treatment of cholera are doxycycline and tetracycline. She admitted that cyperfloxacin is not a first line treatment for cholera but it could help. When further cross examined, she testified that HIV does not have any clinical manifestation. She also testified that a CD4 count of 6 is extremely low for survival and that a patient with such a low CD4 count if infected with cholera, how long they survived depended on volumes of fluids lost. She agreed that such a patient needed to be treated as soon as possible. She also admitted that according to the record, the deceased was referred to UTH for anaemia.

DW1 reiterated that Dr. Ngalamika saw the deceased at UTH on 14th December, 2009 at 15:30 or 15:50 hours as indicated in his notes at page 3 of the first and second defendants' bundle of documents. According to the record the deceased was referred to UTH for anaemia and that she had diarrhoea and vomiting five days prior to admission. She conceded that Dr. Ngalamika was a junior doctor who could have called a senior doctor to assist. She said she could not tell if the drugs ordered by Dr. Ngalamika were administered or not because the drug chart was not before court. She admitted that Dr. Ngalamika did not indicate that he suspected that the deceased had cholera. It was her testimony that the deceased's condition deteriorated rapidly after Dr. Ngalamika saw her. She was in

shock as indicated by Dr. Shanzi at page 5 of the first and second defendants' bundle. DW1 also stated that she could not tell if cyperfloxacin and other treatments ordered by Dr Shanzi were administered because she was not shown the drug chart. She opined that the deceased was not transferred to the filter clinic because she died at 22:30 hours.

DW1 refused to comment on the letters from UTH because she was not the author. She also stated that she could not comment on whether the last sentence of the letter of 13th September, 2009 implied that cholera was negative in the deceased. She also stated that she would not know if there was an outbreak of cholera in 2009 and if chipata clinic was a cholera centre in 2009.

That was the evidence on behalf of the first and second defendants.

The third defendant called one witness (DW2), Derrick Mbuzi, a senior health inspector also acting as funeral superintendent. He testified that he has worked with the 3rd defendant for four years. He stated the procedure involved when disposing of bodies with infectious diseases. That the council collects the bodies from the centre or health institution where the death occurred and this is treated as an emergency. The body is buried immediately and only one or two relatives of the deceased are allowed to witness the burial.

In cross examination, he conceded that he was not working for the council at the time it buried the deceased. He admitted that he learnt about her case from others like the late Julu and John who was the driver of the hearse. It was his testimony that Julu was neither a health inspector nor an environmental technician but was a supervisor based at the cemetery.

That was the evidence on behalf of the third defendant.

Learned counsel for the plaintiff filed written submissions, to the effect that hospitals are liable for the negligence of the nurses or doctors. That according to the authors of **Clerk and Lindsell On Torts**, a medical practitioner owes a duty in tort to his patient irrespective of any contract between them. Once a patient has been accepted as a patient, the medical practitioner must exercise reasonable care and skill in his treatment of that patient. Any negligent error in carrying out treatment and any negligent omission to provide adequate treatment will be actionable. Further that in negligence, liability of a defendant hospital or medical institution is not only limited to the direct harm occasioned by an attending physician. A hospital can be liable if a person picks up a disease from the hospital premises. The case of **Lindsey C.C Marshall**[1] was relied upon where the hospital was liable for disinfecting it without giving warning of the danger to the plaintiff.

It was further submitted that the Court should use discretion in relying on the testimony of DW1, an expert. Counsel cited the case of **Attorney General v Rosemary Mulenga**[2] where the supreme court held that ***"while expert testimony is necessary in negligence claims, there are also dangers in over reliance on medical experts selected, paid and prepared for trial by the parties. There is the obvious risk of bias and lack of objectivity, and the danger that the outcome of cases may too often depend on the expert's success in promoting their clients' side, rather than in objectively educating the trier of fact and facilitating a just resolution of the matter....This is why we have time and again said the opinion of an expert can only be a***

guide, though a strong guide, to the court in arriving at its own conclusion on the evidence before it."

Regarding the proof of claim for damages for shock and anguish, counsel contends that it is not necessary for the plaintiff to prove that the plaintiff suffered from shock and anguish as the Court can infer from the circumstances. The Supreme Court decision in the case of **Ndola Central Hospital Board of Management v Alfred Kaluba and Priscilla Kaluba**[3] was relied upon that:

"the loss of a child is not only a great loss but a traumatic experience. We bear in mind the facts and the circumstances and accept that the parents suffered in the extreme, they probably continue to suffer. We are alive also to the absence of any medical evidence regarding the shock inflicted upon the parents. However, the circumstances leave no room for doubting that this was a serious case of unimaginable proportions. We must emphasise that the damages are for the shock suffered and not for the loss of the child suffered. As such no amount of money could ever compensate for the loss of a child".

Citing rules 7 and 5 of the Public Health (Infectious Diseases) Regulations and sections 3 and 5 of the Evidence Act Chapter 43 of the Laws of Zambia and the criminal cases of **Robertson Kalonga v The People**[4] **and John Nyambe Lubinda v The People**[5], on the documentary evidence before me and the failure to produce certain documents including the failure by Dr. Ngalamika to order fluids for the deceased, it was submitted that the first defendant was negligent. According to counsel it is a fact that the deceased had diarrhoea and vomiting five days prior to admission, at

the very least the first defendant should have given fluids to sustain her. Counsel contends that Dr. Ngalamika and the nurses concluded that the deceased was not in immediate danger and did not require emergency treatment as highlighted in the purported medical report and confirmed by DW1. Due to the deceased's continuous loss of fluids, a fact well known by the physicians, and a fact which eventually caused her death to hypovoleamic shock.

Learned counsel contends that the medical report and fluid balance chart were created after the fact as the authors were not called as witnesses. The report is also contradictory of the letters from UTH which indicate that the deceased gave birth at UTH and that she was referred there for cholera. Additionally, the shade in the report was different proving that they were made by different people on different dates and using different stationary. As such the court should attach minimal or no evidentiary value to the documents and that any contents may have been made with a motive to protect the first defendant from any liability. Furthermore, that the first defendant has failed to prove that the deceased was attended to in time. No drug chart or lab report was produced. Relying on the criminal cases above it was argued that the failure to produce the lab report raises a rebuttable presumption that the same was not prepared and no tests were done to correctly diagnose the deceased's illness. Similarly, no drugs were administered as no drug chart was produced. The Court has been urged to infer that the drug chart and lab report would have confirmed that the first defendant was negligent.

It was also submitted that the actions of the third defendant of burying without following any written rules as testified by DW2 makes it negligent, prima facie. This makes it impossible to ascertain where a person was

buried and causes anguish, sorrow and grief to the plaintiff and her family. The failure to get the details of the plaintiff and family and to notify them by the third defendant is contrary to the regulations and caused further anguish and shock to them. In conclusion, counsel states that the deceased died of hypovoleamic shock due the first defendant's failure to treat her in time and not of cholera.

The learned state advocate submits that the test to be applied in relation to any claim for professional negligence was laid down in the case of **Bolam v Friern Hospital Management Committee**[6], which arose out of medical negligence that;

"the test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not profess the highest expert skill, it is well established law that it is sufficient if he exercises the ordinary skill of a competent man exercising that particular art....a practitioner who acts in conformity with an accepted, approved and current practice is not negligent merely because there is a body of opinion which would take a contrary view".

In the Zambia case of **Cicuto v Davidson and Oliver**[7] it was held that **"A medical man is not guilty of negligence, if he has acted in accordance with a practice accepted as proper by reasonable body of medical men skilled in that particular act, merely because there is a body of opinion who would take a contrary view, a wrong diagnosis is not necessarily an unskilled or negligent diagnosis"**. It is contended that in claims grounded in professional negligence, it is incumbent upon the plaintiff to lead evidence from a professional medical practitioner in

accordance with the obiter dictum in **Moy v Pettman Smith (a firm) and Another[8].**

It is argued that the first defendant was not negligent as claimed by the plaintiff because the deceased was already dying as she was taken to UTH since she had a CD4 count of 6. That Dr. Ngalamika prescribed some medicine to the deceased when he first saw her. Accordingly the first defendant was not negligent. Given the circumstances that led to the deceased's death any reasonable practitioner would have concluded that she died of hypovoleamic shock due to cholera given the large volumes of fluids she lost due to diarrhoea and the appearance of the stool. Thus no reasonable medical practitioner would have diagnosed her as suffering from dysmenorrhoea (stomach aches and vomiting during menstruation) since she had just given birth. The two conditions cannot co-exist. Therefore, the doctors did not commit any error in line with the case of **Duff Kopa Kopa (suing as Next Friend and Administrator of the estate of Chuubo Kopa Kopa) v University Teaching Hospital Board of Management[9].**

I am grateful to counsel for the submissions. It is common cause that the deceased died at UTH on 14th December, 2009 a few hours after her admission. It is also an undisputed fact that the deceased was HIV positive and was taking ARVs. Her CD4 count at the time was 6. She was taken to UTH on 14th December, 2009 after delivering a still born at her mother's home in garden compound. It was also not disputed that she was buried by the third defendant without involvement of her relatives. This was after the UTH requested the third defendant to pick and bury the deceased because she had died of suspected cholera. The plaintiff alleges that the deceased did not have cholera and that the defendants were

negligent in the manner they handled her case right up to her burial. As a result the plaintiff has suffered shock, anguish and pain for which the defendants are liable in damages.

The issues that fall for determination are whether the first defendant's doctors and nurses were negligent in treating the deceased and whether the first and third defendants were negligent for treating the deceased as a case of suspected cholera and for the third defendant to bury her as such. It is for the plaintiff to prove negligence as pleaded. The critical question is, did the first defendant negligently cause the deceased's death? To address this question it is imperative for me to examine the ingredients of the tort of negligence. These are that the defendant owed a duty of care in the circumstances, the defendants or his agent or servant breached that duty and finally that the plaintiff has suffered damage as a consequence of that breach. It was not disputed and it is a fact that the deceased was admitted to the first defendant hospital on 14th December, 2009 and died the same day.

It is trite that medical doctors or nurses owe a duty of care to patients. I am persuaded by the High Court decision in **Nyasulu v Attorney General**[10] where Sakala, J as he then was, held that, ***"a doctor owes a duty of care to a patient which when breached will result in his liability."*** Further, that ***"the court will not draw an inference of negligence in cases involving professionals unless there is direct evidential proof thereof on a balance of probabilities."*** In the case of **Rosemary Bwalya v Zambia Consolidated Copper Mines Limited and Others**[11], the supreme court following the Bolam case, which has been relied upon by the state advocate in *casu*, per Sakala CJ, as he then was, observed that ***"the negligence had to be established in accordance***

with the generally accepted principles and tests for determination of professional liability with specific reference to alleged medical negligence. In these cases it is usual and normal to expect that the plaintiff will have expert evidence which supports that any error made was a negligent error. It is therefore, of the highest importance in such cases for the plaintiff to assemble competent opinion."

In that case the plaintiff alleged negligence in the performance of the BTL operation because she fell pregnant a few years after that operation, which she did to avoid pregnancy. The Supreme Court stated furthermore that:

> ***"the standard that was required in the performance of the BTL operation was that of the ordinary skilled doctor professing to have that special skill. It was not a question of professing the highest expert skill. Thus, in Thacke v Maurice, Neil L.J, discussing the issue of warranty in the House of Lords had this to say: furthermore, I do not consider that a reasonable person would have expected a responsible medical man to be intending to give a guarantee. Medicine, although a highly skilled profession is not generally regarded as an exact science. The reasonable man would have expected the defendant to exercise all the proper skill and care of a surgeon in that specialty, he would not in my view have expected the defendant to give a guarantee of one hundred percent success."***

I am alive to the fact that the case in hand does not involve an operation but I am of the considered view that the principles are applicable. I also wish to state from the outset that as established in the cases cited above, the first defendant and its agents or servants clearly owed a duty of care to the deceased as a patient at the hospital. The plaintiff alleges that the first

defendant was negligent first because it did not attend to the deceased immediately. That she was made to wait for hours before being seen by a doctor. The plaintiff relied on her testimony and that of PW3, in this regard. PW3 who took the deceased to the hospital testified that they got there around 15 hours and she left her at 18 hours and by that time she had not been seen by a doctor. The plaintiff also alleged that another person filled in the time and that there is a slight difference in the shade and handwriting.

DW1 testified that according to the doctor's notes on record the deceased was first seen at 15:30 or 15:50 hours, as she could not read the time clearly. I perused the notes by Dr. Ngalamika dated 14th December, 2009. Indeed the time is not clearly written. However, the plaintiff neglected to call a handwriting expert to testify with certainty that another person other than the doctor filled in the time. I am inclined to accept the testimony of DW1 that the deceased was seen at 15:30 or 15:50 hours as indicated in the record for the following reasons. First, during examination in chief PW3 initially testified that she took the deceased to UTH around 15:00 hours and waited up to 16:00 hours when she complained and then she left at 18:00 hours. Second, PW1 testified that PW3 returned home around 17:00 hours and told her that she was not allowed to remain with the deceased at UTH. I find that PW3 was not present at UTH all the time and that Dr. Ngalamika saw the deceased around 15:30 or 15:50 hours, at which point PW3 had left and was back home in garden compound around 17:00 hours as testified by PW1. Thus, the plaintiff has failed to prove that the time was written by someone else other than Dr. Ngalamika and that she was not attended to for hours.

I note also the contradictions and inconsistencies by PW3 and others as to the exact condition of the deceased at the time. PW3 in one breath states that the deceased was not very sick and was able to walk unaided. In another that she was very sick and just lay on a bench. She also testified that after leaving chipata clinic in the morning she took the deceased back home and only took her to UTH in the afternoon. The plaintiff has also questioned the authenticity of the doctors' notes on record since the authors were not called to testify. Further, that I should not attach much weight to the testimony of DW1 and the notes because they were incomplete as they did not contain the drug chart. The plaintiff further alleges that Dr. Ngalamika who first attended to the deceased was negligent because he did not administer fluids immediately since she had had diarrhoea five days prior to admission.

It is settled law that he who alleges must prove, never mind the opponent's case as elucidated by the supreme court in cases like **Mohamed v The Attorney General**[12] and **Zulu v Avondale Housing Project Ltd**[13]**.** In this case it must be accepted that the deceased was in poor health before she was admitted at UTH. She was HIV positive, had a CD4 count of 6 and had just delivered a still born (MSB). DW1 testified that a person with a CD4 count of 6 had a very low chance of survival and was susceptible to opportunistic infections. She was on ARVs which Dr. Ngalamika recommended she continue taking after he saw her. He also prescribed septrine, an antibiotic and christerpen injection. The ultimate analysis in this case therefore, is whether the conduct (failure to administer fluids by first doctor) complained of fell short of the appropriate standard or care of a medical personnel. In **Attorney General v. Rosemary Mulenga**[2] it was held that, ***"it is trite that to establish negligence, the plaintiff must***

prove that the practitioner's actions fell below the accepted standard of care, or the degree of care a reasonable similarly qualified health care provider would have provided under the same or similar circumstances" .

Going by DW1's testimony, the medical record revealed that when Dr Ngalamika examined the deceased he found that she was *"ill for some time not sudden, not hot to touch, breathing not smooth a bit fast, not pale, pulse normal, chest clear and the uterus showed she had just given birth"*. The doctor then based on what he observed ordered malaria slide, FBC, kidney and liver tests, x-ray and christerpen injection. And that she continues with treatment of septrine and ARVs. Clearly, the doctor did not find that the deceased was dehydrated. It is worthy of note that he stated *"not pale, ill for some time not sudden"*. He examined the patient and prescribed treatment based on what he observed.

DW1 further testified that the deceased's condition deteriorated rapidly because when the second doctor, Shanzi, saw her he observed that she had received *"three litres of drips, she was very ill, not hot to touch, temperature was normal, pulse not felt, BP was unrecordable."* The doctor confirmed that she had just given birth and was not bleeding from the vagina. Dr Shanzi also noticed a dish of white stool which he diagnosed as *"shock secondary to cholera in retroviral disease"*. Then he ordered two drips plus ringers lactate fluid and prescribed cyperfloxacin, an antibiotic. He also ordered that she be transferred to filter clinic due to dehydration. Thus, I am inclined to find that the first defendant was not negligent. The deceased was seen by two doctors who prescribed treatment based on what they observed. Dr Ngalamika did not observe that the deceased was dehydrated and so did not prescribe fluids.

Furthermore, I am not persuaded that failure by Dr. Ngalamika to give fluids to the deceased caused her death. As stated in the **Thacke v Maurice**[15] case, medicine is not regarded as an exact science. As such it is not a proven fact that the deceased would have survived had she been given fluids upon her admission at UTH. As observed in the case of **Rosemary Bwalya v. Zambia Consolidated Copper Mines and others**[11], the doctor is not expected to exercise the highest skill and expertise but only general level of skill. I find that the first defendant's agents acted in conformity with accepted, approved and current practice as held in the case of **Bwalya v. Zambia Consolidated Copper Mines Ltd and Others**[11]. I am also fortified by the Bolam case (supra) that "a practitioner who acts in conformity with an accepted, approved and current practice is not negligent merely because there is a body of opinion which would take a contrary view".

The plaintiff has made a lot of assumptions and allegations some of which contradict but did not call any medical evidence to prove their claims which is critical in medical negligence cases as elucidated in the Bwalya case (supra). I therefore, find that the first defendant was not negligent as alleged by the plaintiff. There is no evidence to suggest that the doctors and nurses conducted themselves in a manner constituting negligence. If anything the family also delayed to take her to the hospital and kept her home for five days with diarrhoea and vomiting. Yet she was known to be pregnant and HIV positive.

As I see it, the real issue in this case is whether the plaintiff has discharged the onus of establishing negligence. It is settled law that the benchmark for negligence is what a reasonable person, (doctor herein) would have done in the same circumstances as the defendant experienced.

The first defendant examined the deceased and prescribed treatment. As aforestated it is incumbent on the plaintiff to prove negligence never mind the opponent's case. It is not sufficient in these circumstances to establish a prima facie case as the plaintiff's counsel seems to suggest nor in so doing does the burden of adducing evidence shift to the defendant. Even where the defendant adduces no evidence, the plaintiff must prove negligence on a balance of probabilities. The plaintiff should have proved the particulars as alleged that is, that the defendant failed to conduct a proper examination of the deceased and other particulars as stated in the statement of claim and called medical evidence. DW1 testified that the record revealed that the deceased was referred to UTH for anaemia and not vomiting and diarrhoea as alleged by the plaintiff. Therefore, whether chipata clinic is a cholera centre or not is immaterial as the deceased was sent to UTH for anaemia. In addition cholera was suspected later by the second doctor who saw her. The plaintiff also failed to prove that the nurse at chipata clinic said she referred her to UTH for vomiting and diarrhoea, not anaemia. Letters from UTH are also not helpful as they were written by administrators as stated by DW1 and not medical personnel who attended to the deceased. Further, the authors of the letters were not called to testify to the contradictions highlighted for instance that the deceased gave birth at UTH when in fact not. It is an established fact that she delivered at home as stated by the medical record as testified by DW1 and also PW1 and PW3.

I am also unable to agree with submissions by the plaintiff's counsel on failure to call the two doctors and other authors of the documents on record like the fluid chart and that I should not attach much weight to the testimony of the expert DW1. It is trite law that expert evidence is there to

provide the Court with necessary scientific criteria for testing the accuracy of the facts before it so as to enable the Court to form its own independent judgment. See **Lupupa v The People**[16]**.** Thus the Court is not bound by the testimony of the expert but should form its own independent judgment based on all the facts before it. In casu, DW1 testified in line with the medical documents on record. I observed her to be a credible witness who did not contradict herself unlike the plaintiff and her witnesses. DW1 even admitted some short comings by the first defendant, for instance, that cholera was suspected because of the white stool though not diagnosed or tested and that the deceased could have been given cholera drugs. She also explained why perhaps this was not done.

I equally do not agree with the plaintiff's counsel that the failure to produce a lab report raises a rebuttable presumption that the same was not prepared and no tests were done to correctly diagnose the deceased's illness. I have determined that the deceased was HIV positive, with a CD4 count of 6 and had just delivered a still born, doctors attended to her and prescribed medicines. The doctors observed that she had been ill for some time. DW1 testified that the lab results could be missing because maybe they were not paid for. She also opined they could be missing from the file because the deceased was not taken to the filter clinic because she died looking at the time of death and when the doctor recommended for her to be taken and that she was critically ill then. Again it is for the plaintiff to prove her case. The criminal cases are of no use to the plaintiff's case, she was required to prove her case on a balance of probabilities. The presumption does not discharge the burden of proof. I am also not persuaded with counsel's submission that the 1st defendant (UTH) negligently allowed the deceased to pick up cholera from UTH for failing to treat her with caution as an HIV positive person. I am fortified by the holding in **Attorney General v. Rosemary Mulenga**, supra, that:

> *"It is trite that a hospital, doctor or other health care professional is not liable for all the harm a patient might suffer. They are only liable for all*

the harm or injury that results from their deviating from the quality of care that a competent doctor or health care provider would normally provide in similar situations..."

As already determined, the doctors and nurses acted in conformity with accepted, approved and current practice.

In light of the foregoing, I am unable to find that the plaintiff has discharged the onus which fell upon her to establish the negligence of either the doctors or nurses at UTH in the treatment of the deceased. Accordingly, the plaintiff's case against the first and second defendants is dismissed.

I now turn to consider whether the plaintiff has proved its case against the third defendant. It is a fact that the cholera diagnosis was not confirmed. The first defendant merely suspected it because of the white stool which according to DW1 was a major suspicion of cholera. It is trite law that a wrong diagnosis does not mean negligence as elucidated in **Cicuto v. Davidson and Oliver**[7]**.** And according to Halsburry's Laws of English at paragraph 6223 at page 447, *"an error of judgement will not amount to negligence unless it is one that would not have been made by a reasonably competent professional with the standard and type of skill of the defendant acting with ordinary care."* Thus, the first defendant is not liable in negligence for suspecting cholera. Dr. Shanzi noticed the white stool which is a strong suspicion of cholera which could have been made by a reasonable competent professional.

The question is, was the third defendant negligent in treating the deceased's body as that of an infectious disease? Were they justified in burying without informing the relatives? The third defendant averred that it is mandated under the Public Health Act to bury infectious bodies and it

to avoid the disease spreading. Consequently the claim for damages for anguish, shock, pain and suffering cannot be sustained.

In the net result, I find that the plaintiff has failed to prove her case against the defendants to the required standard. The case is dismissed with costs, to be taxed failing agreement.

Delivered at Lusaka this 20th day of December, 2016

J.Z. MULONGOTI
HIGH COURT JUDGE