IN THE SUPREME COURT OF ZAMBIA
HOLDEN AT LUSAKA
(CIVIL JURISDICTION)

APPEAL NO 201/2015

BETWEEN:

DR. SULTANOVA ZUMRAD — APPELLANT

AND

KASAMBA KALINDA — 1ST RESPONDENT

ROY KALINDA — 2ND RESPONDENT

CORAM: MAMBILIMA CJ, WOOD AND KAOMA JJS;
On 10th July, 2018 and 19th September, 2018

For the Appellant : Mr. C.K. Banda, standing in for Dr. O.M.M. Banda, of OMM Banda and Company

For the Respondents : Mr. N.M. Nga'ndu, of Shamwana and Company

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JUDGMENT

MAMBILIMA, CJ delivered the Judgment of the Court.

CASES REFERRED TO:

1. NDOLA HOSPITAL BOARD OF MANAGEMENT V ALFRED KALUBA AND PRISCILLA KALUBA (1995-1997) ZR 183
2. INDUSTRIAL GASES LTD V WARAF TRANSORT LTD AND MUSSAH MOGEEHAID (1995-1997) ZR 183
3. CASSIDY V MINISTRY OF HEALTH (FAHRNI, THIRD PARTY (1951) 1 ALL ER 574

WORKS AND LEGISLATION REFERRED TO:

(a) CHARLESWORTH & PERCY ON NEGLIGENCE 12TH EDITION PARAGRAPH 3-098
(b) MEDICAL NEGLIGENCE (2ND EDITION) PAG 168 PARAGRAPH 4-006 PAGE 191 PARAGRAPH 4-044
(c) BLOCKS LAW DICTIONARY 8TH EDITION PAGE 1527
(d) RULE 58 (2) SUPREME COURT RULES, CAP 25 OF THE LAWS OF ZAMBIA

The facts leading to this case are not in dispute. The 1st Respondent, Kasamba Kalinda, was an antenatal patient at Teba Medical Centre Limited (TEBA hospital). She was being attended to by the Appellant, who was a visiting Consultant in Obstetrics Gynaecology. On 23rd March, 2017 she reported to TEBA hospital in her 37th week of pregnancy, complaining of abdominal pains. The nurse on duty found that she was not in active labour and advised her to go back home. But because the 1st Respondent mentioned that she had a history of precipitate labour (to mean short term labour) the nurse referred her to the Appellant.

The Appellant admitted the 1st Respondent overnight for observation and rest. Before leaving the hospital, she gave instructions to DW2, the nurse on duty, that she should be called if anything such as bleeding, contractions or draining arose. The

Appellant also indicated to the 1st Respondent that she might have to conduct a caesarean section on her the following day because the baby, who was estimated to weigh 4.9kg, was too big.

That same night, the 1st Respondent went into active labour. At this time, DW2 had knocked off and DW3 was the nurse on duty. By midnight, the 1st Respondent had fully dilated and she was moved onto the delivery bed. Then DW3, encouraged her to bear down (push). The 1st Respondent pushed until the baby presented its head at 01:00 hours. She continued to push but the baby stopped moving. It was stuck by the shoulders.

A general practitioner and the midwives who were present in the maternity ward failed to dislodge the baby. DW3, as the nurse on duty decided to call the Appellant, but the hospital phone had no air time. The nurse ended up using the 1st Respondent's phone to reach the Appellant. The Appellant arrived at the hospital at 01:40 hours and delivered the baby at 01:45 hours. But by then, the baby was dead.

Aggrieved by this turn of events, the 1st and 2nd Respondents sued the Appellant and TEBA Hospital (as 1st and 2nd Defendants) for medical negligence and causing the death of their baby.

The Appellant (DW1) denied the allegations. She averred that she left instructions with the 1st Respondent and the nurse on duty to call her the moment labour started but no one called until the baby got stuck. That she left the 1st Respondent in the observation ward and did not know who moved her to the maternity ward.

TEBA Hospital called two witnesses; DW2 the nurse who first attended to the 1st Respondent and DW3, the nurse who attempted to deliver the 1st Respondent. DW2 said she followed the doctor's written instructions to administer IV fluids to help the 1st Respondent and her unborn baby to rest. DW3 told the Court that she was not told to call the Appellant when the Appellant went into labour, and neither were there any written instructions to that effect. That the only alert she had was that the patient had a history of precipitate labour. That she did not read on the file that the baby was 4.9kg. That in any event, she was a senior midwife with 40 years' experience and had delivered big babies before. That she

proceeded with normal delivery and only called the doctor when she noticed a problem.

Upon considering the evidence that was before him, the trial Judge held that the Appellant and TEBA hospital were both negligent. In terms of liability, the learned trial Judge held that since the Appellant was an employee of the hospital, albeit part-time, the hospital was vicariously liable for her acts. Further, that as a servant, the Appellant was also personally liable. The learned trial Judge also found that DW2, the nurse who was instructed to call the Appellant was negligent but according to the Judge: ***"....the Plaintiff did not sue her in her personal capacity but decided to sue the 2nd Defendant for the negligence of its employees and the 2nd Defendant did not join her as a party. DW2 is not a party to this action and therefore not personally liable for negligence."***

The Court awarded the Respondents a total sum of K50, 000.00 as damages for mental anguish and pain. The liability was apportioned equally between the Appellant and TEBA Hosptal. In making the award, the Judge relied on our decision in the case of

NDOLA CENTRAL HOSPITAL BOARD OF MANAGEMENT V ALFRED KALUBA AND PRISCLLA KALUBA[3] in which Ngulube C.J. (as he then was) stated that ***"...the now well established principle of awarding damages for nervous shock can, and should be extended to cover the novel situation where the shock resulted from the negligent loss of the baby."***

The Appellant was not satisfied with the decision of the lower Court. She has appealed to this Court advancing three grounds, that:-

1. **The learned trial Judge erred and misdirected himself both in fact and law by ignoring the fact that the Appellant was an employee of the 2nd Defendant in the Court below who committed the offence if any in the course of her official duties of which the 2nd Defendant is liable.**

2. **The learned trial Judge erred and misdirected himself both in fact and law by holding that the Appellant was negligent when the evidence from the Respondents and 2nd Defendant's witnesses clearly demonstrates that the Appellant was not negligent.**

3. **The learned trial Judge erred and misdirected himself by entering judgement against the Appellant without evidence warranting entry of judgment against her**

In support of the first ground of appeal, the Appellant has argued that the learned trial Judge was wrong to hold her

personally liable for the loss of the baby. That TEBA Hospital is a limited company with a separate legal personality while she is a part-time employee of the Hospital. That in the circumstances TEBA Hospital is vicariously liable for any acts or omissions done by her in the course of her employment. Further, that she can only be held personally liable if she undertook responsibility for whatever happened to the 1st Respondent. To support her submission, the Appellant has relied on several authorities, among which is the case of **INDUSTRIAL GASES LIMITED V WARAF TRANSPORT LIMITED AND MUSSAH MOGEEHAID**[2] in which this Court held that:-

> **"As long as the wrong is committed by an employee in the course of his employment the general rule is that the employer will be vicariously liable."**

This is the correct position of the law on vicarious liability in an ordinary master/servant relationship. Vicarious liability is anchored on the principle that the wrong of a servant or agent, for which the master/principal is liable, is one which is committed in the course of employment or in the course of his authority. According to the learned authors of **CHARLESWORTH AND PERCY**

ON NEGLIGENCE[a], the doctrine of vicarious liability finds its roots in early common law. They state:-

> **"It came to be established that the liability of an employer for the tort of his employee was based, not on a fiction that he had impliedly commanded his employee to act as he did, but on the ground that the employee had acted within the scope of, or during the course of, his employment or authority."**

As regards liability for employees under a contract of service or a contract for service, Lord Denning in the case of **CASSIDY V MINISTRY OF HEALTH (FAHRNI, THIRD PARTY)**[3] opined as follows:-

> **"...This Court is free to consider the question on principle, and this leads inexorably to the result that, when hospital authorities undertake to treat a patient and themselves select and appoint and employ professional men and women who are to give the treatment, they are responsible for the negligence of these persons in failing to give proper treatment, no matter whether they are doctors, surgeons, nurses, or anyone else. Once hospital authorities are held responsible for the nurses and radiographers, as they have been in GOLD's[1] case ([1942] 2 All E.R. 250), I can see no possible reason why they should not also be responsible for the house surgeons and resident medical officers on their permanent staff. It has been said, however, by no less an authority than Goddard, L.J., in GOLD's[1] case that the liability for Doctors on the permanent staff depends 'on whether there is a contract of service, and that must depend on the facts of any particular case.' I venture to take a different view. I think it depends on this: Who employs the doctor or surgeon? Is it the patient or the hospital authorities? If the patient himself selects and employs the doctor or surgeon, as in HILLYER's[2] case, ([1990] 2K.B.820) the hospital authorities are, of course, not liable for his negligence, because he is not employed by them. Where, however, the doctor or surgeon, be he a consultant or not, is**

employed and paid, not by the patient, but by the hospital authorities, I am of the opinion that hospital authorities are liable for the negligence in treating the patient. It does not depend on whether the contract under which he was employed was a contract of service or a contract for services. That is a fine distinction which is sometimes of importance, but not in cases such as the present where the hospital authorities are themselves under a duty to use care in treating the patient.

I take it to be clear law, as well as good sense, that where a person is himself under a duty of care, he cannot get rid of his responsibility by delegating the performance of it to someone else no matter whether the delegation be to a servant under a contract of service or to an independent contractor under a contract for services."

It is clear from the above that a doctor who has been negligent may not be the only Defendant in a medical negligence case. The hospital that retained the doctor on its staff can be held vicariously liable for the doctor's negligence. Hospitals can also be held directly liable for their own negligence. Vicarious liability means a party is held responsible not for its own negligence but for the negligence of another. In the case in casu, the Appellant was a part time obstetric gynaecologist at TEBA Hospital and in that capacity, she attended to the 1st Respondent. It follows, therefore, that TEBA Hospital was vicariously liable for the acts or omissions of the Appellant (if any) and/or its servants or agents, committed in the course of their duties, irrespective of whether they were

independent contractors or servants under a contract of service. We, therefore, find merit in the 1st ground of appeal. The Court below should not have glossed over this fundamental principle of law in relation to the Appellant.

Coming to the second ground of appeal, it is not in dispute that the Appellant owed a duty of care to the 1st Respondent by virtue of her profession and skill. She was discharging this duty on behalf of TEBA Hospital. The Court below found her to have been negligent because she did not leave any written instructions for the nurses to call her once the 1st Respondent went into labour. The Appellant, however, told the Court below that she left oral instructions with DW2, the nurse on duty that she should be called in the event that the patient went into labour, but these instructions were not communicated to DW 3, the nurse who was on duty when the 1st Respondent went into labour. As a result, DW 3 proceeded with normal delivery, resulting in a complication called ***shoulder dystocia.*** This led to the death of the Respondents' baby. The learned trial Judge found that the failure to

communicate the instructions to call the Appellant constituted negligence. He stated:-

> **"The negligent act was a result of a chain of events that prevented the Appellant from exercising her expert medical skills which would have saved the baby's life...the Appellant told DW 2 to call her in the event that normal labour started, but she (the Appellant) did not record those instructions...the omission by the Appellant and TEBA to record or pass on critical information to DW 3 put the baby at risk with fatal consequences."**

The Appellant has, argued on this ground of appeal, that the learned trial Judge erred by holding that she was negligent. That both the oral and documentary evidence on record demonstrates that the Appellant was not negligent. That it was in fact DW 2 and DW 3 who were negligent and that DW 3 even went ahead to deliver the baby normally without following the Appellant's specific instructions to be called once the labour started. That in the circumstances, it is TEBA Hospital which should have been held liable for the acts of DW2 and DW 3.

Admittedly, the evidence on record shows that when she was called, the Appellant managed to dislodge the baby quickly. She arrived at the hospital at 01.40 hours and dislodged the baby by 01.45 hours, but by this time, the baby had already died from

strangulation. This evidence is consistent with the testimonies of all the witnesses as well as the statements made to the Medical Council of Zambia. We agree with the observation by the learned trial Judge on page 26 of the record of appeal, that the 1st Respondent suffered at the hands of poor ***"administrative protocols and procedure of recording and handing over of information between shifts and between doctors and nurses at the hospital."***

According to Michael Jones, in his book **MEDICAL NEGLIGENCE**[b]:-

> **"A hospital which offers obstetric services has a duty to provide an adequate system for securing attendance, within reasonable time, of doctors with sufficient expertise to deal with an emergency in the course of delivery."**

The same author also rightfully observed that ***"A breakdown in essential communication between healthcare professionals with responsibility for the patient can have dangerous consequences for the parties"***[b]. Such was the situation in this case. In fact, the evidence of the 1st Respondent and DW 3 was that the hospital phone had no airtime. It is apparent that the hospital lacked an effective communication system to summon specialist

assistance when needed. From the evidence on record, no negligence can be attributed to the Appellant in the manner that she handled the patient. We agree with her assertion that she acted in conformity with the accepted, approved and current practice. She was able to dislodge the baby within minutes of arrival at the hospital. She opined that had she been called earlier, the baby would not have died. She maintained that she did tell the nurse on duty to call her the moment the patient went into labour because the baby was big. This critical information was not passed on to DW3 during the change of shift.

DW2 told the lower Court that before knocking off, she documented what had happened in her notes and handed them over to her colleague. It is clear that in this hand over, she omitted to convey the instructions from the Appellant. In our view, the buck stops at DW2 since she is the one who **'documented'** what had happened and handed over to her colleague. It was incumbent upon her to pass on the instructions of the doctor whether oral or written to the nurse taking over the shift.

We have considered whether the Appellant could have been a joint tortfeasor in this case. According to **BLACK LAW DICTIONARY**[(C)] joint tortfeasors are two or more wrong doers who contributed to the claimant's injury and who may be joined as defendants in the same lawsuit. In many cases the joint tortfeasors are jointly and severally liable for the damage, meaning that any of them can be responsible to pay the entire amount no matter how unequal the negligence of each party was. In our view, on the facts of this case, the Appellant cannot be considered to have been a joint tortfeasor with the hospital as her actions did not contribute to the death of the baby. Her position was that had she been called, the baby would not have died and indeed, she dislodged the baby within minutes of her arrival. Consequently, we also find merit in the second ground of appeal.

The third ground of appeal, in our view, is not properly formulated. It reads:

> **"The learned trial Judge erred and misdirected himself by entering judgment against the Appellant without evidence warranting entry of judgment against her."**

This ground is vague and does not raise any specific objection to the judgment appealed against. **RULE 58(2) OF THE SUPREME COURT RULES**[d] provides that the Memorandum of Appeal ***'shall specify the points of law or fact which are alleged to have been wrongly decided."*** In the way that the third ground of appeal is couched, it does not sufficiently disclose the points of law or fact that the Appellant is objecting to. Further, Counsel for the Appellant does not advance any arguments distinctly in support of this ground. He simply states, that he adopts the submissions in support of the first and second grounds of appeal. The third ground, is therefore, incompetent.

Arising from what we have stated above, we find merit in this appeal. It is allowed. We have found that TEBA Hospital is vicariously liable for the actions of DW2 which led to the death of the Respondent's baby. We order that it pays the entire damages of K50,000.00 as ordered by the lower Court together with interest also as ordered. Costs shall be for the Appellant, as against TEBA Hospital, to be taxed in default of agreement.

I.C. Mambilima
CHIEF JUSTICE

A.M. Wood
SUPREME COURT JUDGE

R.M.C. Kaoma
SUPREME COURT JUDGE