Gilgil Hills Academy Limited v Koech & another (Suing as the legal representatives of the Estate of LCK - Deceased) (Civil Appeal E002 of 2021) [2025] KECA 2159 (KLR) (10 December 2025) (Judgment)

Neutral citation: [2025] KECA 2159 (KLR)

REPUBLIC OF KENYA

IN THE COURT OF APPEAL AT NAKURU

CIVIL APPEAL E002 OF 2021

MA WARSAME, JM NGUGI & GV ODUNGA, JJA

DECEMBER 10, 2025

BETWEEN

GILGIL HILLS ACADEMY LIMITED .... APPELLANT

AND

JOSEPH KIPLANGAT KOECH & ROSE CHESANG KOECH (SUING AS THE LEGAL REPRESENTATIVES OF THE ESTATE OF LCK - DECEASED) .... RESPONDENT

(Being an appeal from the Judgment and Decree of the High Court at Nakuru (Mulwa, J.) dated 24{{^th}} January, 2019 in HCCC No. 337 of 2019)

JUDGMENT

1. The respondents instituted a suit as the personal legal representatives of their late daughter, Linda Chepkorir Koech ("the deceased").
2. At the time of her death, the deceased was 13 years old and a Class Seven pupil at Gilgil Hill Academy, the appellant's school, where she was a boarder.
3. In their plaint dated 3rd December, 2009, the respondents pleaded that the deceased returned to school after the holiday in good medical condition. However, on or about 28th July, 2008, she succumbed to a medical condition later established by the pathologist to be peritonitis, while receiving treatment from the school nurse. They attributed her death to the appellant's breach of its contractual/fiduciary duty to take reasonable care of the deceased's physical and psychological wellbeing while in its custody.
4. They particularized negligence against the appellant, including:
    a. failure by the school nurse to properly diagnose or examine the deceased before dispensing treatment;

b. engaging a professionally incompetent nurse/clinician, resulting in improper medical intervention;

c. failure to inform the respondents of the child's deteriorating condition, denying them the opportunity to determine an appropriate medical response.

5. They sought: general damages; punitive and exemplary damages; special damages of Kshs. 165,000/=; interest; and costs.

6. In its statement of defence, the appellant denied liability and in the alternative contended that the respondents failed to disclose the deceased's alleged pre-existing medical condition and failed to secure specialised treatment during the school holidays.

7. The appellant denied negligence or breach of contract and asserted it was not liable to pay any damages.

8. During trial, the respondents called three witnesses and the appellant called four witnesses.

9. PW1, the deceased's father, recounted that on 28th July, 2008 he and his wife received a call summoning them to the school. Before they arrived, a teacher redirected them to a private hospital in Gilgil, where they found the principal, a teacher, and two police officers who escorted them to the mortuary. There, to their shock, they found their daughter's body already placed in a coffin. He testified that no coherent explanation was offered, save for an inconsistent suggestion by school staff that the deceased had "ulcers and collapsed."

10. PW1 testified that two weeks after the burial he returned to the school seeking clarity. The school nurse reported that she had treated the deceased on 26th July, 2008 for a throat infection using Septrin and Piriton, and on the following day had administered Cortexin — a malaria drug — after a telephone consultation with a clinical officer. PW1 emphasised that no clinical examination or diagnostic tests were ever conducted. He maintained that the deceased had been unwell for three days under the school's watch without being seen by a doctor, and that the school never offered an apology.

11. PW1 further stated that while the deceased had once asked to carry milk to school at the beginning of a term, she had never been diagnosed with ulcers or any chronic condition. He asserted that he first heard any mention of ulcers only after his daughter's death, from the school nurse.

12. PW2, Dr. Jane Wasike Simiyu, a pathologist, conducted an autopsy on 29th July 2008. She found septic ascitic fluid in the abdominal cavity and opined that the cause of death was peritonitis. She explained that abdominal pain requires careful assessment — location, pattern, and severity guide diagnosis — and noted that she could not ascertain the underlying cause but stressed that peritonitis typically requires urgent clinical intervention.

13. PW3, Dr. Timothy Olweny, testified as an expert. He reviewed the autopsy report and the witness statements of the school nurse and clinical officer. He explained in detail that peritonitis can be spontaneous or secondary to abdominal infection. PW3 emphasized that proper management required clinical examination, diagnostic tests, continuous observation, and escalation where symptoms worsen. He was categorical that none of these were done. He faulted the nurse for administering Cortexin without examination, and the clinical officer for prescribing via telephone, which he described as an egregious departure from professional standards. He opined that with proper diagnosis and timely referral, the deceased's condition "would most likely have been controlled".

14. PW3 further testified that a nurse's role does not include diagnosing or prescribing treatment without a doctor's oversight, and certainly not via phone consultations. He stated that DW4 exceeded her scope of practice.

15. DW1, Beth Wangechi Kanyi, the school principal, testified that the school employed a nurse supervised by a clinical officer at Gilgil District Hospital. For serious cases, pupils were sent to public hospitals. She stated that on 28th July, 2008, when the clinical officer indicated he could not handle the case, the respondents were summoned to take the deceased to a hospital of their choice.

    She added that the respondents had not disclosed any special medical condition and that the school had not permitted milk to be supplied.

16. DW1 conceded that the clinical officer erred by prescribing a malarial drug without tests. She further stated that the nurse never informed her of the deceased's illness until the morning of 28th July, 2008 when the deceased was brought to the dispensary unresponsive. She conceded that had she been informed earlier, she would have summoned the parents immediately.

17. DW2, the deceased's class teacher, testified that the deceased appeared well the day before her death. She said the deceased's mother once mentioned ulcers during holidays and the requirement for milk, and she advised her to seek permission from the administration but did not follow up.

18. DW3, another teacher, testified that the deceased's mother had mentioned ulcers and the need for milk on visiting day, but this information was never passed to the administration.

19. DW4, the school nurse, gave an extended account of her interaction with the deceased. She testified that on 26th July, 2008, the deceased complained of cough and chest pain, and she gave Septrin and Piriton. The next day, the deceased complained of abdominal pain; DW4 called a clinical officer by phone, received advice, and administered Cortexin. She directed the deceased to return the next morning for a second dose. That morning, the deceased was found unresponsive in her dormitory.

20. DW4 insisted the symptoms were not severe enough to alert the parents or administration; that she was never called at night, and that she was unaware of any ulcer history.

21. After evaluating the evidence and submissions, the learned Judge framed the following three issues for determination:

    a. Whether the appellant by itself, its servants and agents was negligent in the manner it handled the deceased;

    b. Whether the appellant's acts of commission and omissions by its servants and agents contributed to the deceased's death; and

    c. Whether the respondents were entitled to the reliefs sought in the plaint, and if so, the quantum of damages.

22. The learned Judge held that once a parent entrusts a child to a boarding school, the school and its staff owe a duty of reasonable care, including provision of appropriate medical attention. She faulted DW4 for administering a malarial drug without any examination or tests and for failing to notify either the school principal or the parents.

23. The learned Judge also held that since the clinical officer who allegedly prescribed Cortexin did not testify, DW4's reliance on him amounted to hearsay with no evidential value. She further noted that DW4 was found negligent in Nakuru Inquest No. 8 of 2009, Republic vs. Linda Chepkorir Koech.

24. The learned Judge held that DW4 did not produce evidence of academic or professional qualification as a registered nurse. PW3's criticism of her conduct reinforced the finding that she acted incompetently and recklessly.

25. On contributory negligence, the learned Judge held that the respondents contributed to the death by permitting the deceased to carry milk to school without permission and by failing to disclose the alleged ulcer history to the administration. The Judge considered that the respondents' failure deprived the school of material information that might have informed its assessment of the deceased's complaints. The learned Judge therefore apportioned liability at 70% against the appellant and 30% against the respondents.

26. On quantum, the learned Judge held that the respondents did not particularize general, punitive, or exemplary damages. She determined that a global award was appropriate, considering inflation, the deceased's age, her promising academic record, and comparable precedents. She awarded Kshs. 2,000,000 in general damages and Kshs. 165,000 in special damages. She declined to award punitive/ exemplary damages for want of proof.

27. The appellant lodged six grounds of appeal as follows:

    1. The learned judge erred in law and fact in failing to properly evaluate the evidence adduced on the issue of liability thereby rendering judgment that is unsound in principle and not reflective of the evidence adduced.

    2. The learned judge erred in failing to appreciate the principles of admissibility of evidence in relying on the findings of the inquest court in Nakuru Inquest No. 8 of 2009, when these proceedings were excluded from admission by the High Court in Judicial Review Case Number 59 of 2012 by Justice Emukule, thus arriving at an unsound finding on the limb of liability.

    3. The learned judge erred in failing to appreciate the scope of duty of care placed on teachers towards their students is limited to that of educating and caring for the child but instead placed a duty of care on the appellants herein comparable if not exceeding that placed on hospitals towards their patients and thereby erroneously imposing liability on the appellants herein to the extent of 70%.

    4. The learned judge erred in law and fact by failing to appreciate the principles governing awards under Fatal Claims prescribed under the Fatal Accident Act by resorting to making a global award as if it was a case of body injury without particulars to whom and how the award made would devolve having been pleaded.

    5. The learned judge erred in law in making award on damages that are manifestly high and punitive in violation of principles of making award of damages in case of the nature of the instant suit.

    6. The judgment of the trial court is unreasonable and contrary to law, principle and facts of the case presented before the trial court.

28. During the virtual hearing of the appeal, learned counsel, Mr. Mwenesi, appeared for the appellant and there was no appearance for the respondents despite having been duly served with the hearing notice. The appellant relied on its written submissions while the respondents did not file their submissions.

29. The appellant elaborated that the learned Judge erred by referring to findings in the inquest despite a prior High Court order excluding those proceedings. According to the appellant, this reliance violated the right to a fair trial under Article 50 of *the Constitution*. It argued that inquest proceedings do not meet the evidentiary threshold required in civil claims and cited Gatirau Peter Munya v Dickson Mwenda Kithinji & 3 Others, SC Petition No. 2B of 2014 [2014] eKLR and S v Tandwa (800/2015)

(2016) ZASCA 148 for the principle that appellate courts must rely solely on evidence properly adduced.

30. It argued further that even if admissible, inquest findings are merely confirmatory of death and cannot be relied on as proof of negligence, citing Zipporah Mumiria v Paul Muthuri & Another [2018] eKLR and R (On the application of Maughan v Her Majesty's Senior Coroner for Oxfordshire 2020 UKSC 46, emphasizing that inquests are inquisitorial and not adversarial.

31. The appellant also contended that the learned Judge imposed an erroneous standard of care — akin to that owed by hospitals — contrary to the holding in Blyth v Birmingham Water Works (1856) and Roe v Minister of Health (1954), which require only the standard of a reasonable professional.

32. The appellant relied on Richards v State of Victoria, 1969 VR 136 at 138 and WJ & Another v Astarikoh Henry Amkoah & 9 Others [2015] eKLR to argue that a school's duty is limited to reasonable supervision, not medical precision. It stressed that employing a nurse was an additional service not required by law and that DW4 followed reasonable procedures, including consulting a clinical officer.

33. The appellant further submitted that the respondents' failure to disclose the alleged ulcer condition was the primary contributor to the deceased's demise. It contended that the learned Judge did not give due weight to the respondents' omissions.

34. On quantum, the appellant argued that the award of Kshs. 2,000,000 was excessive and not anchored in the *Fatal Accidents Act* framework.

35. As a first appellate court, we are guided by Selle v Associated Motor Boat (1968) EA 123 and Jabane v Olenja (1968) KLR 661 to re-evaluate the evidence while respecting the trial court's advantage of seeing the witnesses.

36. On the alleged reliance on the inquest, our reading shows the learned Judge referred to it only in passing, after independently finding DW4's account unsupported because the clinical officer did not testify. The learned Judge's reasoning on breach of duty was grounded in the evidence adduced before her. We, therefore, reject the contention that the finding on liability was founded on inadmissible inquest material.

37. Turning to the question whether negligence was proved, we begin by noting that the elements of the tort of negligence are settled: the claimant must establish the existence of a duty of care owed by the defendant; a breach of that duty; causation (that the breach caused or materially contributed to the damage); and resultant loss or damage.

38. As the learned Judge correctly reminded herself, sections 107 and 108 of the *Evidence Act* place the legal and evidential burden on the party who asserts a fact. The plaintiffs bore the burden of proving negligence on a balance of probabilities; a plaintiff in negligence must prove the acts or omissions complained of and show that they fall below the standard of a reasonable person in the defendant's position.

39. It is not seriously contested that once parents entrust a child to a boarding school, the school assumes comprehensive responsibility for that child's safety and welfare during term time. The appellant is a private boarding school that voluntarily undertook to provide, among other things, on-site medical care to its pupils through a resident nurse linked to a clinical officer. Having chosen to hold itself out as possessing such capacity, it owed its boarders the duty to ensure that: 1) the nurse was properly qualified and competent; 2) reasonable systems were in place for monitoring sick pupils; and 3) timely

escalation and referral to a medical facility occurred whenever a child's condition did not respond to initial treatment or raised red flags.

40. We, therefore, agree with the learned Judge that the appellant owed the deceased a clear duty of care in respect not only of day- to-day supervision, but also of the provision of basic and emergency medical attention and appropriate referral.

41. The central contest on appeal is whether the appellant's conduct breached this duty; and if so, if the breach caused the death of the deceased.

42. The evidence is not seriously disputed that: the deceased complained of cough, chest pain, and later abdominal pain over a period of about two days; medication (including septrin, piriton and cortexin) was prescribed through telephone conversations with a clinical officer, without any physical examination or diagnostic tests by a doctor; the deceased did not improve; yet the nurse neither informed the principal nor contacted the parents; and the deceased was discovered lifeless in her dormitory and was only then taken to the dispensary, where she was pronounced dead.

43. PW3, Dr. Olweny, provided detailed expert evidence critiquing this management. He testified that peritonitis is a potentially fatal condition which, even if initially non-specific, soon manifests persistent abdominal pain, tenderness, and systemic signs that any trained nurse should recognise as warranting urgent referral for physician review and possible surgery. His evidence was that maintaining the child at school for 48 hours, on telephone prescriptions, without improvement, fell below acceptable standards of nursing care.

44. The learned Judge, having weighed the expert evidence and the nurse's own testimony, found that there was no justification for continuing to treat the deceased in school, on the basis of telephone prescriptions, when her "minor ailment" had failed to resolve. The nurse did not explain why she failed to escalate the matter to the principal or to call the parents. That factual finding has not been shown to be based on any misapprehension of the evidence.

45. We see no error in the conclusion that DW4's conduct fell below the standard of a reasonably competent nurse entrusted with the health of boarding pupils.

46. As to the school's liability, the principle of vicarious liability for the negligent acts of employees acting in the course of their employment is equally settled. We, accordingly, agree with the High Court that the appellant, through its nurse and its administrative omissions, breached its duty of care to the deceased. When parents entrust a child to a boarding school, they do so in reliance on the school's promise – explicit or implicit – that their child will be reasonably safe, supervised, and cared for. That trust includes the expectation that when a child falls ill, her condition will not be managed casually or experimentally, but with the seriousness, urgency, and professional competence that the situation demands.

47. The appellant's argument that employing a nurse exceeded statutory requirements does not absolve negligence. Once the school undertook to provide medical care, it was obliged to do so competently.

48. The appellant also sought, both at trial and on appeal, to shift the blame to the respondents for allegedly failing to disclose that the deceased had a history of abdominal ulcers and for arranging for her to take milk in school without formal authorisation.

49. The High Court examined this contention and, while critical of the lack of formal disclosure, ultimately treated the central question as whether the nurse and the school responded reasonably to the symptoms actually presented during the two days before the child's death. We agree with

that approach. The learned Judge carefully considered the respondents' omissions and reasoned that disclosure was material because it would have aided the school in assessing abdominal complaints.

50. The allocation of liability at 70:30, in our view, reflects a balanced weighing of both parties' conduct. We are not persuaded that the non-disclosure by the parents was of such character as to break the chain of causation or to absolve the school altogether. The learned Judge was correct in finding that the primary and immediate duty, once the child presented with persistent abdominal pain and systemic signs, lay with the nurse and the school administration. Suffice it to say that nothing in the record justifies interference in favour of the appellant on this ground.

51. Finally, the appellant challenges the award of damages as excessive. The learned Judge, faced with the death of a 13-year- old child, opted for a global award of general damages, rather than deploying the conventional multiplicand/multiplier approach. In doing so, she drew guidance from decisions such as Daniel Mwangi Kimemi & 2 others v JGM & another [2016] eKLR; Chen Wembo & 2 others v IKK & others [2017] eKLR, and JNK v Chairman Board of Governors of [...] Boys School [2018] eKLR, among others, where courts had adopted global sums for the deaths of children and minors.

52. It is trite that assessment of damages is an exercise of judicial discretion. An appellate court will not disturb an award unless it is shown that the trial court took into account an irrelevant factor, ignored a relevant one, or that the award is so inordinately high or low as to represent an entirely erroneous estimate.

53. The deceased here was a 13-year-old pupil, with uncontroverted evidence that she was bright and promising, and that her parents had aspirations for her future. There was also the undeniable anguish of her sudden and unnecessary death while under the school's care. The learned Judge considered comparable awards in roughly contemporary decisions, the age and circumstances of the deceased, and inflationary trends before arriving at the global figure.

54. Having reviewed those authorities and the rationale expressed in the judgment, we cannot say that the award is so out of step with comparable Kenyan decisions on the death of minors as to justify interference. The appellant has not demonstrated error of principle. Its complaint amounts to an invitation to this Court to substitute its own view of what might be "more appropriate" – which is not the appropriate test on appeal against the use of discretion.

55. As for special damages, the High Court accepted a modest claim for funeral-related expenses, correctly noting that in cases of bereavement, strict proof by receipts is not always feasible and that reasonable funeral expenses should ordinarily be allowed. That approach is consistent with decisions such as Jacob Ayiga Maruja & another v Simeon Obayo [2005] eKLR and subsequent authorities. We see no basis to upset that finding either.

56. In the end, we find that the learned Judge properly evaluated the evidence, applied correct legal principles, and exercised her discretion judicially. The appeal has no merit and we hereby dismiss it.

57. As the respondents did not participate in the appeal, there shall be no order as to costs.

58. Orders accordingly.

DATED AND DELIVERED AT NAKURU THIS 10TH DAY OF DECEMBER, 2025.

M. WARSAME

JUDGE OF APPEAL

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JOEL NGUGI

JUDGE OF APPEAL

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G. V. ODUNGA

JUDGE OF APPEAL

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

Signed

DEPUTY REGISTRAR