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Hon. Speaker
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31/5/23

THIRTEENTH PARLIAMENT

THE SENATE

APPROVED
31/5/23

THE STANDING COMMITTEE ON HEALTH

REPORT ON THE DEATH OF THE LATE MAUREEN ANYANGO AT MAMA LUCY KIBAKI HOSPITAL DUE TO ALLEGED MEDICAL NEGLIGENCE

PAPERS LAID	
DATE	31/5/2023
TABLED BY	Committee Chair
COMMITTEE	Health
CLERK AT THE TABLE	Chania

Clerks Chambers,

Parliament Buildings,

NAIROBI

MAY, 2023

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List of Abbreviations

BSK	-	**Bioethics Society of Kenya**
COFPAK	-	**Confraternity of Patients of Kenya**
CS	-	**Cesarean section**
IV	-	**Intravenous**
EMKF	-	**Emergency Medicine Kenya Foundation**
LSK	-	**Law Society of Kenya**
KCOA	-	**Kenya Clinical Officers Association**
KHPOA	-	**Kenya Health Professionals Oversight Authority**
KL5H	-	**Kiambu Level 5 Hospital**
KMA	-	**Kenya Medical Association**
KMPDC	-	**Kenya Medical Practitioners and Dentists Council**
KMPDU	-	**Kenya Medical Practitioners and Dentists Union**
KNUN	-	**Kenya National Union of Nurses**
KUCO	-	**Kenya Union of Clinical Officers**
MLKH	-	**Mama Lucy Kibaki Hospital**
MoH	-	**Ministry of Health**
NCCG	-	**Nairobi City County Government**
NCK	-	**Nursing Council of Kenya**
PCC	-	**Professional Conduct Committee**
PIC	-	**Preliminary Inquiry Committee**

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PRELIMINARIES

A. Establishment and Mandate of the Standing Committee on Health

The Standing Committee on Health is established pursuant to standing order 228 (3) and the Fourth Schedule of the Senate Standing Orders and is mandated to *consider all matters relating to medical services, public health and sanitation.*

B. Membership of the Committee

The Committee is comprised of the following Members:

1. **Sen. Jackson Kiplagat Mandago, EGH, MP** - **Chairperson**
2. **Sen. Mariam Sheikh Omar, MP** - **Vice Chairperson**
3. Sen. Erick Okong'o Mogeni, SC, M
4. Sen. Ledama Olekina, MP
5. Sen. Abdul Mohammed Haji, MP
6. Sen. Hamida Kibwana, MP
7. Sen. Joseph Nyutu Ngugi, MP
8. Sen. Raphael Chimera Mwinzagu, MP
9. Sen. Esther Anyieni Okenyuri, MP

C. Functions of the Committee

Pursuant to Standing Order 228(3), the Committee functions to –

1. Investigate, inquire into, and report on all matters relating to the mandate, management, activities, administration and operations of its assigned ministries and departments;

2. Study the programme and policy objectives of its assigned ministries and departments, and the effectiveness of the implementation thereof;

3. Study and review all legislation referred to it;

4. Study, assess and analyze the success of the ministries and departments assigned to it as measured by the results obtained as compared with their stated objectives;

5. Consider the Budget Policy Statement in line with Committee's mandate;

6. Report on all appointments where the Constitution or any law requires the Senate to approve;

7. Make reports and recommendations to the Senate as often as possible, including recommendations of proposed legislation;

8. Consider reports of Commissions and Independent Offices submitted to the Senate pursuant to the provisions of Article 254 of the Constitution;

9. Examine any statements raised by Senators on a matter within its mandate; and

10. Follow up and report on the status of implementation of resolution within their mandate.

D. Government Agencies and Departments

In exercising its mandate, the Committee oversees the County Governments, the Ministry of Health and its various Semi-Autonomous Government Agencies (SAGAs).

ADOPTION OF THE REPORT OF THE STANDING COMMITTEE ON HEALTH OF THE SENATE

We, the undersigned Members of the Standing Committee on Health of the Senate, do hereby append our signatures to adopt the Report-

1. Sen. Jackson Kiplagat Mandago, EGH, MP .....
2. Sen. Mariam Sheikh Omar, MP .....
3. Sen. Raphael Chimera Mwinzagu, MP .....
4. Sen. Joseph Nyutu Ngugi, MP .....
5. Sen. Esther Anyieni Okenyuri, MP .....
6. Sen. Erick Okong'o Mogeni, SC, MP .....
7. Sen. Ledama Olekina, MP .....
8. Sen. Abdul Mohammed Haji, MP .....
9. Sen. Hamida Kibwana, MP .....

CHAIRPERSONS' FOREWORD

Standing order 53 (1) of the Senate Standing Orders provides that a Senator may request for a Statement from a Committee relating to any matter under the mandate of the Committee that is of county-wide, inter-county, national, regional or international concern.

Pursuant to this provision, at the sitting of the Senate held on Wednesday, 26th October, 2022, Sen. Hamida Kibwana, MP, requested for a Statement from the Committee regarding cases of alleged medical negligence at Mama Lucy Kibaki Hospital.

The Statement sought to establish the circumstances that led to the avoidable death of Maureen Anyango a mother who died after bleeding profusely following the delivery of her twin babies at Mama Lucy Kibaki Hospital on 7th September, 2022.

In responding to the issues raised in the Statement, the Committee held meetings with members of the family of the deceased patient, Nairobi City County officials, the management of Mama Lucy Kibaki Hospital (MLKH) and Kiambu Level 5 Hospital (KL5H), relevant regulatory bodies, health professional associations, health worker unions and various civil society organizations.

The meetings were aimed at investigating the circumstances that led to the death of the late Maureen Anyango, as well as understanding the broader legal, policy, regulatory and structural factors that may have contributed to her unfortunate and untimely death.

a. Issues for Determination

In conducting this inquiry, the Committee noted that the key issues for determination centered around the following-

1. The treatment and management of the deceased at Mama Lucy Kibaki Hospital (MLKH) from the time she was received, to the time she was referred to Kiambu Level 5 Hospital;
2. The treatment and management of the deceased at Kiambu Level 5 Hospital (KL5H) from the time she was received and admitted to the intensive care unit (ICU), to the time she met her death; and
3. Whether there were any avoidable delays in her care and management that contributed to the late Maureen meeting her untimely death.

b. Committee Findings

In conducting its investigations, the Committee found that, on 5th September, 2023, at 10.45 pm, the late Maureen Anyango was admitted to Mama Lucy Kibaki Hospital (MLKH) with a diagnosis of severe pre-eclampsia (high blood pressure in pregnancy) and malpresentation in twin pregnancy.

She delivered twins via an emergency cesarean section on 6th September, 2023, at approximately 7.00 am. Post-operatively, she developed vaginal bleeding for which she was taken to theater for examination under anesthesia. However, she failed to reverse from general anesthesia, and was maintained on mechanical ventilation.

She was referred to Kiambu Level 5 Hospital (KL5H) for critical care and was admitted to the ICU team on 7th September, 2023, at approximately 1.20 am. Patient care and management continued from 1.20 am to 7.00 am when she succumbed and was certified dead.

A Maternity Mortality Audit meeting held at KL5H on 9th September, 2022, concluded the cause of death as Hypovolemic Shock secondary to postpartum hemorrhage in severe preeclampsia with twin pregnancy.

A post-mortem conducted on 14th September, 2022, indicated the cause of death as cerebral edema, pulmonary edema and anemia in the background of pre-eclampsia and post-partum hemorrhage.

c. Committee Observations

Based on the evidence before it, in relation to the treatment and management that the late Maureen received, the Committee observed that-

1. Being a first-time mother with a high-risk pregnancy (twin gestation with malpresentation and pre-eclampsia), the late Maureen ought not to have progressed to term, and should have been advised accordingly during her Ante-Natal Clinic (ANC).
2. There was an unjustifiable delay of at least eight hours from the time that the late Maureen was admitted to MLKH (10.45 pm on 5th September, 2022), to the point that she was transferred to theater for the emergency cesarean section (6.40 am on 6th September, 2022). This translated to at least 12 hours of active labor at MLKH from the time of admission to delivery.

3. The Committee observed that contrary to submissions made by Nairobi City Council Government (NCCG) that delays in conducting the emergency obstetric procedure had been necessitated by the need to stabilize the patient's pre-eclampsia, a joint statement by the relevant health regulatory bodies found that-

    a) The decision to conduct the emergency cesarean section was first made at 12.26 am, with the late Maureen signing an informed consent form at 12.53 am;

    b) On at least two other separate occasions prior to her procedure, that is, 2.31 am and 5.00 am, an emergency cesarean section was recommended owing to non-reassuring fetal status;

    c) There was lack of evidence that any standard tests for pre-eclampsia had been conducted; and,

    d) There were inconsistencies in the documentation of vital signs from the time of her admission at 10.45 pm to the time she was taken to the theater at 6.45 am.

4. The Committee further observed that despite being a high-risk patient, as per records submitted to the regulator, MLKH failed to produce evidence to suggest that the patient's vital signs (blood pressure, pulse, fundal height, urine output and vaginal bleeding) were observed, or that there was any record of the patient's status post-operatively between 10.05 am to 1.20 pm on 6th September, 2022.

5. In relation to the above, the Committee observed that during this time, i.e. between 10.05 am and 1.20 pm, as per submissions made by Mr. Robert Omondi, the late Maureen, had been bleeding in varying degrees of severity (at first mildly, and then heavily). However, as per his account, despite attempting to obtain the assistance of a nurse during this period, he was repeatedly ignored.

6. As per the Statement submitted by the NCCG, the Committee noted that it was suggestive that by 1.20 pm, the late Maureen, was already in shock as evidenced by the following-

    a) She was reported as markedly pale and weak;

    b) Her BPs had fallen precipitously from 161/84 mmHg at 6.45 am the morning (PR - 108 bpm), to 124/80 mmHg and a PR of 103 bpm.

7. The Committee further observed that as per submissions made by NCCG, upon discovering that she was bleeding, the late Maureen was transferred to theater at 1.20 pm for examination under anesthesia (EUA). She was put under general

anesthesia (GA) but failed to reverse. Following her failure to reverse from anesthesia, the late Maureen was maintained on mechanical ventilation. At 5.00 pm, a decision was made to refer her for critical care.

8. The Committee observed that by the hospital's own account, there was a delay of at least eight hours from the point that a decision was reached to refer the late Maureen for critical care (5.00 pm), to when she was admitted at the ICU facility at Kiambu CRH (1.20 am). The Committee further noted that by the time Maureen was received at Kiambu CRH, she was unconscious and her condition was critical. She subsequently succumbed six hours later at 7.00 am, and was certified dead.

9. A Maternity Mortality Audit meeting held at Kiambu Level 5 Hospital on 9th September, 2022, concluded that Maureen had died as a result of Hypovolemic Shock secondary to postpartum hemorrhage in severe preeclampsia with twin pregnancy.

10. A post-mortem conducted on 14th September, 2022, indicated the cause of death as cerebral edema, pulmonary edema and anemia in the background of pre-eclampsia and post-partum hemorrhage.

11. The Committee observed that, as per a statement given by Dr. Eunice Mugweru, the Consultant Pathologist who conducted the post-mortem, possible etiologies for the cerebral oedema included- tumors, trauma, hypoxia, infection, metabolic derangements or acute hypertension.

12. Significantly, as per the minutes of the Maternal Mortality Audit, the late Maureen was exposed to hypoxia on at least two occasions during the course of her treatment at MLKH- (i) When she was intubated and then extubated while in the MLKH theater; and, (ii) when the oxygen cylinder ran out before she arrived at KL5H, and she was bagged using room air as the MLKH ambulance had lacked the key to the spare oxygen cylinder.

13. Based on the foregoing, the Committee noted that the death of the late Maureen would have been avoided if the proper procedures had been followed at MLKH from the point of her admission, to her subsequent transfer to KL5H.

d. Committee Recommendations

Based on the foregoing, amongst others, the Committee recommended that-

i) Mama Lucy Kibaki Hospital be investigated by the relevant health regulatory bodies for culpability in the wrongful death of the late Maureen Anyango owing to proof of medical negligence at the facility;
ii) Further, the Ministry of Health, in collaboration with the Kenya Medical Practitioners and Dentists Council, inspect MLKH with a view towards recommending a technical classification commensurate with its actual level of healthcare service delivery.

A comprehensive summary of the Committee's findings, observations and recommendations in relation to the case have been included in the body of the report for reference.

The Committee acknowledges that any public investigations of this nature risks generating negative publicity towards health workers, and damaging the reputation of the health system.

In addition, the Committee acknowledges that, in the ideal situation, health regulators mandated with the role of regulating the health system should be held responsible for conducting such inquiries.

Indeed, it is a sign of failure in the regulatory regime when such cases come out in the public domain, and necessitate a parliamentary inquiry.

In light of this, I wish to urge the Ministry of Health and the relevant regulatory bodies to strengthen the policy and regulatory processes in the sector to avoid similar cases from occurring in the future.

The Standing Committee on Health wishes to sincerely condole with the family and friends of the late Maureen Anyango. The Committee also condoles and empathizes with the families and friends of the hundreds of Kenyans who lose their lives every day as a result of being unable to access emergency health care.

ACKNOWLEDGEMENT

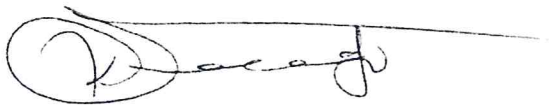
The Committee wishes to thank Sen. Hamida Kibwana, MP, for bringing this very important matter to the attention of the House.

The Committee, further, wishes to thank the various stakeholders who came before the Committee and submitted their statements, including- the Governor, Nairobi City County, the Governor, Kiambu County, Kiambu County Government officials, the

management of Mama Lucy Kibaki Hospital and Kiambu County Referral Hospital, the Kenya Health Professionals Oversight Authority (KPOA), Kenya Medical Practitioners and Dentists Council (KMPDC), Nursing Council of Kenya (NCK), Kenya Clinical Officers Council (KCOC), Kenya Medical Association (KMA), National Nurses Association of Kenya (NNAK), Kenya Clinical Officers Association (KCOA), Kenya Medical Practitioners and Dentists Union (KMPDU), Kenya National Union of Nurses (KNUN), Kenya Union of Clinical Officers (KUCO), Emergency Medicine Kenya Foundation (EMKF), Bioethics Society of Kenya (BSK), the Law Society of Kenya (LSK) and Confraternity of Patients of Kenya (COFPAK).

The Committee also thanks the Offices of the Speaker and Clerk of the Senate for their support during the entire process of considering this matter.

It is now my pleasant duty and privilege to present this report of the Standing Committee on Health, for consideration and approval by the House pursuant to Standing Order No. 223(6) of the Senate Standing Orders.



Signed: ----------

Date: .....**23/3/2023**.....

SEN. JACKSON MANDAGO, EGH, M.P.

CHAIRPERSON, STANDING COMMITTEE ON HEALTH

CHAPTER ONE

INTRODUCTION

A. Background

On 5th September, 2022, at 10.45 pm, the late Maureen Anyango presented at Mama Lucy Kibaki Hospital (MLKH). She had been referred from Kayole 2 Hospital where she had been started on treatment for preeclampsia. On admission, she was diagnosed with twin pregnancy, malpresentation, preeclampsia and drainage of liquor in a *primigravida (Annex 1b,c,d & 4).*

As per the hospital's account, upon being admitted, the late Maureen was continued on anti-hypertensive treatment for the management of preeclampsia. On 6th September, 2022, at 7.00 am, approximately 8 hours after being admitted, the late Maureen was wheeled to the theater for an emergency cesarean section. She delivered twin males in good condition, and having been found to be stable, was subsequently transferred to the Post-Anaesthesia Care Unit (PACU) at 8.10 am *(Annex 1b,c,d & 4).*

At the PACU, the late Maureen was administered prophylactic misoprostol, and was started on an oxytocin infusion to enhance uterine contractions, and prevent excessive bleeding. She was subsequently transferred to the Post-Natal Unit at 10.00 am whereupon breastfeeding was initiated *(Annex 1b,c, & d).*

It was the evidence of her husband, Mr. Robert Omondi, that having been informed of his wife's successful delivery, he arrived at MLKH at approximately 10.45 am. He found her in the ward receiving an IV infusion. She was sharing a bed with her twin sons and was conscious and speaking. She asked him for help with positioning one of the twins whereupon he noticed that she was bleeding from her vagina. As per his account, the IV infusion soon ran out and the late Maureen's bleeding got progressively worse. However, his attempts to get help from the ward nurse were reportedly repeatedly ignored *(Annex 2).*

According to the hospital, at 1.20 pm, it was observed that the late Maureen was experiencing vaginal bleeding. On examination, she was found to be markedly pale and weak. Management for postpartum hemorrhage was commenced, and she was subsequently transferred to the theater for examination under anesthesia (EUA). She was put under General Anaesthesia (GA) for the EUA at 2.25 pm. However, she failed to reverse from anesthesia and was maintained on mechanical ventilation *(Annex 1b,c,d & 4).*

At 5.00 pm, a decision to transfer her for critical care was made. Attempts to secure an ICU bed at Kenyatta National Hospital (KNH) and Kenyatta University Teaching, Research and Referral Hospital (KUTRRH) were unsuccessful. An available ICU bed was eventually found in Kiambu Level 5 Hospital at 8.00 pm. The late Maureen was then transferred to Kiambu County Referral Hospital at 11.00 pm. She was received at the hospital on 7th September, 2023, at approximately 1.20 am *(Annex 3 & 4)*.

At Kiambu County Referral Hospital, the late Maureen was admitted to the ICU where critical care management immediately commenced with oxygen supplementation, pain relief, blood transfusion, antibiotics, IV fluids, anti-ulcer treatment and continuous monitoring. Patient care and management continued from 1.20 am to 7.00 am when she succumbed and was certified dead *(Annex 3)*.

A Maternity Mortality Audit meeting held at Kiambu County Referral Hospital on 9th September, 2022, concluded the cause of death as Hypovolemic Shock secondary to postpartum hemorrhage in severe preeclampsia with twin pregnancy *(Annex 3)*.

A post-mortem conducted on 14th September, 2022, indicated the cause of death as cerebral edema, pulmonary edema and anemia in the background of pre-eclampsia and post-partum hemorrhage *(Annex 3)*.

B. Referral to the Standing Committee on Health under Standing Order 53(1)

Standing order 53 (1) of the Senate Standing Orders provides that a Senator may request for a Statement from a Committee relating to any matter under the mandate of the Committee that is of county-wide, inter-county, national, regional or international concern.

Pursuant to this provision, at the sitting of the Senate held on Wednesday, 26th October, 2022, Sen. Hamida Kibwana, MP, requested for a Statement regarding alleged medical negligence at Mama Lucy Kibaki Hospital. In the Statement, the Senator requested the Committee to-

1. Shed light on the circumstances that led to the avoidable deaths of Maureen Anyango a mother who died after bleeding profusely after delivering her twin babies and one Eddy, who died at the same facility from injuries sustained in a road accident, stating the respective dates of their admission, the time they were attended to, and the date and time of their respective deaths;

2. Indicate the emergency care procedures performed on the respective patients, if any, prior to their deaths;

3. Undertake an investigation into the conduct of the hospital management, with a view to recommending disciplinary measures against persons found culpable;

4. Investigate the state of facilities at the facility as well as the standards of service provision, including the medical officers to patient ratio;

5. State the amount in public funds disbursed to the facility in the last one year and provide an audit of the functions undertaken within the same period, making specific reference to the medical supplies procured; and

6. Conduct an assessment of the emergency care preparedness at Level 5 hospitals in the counties, stating the competences available for emergency care.

The Statement was consequently committed to the Standing Committee on Health.

A copy of the statement has been attached to this report as Annex 14.

C. About Mama Lucy Kibaki Hospital (MLKH)

Mama Lucy Kibaki Hospital is a high-volume Level 5 Hospital located in the populous Eastlands area. It has the third largest maternity unit in Kenya by workload, with an average of 30 deliveries/per day. Between July and September 2022, the facility conducted 2,770 deliveries *(Annex 1b,c & d)*.

According to the Ministry of Health (Norms and Standards), the ideal doctor to patient ratio in a maternity unit is 1:4 (*Annex 1b,c & d)*. However, owing to a heavy workload at the hospital, the average nurse to patient ratio at the hospital is 1:35 *(Annex 3)*.

In the FY 2021/2022, the hospital received a total approved budget of KShs.241,438,541.00 against a budget requirement of KShs.535,444,355.20, translating to a budget deficit of approx. -54.91%.

Notably, as demonstrated in the table below, as submitted to the Committee by MLKH, despite serving as one of the largest County referral facilities in Nairobi, during the FY 2021/2022, the hospital did not receive any direct funding from the Nairobi City County Government.

No	Quarter	Budget Estimates	County Allocation	FIF/ Approved Budget	% Deficit
1.	1st Quarter	118,365,611.20	–	43,511,284.00	-63.24%
2.	2nd Quarter	121,184,708.00	–	84,363,253.00	-30.38%
3.	3rd Quarter	146,471,789.00	–	60,450,528.00	-58.73%
4.	4th Quarter	149,422,247.00	–	53,113,476.00	-64.45%
	Total	535,444,355.00	–	241,438,541.00	-54.91%

Source: Statement by the Governor, Nairobi City County dated 10th November, 2022.

C. Methodology

Standing Order 53 (3) provides that, where a statement has been requested from a Committee pursuant to paragraph (1) – *the Committee may invite the Senator who requested the Statement, relevant Cabinet Secretary or any other person during deliberations on the Statement and may prepare and Table a report on the matter.*

Accordingly, at its sitting held on 25th October, 2022, the Committee considered the Statement and resolved to invite various stakeholders in relation to the matters raised as follows-

a) Members of the family of the deceased patient;

b) The Governor, Nairobi City County, and the management of Mama Lucy Kibaki Hospital;

c) The management of Kiambu County Referral Hospital;

d) Relevant regulatory bodies, including the-

- Kenya Health Professionals Oversight Authority (KHPOA)
- Kenya Medical Practitioners and Dentists Council (KMPDC)
- Nursing Council of Kenya (NCK)
- Kenya Clinical Officers Council (KCOC)

e) Health Professional Associations, including-

- Kenya Medical Association (KMA)
- National Nurses Association of Kenya (NNAK)
- Kenya Clinical Officers Association (KCOA)

f) Health worker unions-

- Kenya Medical Practitioners and Dentists Union (KMPDU)
- Kenya National Union of Nurses (KNUN)
- Kenya Union of Clinical Officers (KUCO)

g) Civil society organizations-

- Emergency Medicine Kenya Foundation (EMKF)
- Bioethics Society of Kenya (BSK)
- Law Society of Kenya (LSK)
- Confraternity of Patients of Kenya (COFPAK)

A schedule of the Committee's meetings in relation to the same has been annexed to this report as *Annex 15*.

Further to the above, the Committee reviewed technical, non-partisan output from the Parliamentary Budget Office, the Senate Directorate of Legal Services and the Senate Research Services.

The aforementioned Committee proceedings were aimed at investigating the circumstances that led to the death of the patient, as well as understanding the broader legal, policy, regulatory and structural factors that may have contributed to her unfortunate and untimely death.

The Committee's findings, observations and recommendations arising from this process are contained in this report.

CHAPTER TWO

CONSTITUTIONAL, LEGAL AND REGULATORY CONSIDERATIONS

This Chapter contains an analysis of legal provisions that the Committee relied on, during its consideration of the statement.

1. The Constitution of Kenya, 2010

Article 43(1) and (2) of the Constitution provides that-

(1) Every person has the right –

a) to the highest attainable standard of health, which includes the right to health care services, including reproductive health care;

(2) A person shall not be denied emergency medical treatment.

Article 26 of the Constitution stipulates that every person has the right to life and that a person shall not be deprived of life intentionally, except to the extent authorized by the Constitution or other written law.

Article 28 of the Constitution provides that every person has inherent dignity and the right to have that dignity respected and protected.

Article 46 (1) (a) of the Constitution further states that consumers have the right to goods and services of reasonable quality and to the protection of their health, safety, and economic interests;

2. The Health Act, (No. 21 of 2017)

Section 2 of the Health Act has defined 'emergency treatment' as the necessary immediate health care that must be administered to prevent death or worsening of a medical situation.

Section 4 of the Health Act indicates that it is a fundamental duty of the State to observe, respect, protect, promote and fulfill the right to the highest attainable standard of health including reproductive health care and emergency medical treatment.

Section 5 of the Health Act states that every person has the right to the highest attainable standard of health which shall include progressive access for provision of promotive, preventive, curative, palliative and rehabilitative services.

Section 7 of the Health Act further states that every person has the right to emergency medical treatment which includes —

a) pre-hospital care;
b) stabilizing the health status of the individual; or
c) arranging for referral in cases where the health provider of the first call does not have facilities or capability to stabilize the health status of the victim.

Additionally, section 7(3) of the Health Act states that any medical institution that fails to provide emergency medical treatment, while having the ability to do so, commits an offense and is liable upon conviction to a fine not exceeding three million shillings. Besides medical institutions, healthcare providers, whether in the public or private sector, also have a personal duty to provide emergency medical treatment as provided under section 12 of the Act.

Section 12(2) of the Health Act further provides that all healthcare providers, whether in the public or private sector, shall have the duty to provide health care, conscientiously and to the best of their knowledge within their scope of practice and ability, to every person entrusted to their care or seeking their support; to provide emergency medical treatment as provided for under section 7(2) of the Health Act; to inform a user of the health system, in a manner commensurate with his or her understanding, of his or her health status, provided that where this would be contrary to the best interests of the user, then in such cases, the requisite information should be communicated to the next of kin or guardian as case may be.

Section 14 of the Health Act provides for the right to file a complaint about the manner in which any person may have been treated at a health facility. The relevant national and county governments are required to establish and publish the procedure for the laying of complaints within public and private health care facilities in those areas of the national health system for which they are responsible.

Section 15 of the same Act imparts a duty upon the government to achieve the following as part of the realization of emergency medical treatment-

a) develop policies, laws and procedures, in consultation with the county governments and other stakeholders for the realization of emergency care.

b) ensure that financial resources are mobilized for uninterrupted access to all health services.

c) establish an emergency medical treatment fund for unforeseen situations; and

d) provide policy and training, maintenance of standards and co-ordination mechanisms for the provision of emergency healthcare.

In addition to the above provisions, section 91 of the Health Act goes further to impose an obligation on all licensees, specifically private hospitals and private health workers, to provide emergency services in their field of expertise required or requested either by individuals, population groups or institutions, without regard to the prospect or otherwise, of direct financial reimbursement.

Section 112(i) of the Health Act requires the Cabinet Secretary in consultation with the Director General of Health to enact regulations for emergency medical services and emergency medical treatment. Additionally, the Medical Practitioners and Dentists Council in its ruling on PCC case no. 2 of 2016 between Jesca Moraa on behalf of the late Alex Madaga Matini and Kenyatta National Hospital and Coptic Hospital recommended that-

> *The Medical Practitioners and Dentists Board liaise with the Ministry of Health, the Council of Governors, and any other key stakeholders to develop and implement regulations and guidelines for registration, licensing and operation of ambulance services.*

3. International treaties, conventions and agreements

Kenya is a signatory to various international treaties and conventions including the International Covenant on Economic, Social and Cultural Rights, the African Charter on Human and People's rights, among others. These treaties and conventions are applicable in Kenya by virtue of Article 2(6) of the Constitution which provides that any treaty or convention ratified by Kenya shall form part of Kenyan law under the Constitution.

Article 12 of the International Covenant on Economic, Social and Cultural Rights to which Kenya is a party to, provides that the States Parties to the Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

Further to this, paragraph 11 of General Comment No 14 on the right to the highest attainable standard of health (Twenty-second session, 2000), the right to health envisaged under Article 12(1) of the International Covenant on Economic, Social and

Cultural Rights captures, inter alia, access to "timely and appropriate health care." There is also a requirement placed on the Party States to make available "functioning public health and health-care facilities, goods and services", which will include, among others, "hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries."

The African Charter (to which Kenya is a State Party) also provides that "Every individual shall have the right to enjoy the best attainable state of physical and mental health," and further, that "State Parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.

4. The Kenya Medical Practitioners and Dentists Act (Cap 253)

Section 2 of the Kenya Medical Practitioners and Dentists Act defines professional misconduct as-

> *"a serious digression from established or recognized standards or rules of the profession, that includes a breach of such codes of ethics or conduct as may be prescribed for the profession from time to time."*

Section 3 of the Kenya Medical Practitioners and Dentists Act establishes the Kenya Medical Practitioners and Dentists Council. Under section 4 of this Act, the Council regulates the conduct of registered medical and dental practitioners and takes such disciplinary measures for any form of professional misconduct.

Section 20 of the Kenya Medical Practitioners and Dentists Act stipulates that any person who is dissatisfied with any professional service offered, or alleges a breach of standard by a registered or licensed person under the Act, may lodge a complaint in the prescribed manner to the Council.

The Kenya Medical Practitioners and Dentists Act, as read together with the Medical Practitioners and Dentists (Disciplinary Proceedings) (Procedure) Rules refers to conduct warranting disciplinary proceedings. Rule 2 and Section 19A, KMPD Act provides that such conduct include- a case relating to conviction, where it is alleged that a medical practitioner has been found guilty of an offense either under the Act or under the Penal Code; and infamous or disgraceful conduct in a professional respect, meaning 'serious misconduct judged according to the rules, written or unwritten, which govern the medical and dental professions.

Section 20(1) and (2) of the Kenya Medical Practitioners and Dentists Act provides that any person may lodge a complaint directly to the Council if dissatisfied with professional services received from a medical practitioner. The Council, or through a committee, may inquire into the complaint of professional misconduct, malpractice or any breach of standards.

5. The Medical Practitioners and Dentists (Disciplinary Proceedings) (Procedure) Rules

The Kenya Medical Practitioners and Dentists Act, as read together with the Medical Practitioners and Dentists (Disciplinary Proceedings) (Procedure) Rules refers to conduct warranting disciplinary proceedings. Rule 2 and section 19A, of the Act provides that such conduct includes- a case relating to conviction, where it is alleged that a medical practitioner has been found guilty of an offence either under the Act or under the Penal Code; and infamous or disgraceful conduct in a professional respect, meaning 'serious misconduct judged according to the rules, written or unwritten, which govern the medical and dental professions.

Rule 3 of these Rules establishes the Preliminary Inquiry Committee (PIC) and sets out its powers and functions under Rule 4 which primarily include conducting inquiries into complaints and making recommendations as they deem appropriate. Rule 4(2) further provides that the PIC can either discard the complaint, and apprise the Chairperson of the Council, or refer it, together with its findings and recommendations, to the Professional Conduct Committee for inquiries

Rule 4A (1) and (2) establishes the Professional Conduct Committee (PCC) whose functions include conducting inquiries into county complaints through sittings as specified by the Council and making appropriate recommendations.

Unlike the PIC, the membership of the Professional Conduct Committee is diverse and includes other persons not necessarily from the medical profession.

Rule 6 and 7 further provide that the PIC and PCC may refer matters to the Council, who may then hear the matters as a tribunal. The tribunal exercises quasi-judicial functions in determination of disciplinary matters before it.

According to section 20(6) and (10) of the Kenya Medical Practitioners and Dentists Act and Rules 6,7, and 10, the Council after determining that a practitioner is guilty may reprimand, or issue a caution, in writing to the practitioner; direct remedial training for the practitioner; direct probation, nor more than six months, for the practitioner;

withdraw, cancel or suspend the practitioner's license; permanently remove the practitioner's name from the register, with at least 7 members of the Council present. If the Council deems appropriate under the circumstance, impose a fine; admonish the medical practitioner and conclude the case; order that medical institutions remain closed until the requirements of operating licenses are complied with; or order the payment of costs for the tribunal's meeting(s) by the practitioner or institution.

The scope and jurisdiction of the Council is limited to disciplinary action against the medical practitioners and does not cover compensation to the aggrieved party. This was determined in the case of ***J.O.O. & 2 others v Praxades P Mandu Okutoyi & 2 [2011] eKLR,*** where the High Court observed that *'... the scope and jurisdiction of the Board cannot be assimilated with the Industrial Tribunal or other similar Tribunals which hear and determine the civil claims of the party. The element of penalty attached to the inquiry before the Board and the fact and circumstances of the inquiry heard and determined definitely removed the Board from the ambit of a civil tribunal.' The court noted that 'the standard which the Board adopted was of strict responsibility or the ponderance of probability.'*

6. Nurses and Midwives Act (Cap 257)

Section 3 of this Act establishes the Nursing Council as a corporate body whose composition as provided under section 4, largely includes persons in the medical field.

Section 9(1) of the Act states that the functions of the Council include the establishment and improvement of standards the nursing profession in all their dimensions and health care within the community, having concern with the comportment of registered, enrolled or licensed persons, and take such disciplinary action as may be needed to uphold an acceptable benchmark of conduct; having concern with the standard of nursing care, qualified staff, nursing supplies, facilities, condition and environment of health institution and to take such disciplinary action or relevant measures as may be needed to preserve a suitable standard of nursing care in health institutions.

Section 18A of the Nurses and Midwives Act defines professional misconduct as constituting among other acts, failure to observe and apply professional, technical, ethical or other standards prescribed by the Council as guidelines for practice by registered nurses. This section further stipulates that a nurse may be found culpable of professional misconduct if he/ she fails to observe and apply professional, technical, ethical or other standards stipulated by the Council or is guilty of gross negligence while conducting his/her duties in a professional capacity.

Section 18B (1) of the same Act further provides that the Nursing Council may on its own or through a committee, inquire into an allegation of misconduct and in accordance with section 18B(3) may resolve that no additional action be taken against that nurse; the nurse be reprimanded; the nurse pays to the Council such fine as may be deemed appropriate; the nurse undergoes training at his/her own cost, of such nature and duration and at such establishment as the Council may determine; the nurse carries out his/her professional duties under any contractual arrangement subject of the purported wrongdoing; suspension of any practicing certificate held by the nurse for such a period as may be appropriate; or the nurse be deregistered from the register.

7. The Kenya National Patients' Rights Charter, 2013

This Charter defines and explains the patients' rights and responsibilities and dispute resolution mechanisms. The rights outlined in the charter are anchored in the Constitution of Kenya and in particular Articles 19, 20(5), 21(2), 22(1), 26, 43(1)(2), 46, 53(1)(c) and 70. Specifically, Chapter 1 of the Charter provides as follows-

Every person, patient or client has a-

1. *Right to access health care. Health care shall include promotive, preventive, curative, reproductive, rehabilitative and palliative care.*

2. *Right to receive emergency treatment in any health facility. In emergency situations, irrespective of the patient's ability to pay, treatment to stabilize the patient's condition shall be provided.*

3. *Right to the highest attainable quality of health care products and services. Every person has the right to the highest attainable quality of health care products and services.*

4. *Right to be treated with respect and dignity.*

8. Code of Professional Conduct and Discipline for Medical (6th Edition) (KMPDC)

The Medical Practitioners and Dentists' Council established a Code of Professional Conduct and Discipline due to the emerging challenges in the practice of medicine and dentistry. This Code provides for the professional ethics and ethical conduct of medical practitioners which must be observed by all medical and dental practitioners registered

or licensed to practice in Kenya as well as medical institutions registered under the Medical Practitioners and Dentists Act.

Chapter V(b) of the Code provides for professional and ethical conduct under which are key issues in medical practice which must be complied with. Of importance is section 7 (a), (b), (e), which provides for human rights and it states as follows-

> *(a) Practitioners should always manage patients irrespective of age, race, color, gender, religion, socio-economic status or political affiliations;*
>
> *(b) Practitioners shall, in all their professional activities, respect the dignity and human worth of patients and shall strive to preserve and protect the patient's fundamental human rights; and*
>
> *(c) It is unethical for doctors or health institutions to detain patients for non-payment of fees in cases of emergency treatments. They should resort to legal means to recover the said fees.*

CHAPTER THREE

COMMITTEE PROCEEDINGS

In considering the Statement, between Tuesday, 25th October, 2022, and Wednesday, 7th December, 2022, the Committee held meetings with members of the family of the deceased patient, Nairobi City County officials, the management of Mama Lucy Kibaki Hospital and Kiambu County Referral Hospital, relevant regulatory bodies, health professional associations, health worker unions and various civil society organizations.

A schedule of the Committee's meetings in relation to the same has been annexed to this report as *Annex 15*.

The following section provides a summary of the submissions presented before the Committee by the various stakeholders.

1. Meeting with the Family of the Late Maureen Anyango

The Committee met with the family of the late Maureen Anyango during its sitting held on Tuesday, 1st November, 2022, in Committee Room 4, Main Parliament Buildings.

a) Submissions by Mr. Robert Omondi, Husband to the Late Maureen Anyango

In his testimony, Mr. Robert Omondi, husband to the late Maureen Anyango, provided a chronology of the events that led to her death as summarized below-

i) On 5th September, 2022, at approximately 7.00 pm, the late Maureen went into labor and her waters broke. He immediately called his sister-in-law to assist him, and upon her arrival, rushed the late Maureen to Kayole 2 Hospital where she had been attending her ANC clinics;

ii) At Kayole 2 Hospital, the late Maureen was diagnosed with preeclampsia and was referred to MLKH for further management. A transfer to MLKH was subsequently organized via ambulance. However, according to the testimony of Mr. Omondi, the patient was not accompanied by a nurse or paramedic in the ambulance;

iii) He reported that they arrived at Mama Lucy Kibaki Hospital at approximately 10.45 pm. At the entrance, they were confronted by a security officer who reportedly refused to let anyone but the late Maureen into the hospital. They reportedly tried to plead with him, but he was adamant, and insisted that she

proceeds alone. They had carried two bags full of clothes for the twins they were expecting and the late Maureen was compelled to carry them into the hospital on her own as they watched from outside. After confirming that the late Maureen had gone through registration and been admitted, they left for home, arriving at around midnight;

iv) On the morning of 6th September, 2022, Mr. Omondi left for MLKH by 6.45 am. At the hospital, he found hospital staff transferring his wife to the theater for an emergency cesarean section. Upon consulting with hospital staff, he decided to leave for home to attend to some matters that he had left pending;

v) At approximately 8.00 am, he was called by a 'Dr. Kipsang' who had all along been acting as a liaison between him and the other hospital staff. He informed him that his wife had delivered two healthy babies, sons;

vi) Upon receiving the news, he rushed to MLKH where he found his wife asleep in Ward 5. She had an IV line and was receiving an infusion. Her twin boys had been laid beside her on a narrow bed. According to his account, they had been left exposed and were cold;

vii) At the time, his wife was conscious and speaking. She asked him to help her with one of the babies as she breastfed the other. She was lying on her back, and appeared weak. As he brought the baby towards her to nurse, he noticed that she had slight bleeding from her vagina;

viii) Noting that his wife's IV infusion had finished, he immediately sought help from a nurse who was doing her round. He informed her that the infusion had finished, and that there was a backflow of blood. She however, reportedly ignored him and proceeded with her round. According to his account, the nurse came by the ward for a second and a third time. Each time he asked her for help, the nurse failed to attend to his wife. In the third instance, she reportedly told him to remove the drip himself, which he did;

ix) Shortly after, at around noon, the late Maureen perceived that her bleeding had increased significantly. He examined her to check and found that there was a lot of blood. On her request, he took out two rolls of cotton wool and tried to stem the bleeding by applying pressure. The bleeding however, did not let up - she soaked

through two rolls of cotton wool. By this time, she had been bleeding in varying degrees of severity (at first mildly, and then heavily) from the time he first noticed her bleeding at around 10.00 am;

x) At around 12.55 pm, his sister-in-law, Rose, arrived at the hospital. She was refused entrance at the gate by a security officer. In desperation, he left Maureen and the kids and rushed to the gate. At the gate, he told the watchman, *"mkubwa niko na emergency hapa. Mke wangu ame deliver a few hours ago, lakini amezaa twins. These are my first borns. Mimi sijawai kuwa na experience na watoto. Huyo amekuja ni shemeji yangu, the eldest sister to my wife. Allow her aingie anisaidie ju pia kuna damu inatoka''*. However, the security officer was adamant, and eventually, they reportedly forced their way through;

xi) Back at the ward, as his sister-in-law took over the twins, he reported that he went about seeking help from the staff in the ward. He however, failed to get any help until, in response to protests by the other patients, a young man arrived to try and intervene. Together, they went to the nurse's station where they found the same nurse seated. When the young man asked her to come and assist, she reportedly refused;

xii) He stated that he returned to the ward at around 1.20 pm. Protests by the other patients had grown louder, and in response, a group of doctors arrived. When they arrived, they asked him to step out and placed a screen around Maureen's bed. Shortly after, they heard her screaming. After approximately ten minutes, they wheeled Maureen out, and stated that they were taking her to the theater. Her last words to him while she was being wheeled out were to buy Nan for the babies;

xiii) He further stated that shortly after Maureen was transferred to the theater, some nurses came and changed the beddings. They were reportedly soaked through with blood, and some had even spilled on the floor. These were quickly and efficiently replaced with new beddings. Shortly after, other two nurses arrived. Having stated that they were from the nursery, and reportedly demanded that he hands over the twins because their mother was in theater. He declined;

xiv) At around 4.00 pm, he received a call. He was informed that his wife was doing poorly because she had lost a lot of blood. To stabilize her, three pints of blood had been prescribed. She had already received one, and was receiving her second

transfusion. The caller assured him that by 8.00 pm, after she had finished receiving all three transfusions, she would have stabilized;

xv) At approximately 7.00 pm, he received another call. He was informed that his wife's condition had worsened, and that an urgent referral was needed. One of the doctors then called him aside and informed him that there were two options for referral, either KUTTRH or Machakos Level 5, but that both options required a down payment of KShs.200,000. They were unable to raise the money;

xvi) After approximately ten minutes, another nurse came and informed him that in the absence of any money, a referral to Kiambu Level 5 Hospital could be arranged. Desperate, he agreed;

xvii) At 8.00 pm, he was asked to go and wait in the ward for the ambulance to come. They waited until 10.00 pm. Getting impatient, he went to the nursing station to inquire on what was causing the delay. In response to his queries on why the ambulance had been delayed, the nurses informed him that the ambulance had taken another referral to KNH and that it was yet to return;

xviii) At 12.00 am, he was informed that the ambulance had finally arrived. He made the necessary preparations, and went out to wait. He found the ambulance outside, but the driver was missing. When the driver finally appeared, he stated that they experienced further delays as the hospital prepared Maureen. In the interlude, the driver left and appeared about 15 minutes later. This whole time, he had not been allowed to see Maureen;

xix) Eventually, the late Maureen was wheeled out. She was accompanied by two nurses, the driver and a young man. From their conversation, he stated that they seemed inexperienced and unsure of themselves. He was initially seated with them at the back of the ambulance, but by and by, he was sent to the front;

xx) According to Mr. Omondi, on the way to Kiambu Level 5, the driver decided to take a short cut. He however got lost and ended up using a long and bumpy route. By the time they got to Kiambu Level 5, it was approximately 1.00 am. At Kiambu Level 5, the late Maureen was well received and immediately transferred to ICU;

xxi) At approximately 6.45 am, he was called to the ICU to be informed of her progress. He proceeded to the ICU where he was asked to wait for a while. After waiting for some time, he was informed that Maureen had passed away at 7.00 am that morning;

xxii) He was asked to identify her, and confirmed her dead before heading back to MLKH where the twins were;

xxiii) Back at MLKH, he was invited for a briefing session with the hospital management and offered free counseling. Subsequently, reportedly after some difficulty, he obtained the birth notifications and discharge summaries for his twins;

xxiv) On 8th October, 2022, he reported the matter at Kiambu Police Station and obtained an OB number;

xxv) On 9th October, 2022, he visited the DCI offices at City Hall to record a statement; and

xxvi) On 14th October, 2022, a post-mortem was conducted on the late Maureen.

A copy of the written submissions by Mr. Omondi have been attached herein as Annex 2.

b) Submissions by Ms. Rose Otieno, Sister to the Late Maureen Anyango

In her testimony, Ms. Rose, sister to the late Maureen Anyango, informed the meeting that she only spent a short time with the late Maureen on that fateful day- that is, between 12.56 pm when she arrived, and 1.20 pm when Maureen was taken to the theater.

She stated that upon arriving at the ward, the late Maureeen asked her to assist her with dressing the babies. It was while taking one of the children that she noticed that Maureen's blood had soaked through the beddings. The nurses were alerted and one of them came to check what was happening. Upon seeing Maureen's condition, she called more staff and they came and surrounded Maureen. The relatives were then asked to leave, and shortly after, Maureen was transferred to theater.

She further reported that shortly after Maureen was transferred to the theater, two nurses came to collect the babies in order to transfer them to the nursery. She however,

reportedly declined to release them, on the grounds that they were healthy and had good weight at 3.8kg and 3.9kg respectively. Following that incident, she remained with the children throughout and did not leave their side.

The morning after Maureen's referral to Kiambu Hospital, she stated that she received a phone call from Mr. Omondi, and was informed that her sister had passed away. Emotional, she called a journalist that she knew and informed him about what had happened. He then mobilized members of the media to come cover the story.

She further informed the Committee that prior to her death, the late Maureen called her twice: The first time, when she was about to go to the theater for her cesarean section, and the second time to ask for assistance with the babies after they were born.

2. Meetings with the Governor, Nairobi City County and the Management of Mama Lucy Kibaki Hospital (MLKH)

The Committee met with Nairobi City County and the management of Mama Lucy Kibaki Hospital (MLKH) led by the Governor, Hon. Johnson Sakaja, during its sittings held on 10th November, 2022, and 7th December, 2022.

In their submissions, NCCG indicated that MLKH had the third largest maternity in Kenya by workload. According to the Governor, the facility was severely overstretched, having 71 beds against approximately 2,770 deliveries between July and September, 2022 (compared to Nakuru Referral Hospital at 2,954 deliveries against 250 beds; and, Pumwani Maternity Hospital at 4,780 deliveries against 354 beds). On 5th September, 2022, when the late Maureen was admitted to the hospital, a total of 16 normal deliveries, and 12 caesarian sections were conducted at the hospital in addition to 4 emergency gynecological procedures.

Further to the above, NCCG submitted that the hospital was severely overstretched with a doctor to patient ratio of 1:48 and a nurse to patient ratio of 1:32 against the recommended norms of 1:4 and 1:2, respectively.

In addition, NCCG submitted that MLKH had a heavy workload with 17,222 patients having visited the hospital between April and September, 2022.

On revenues at the hospital, NCCG submitted it had received a total of KShs.241,438,541.00 under the Facility Improvement Fund against a hospital budget of KShs.535,444,355.00 equalling a deficit of approximately - 54.9%.

With regards to the late Maureen, NCCG submitted that she was admitted on 5th September, 2022, having been referred from Kayole 2 Hospital with a diagnosis of malpresentation, preeclampsia and drainage of liquor in a primigravida with twin pregnancy.

Prior to her admission at MLKH, she had been started on anti-hypertensives and Magnesium Sulphate at Kayole 2 Hospital. As per the submissions made by NCCG, the late Maureen was escorted by a nurse and a driver attached to Kayole 2 Hospital and handed over to the nurse in the Triage and Admission Room at MLKH.

She was received at MLKH at 10.45 pm. On being triaged, she was found to have high blood pressures of 171/106 mmHg, and a high pulse rate of 106 beats/min. She was admitted and started on medication to lower the blood pressure. Investigations were done, and monitoring of the maternal vital signs and the fetal heartbeat commenced.

At 12.26 am, 6th September, 2022, her BPs were taken again and found to be high at 170/96 mmHg. She was continued on anti-hypertensives to stabilize her blood pressures.

At 1.16 am, normal full hemogram results were obtained from her investigations. In addition, blood cross-matching and ultrasound were done. The latter revealed twin gestation, with the first twin in breech, and the second twin in cephalic presentation.

Another BP reading was taken at 2.31 am, during which time her BPs were found to be still high at 161/105mmHg, with a high pulse rate of 115 beats/min.

As per the hospital's account, at 6.45 am, her BPs having stabilized at 161/84mmHg with a pulse rate of 108 beats/min, the late Maureen was taken to theater for an emergency cesarean section.

The emergency cesarean was done at 7.00 am under spinal anesthesia. The outcome was twin males in good condition. The procedure was reported as having been uneventful, and the late Maureen remained in stable condition. Estimated blood loss during the operation was within the normal limit at 600 mls. To prevent bleeding and enhance uterine contraction, the late Maureen was started on prophylactic misoprostol and IV oxytocin.

At 8.10 am, she was transferred to the post-anaesthesia care unit (PACU) for post-operative monitoring. At the time, she was noted to be fairly stable with controlled blood pressure and minimal per vaginal blood loss.

At 10.00 am, she was received in the post-natal unit in stable condition (BP 140/84mmHg with minimal per vaginal blood loss) and breastfeeding was initiated.

At 11.10 am, she was found to be in stable condition with a BP of 139/84mmHG, and a pulse rate of 111 beats/min.

At 1.20 pm, she was found to be experiencing vaginal bleeding. Upon being reviewed, she was found to be markedly pale and weak with a BP of 124/80mmHg and a pulse rate of 90 beats/min. Upon examination, her uterus was found to be well contracted. Management for postpartum hemorrhage (PPH) commenced by expelling blood clots, introducing a second IV access line, and starting the patient on an IV infusion of Oxytocin 20 iu and IV tranexamic acid. She was then prepared for examination under anaesthesia (EUA).

At 1.50 pm, she was received in theater with vital signs of BP 120/84 mmHg and a pulse rate of 103 beats/min.

At 2.25 pm, she was put under general anaesthesia (GA) for examination under anaesthesia (EUA). Findings during the EUA were unremarkable with no uterine atony, no tears, normal cervix and a well contracted uterus. Blood clots of 600mls were expelled. Hemostasis was achieved, and the patient received a transfusion at 3.00 pm.

At 3.10 pm, a failed attempt to reverse the patient from anesthesia was made. The patient was therefore maintained on mechanical ventilation.

At 4.00 pm, upon consultation, a decision was made to continue on conservative management with blood transfusion, investigations and close monitoring of vital signs and fluid input and output.

At 4.30 pm, the late Maureen received more blood and blood products. She remained on ventilation with BPs of 189/119 mmHg, a pulse rate of 160 beats/min and oxygen saturations of 94%.

At 5.00 pm, a decision was made to refer the patient for critical care. A call was made to Kenyatta National Hospital (KNH), but no ICU space was found available.

Kenyatta University Teaching, Referral and Research Hospital (KUTRRH) was contacted. It however gave a quotation of KShs.200,000.00 deposit which the relatives were unable to raise.

At 7.48 pm, the plan of management continued with- random blood sugar (RBS) monitoring, maintain sedation, analgesics, monitoring of fluid input/output (output noted to be 2500 ml), further laboratory investigations and apprising of next of kin. Efforts were also made to obtain more blood and to secure ICU space.

At 8.00 pm, ICU space was secured at Kiambu County Referral Hospital. Vitals at this point were BP - 148/78 mmHg, pulse rate - 114 beats/min and oxygen saturation - 99%.

At 9.00 pm, her vitals were as follows- BP - 140/99 mmHg, pulse rate - 162 beats/min, oxygen saturation - 97%. During this time, the patient was on continuous care in theater while on mechanical ventilation. She was further transfused with two units of fresh frozen plasma (FFP) before being continued on blood transfusion.

At 11.00 pm, the patient was transferred to Kiambu Level 5 Hospital while still undergoing transfusion. She was received at the Kiambu Level 5 Hospital ICU at 12 midnight on 7th September, 2022, and left on ventilation and blood transfusion.

Unfortunately, she succumbed later that morning. Counseling services were then offered to the spouse at MLKH by the hospital psychologist.

On what measures the hospital had taken after the incident, NCCG submitted that it-

a) Conducted a family conference immediately upon Maureen's demise;

b) Provided grief counseling and psychological support to the immediate family and spouse;

c) Advised the family to allow a postmortem to be conducted;

d) Provided nutrition counseling to the husband for the sake of the twins;

e) Conducted a Near miss audit at the department with a view to identifying possible gaps and addressing them;

f) Conducted a hospital Maternal and Prenatal Death Surveillance and Response (MPDSR) meeting with the county team in attendance;

g) Obtained Statements from the staff involved;

h) Conducted a special hospital management board meeting on 2nd November, 2022, to discuss the matter.

Further, NCCG submitted that the Kenya Medical Practitioners and Dentist Council was investigating the matter and they were waiting for its response and recommendations.

A copy of the written submissions by NCCG have been attached herein as Annex 1b, c & d.

3. Meeting with Kiambu Level 5 Hospital Officials

The Committee met with officials of Kiambu Level 5 Hospital led by the Medical Superintendent, Dr. Anthony Murage, at its sitting held on 7th December, 2022.

a) Submissions by Dr. Anthony Murage, Medical Superintendent

In his submissions, Dr. Murage stated that Kiambu Level 5 Hospital is located 19.6 km from Mama Lucy Kibaki Hospital via Kiambu Road, 21.9 km via Outer Ring Road and 23.6 km via the Northern bypass.

With regards to the late Maureen, he stated that on the night of 6th September, 2022, at 8.15 am, the Consultant Anaesthesiologist, Dr. Linda Nguu, received a distress call from a fellow Consultant Anaesthesiologist, Dr. Esther Mokaya from MLKH. The call was requesting for an ICU bed for a 28-year-old female who had previously undergone an emergency cesarean section.

The indication for the cesarean section had been preeclampsia in twin pregnancy. Further information revealed that the patient had developed postpartum hemorrhage that had necessitated examination under anesthesia. However, the patient had reportedly failed to reverse from anesthesia and hence required critical care. At 8.20 pm, Dr. Nguu confirmed the availability of a bed.

Dr. Nguu then immediately alerted her team at the hospital and instructed Ms. Purity Wangui Kamau, a critical care nurse, to prepare a bed for the patient.

At 11.00 pm, two and a half hours from the point at which Dr. Nguu had been informed about the patient, Ms. Kamau called MLKH to inquire about the patient. She was informed by a health staff member by the name Ms. Ruth that they were waiting for the ambulance.

On 7th September, 2022, at 1.20 am, the late Maureen arrived at the hospital in an ambulance accompanied by an anesthetist, a male nurse, the ambulance driver and her

husband. She was received by the two critical care nurses on duty, namely, Ms. Kamau, and Ms. Grace Kabui Karanja.

After settling the patient in the ICU, she was seen by Dr. Alex Gitonga, the Medical Officer Intern, and started on the following management in consultation with Dr. Nguu-

a) Oxygen supplementation via endotracheal tube
b) Analgesia
c) Blood transfusion (two pints)
d) Antibiotics
e) Gut protection via proton pump inhibitors
f) IV fluids

The patient was also started on continuous monitoring, and the following laboratory tests were done- chest X-Ray; blood group and crossmatch; random blood sugar; full blood count; urea, electrolytes and creatinine and liver function tests.

Patient care and management continued from 1.20 - 7.00 am when the patient succumbed. An urgent MPDSR was called, and an audit chaired by Dr. Mary Maina involving both Kiambu and MLKH staff was conducted.

Subsequently, a post-mortem was conducted on 14th September, 2022, with a team comprising both Kiambu and MLKH staff, DCI and a family representative.

The post-mortem took three hours and an initial finding of the cause of death as cerebral oedema, pulmonary oedema and blood loss in the background of preeclampsia and postpartum hemorrhage was made.

b) Submissions by Ms. Purity Wangui Kamau, Critical Care Nurse

According to the submissions made by Ms. Kamau, she received a call on 6th September, 2022, at approximately 9.00 am from the Consultant Anaesthesiologist, Dr. Nguu, informing her about a referral from MLKH. She then prepared a bed for the patient, and ensured that the necessary equipment was ready.

At 11.00 pm, she made a follow-up call with MLKH having become concerned with how long the referral was taking. She was informed by a MLKH staffer identified as Ruth that they were waiting for an ambulance that had taken another patient.

At 1.20 am, on 7th September, 2022, Kiambu Hospital received the patient. She was accompanied by four people including an anesthetist, a nurse, the driver and her husband.

The patient was lying on a stretcher facing up with her head tilted to the side, and a tube inserted in her windpipe that was being bagged.

On examination, the patient was in respiratory distress with oxygen saturation levels of 79%. On inquiring from the MLKH team why they were bagging the patient with room air instead of using oxygen via a cylinder, she was informed that the oxygen had run out along the way, and that they had been unable to use the extra cylinder of oxygen since they had not carried a spanner and had thus been unable to open it.

The patient was then moved to her ICU bed where she was immediately connected to the hospital breathing support machine. Her Oxygen saturation levels began to progressively improve and climbed up to 99%.

On the condition of the patient at the time, she was found to be unconscious with a swollen mouth. She was very pale, with a capillary refill of more than 3 seconds, and her heart rate was 172 beats/min. A blood transfusion was ongoing. Her uterus was well contracted at 20 weeks, and her C-section wound was clean. She had a catheter draining urine with an estimated output of 600 mls.

At 2.00 pm, blood transfusion commenced. Her vitals at the time were- BP 138/81 mmHg, pulse rate 168 beats/min, and oxygen saturation of 99%.

At 3.00 am, the patient developed distress, and in consultation with Dr. Nguu, a decision was made to sedate her so as to reduce brain activity.

At 6.00 am, the patient was started on another pint of blood. This was ongoing with the sedation and IV fluids. Her vitals at this time were- BP 131/87 mmHg, pulse rate 62 beats/min and oxygen saturation 90%.

At 6.30 am, the patient's condition changed for the worse. Sedation was stopped, and resuscitation efforts were started with the patient receiving chest compressions, adrenaline and calcium gluconate. The resuscitation was unsuccessful and the patient was certified dead at 7.00 am.

c) Submissions by Ms. Grace Kabui Karanja, Critical Care Nurse

According to the submissions made by Ms. Karanja, her colleague, Ms. Kamau, a critical care nurse, received a call on 6th September, 2022, at approximately 9.00 am from the Consultant Anaesthesiologist, Dr. Nguu, informing her about a referral from MLKH. Together, they then prepared a bed for the patient, and ensured that the necessary equipment was ready.

At 11.00 pm, Ms. Kamau made a follow-up call with MLKH having become concerned with how long the referral was taking. She was informed by a MLKH staffer identified as Ruth that they were waiting for an ambulance that had taken another patient.

At 1.20 am, on 7th September, 2022, Kiambu Hospital received the patient. She was accompanied by four people including an anesthetist, a nurse, the driver and her husband.

The patient was lying on a stretcher facing up with her head tilted to the side, and a tube inserted in her windpipe that was being bagged. Her oxygen saturation was low at 79% , and she was hypotensive with a BP of 89/39mmHg, and a pulse rate of 172 beats/min. She was also febrile with temperatures of 37.9 degree Celsius.

The patient was then moved to her ICU bed where she was immediately connected to the hospital breathing support machine. Her Oxygen saturation levels began to progressively improve and climbed up to 99%.

At 1.30 am, the patient was reviewed by Dr. Gitonga, the Medical Officer Intern. On examination, the patient was found to be comatose with a tube inserted through the mouth (size 7.5) and secured tightly with gauze. Her mouth was swollen. She was pale with a capillary refill of more than three seconds, and there was a blood transfusion in progress. Her uterus was well contracted at 20 weeks, and her C-section wound was clean. She had a catheter draining urine with an estimated output of 600 mls.

She was started on medication as follows: analgesia, antipyretic, antibiotics and IV fluids (Ringers Lactate).

At 2.00 am, blood transfusion commenced. Her vitals at the time were: BP 138/81 mmHg, pulse rate 168 beats/min, and oxygen saturation of 99%.

At 2.09 am, the patient was still in critical condition. A chest X-Ray showed patchy opacities on the right lung.

At 3.00 am, the patient developed distress, and in consultation with Dr. Nguu, a decision was made to sedate her so as to reduce brain activity, and to start her on steroids. Vitals at the time were: BP 143/107 mmHg, pulse rate 170 beats/min, oxygen saturation 98%, respiratory rate - 24 a/m, temperature 36.9 degrees Celsius.

At 4.00 am, the patient was found to still be having difficulty breathing with a low oxygen saturation of 91% despite being on the breathing support machine. She was reviewed by Dr. Gitonga who noted bilateral chest crepitations and started her on diuretic medication. The patient's saturation improved to 98% but she was still in respiratory distress.

At 5.00 am, her first pint of blood transfusion ended with no noted reaction.

At 6.00 am, another pint of blood commenced. This was ongoing with the sedation and IV fluids. Her vitals at this time were: BP 131/87 mmHg, pulse rate 62 beats/min and oxygen saturation 90%.

At 6.30 am, the patient's heart rate began decreasing on the patient monitor. On palpation, no pulse could be detected of the carotid artery. The patient was assessed by Dr. Gitonga who found her to be unresponsive, with no pulse and no cardiac activity.

Sedation was stopped, and resuscitation efforts were started with the patient receiving chest compressions, adrenaline and calcium gluconate. The resuscitation was unsuccessful and the patient was certified dead at 7.00 am.

d) Submissions by Dr. Alex Muriithi Gitonga, Medical Officer Intern

According to the submissions made by Dr. Alex Muriithi Gitonga, Medical Officer Intern, on 7th September, 2022, at 1.30 am, he received a call from Ms. Kamau, regarding a patient who had been transferred to KL5H from MLKH for critical care.

On examination, the patient was in critical condition and unconscious. She had an ongoing blood transfusion through a vein on her left arm. She had been intubated and was on assisted breathing. She was pale, and her pupils were unequal and sluggishly reactive to light. Her oxygen saturation was low at 79%, and she was hypotensive with a BP of 89/39mmHg, and a pulse rate of 172 beats/min. She was also febrile with temperatures of 37.9 degree Celsius. Her uterus was well contracted at 20 weeks, and her C-section wound was clean. She had a catheter draining urine with an estimated output of 600 mls.

At 1.40 am, in consultation with Dr. Nguu, the patient was started on analgesia, antipyretic, antibiotics and IV fluids.

At. 2.00 am, blood transfusion commenced. Her vitals at the time were: BP 138/81 mmHg, pulse rate 168 beats/min, and oxygen saturation of 99%.

At 3.00 am, the patient developed respiratory distress with vitals recorded as: BP 129/93 mmHg, pulse rate 170 beats/min, temperature 36.9 degrees Celsius and oxygen saturation of 99%. A chest x-ray revealed patchy opacifications of the right lung that were suggestive of aspiration pneumonia. In consultation with Dr. Nguu, a decision was made to sedate her so as to reduce brain activity, and to start her on a steroid.

At 4.00 am, the patient's respiratory distress had worsened. On examination, she was found to have reduced breath sounds on the right lung, and bilateral crepitations. These findings were suggestive of pulmonary oedema. Vital signs were as follows: BP 165mmHg, pulse rate 141 beats/min, and oxygen saturation of 91%. In consultation with Dr. Nguu, the settings on the ventilator were adjusted upwards, and measures were put in place to prepare for possible resuscitation. The patient remained critically ill.

At around 5.00 am, vital signs were recorded as follows: BP 131/87mmHg, pulse rate 62 beats/min, and oxygen saturation of 90%.

At 6.30 am, he was informed that the patient's condition had changed. On palpation, no pulse could be detected of the carotid artery. The patient was assessed by Dr. Gitonga who found her to be unresponsive, with no pulse, fixed and dilated pupils, no corneal reflex, no gag reflex and no cardiac activity. She was then certified dead.

e) Submissions by Dr. Linda Nguu, Consultant Anaeasthesiologist

According to the submissions made by Dr. Linda Nguu, Consultant Anaesthesiologist, on 6th September, 2022, at 8.30 pm, she received a call from Dr. Esther Mokaya, the Consultant Anesthesiologist at MLKH, regarding a patient who needed to be transferred to KL5H from MLKH for critical care. She confirmed the availability of a bed, and immediately alerted her team at the hospital and instructed Ms. Purity Wangui Kamau, a critical care nurse, to prepare a bed for the patient.

On 7th September, 2022, at 1.40 am, she received a call from Dr. Gitonga, the Medical Officer Intern, who reported that the patient had been received at the ICU in KL5H unconscious and in critical condition. She had been intubated and was being bagged with room air. Her vitals on admission were: BP 89/35mmHg, pulse rate 172 beats/min,

oxygen saturation 79%, and temperature of 37.9 degree Celsius. On examination, she was unconscious and unresponsive with her pupils unequally reactive to light. There was also reduced air entry into her right lung. Her uterus was well contracted at 20 weeks, and her C-section wound was clean. She had a catheter draining urine with an estimated output of 600 mls.

She was then started on treatment as follows- analgesia, antipyretic, antibiotics, IV fluids, antacids.

The patient's vitals then began to improve with oxygen saturation rising to 99%, and BP reading at 129/93 mmHg and pulse rate 179 beats/min.

At 3.00 am, the patient developed respiratory distress with vitals recorded as: BP 129/93 mmHg, pulse rate 170 beats/min, temperature 36.9 degrees Celsius and oxygen saturation of 99%. A chest x-ray revealed patchy opacifications of the right lung that were suggestive of aspiration pneumonia. A decision was made to sedate her so as to reduce brain activity, and to start her on a steroid so as to reduce inflammation of her lungs.

At 4.00 am, the patient's respiratory distress had worsened. On examination, she was found to have reduced breath sounds on the right lung, and bilateral crepitations. These findings were suggestive of pulmonary oedema. Vital signs were as follows: BP 165mmHg, pulse rate 141 beats/min, and oxygen saturation of 91%. To manage the pulmonary oedema, the patient was started on diuretic treatment. In addition, she advised the team to be on standby and prepare for possible resuscitation.

At 7.00 am, she received a call from Dr. Gitonga that the patient had lost her pulse and that all efforts at resuscitation had been unsuccessful. She was certified dead.

f) Submissions by Dr. Mary Wanjiku Maina, Consultant Obstetrician/ Gynecologist

According to the submissions made by Dr. Mary Wanjiku Maina, Consultant Obstetrician/Gynaecologist, and Chair of the Hospital and County Maternal, Perinatal Disease Surveillance and Response Team (MPDSR), she was alerted concerning a maternal death at the hospital ICU on 7th September, 2023, between 8 and 9 am.

As per the County MPDSR guidelines, any patient maternal death occurring within 24 hours of referral must be reviewed by both teams from the referring and the receiving facilities.

Accordingly, the team at MLKH that had managed the patient were invited to a meeting of the hospital MPDSR on 8th September, 2022. The MLKH team comprised an Obstetrician/Gynaecologist, a medical officer, an anesthetist and two nurses.

During the MPDSR, the meeting found that the late Maureen was admitted as a primigravida with twin gestation and severe pre-eclampsia. She underwent an emergency C/S with an outcome of two live males weighing 3.9kg and 3.8kg.

Seven hours' post-op, the late Maureen was noted to be bleeding with soiled beddings and an estimated blood loss of 1.5 liters. She was taken to theater for EUA where she was intubated and then extubated. She however failed to reverse from anesthesia. She was then referred to KL5H where a bed was confirmed available at 9.00 pm. She however arrived at 1.20 am.

The MPDSR meeting identified the following gaps in the patient's care at MLKH-

i) Severe pre-eclampsia with sudden BP drops should have indicated postpartum hemorrhage;
ii) From the time that the cesarean section was done, to the 7 hours' post-op the patient lost approx. 1.5 liters of blood;
iii) Pad monitoring was not done properly at MLKH between 11 am and 1.30 pm with the result that the patient bled excessively;
iv) Referral notes were scanty and no anesthetic notes were included;
v) The patient was intubated and then extubated leading to hypoxia before she was referred while in theater;
vi) Severe pre-eclampsia and twin gestation carry a high risk for PPH. The mother ought to have been monitored closely; and
vii) The oxygen cylinder ran out before the patient arrived at KL5H, and the the patient was bagged using room air as they did not have the key to the spare oxygen cylinder

The meeting concluded that the cause of death was hypovolemic shock secondary to postpartum hemorrhage in severe preeclampsia with twin pregnancy.

g) Submissions by Dr. Eunice Mugweru, Consultant Pathologist

According to the submissions made by Dr. Eunice Mugweru, Consultant Pathologist, on 14th September, 2022, at 9.00 pm, she received a call from Dr. Murage, the Medical Superintendent at KL5H, requesting her to conduct a post mortem on the body of the

late Maureen. She was joined by the family Pathologist, Dr. Dorothy Njeru, and the Consultant Pathologist at MLKH, Dr. Atandi.

The post mortem started at 1.00 pm, with the husband positively identifying the late Maureen's body. Present at the post mortem was a team comprising both Kiambu and MLKH staff, DCI and a family representative.

The post-mortem took three hours and an initial finding of the cause of death as cerebral oedema, pulmonary oedema and anemia in the background of preeclampsia and postpartum hemorrhage.

According to Dr. Mugweru, possible etiologies for the cerebral oedema included: tumors, trauma, hypoxia, infection, metabolic derangements or acute hypertension.

Further, possible etiologies for the pulmonary oedema included: heart failure, pneumonia, toxins, medication, trauma to the chest wall and traveling or exercising at high altitudes.

A copy of the written submissions by KL5H have been attached herein as Annex 3.

4. Visit to Mama Lucy Kibaki Hospital

The Committee conducted a site visit to MLKH on Tuesday, 7th December, 2022. They were received by members of the Hospital Board led by Mr. Joe Aketch, and the Chief Executive Officer, Dr. Emma Mutio.

a) Submissions by Mr. Joe Aketch, Chairperson, MLKH

In his submissions, the Chairperson noted that despite the hospital having a dedicated team, they served a very large population and were thus working under constrained conditions.

In addition, noting that it was the hospital policy to accept all patients, he stated that the facility was overstretched and overcrowded with up to three patients sharing a bed during peak seasons.

He further noted that the hospital lacked an ICU facility, and appealed to the Senate to help fast track the completion of the ICU and extension unit which had stalled owing to lack of resources. He noted that the ICU would help save many lives and that the hospital extension would increase the bed capacity at the hospital and thus improve service delivery.

He further noted that the hospital had established an oxygen plant that was supplying oxygen to several facilities within Nairobi County.

b) Submissions by Ms. Jane Ogonji, Chairperson, Finance Committee, MLKH Board

In her submissions, Ms. Ogonji, Chairperson of the Finance Committee of the MLKH Board, welcomed the Committee's visit noting that it would help generate lasting solutions to the problems that were facing the hospital.

She noted that the biggest challenge the hospital faced was shortage of resources. In reference to human resource, she noted that in the year, over 30 nurses had left the hospital in search of greener pastures and were yet to be replaced.

With regards to financial resources, Ms. Ogonji stated that the hospital received a quarterly budget of KShs.60M, against a budgetary requirement of KShs.220M. In order to meet the deficit, the Hospital Board had been compelled to redistribute resources for medication and essential services. She noted that it was almost impossible to provide satisfactory services within those resource constraints.

Further, she noted that on the day that the late Maureen died, the hospital had served a total of 28 mothers in the maternity ward against three nurses on duty. She further observed that the low proportion of nurses against patient numbers was a key factor that had limited the ability of the nursing team to provide optimal monitoring to Maureen.

c) Submissions by Dr. Emma Mutio, CEO, MLKH

In her submissions, Dr. Emma Mutio gave a brief history of the hospital stating that the hospital was a donation to the country by the People Republic of China and that it officially opened in 2013 after being elevated to level 5 hospital.

She iterated that MLKH served as the primary referral hospital in the Nairobi Eastland's area, and saw up to 1,200 patients on average daily.

She noted that the hospital had a total bed capacity of 200 beds. The maternity department had 71 beds but admitted over 150 patients at any one time which translated to a bed occupancy of 200% on average as the hospital never turned away any mother.

With regards to the operationalization of the hospital ICU, the CEO stated that a task force had been appointed to oversee the project and that more than 80% of the structure was complete. However, at the time of the visit, the hospital was referring patients to

KNH and KUTRRH for critical care. She however noted that KUTRRH required patients to make an initial deposit before admission. Most of the referral cases were for ICU and CT scans.

The CEO further told the Committee that the hospital relied mostly on NHIF reimbursements for its revenue. She noted that the resources were not adequate, and appealed for the County Government to allocate more funding in order to provide better services.

She further noted that the hospital had around 681 staff, with 32 medical doctors, 45 consultants and 230 nurses. She noted that the number of nurses was inadequate as the numbers required were 330.

In conclusion, she stated that the hospital was looking forward to the Committee's recommendations and pledged to implement them for the betterment of the hospital.

5. Meeting with Relevant Health Regulatory Bodies

The Committee met with the relevant health regulatory bodies led by Dr. Jackson Kioko, CEO, Kenya Health Professionals Oversight Authority (KHPOA) at its sitting held on 22nd November, 2022.

a) Submissions by the Kenya Health Professionals Oversight Authority (KHPOA)

In his submission, Dr. Jackson Kioko, CEO, KHPOA, stated that his submissions were the result of a Joint Inspection of Mama Lucy Kibaki Hospital by members of the Kenya Medical Practitioners and Dentists Council (KMPDC), the Clinical Officers Council (COC), the Pharmacy and Poisons Board (PPB), the Kenya Medical Laboratory Technologists and Technicians Board (KMLTTB) and the Nursing Council of Kenya on 9th September, 2022.

He noted that according to the patients' notes and records retrieved from the hospital management team, on 5th September, 2022, the late Maureen Anyango, then a 28-year-old primigravida at term (39 weeks and 5 days) gestation with a twin pregnancy, was referred from Kayole 2 Sub County Hospital to MLKH with malpresentation in twin gestation and severe pre-eclampsia.

The referral notes recorded examination findings as follows- BP 170/96mmHg, pulse rate 81 bpm, the repeat at 10.00 pm was BP 169/93mmHg, pulse 99 bpm. She was

started on nifedipine 20mg, methyldopa 250mg and a loading dose of magnesium sulphate (IV MgSO4 4g and IM 10g) at 10.15 pm. Her referral from Kayole 2 SCH was timely and appropriate.

She arrived at the Mama Lucy Kibaki Hospital Maternity triage at 10.45 pm. On admission, she was found to have a BP of 171/106mmHg, and a pulse of 106 bpm. As per the nurse's notes, the next MgSO4 dose would be at 2.15 am.

On 6th September 2022 at 12.26am, the patient was admitted to the labor ward. The admission notes indicated that the patient had a history of hypertension in pregnancy but was not on medication. On examination, the patient was found to have: bilateral pitting oedema and facial puffiness, with BP of 170/96mmHg, pulse 81 bpm. Fundal height was term, with presentation of the first twin in breech. Vaginal examination noted cervical dilatation at 2cm. A decision to conduct an emergency Cesarean section was made, and blood grouping and crossmatch (GXM) was done. The patient signed the consent form at 12.53 am. The FHG result posted at 1.17am was normal with Hb 13.1g/dL, platelet count 249×109/L.

As per the nursing cardex record at 2.31 am, the patient reported that she could feel fetal movements for only one twin. Her BP was now 161/105mmHg, pulse 115 bpm FHR 140 bpm. A dose of IM MgSO4 5 mg was administered and the next dose was to be given at 6.31am.

The next cardex entry at 2.40am recommended an emergency cesarean owing to non-reassuring fetal status.

At 5am, the nurse noted that the patient was still waiting for theater and that the fetal heart rates were Twin A 102 bpm, Twin B 130 bpm. The patient was handed over to the theater team at 6.40am.

At 8.10am, the patient was received in the Post Anaesthetic Care Unit (PACU) for observation and the babies-initiated breastfeeding. As per the hospital notes, she was reported stable with the BPs ranging between 84/64mmHg and 159/76mmHg, pulse 70-132 bpm, respiratory rate 18- 20cpm, and SpO2 95-97%. The patient and her babies were handed over to the postnatal ward team at 10.05am.

At 1.30 pm, Dr. Kiptoo was called to review the patient. She was pale and weak, with BP 124/80mmHg, pulse 90 bpm. The uterus was bulky, fundal height was 22/40 and the incision was clean and dry. The patient was bleeding actively per vagina. Clots

were expelled and IV tranexamic acid, oxytocin infusion, IV fluids, rectal misoprostol 800 mcg were given.

While in the theater, the uterus was found to be bulky and clots were expelled. The uterus was then reported to be well contracted. The cervix was intact, and haemostasis was achieved at 2.50 pm.

Reversal from general anesthesia was started but failed at 3.10 pm; therefore, a decision was made to maintain the patient on mechanical ventilation while awaiting referral for critical care.

At 4.04 pm, the consultant on call gave instructions on patient management.

At 5.00 pm, a decision was reached to refer the patient for critical care. Attempts to secure an ICU bed at Kenyatta National Hospital and Kenyatta University Teaching Research and Referral Hospital were futile, owing to lack of available ICU beds on the part of KNH, and a requirement of a deposit of KShs. 200,000 at KUTRRH.

However, the hospital continued to source an ICU bed for the patient, and it secured an ICU bed at 8.00 pm at KL5H.

An ambulance was confirmed to have started the transfer of the patient to KL5H at 11.00 pm, representing a delay of seven (7) hours from the point at which a decision was made to refer the patient for critical care management.

On 7th September 2022 at 1.00 am, the patient was received at Kiambu level 5 Hospital ICU.

At 6.45 am, the patient's condition was critical, and at 9.00 am, relatives were informed that the patient had succumbed.

With regards to the treatment and care that the late Maureen received, he noted that her monitoring as someone who had been diagnosed with severe pre-eclampsia on admission was wanting as highlighted below-

a) Her file did not contain a severe pre-eclampsia monitoring chart or any form of documentation to show that they were monitoring a high-risk patient with severe pre-eclampsia;

b) There was inconsistency of documentation of vital signs from the time of admission at 10.45 pm to the time the patient was taken to the theater; and

c) At no point before the delivery was a plan of management made, nor were samples taken to check for proteinuria, liver and renal function, and the coagulation profile, all of which can be deranged in severe pre-eclampsia.

Further to the above, he stated that there had been a delay of two (2) hours from the time of admission (10.45 pm) to 12.53 am when an emergency Cesarean section was first prescribed;

And a further delay of six (6) hours from the time the decision for emergency Cesarean section was made (12.53 am) to when the patient was wheeled to the theater at 6.40 am.

He noted in the hospital management's response that there was inadequate documentation to support claims by the hospital management that the delay had been caused by the need to stabilize the patient's condition before the operation.

He further noted that whereas the Cesarean section was conducted as per the standard operating procedure, the postoperative management plan for the patient was too generic, and ignored the fact that she had been diagnosed with preeclampsia. Further, given that twin pregnancy and pre-eclampsia increase the risk of developing postpartum hemorrhage, the post-operative management plan ought to have included instructions on close monitoring of the patient's blood pressure, pulse, fundal height, urine output and vaginal bleeding. These were however, not observed, nor was there any record or entry of the patient's status post-operative from 10.05 am until the patient was wheeled back to the theater at 2.00 pm.

Overall, he noted that there had been delays in the management of the patient, which led to poor maternal outcomes.

A copy of the written submissions by KHPOA have been attached herein as Annex 4.

b) Submissions by the Kenya Medical Practitioners and Dentists Council (KMPDC)

Dr. David Kariuki, Chief Executive Officer (CEO) of the Kenya Medical Practitioners and Dentists Council (KMPDC) made submissions on behalf of the Council as follows-

That, of its own motion, pursuant to Rule 6 of the Medical Practitioners and Dentists (Inquiry and Disciplinary Proceedings) (Procedure) Rules, 2022, instituted investigations into the matter of the late Maureen.

Vide a letter dated 1st November, 2022, the Council had directed MLKH to submit-

a) A comprehensive report detailing the treatment and management that the late Maureen had received.

b) Detailed statements from all the health professionals who managed the late Maureen from the time of her admission to the time of her referral to KL5H;

c) A certified and paginated copy of the patient's file;

d) A Statement of action taken by the management in light of the occurrence; and

e) Any other relevant document of information that would assist the Disciplinary and Ethics Committee of the Council to conduct its investigations.

He submitted that the aforementioned information was submitted to the Council by MLKH on 7th November, 2022.

He further stated that vide a letter dated 1st November, 2022, KL5H was requested to submit information as follows-

a) A comprehensive report detailing the treatment and management that the late Maureen had received.

b) Detailed statements from all the health professionals who managed the late Maureen from the time of her admission to the time of her referral to KL5H;

c) A certified and paginated copy of the patient's file;

d) A Statement of action taken by the management in light of the occurrence

He submitted that the aforementioned information was submitted to the Council by KL5H on 4th November, 2022.

He further confirmed that as part of its investigations, the Council in collaboration with other health regulatory bodies conducted a joint inspection of MLKH on 9th November, 2023.

Thereafter, and in line with the Medical Practitioners and Dentists (Inquiry and Disciplinary Proceedings) (Procedure) Rules, 2022, the inspection report, and documentation received was going to be tabled before the Disciplinary and Ethics Committee.

Also present at the meeting were Ms. Edna Tallam, Registrar of the Nursing Council of Kenya (NCK), and Mr. Ibrahim Wako, Registrar and CEO of the Kenya Clinical Officers Council (KCOC). They aligned themselves to the joint statement by Dr. Kioko, CEO, KHPOA, likewise committed to conduct a thorough investigation on the matter through their respective Councils.

A copy of the written submissions by KMPDC have been attached herein as Annex 5.

6. Meeting with Health Professional Associations and Health Worker Unions

The Committee met with various health professional associations and health worker unions at its sitting held on 22nd November, 2022.

a) Submissions by the Kenya Medical Association (KMA)

Led by its President, Dr. Simon Kigondu, KMA submitted that the case of the late Maureen was a reflection of what was happening in the public health care system. Having collected views and reports from members of KMA working at the institution, he submitted the following observations-

1) There was a need to use this unfortunate health outcome to strengthen the current health systems.

2) There was a need to come up with measures to mitigate the strain that came with the loss of any Kenyan through disease or accident.

3) There was a need to protect medical professionals, medical institutions and indeed any person working towards the medical care of patients from negative publicity occasioned by a weak health system, or a lapse in the health system. This protection included protection from adverse media.

4) There was a need to allow bodies that are charged by law to deal with medical issues to do so without undue interference. He further noted that it was time that audits in healthcare adopted the aviation industry audit model whose implementations were immediate.

5) There was a need for the government to support the work of health workers through adequate funds allocation.

6) There is a need to look into the coordination of health regulatory bodies to provide for patient-centeredness. He noted that the current regulatory

framework was disjointed with various cadres having different levels of accountability.

7) He further noted that adverse medical outcomes needed to be approached from a Health Systems Strengthening point of view as per the WHO framework.

He went further to commend the Committee for taking up the case as it was a matter of public interest. That notwithstanding, he noted that it was important for individual health facilities and the KMPDC to be allowed to complete their investigation, and for the Senate to oversee the implementation of their recommendations.

He further noted that the initial hearings in the Senate ought not to have been made public, but that the eventual recommendations should have been publicized widely and implemented. This was in order to avoid taking the families that had suffered loss through a repeat roller coaster of emotions; to protect the medical practitioners who are bound by the International Code of Medical Ethics not to reveal confidential patient information unless it is in the context of a medical regulatory context; and, to avoid sensational journalism that may not give the proper context of their headlines, but whose effect was to damage the reputation of a health system that worked specifically because of trust and continuous improvement.

He further added that there was a need to operationalize a professional, well equipped Kenya National Ambulance Services (KNAS), and to recruit and train emergency care personnel.

He recommended pre-service training of emergency care for all cadres of medical personnel, and noted that there was a need to ensure that adequate funding was allocated to enable the operation of emergency services on a 24-hour basis. Further, that there was a need to link the service to the National Police Service in order to minimize pre-hospital exacerbation of injuries that lead to further injuries.

He further noted that the operationalization of the Emergency fund was paramount as it would remove the burden of providing emergency services away from the receiving institution and avoid restrictions of access due to lack of funding.

In addition, he noted that there was a need to invest in emergency medicine training and deployment of emergency medicine personnel to all our public hospitals.

He further recommended the enactment of a National Referral Health Facilities Bill to provide for the establishment of a National Referral Health Facilities Authority that could be mandated with continuous improvement of the referral process.

On strengthening the maternal mortality audit process, he noted that whereas Maternal Mortality audits were generally well developed, there was a need to fund Confidential Enquiries on Maternal Deaths that had traditionally relied on donor funding, stating that the output of such inquiries was objective and led to data that improved the health systems.

He further noted that it was important to improve documentation of the patient's journey so as not to be subjective. He called for the installation of CCTV cameras in health facilities in order to avoid he-say she-say encounters that followed bad outcomes in health.

In addition, he recommended the full operationalization of the Coroners Act as this would improve lessons from deaths, and lead to strengthening of the health system.

With regards to coordination of the health sector, he called for the establishment of a General Medical Council to deal with emerging issues like conflicting scopes of practice and a segmented health system approach. He noted that this would help tease out issues regarding indemnity and accountability.

With regards to funding, he noted that overall allocations to the Ministry of Health had remained, on average, at about six percent of the total government budget. As such, the health sector was predominantly financed by private sector sources including households' out-of-pocket spending. The high out-of-pocket spending on health care had the implication of dissuading Kenyans from seeking health care.

He further noted that training and development of the Human Resources for Health (HRH) was one of the most critical functions of government. Noting that there was a critical shortage of specialists, he called for specialized services to be made more accessible to Kenyans especially the poor and vulnerable.

He concluded his submissions by calling for the establishment of a Health Service Commission. Noting that the Health Sector Medium Term Plan of the Vision 2030 recognized the need to de-link the Ministries of Health (Medical Services, Public Health and Sanitation) from service delivery through the establishment of a Health Service Commission, he noted that this would make the MoH focus on formulation of policies, standards, guidelines, and regulation of delivery of health services, and help generate

data for the management of HRH. He further stated that the establishment of the HSC would not take away the roles of County Public Service Boards, but rather, serve to strengthen devolution.

He concluded his remarks by recommending the following documentation: the Musyimi Taskforce Report, the Final Baseline and Workload Indicator Assessment Report (April, 2013), the Late Ken Walibora Senate Health Committee Report, Legal Notice No. 269 on the Kenya Medical Practitioners and Dentists Act, the Medical Practitioners and Dentists (Medical Institution) Rules, the National Emergency Medical Care Treatment Guidelines, the PCC Alex Madaga Ruling and the Health Service Commission Bills of 2012 and 2018.

A copy of the written submissions by KMA have been attached herein as Annex 6.

b) Submissions by the National Nurses Association of Kenya (NNAK)

Led by its National Chairman, Mr. Collins Ajwang, NNAK thanked the Committee for taking up the cases of avoidable deaths that occurred at Mama Lucy Kibaki Hospital in Nairobi County and Kenyatta National Hospital respectively; and for inviting the association to make suggestions on how to improve emergency healthcare service and to avoid such incidents from recurring in the future.

He noted that NNAK was established to ensure that nurses and midwives practice in a safe environment, and that the public who are the consumers of their services are safe from any harm, negligence, and or malpractice.

He further stated that NNAK recognized the right to health for every person in Kenya as guaranteed in Article 43 (1) (a) of the Constitution which stated that, *"Every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive healthcare".*

He noted that the death could have been avoided, and stated that NNAK held the view that there had been a deliberate and selective implementation of health policies and guidelines by the national government for use by counties. For example, the Kenya Health Sector Strategic Plan 2018-2023, Emergency Medical Care Policy 2020-2030, and Kenya Quality Health Model of 2018.

He further noted that the National government had since 2018, refused to implement provisions section 18 of the Health Act of 2017, which defined the structure at the Ministry headquarters. He therefore called for the Committee to act to ensure that the

structure of the ministry is streamlined and that it takes into account the various directorates that have been suggested in the Act.

In addition, he noted that regulatory oversight by relevant regulatory bodies had been wanting as many facilities were understaffed.

He further called for the review of the position that held that only certain cadres could hold leadership positions.

He further noted that emergency medical/surgical services should be provided to all patient regardless of their ability to pay.

In addition, he noted that every maternal death that happens in hospitals whether public, private, or faith-based must be documented and proper audit done and reported to the ministry of health. And further, where professional negligence was reported, that the regulatory body must take up the matter and propose a remedy to correct the gap - including imposing suctions deemed necessary and in accordance with the provisions of their various acts.

He called for the establishment of a Health Service Commission in order to address issues facing human resources for health centrally.

Further, noting that ambulance services had been taken up by the private sector and NGOs, for instance AMREF, Red Cross and St. John's Ambulances, he called for counties to invest in quality and functional ambulance services that were responsive to emergencies and affordable.

He concluded his remarks by calling for the establishment of a task force comprising the law makers and key stakeholders to assess the state of health in the counties, and to come up with recommendations that would inform the future direction on health.

A copy of the written submissions by NNAK have been attached herein as Annex 7.

c) Submissions by the Kenya Medical Practitioners and Dentists Union (KMPDU)

Led by its Secretary-General, Dr. Davji, KMPDU submitted as follows-

That the circumstances surrounding the unfortunate demise of the late Maureen and other innocent Kenyans was a clear reflection of a failed health care system.

He further noted that the true negligence was not on the part of healthcare workers who bore the brunt of blame, but on negligence on the part of the government to invest in making the healthcare system work.

He observed that there was an urgent need for dialogue with all stakeholders across the country with a view to identifying the challenges with Kenya's healthcare system and improving service delivery.

He further noted that there was a need to equip all level 5 hospitals with the requisite number of personnel, equipment and essential medical supplies across the country to handle emergency medical cases.

He called for the Government to adequately finance healthcare to meet the 15% of the total National budget as per the Abuja Declaration of 2001.

He further stated that there was a need to protect healthcare care workers and medical institutions from negative publicity occasioned by a weak health system, or a lapse in the health system including protection from adverse media.

And called for the coordination of health regulatory bodies to make them patient centered, accountable and cohesive. He further noted that there was a need to allow mandated bodies to deal with cases of medical negligence with undue interference.

He further added that there was a need to operationalize a professional, well equipped Kenya National Ambulance Services (KNAS), and to recruit and train emergency care personnel.

He recommended pre-service training of emergency care for all cadres of medical personnel, and noted that there was a need to ensure that adequate funding was allocated to enable the operation of emergency services on a 24-hour basis. Further, that there was a need to link the service to the National Police Service in order to minimize pre-hospital exacerbation of injuries that lead to further injuries.

He further noted that the operationalization of the Emergency fund was paramount as it would remove the burden of providing emergency services away from the receiving institution and avoid restrictions of access due to lack of funding.

In addition, he noted that there was a need to invest in emergency medicine training and deployment of emergency medicine personnel to all our public hospitals.

He further recommended the enactment of a National Referral Health Facilities Bill to provide for the establishment of a National Referral Health Facilities Authority that could be mandated with continuous improvement of the referral process.

On strengthening the maternal mortality audit process, he noted that whereas Maternal Mortality audits were generally well developed, there was a need to fund Confidential Enquiries on Maternal Deaths that had traditionally relied on donor funding, stating that the output of such inquiries was objective and led to data that improved the health systems.

He further noted that it was important to improve documentation of the patient's journey so as not to be subjective. He called for the installation of CCTV cameras in health facilities in order to avoid the he-say she-say encounters that followed bad outcomes in health.

In addition, he recommended the full operationalization of the Coroners Act as this would improve lessons from deaths, and lead to strengthening of the health system.

With regards to coordination of the health sector, he called for the establishment of a General Medical Council to deal with emerging issues like conflicting scopes of practice and a segmented health system approach. He noted that this would help tease out issues regarding indemnity and accountability.

With regards to funding, he noted that overall allocations to the Ministry of Health had remained, on average, at about six percent of the total government budget. As such, the health sector was predominantly financed by private sector sources including households' out-of-pocket spending. The high out-of-pocket spending on health care had the implication of dissuading Kenyans from seeking health care.

He further noted that training and development of the Human Resources for Health (HRH) was one of the most critical functions of government. Noting that there was a critical shortage of specialists, he called for specialized services to be made more accessible to Kenyans especially the poor and vulnerable.

He concluded his submissions by calling for the establishment of a Health Service Commission. Noting that the Health Sector Medium Term Plan of the Vision 2030 recognized the need to de-link the Ministries of Health (Medical Services, Public Health and Sanitation) from service delivery through the establishment of a Health Service Commission, he noted that this would make the MoH focus on formulation of policies, standards, guidelines, and regulation of delivery of health services, and help generate

data for the management of HRH. He further stated that the establishment of the HSC would not take away the roles of County Public Service Boards, but rather, serve to strengthen devolution.

He concluded his remarks by recommending the following documentation: the Musyimi Taskforce Report, the Final Baseline and Workload Indicator Assessment Report (April, 2013), the Late Ken Walibora Senate Health Committee Report, Legal Notice No. 269 on the Kenya Medical Practitioners and Dentists Act, the Medical Practitioners and Dentists (Medical Institution) Rules, the National Emergency Medical Care Treatment Guidelines, the PCC Alex Madaga Ruling and the Health Service Commission Bills of 2012 and 2018.

A copy of the written submissions by KMPDU have been attached herein as Annex 8.

e) Submissions by the Kenya National Union of Nurses

In their submissions, the Kenyan National Union of Nurses (KNUN) noted that there existed a serious shortage of nursing personnel at MLKH, thus making it difficult to offer efficient and quality services.

On the material day at MLKH, there were a total of 136 patients against 4 nurses on duty, which translated to a ratio of 1:35.

The KNUN further submitted that Nairobi County lacked a single ICU bed, and was reliant on KNH for ICU admissions which were already overstretched.

Further, there was a need to upgrade equipment at MLKH to include CT scans and other diagnostic equipment in order to provide for quick interventions in the management of patients.

With regards to staffing norms for nurses, KNUN submitted that as per the MoH staffing norms and standards, an average ratio of 1 nurse to 4 patients was ideal for a maternity unit.

A copy of the written submissions by KNUN have been attached herein as Annex 9.

f) Submissions by the Kenya Union of Clinical Officers (KUCO)

Led by its Secretary-General, Mr. George Gibore, the Committee received submissions from the Kenya Union of Clinical Officers as summarized below.

He noted that medical negligence was an increasing public health concern among healthcare providers worldwide as it affected patient safety, and posed a significant risk of patient injury, disease, disability, or death.

He further noted that WHO had recognized deficiencies in patient safety as a global healthcare issue to be addressed, and acknowledged efforts by the Ministry of Health to publish a policy on patient and health worker safety.

He noted that there was a need to create a standardized and well-structured accountability framework to tackle medical negligence in the healthcare system that did not confer the burden on healthcare workers alone, but rather evaluated all the six components of an effective health system.

He stated that the Constitution of Kenya under Article 43 guarantees every person the highest attainable standard of health, which includes the right to health care services, including reproductive health care. And further, that the Health Act under section 7 guarantees every person the right to emergency medical treatment which includes pre-hospital care, stabilization, and referral.

In the case of the late Maureen, he noted that her referral from Kayole 2 Sub-County Hospital was timely and appropriate. He further noted that her management at the Mama Lucy Kibaki Hospital (MLKH) had been found to be wanting as she did not receive proper monitoring for severe pre-eclampsia as per pre-eclampsia management protocols.

He further took note that attempts to secure an ICU bed at Kenyatta National Hospital and Kenyatta University Teaching Research and Referral Hospital had been unsuccessful owing to the lack of an ICU bed on the part of KNH, and the requirement of a deposit of KShs.200,000 at KUTRRH which the patient could not afford.

He further noted that delayed patient review and lack of timely check of vital signs could have been the single most important reasons for delayed decision-making by the care provider and thus occasioning the delayed specific intervention.

He further noted that the lack of ICU facilities at MLKH further compounded the issue and extended the delays in her receiving proper care.

He further stated that having examined the case, KUCO had noted with great concern the following issues-

a) Understaffing across the health facilities in Kenya
b) Severe shortages of essential cadres
c) Persistent inability to attract and retain health workers
d) Poor and uneven remuneration among cadres
e) Poor working conditions
f) Inadequate or lack of essentials tools and medical and non-medical supplies
g) Inadequate and inequitable distribution of staff, and
h) Diminishing productivity among the health workforce, etc.

He further noted that the Government of Kenya had made a commitment through the Cabinet Secretary of Health to employ 12,000 health care workers annually for the attainment of Universal Health Coverage and beyond. This commitment was, however, yet to be implemented.

He further observed that there was a discrepancy in the distribution of specialized personnel, with most of them only stationed at the Kenyatta National Hospital and by extension Nairobi Metropolis.

With regards to infrastructure, he noted that the case had brought the matter of inadequate capacity in Kenya's health facilities in terms of infrastructure, equipment, and human resources to the fore as demonstrated by the fact that they were unable to secure an ICU bed in KNH for the late Maureen, and that MLKH itself lacked an ICU.

Noting that the incident illustrated what was happening across most health facilities in the country, he stated that there was an acute shortage of professional health workers to adequately serve the influx of patients seeking health services.

He further noted that health facilities must have an appropriate physical environment, including functional, reliable and safe water, energy, sanitation, hand hygiene, and waste disposal facilities, and that hospital spaces need to be designed, organized and maintained to allow for privacy and facilitate the provision of quality services.

With regards to the case of the late Maureen, he observed that pregnant women should receive the right care, at the right times, and noted that WHO recommends a woman to see a health provider at least 8 times during her pregnancy to detect and manage potential problems and reduce the likelihood of a stillbirth or neonatal death.

In addition, he noted that patients should receive all information regarding their care and should feel involved in all decisions made regarding their treatment.

Acknowledging that the case of the late Maureen had been regrettable and avoidable, he noted that there was a need to take bold and deliberate measures to eradicate incidents of medical negligence in the future. He further made the following general observations-

1. Most health facilities across Nairobi County and the country including MLKH and KNH were not adequately staffed or equipped to provide quality and responsive emergency and accident services;

2. The right to access emergency medical treatment was not guaranteed in most public hospitals since that right was subject to a financial deposit that was out of reach for the majority of Kenyans;

3. Most health facilities did not have adequate health workers to handle the large number of patients seeking health services in the hospitals;

4. Majority of Level 5 facilities did not have the requisite infrastructure, equipment, and commodities required for their level of classification;

5. Some facilities lacked Standard Operating Procedures (SOPs) and Guidelines on emergency care and accident trauma management; and

6. There was acute underfunding of the health sector in Kenya.

Based on the foregoing, he made the following recommendations-

a) That the President constitutes a National Joint Health Taskforce, bringing together all stakeholders to assess the health sector, and identify challenges across the 47 County Governments and National Government and recommend institutional, policy and legal interventions to improve the sector.

b) That a framework be developed for the implementation of the annual employment of healthcare workers to meet the WHO 2013 commitment for the annual employment of 12,000 healthcare workers for the attainment of UHC.

c) That more emergency and critical care personnel be employed to work in the emergency departments at all referral hospitals in order to ensure the right skill mix of health professionals and appropriate equipment.

d) That the Government to increase its budgetary allocation funds for health to 15% of the annual national budget as envisioned by the Abuja declaration 2001.

e) That the Health Act of 2007 be amended with a view towards uplifting Kenya's Health Human Resource Advisory Authority to an Authority with powers to develop policies, monitor their implementation across county governments and national governments as well as enforce compliance.

f) That the management of all public referral hospitals adopt a payment model of Pay-Per-Case for all consultants, in order to address the issue of having very highly paid consultants who do not show up for work or who otherwise devote very little of their time to public facilities and spend most of their time in other private facilities.

g) That all County Level Five (5) facilities be upgraded to Level Six (6) Referral Hospitals, in order to improve access and capacity at the apex referral facilities.

h) That the Emergency Fund be operationalized as provided for under the Health Act of 2017 and that all referral facilities remove all conditions on admission of emergency cases including payment of a deposit to access the same.

i) That adequate funding and strengthening of primary health care services be done with a view towards reducing cases requiring tertiary care services.

j) Strengthening of the implementation of the referral framework/policy, complete with adequate and well-equipped ambulances at the point of need.

k) Review of the policy and regulations that provide for the operation of private wings in the public facilities to realign them with UHC dictates to facilitate access to specialists at the referral facilities when needed.

l) Streamline coordination of referral services at all levels.

m) Ensure that all Level 5 facilities have at least one fully equipped ICU.

Further to the above, the Committee received submissions from the other health worker representative groups who reiterated the submissions made above, including the Kenya Clinical Officers Association and others.

A copy of the written submissions by KUCO have been attached herein as Annex 10.

7. Meeting with Civil Society Organizations

The Committee received submissions from various civil society groups on Thursday, 16th November, 2022, and Thursday, 5th December, 2022. A summary of their submissions has been provided below-

a. Submission by the Emergency Medicine Kenya Foundation (EMKF)

The Committee received submissions from Dr. Benjamin Wachira, Executive Director of EMKF on Thursday, 16th November, 2022. Dr. Wachira submitted the Foundation's views as follows-

The Ministry of Health adopted the World Health Organisation (WHO) Emergency Care System Framework for essential emergency care functions during the development of the Kenya Emergency Medical Care (EMC) Policy 2020-2030. According to the EMC Policy, emergency medical treatment is defined as the necessary immediate health care that must be administered to prevent death or worsening of a medical situation as defined in the Health Act (2017).

He noted that the three cases of medical negligence that were before the Committee, including that of the late Ms Maureen Anyango revealed significant gaps in Kenya's emergency medical care services as follows-

Kenya did not have a public Ambulance Access Number: Noting that emergencies start in the community and not in the hospitals, he highlighted the need to establish a Single Short Code Public Ambulance Access Number in Kenya that the public can call to access emergency medical care services. In many instances, those needing emergency medical care do not make it to the hospital and died within the community or on the way to the hospital while using public or private means.

No Standardized Public Ambulance Services: He noted that the Kenya Bureau of Standards had published guidelines for Ambulances (KS 2429:2019) which provides set out vehicle design, ambulance personnel and medical devices in an ambulance. Unfortunately, he noted that these standards were not enforced, with most of our ambulances not meeting these standards.

Lack of guidelines or regulations for pre-hospital healthcare providers: He noted that Emergency Medical Technicians who are trained and certified pre hospital

healthcare providers are currently not recognized or licensed by the government. While nurses occasionally accompanied patients in ambulances, they lacked formal training in pre-hospital emergency medical care and were thus ill-equipped for the job.

Lack of Standardized Emergency Departments: He observed that Accident & Emergency Departments (ED), must provide emergency medical care twenty-four hours a day, 7-days a week, be well-equipped as per WHO standards, have a well-defined Triage System and have immediate access to a functioning theater for surgical emergencies. He further noted that EDs must be staffed by healthcare providers with specific training in basic principles of Triage, Adult and Pediatric emergency medical care, Obstetric emergency care and Trauma care. Unfortunately, with no clear guidelines/regulations, many emergency departments in Kenya did not meet these requirements and thus did not provide adequate emergency medical treatment.

Training: Noting that emergency medical care training was not part of undergraduate training, and that most emergency medical care training was usually available as certifications after the initial basic training, Dr. Wachira stated that most healthcare providers lacked the knowledge and skills required to provide emergency medical care.

With regards to the late Maureen, he noted that she went into labor at home. In an ideal situation, being a high risk pregnancy, an ambulance ought to have been available to transport her to the hospital immediately.

On arrival at her home, the trained ambulance personnel would have taken her vital signs and immediately identified the high blood pressure, which automatically meant Maureen was having an Obstetric Emergency (Preeclampsia). Having twins and high blood pressure also made Maureen's pregnancy a high risk one, and she would need appropriate definitive care upon arrival at the hospital.

With this information, the ambulance personnel would have informed the Dispatch Centre, who would then have alerted the most appropriate nearby hospital with an Obstetrician, Theatre and Pediatric Resuscitation services available. The trained ambulance personnel would then initiate care using standardized emergency medical treatment protocols en route to the hospital, constantly updating the hospital on her condition and providing any resuscitative measures as appropriate. On arrival at the hospital, Maureen would immediately have been received by the Obstetrician and trained nurses. They would then take over the care and make the most appropriate decision in terms of delivery. Post-delivery, Maureen would have been admitted to an adequately monitored unit as she was at significant risk of bleeding or

having convulsions, ideally a High Dependency Unit (HDU) until stable and out of danger.

Based on the foregoing, he made the following recommendations-

a) There was a need for clear Guidelines and Standards for all the components of the Emergency Medical Care System as provided for by the WHO Emergency Medical Care System Framework, and the Kenya Emergency Medical Care Policy 2020-2030. While the Constitution of Kenya 2010 and the Health Act 2017 guarantee every Kenyan the Right to Emergency Medical Treatment, how this was to be achieved, and to what standard was not yet clear. In addition, there was a need to institute the necessary regulatory mechanisms to ensure that the guidelines and standards were adhered to.

b) Single Short Code Public Ambulance Access Number: He submitted that Kenya needed a single short code public ambulance access number for the public to call in an emergency. The number would be connected to an Ambulance Dispatch Centre with trained personnel who would provide telephonic first aid guidance as an ambulance is dispatched to their location to initiate emergency medical care.

c) Regulation of ambulance services: He noted that all ambulances must be regulated, and must meet specific standards in terms of vehicle design, ambulance personnel and medical devices in the ambulance. Further, they must also have clear Standard Operating Procedures (SOPs) and Guidelines on Emergency Medical Treatment.

d) Pre-hospital healthcare providers must be specifically trained, certified, and licensed in pre-hospital emergency medical care. Only licensed pre-hospital healthcare providers should work in an ambulance, including driving the ambulance.

e) Emergency Medical Care Training - All healthcare providers working in the pre-hospital emergency medical services and those working in emergency departments must have specific training and certification in basic principles of triage, adult and pediatric medical emergency care, obstetric emergency care and trauma care.

f) Emergency Medical Care Financing – A precise mechanism for financing emergency medical care for the public must be well defined. This should include

access to pre-hospital emergency medical care (ambulance services), care in the emergency department and immediate inpatient care for any emergency cases that cannot afford to pay.

g) An Emergency Department must be appropriately designed, labeled and staffed. They must also have a defined Triage System and Guidelines on Emergency Medical Treatment. Only facilities that meet these standards should be allowed to offer emergency medical treatment.

A copy of the written submissions by EMKF have been attached herein as Annex 11.

b. Submission by the Bioethics Society of Kenya (BSK)

The Committee received submissions from Prof. Bukusi, Executive Director of BSK on Thursday, 16th November, 2022. Prof. Bukusi submitted the Society's views as follows-

She noted that there was a need to establish Hospital Ethics Boards as a means to improve health services. According to the professor, only two hospitals in the country had established Ethics Committees i.e. Aga Khan and KNH. She noted that despite several engagements with the Ministry of Health, the ministry was yet to make it a requirement for hospitals to set up the committees.

She further iterated that there were clear ethical issues in the case in question. For example, there were no proper standards set as to ambulance services to evacuate the patients. She noted that often, outsourced ambulances lacked trained personnel to transfer the patients.

She concluded her remarks by noting that BSK would be happy to collaborate on the development of a law to set up Hospital Ethics Committees across the country.

c. Submission by the Law Society of Kenya (LSK)

Led by Mr. Josephat Kirima, LSK submitted that they were following the Committees proceedings on the medical negligence cases as a matter of public interest.

d. Submission by the Confraternity of Patients of Kenya (COFPAK)

The Committee received submissions from Mr. Joab Ogolla, Chairperson of COFPAK, on Thursday, 5th December, 2022. Mr. Ogolla submitted the Society's views as follows-

Mr. Ogolla noted that COFPAK was a nonprofit organization that was established in recognition of the need to have a structured means of representing, promoting, advancing and safeguarding the interests of patients in the healthcare ecosystem.

He iterated that the organization's aim was to collaborate with other stakeholders in the system to ensure that there was access to quality, safe, accountable and sustainable healthcare. He further stated that the main goals of the organization were to-

a) Track trends in patient's expectations as well as contribute to quality of care to patients;

b) Promote resolutions of medical negligence between patients and healthcare providers;

c) Provide guidelines and legislative measures to quality healthcare;

d) Provision of advisory and legal support services to patients and their kins;

e) Inform and empower patients on their rights and roles to information;

f) Promote quality healthcare through sustainable multi sector partnership;

g) Accelerating role of preventive, curative and palliative care system and;

h) Contribute to education of emergency health issues in Kenya.

In so far as the treatment that the late Maureen received, he identified the following gaps-

a) Prolonged turnaround for admissions: He noted that there was a long delay between the time the patient checked into the hospital and the time the patient was admitted and treatment initiated.

b) There was poor patient – provider relationship resulting from lack of effective communication on processes of care and bad attitude by healthcare providers.

c) There was a lack of knowledge by patients and healthcare providers on the Kenya National Patients' Rights Charter.

d) There was understaffing in the hospitals especially MLKH resulting in delays in emergency care provision.

e) They also observed that there was a lack of specialized facilities e.g. CT SCAN and ICU especially in MLKH which hindered prompt care in emergency situations.

f) There was also a lack of accountability in these health institutions from both administration and health workers.

g) Oversight by doctors at the KMPDC had compromised regulation as the doctors tended to cover their own. Further, it was difficult for laymen to ask technical questions in cases of alleged negligence. As such, most cases of negligence were dismissed with the Council hiding evidence collected to protect fellow doctors;

Based on the foregoing, COFPAK recommended the following-

a) Enact legislation on the Statutory Duty of Candour: This will require every healthcare professional to be honest and open with patients and people in their care. He noted that the UK, US and Malaysia had a code of conduct in force.

b) That an independent board be established to deal with disciplinary cases of doctors and hospitals. This would reduce the culture of impunity;

c) To reduce the huge gap in accountability, COFPAK recommended the establishment of tribunals to try cases of alleged medical negligence. This would ensure that whenever a matter was filed, the complainant was provided with findings just like in the penal code hearing before a judge. This information would go a long to help victims convict perpetrators;

d) Establish a better system of inspection of facilities. They noted that while MLKH had several systemic problems, it was proximal to the KMPDC offices;

e) Establishment of a proper referral system;

f) Enhanced training on relationships between patients and healthcare providers;

g) Decongestion of referral hospitals;

h) Involvement of community healthcare providers in the grassroots levels as a way of enhancing preventive care thus reducing curative care on *mwananchi.*

He further stated that there was a need to foster patient safety as a culture in health institutions. Noting that whereas huge sums were allocated to the Ministry of Health every year, very little was set aside for patient safety.

In addition, he recommended that the medical curriculum be interrogated to ensure that doctors and nurses completed specific units in their course of training that promoted good relationships with patients, communication skills and on patients' rights.

A copy of the written submissions by COFPACK have been attached herein as Annex12.

CHAPTER FIVE

COMMITTEE OBSERVATIONS

A. In respect of the late Maureen Anyango

1. Article 26 of the Constitution stipulates that every person has the right to life and that a person shall not be deprived of life intentionally, except to the extent authorized by the Constitution or other written law.

2. Article 46 (1) (a) of the Constitution further states that consumers have the right to goods and services of reasonable quality and to the protection of their health, safety, and economic interests.

3. Section 4 of the Health Act indicates that it is a fundamental duty of the State to observe, respect, protect, promote and fulfill the right to the highest attainable standard of health including reproductive health care and emergency medical treatment.

4. Section 7 of the Health Act provides that every person has the right to emergency medical treatment which includes pre-hospital care, stabilizing the health status of the individual or, arranging for referral in cases where the health provider of first call does not have facilities or capability to stabilize the health status of the victim.

5. Section 12(2) of the Health Act, further, provides that all healthcare providers, whether in the public or private sector, shall have the duty to provide health care, conscientiously and to the best of their knowledge within their scope of practice and ability, to every person entrusted to their care or seeking their support; to provide emergency medical treatment as provided for under section 7(2) of the Health Act; and, to inform a user of the health system, in a manner commensurate with his or her understanding, of his or her health status.

6. Section 91 (b) of the Health Act provides that private institutions and private health workers shall "*...provide emergency services in their field of expertise as required or requested either by individuals, population groups or institutions, without regard to the prospect or otherwise of direct financial reimbursement.*".

7. The Committee noted that the late Maureen Anyango, then a 28-year-old primigravida at term (39 weeks and 5 days) gestation with a twin pregnancy, was

referred from Kayole 2 Sub County Hospital to MLKH with malpresentation in twin gestation and severe pre-eclampsia. As per a joint statement by the relevant health regulatory bodies, the referral notes from hospital recorded examination findings, and indicated that she had been started on antihypertensives (i.e. Nifedipine 20 mg, Methyldopa 250mg and a loading dose of Magnesium Sulphate (IV MgSO4 4g and IM 10g) at 10.15 pm. Her referral from Kayole 2 SCH was therefore timely and appropriate.

8. The Committee noted that it had been the evidence of Mr. Robert Omondi, husband to the late Maureen, that upon arrival at MLKH, the hospital security team compelled the late Maureen to enter the hospital alone, despite being a referral, and despite carrying two heavy bags while in active labor.

9. Regarding the pre-operative care and management that the late Maureen received at MLKH, the Committee observed that, on admission, a diagnosis of twin pregnancy in a *primigravida* (first pregnancy), in active labor, with malpresentation, drainage of liquor and pre-eclampsia was made. This ought to have automatically triggered a decision to carry out an emergency cesarean section. However, the emergency cesarean section was repeatedly delayed as evidenced by the following-

    a) According to the joint report by the health regulatory bodies, there was a 2-hour delay from the time the late Maureen was admitted (10.45 pm) to when a decision was made to conduct an emergency C-section (12.26 am). Blood grouping and crossmatch (GXM) was done, and the late Maureen signed consent at 12.53 am;

    b) At 2.31 am, as per the nursing cardex, the late Maureen reported that she could feel fetal movements for only one twin. A nursing cardex entry recorded at 2.40 am recommended an emergency cesarean owing to non-reassuring fetal status;

    c) At 5.00 am, two and a half hours late, the nursing cardex recorded that the patient was still waiting for theater and that the fetal heart rates were: a) Twin A 102 bpm; and, (b) Twin B 130 bpm. However, the patient was not handed over to the theater team until 6.40 am.

    Based on the foregoing, the Committee observed that, despite being an emergency case from admission, it took at least eight hours from the time that

the late Maureen was admitted (10.45 pm on 5th September, 2022), to the time she was wheeled to the theater for the emergency procedure (6.40 am on 6th September, 2022).

10. In addition to the above, the Committee observed that MLKH, through the hospital Obstetrician/Gynaecologist, Dr. Lazarus Kumba, submitted that the decision to defer the late Maureen's emergency cesarean section till 6.40 am had been informed by the need to stabilize her preeclampsia. However, the Committee found that this submission was rendered false by evidence obtained from relevant health regulators that showed that-

    a) The decision to conduct the emergency cesarean was made on 6th September, 2022, 12.26 am, with the late Maureen consenting at 12.53 am the same day; and

    b) There was inadequate documentation to support the claims by MLKH as demonstrated by: (1) lack of evidence that any standard tests for preeclampsia had been conducted; and, (2) inconsistencies in the documentation of vital signs from the time of her admission at 10:45 pm to the time she was taken to theater at 6.45 am.

11. Regarding the post-operative care and management that the late Maureen received at MLKH, the Committee observed that-

    a) It was the evidence of the relevant health regulatory bodies that-

        - The post-operative management plan for the late Maureen was generic, and ignored the fact that her preeclampsia in twin pregnancy predisposed her to postpartum bleeding; and

        - MLKH had failed to produce evidence to suggest that the patient's vital signs (blood pressure, pulse, fundal height, urine output and vaginal bleeding) were observed, or that there was any record of the patient's status post-operatively between 10.05 am to 1.20 pm on 6th September, 2022.

    b) It was the evidence of Mr. Robert Omondi that between 10.05 am and 1.20 pm, had been bleeding in varying degrees of severity (at first mildly. However, as per his account, despite repeatedly attempting to obtain assistance from a ward nurse during this period, he was ignored.

c) The Committee further took note that as per submissions made by Mr. Omondi, an IV infusion of Oxytocin that the late Maureen had been receiving, ran out soon after he had arrived in the ward at 10.05 am. When he attempted to seek the help of the ward nurse to remove the line, she reportedly asked him to remove it himself. To note, the Oxytocin infusion had been prescribed prophylactically to prevent bleeding.

d) As per the statement submitted by the NCCG, the Committee noted that it was suggestive that by 1.20 pm, the late Maureen, was already in shock from blood loss as evidenced by the following-

- She was reported as markedly pale and weak; and
- Her BPs had fallen precipitously from 161/84 mmHg at 6.45 am in the morning (PR - 108 bpm), to 124/80 mmHg and a PR of 103 bpm.

12. The Committee observed that as per submissions made by MLKH, upon discovering that she was bleeding, the late Maureen was transferred to theater at 1.20 pm for examination under anesthesia (EUA). She was put under general anesthesia (GA) but failed to reverse. Following her failure to reverse from anesthesia, the late Maureen was maintained on mechanical ventilation. At 5.00 pm, a decision was made to refer her for critical care.

13. Regarding the transfer of the late Maureen to critical care, the Committee observed-

a) While a decision was reached to refer the late Maureen for critical care at 5.00 pm on 6th September, 2022, she was transferred to the ICU facility at KL5H (i.e. on 7th September, 2022, at 1.20 am).

b) There was an approximately eight-hour unwarranted delay in transferring the late Maureen from MLKH to KL5H for critical care: At least two hours of the delay were lost in transit, with evidence showing that the ambulance took almost two hours to arrive in KL5H from MLKH despite the two hospitals being approximately 20 km apart.

c) Owing to the lack of a basic spanner, the ambulance team was unable to open an oxygen cylinder for use by the patient prior to her arrival at KL5H, and were thus forced to bag her using room air. Noting that at the

time, the late Maureen was unconscious and oxygen-dependent, the Committee observed that the undefined period during which she was not on oxygen negatively impacted her possible outcome.

By the time Maureen was received at KL5H, she was unconscious and her condition was critical. She subsequently succumbed six hours later i.e. at 7.00 am, and was certified dead.

14. The Committee observed that MLKH had attempted to secure an ICU bed for the late Maureen at KNH and KUTTRH. However, this had proved futile owing to the lack of a bed on the part of KNH, and the requirement of an exorbitant deposit of KShs.200,000.00 by KUTTRH.

15. The Committee noted that by prioritizing monetary security prior to admission of a patient and provision of emergency care, KUTRRH acted in violation of Article 43 of the Constitution, sections 7(3) and 91 of the Health Act and the Kenya National Patients' Rights Charter, and should therefore be sanctioned for failure to provide emergency care treatment.

16. The Committee noted that the minutes of a Maternity Mortality Audit meeting held at Kiambu Level 5 Hospital on 9th September, 2022, concluded that Maureen had died as a result of Hypovolemic Shock secondary to postpartum hemorrhage in severe preeclampsia with twin pregnancy. The Committee further noted that the maternal mortality audit meeting identified the following gaps in the patient's care at MLKH as contributing factors to her death-

    a) Severe preeclampsia with sudden drops in her blood pressure should have indicated postpartum hemorrhage;

    b) From the time that the cesarean section was done, to 7 hours post-op the patient lost approx. 1.5 litres of blood;

    c) Pad monitoring was not done properly at MLKH between 11.00 am and 1.30 pm with the result that the patient bled excessively;

    d) Referral notes were scanty and no anesthetic notes were included;

    e) The patient was intubated and then extubated leading to hypoxia before she was referred while in theater;

    f) Severe pre-eclampsia and twin gestation carried a high risk for PPH. As

such, the mother ought to have been monitored closely; and

g) The oxygen cylinder (in the ambulance) ran out before the patient arrived at KL5H, and the patient was bagged using room air as they did not have the key to the spare oxygen cylinder

17. A post-mortem conducted on 14th September, 2022, indicated the cause of death as cerebral edema, pulmonary edema and anemia in the background of pre-eclampsia and post-partum hemorrhage.

18. The Committee observed that as per a statement given by Dr. Eunice Mugweru, the Consultant Pathologist who conducted the post-mortem, possible etiologies for the cerebral oedema included: tumors, trauma, hypoxia, infection, metabolic derangements or acute hypertension.

    Significantly, as per the minutes of the Maternal Mortality Audit conducted in KL5H, the late Maureen was exposed to hypoxia twice during the course of her treatment at MLKH i.e. when she was intubated and then extubated while in the MLKH theater; and, when the oxygen cylinder ran out before she arrived at KL5H, and she was bagged using room air as the MLKH ambulance had lacked the key to the spare oxygen cylinder.

19. Based on the foregoing, the Committee noted that the death of the late Maureen would have been avoidable if the proper procedures had been followed at MLKH from the point of her admission, to her subsequent transfer to KL5H.

20. Further, the Committee observed that there had been an apparent attempt by MLKH to cover-up key details regarding the care that the late Maureen received at the hospital as demonstrated by the following-

    a) Falsified reasons regarding the reason that the late Maureen's emergency cesarean section was delayed by approximately eight hours as described above;

    b) Reports by the husband that promptly after the late Maureen had been discovered bleeding on her bed at 1.20 pm, and transferred to the theater, her blood-soaked beddings were quickly changed, and the floor where her blood her seeped through promptly cleaned;

c) Submissions made by MLKH that the findings during the Examination under Anaesthesia (EUA) were unremarkable with no clots, no uterine atony, no tears, normal cervix and a well-contracted uterus; whereas the joint report by the health regulators indicated that the uterus was bulky and that blood clots were expelled before the uterus contracted; and

d) Inconsistent timings provided by MLKH regarding when the ambulance transferred the late Maureen to KL5H for critical care with other evidence before the Committee: For example, while MLKH submitted that the late Maureen was received at KL5H on 7th September, 2022, at 12.00 am, evidence obtained from KL5H indicated that she was received at 1.20 am, indicating a variance of at least one hour and twenty minutes.

B. In respect of Mama Lucy Kibaki Hospital (MLKH)

21. The Committee observed that MLKH was a high-volume Level 5 Hospital located in the populous Eastlands area. It had the third largest maternity unit in Kenya by workload, with an average of 30 deliveries/per day. Between July and September 2022, the facility conducted 2,770 deliveries.

22. The Committee noted that as per submissions made by the hospital management, the maternity department at MLKH had 71 beds but admitted over 150 patients at any one time - translating to a bed occupancy of 200% on average.

23. The Committee further observed that according to the Ministry of Health (Norms and Standards), the ideal doctor to patient ratio in a maternity unit was 1:4 (*Annex 1)*. However, owing to a heavy workload at the hospital, the average nurse to patient ratio at the hospital was 1:35 *(Annex C)*.

24. The above factors notwithstanding, on the night that the late Edward was received at the hospital, nursing personnel were available, but unresponsive.

25. In light of the several challenges facing the hospital as highlighted by the various health regulatory bodies (e.g. lack of guidelines and protocols, scanty documentation, inadequate equipment and supplies, limited infrastructure (e.g. limited space), staff shortages, poor attitude and complacency among staff, lack of a sense of accountability and responsibility, etc), the Committee observed that there were evident failures in the management and administration of the hospital.

spanner to open it. Owing to this, the ambulance personnel were forced to bag the late Maureen using ambient air with the result that she suffered hypoxia.

34. The Committee observed that whereas the Kenya Bureau of Standards (S) had published guidelines for Ambulances (KS 2429:2019), which set out the standards for ambulances, including vehicle design, ambulance personnel and medical devices, these standards were not being enforced. As such, even where ambulance services were available, they were often not up to standard.

35. In order to improve access to ambulance services, the Committee observed that there was a need to establish a Single Short Code Public Ambulance Access Number in Kenya that was easily accessible to members of the public in cases of emergencies.

E. Upholding Professional Standards of Care

36. The Committee observed that it was a primary role and responsibility for professional health associations to help define and set standards for their professional fields, and to promote high standards and quality of care.

37. However, the Committee observed that the health professional bodies that submitted evidence before it largely failed to address any of the pertinent issues surrounding the case at hand. While they provided valuable information regarding the broader structural issues affecting the case, little effort was made to uphold any professional accountability and/or responsibility on the part of the health workers with regards to the case.

38. In relation to the above, the Committee observed that there was a need to draw a distinction between the structural issues affecting human resources for health, and the practice and conduct of the health workers: For instance, the Committee noted that, with specific regard to the care that the late Maureen received at Mama Lucy Kibaki Hospital (MLKH), the key issue was not so much a lack of staff and/or equipment at the critical time of the emergency, but the poor attitude and conduct of the staff that was on duty at the time. According to the testimony of the husband, he sought help from the nurse on duty at least three times but was ignored. Rather than be defended, the Committee observed that the specific nurse(s) in question ought to be held accountable for their management of the patient.

F. Regulatory Failures in the health sector

39. Noting that health regulators were the bodies mandated with regulating the health sector, the Committee observed that the fact that the case had led to such massive public outcry as to necessitate a parliamentary inquiry, was evidence of weaknesses, failures and/or lapses within the regulatory regime of the health sector.

G. In respect to the management of professional misconduct

40. The Committee further noted that Section 14 of the Health Act stipulates the procedure for raising complaints: It states that any person has a right to file a complaint about the manner in which he or she was treated at a health facility and have the complaint investigated appropriately.

41. Section 14 of the Health Act further placed an obligation on County Governments and the National Government to establish and publish the procedure for the laying of complaints within public and private health care facilities in those areas of the national health system for which they were responsible.

42. The Committee observed that the three-tier process of handling complaints under the Kenya Medical Practitioners and Dentists Act (i.e. the Preliminary Inquiry Committee, the Professional Conduct Committee and the Council when it sits as a Tribunal) as established under sections 3, 4. 6, 7 and 10 of the Medical Practitioners and Dentists (Disciplinary Proceedings) (Procedure) Rules was a prolonged process. Further, that it did not provide for any timelines for the resolution of complaints, or for their referral between the committees and the Council.

43. The Committee further noted that the composition of the PIC and the Council as provided for under the KMPD Act were largely composed of medical professionals. The Committee observed that this had raised concerns of lack of fairness and objectivity, and hindered the objective of holding medical professionals ethically accountable.

44. Further, the Committee noted that whereas the disciplinary committees mainly focused on disciplining the medical practitioner, complainants had to seek redress from the courts. In relation to the above, the Committee noted that attempts had been made through the Health Laws Amendments Act of 2019 to

introduce the requirement for medical practitioners in Kenya to take a professional indemnity cover annually, and for health institutions to insure against professional liability associated with its employees. However, the Amendment Act was declared unconstitutional by a high court ruling. As such, there remained a *lacuna* with dealing with the compensation of victims.

45. In addition, noting that owing to the different cadres of health workers falling under different regulatory bodies, the Committee observed that this had resulted in conflicting scopes of practice, and a segmented health regulatory approach. As such, the Committee noted that there was a need to harmonize disciplinary mechanisms among the various health professionals in order to improve indemnity and accountability.

H. Security concerns at MLKH

46. In addition, the Committee noted that the fear and hyper vigilant attitude expressed by Mr. Robert Omondi, husband to the late Maureen, and Ms. Rose Otieno, sister to the late Maureen, when two nurses came to pick up the twin boys after the late Maureen was transferred to theater for EUA portrayed a deep-seated distrust of the goings-on at the hospital that warranted further investigation and remedial action by the hospital.

CHAPTER SIX

COMMITTEE RECOMMENDATIONS

Based on the foregoing, the Committee recommended that-

1. Mama Lucy Kibaki Hospital (MLKH) be investigated by the relevant health regulatory bodies for culpability in the wrongful death of the late Maureen Anyango owing to proof of medical negligence at the facility.

2. The professional conduct of Dr. Lazarus Kumba, the hospital Obstetrician/Gynaecologist, be investigated by KMPDC for submitting false evidence before the Committee.

3. The professional conduct of the nurse(s) on duty who were responsible for managing the late Maureen between the time she was transferred to the postnatal ward, and the time she was transferred to theater for examination under anesthesia (EUA) be investigated by the Nursing Council of Kenya, and held accountable for their mismanagement of the patient.

4. The management and staff of Kiambu Level 5 Hospital be formally recognized for the professional, timely and appropriate care that was extended to the late Maureen at the facility.

5. In view of evident failures in the management and administration of Mama Lucy Kibaki Hospital, the Chief Executive Officer of the hospital, and management of the maternity department be held liable for failing to ensure the provision of emergency treatment and care at the facility contrary to Article 43(2) of the Constitution which guarantees every person the right to emergency medical treatment; section 7(3) of the Health Act which provides for emergency treatment; and, the Kenya Emergency Medical Care policy.

6. The Ministry of Health, in collaboration with the Kenya Medical Practitioners and Dentists Council, inspect MLKH with a view towards recommending a technical classification commensurate with its actual level of healthcare service delivery.

7. The Ministry of Health, in collaboration with the Council of Governors and County Governments, develop and disseminate standard emergency operating procedures for all levels of care.

8. The Ministry of Health, in collaboration with the Council of Governors and County Governments, take measures to provide for the measurable, and progressive realization of the MoH Norms and Standards across the different levels of care within a 4.5 year period.

9. Nairobi City County Government take urgent action to address the personnel, infrastructural and health financing needs of MLKH, including, but not limited to-
    a) the completion of the ICU;
    b) Expansion and restructuring of the maternity department;
    c) expansion of the hospital's theater and bed capacity;
    d) development and implementation of standard operating procedures (SOPs) and guidelines for triage and emergency care; and
    e) urgent training and capacity-building of all staff deployed to the maternity department in basic and advanced emergency obstetric care.

10. The Chief Executive Officer and the Board of KUTRRH be held liable for requiring a down payment of KShs.200,000.00 as a pre-condition for admitting the late Maureen for critical care, in contravention of Article 43(2) of the Constitution which guarantees every person the right to emergency medical treatment; section 7(3) of the Health Act which provides for emergency treatment; and, section 91 (b) of the Health Act provides that private institutions and private health workers shall "*...provide emergency services in their field of expertise as required or requested either by individuals, population groups or institutions, without regard to the prospect or otherwise of direct financial reimbursement*".

1. The Cabinet Secretary of Health, in accordance with section 112(i) of the Health Act, enact regulations for emergency medical services and emergency medical treatment, including the regulation and licensing of ambulances.

2. Measures be taken to provide for the immediate implementation and enforcement of the Kenya Bureau of Standards (KS 2429:2019) guidelines for ambulances;

3. Measures be taken to ensure the proper regulation of ambulance services, including, but not limited to, issuance with certificates of inspection to ensure compliance with the standards set, for instance, the availability of oxygen; and, training and licensing of ambulance personnel, including drivers.

4. Establishment of a Single Short Code Public Ambulance Access Number for purposes of ensuring easy access to members of the public in case of emergencies.

5. Expansion of the role and mandate of the Government Check Unit to include checking both public and private ambulances for compliance with the KEBS ambulance standards in the short-term.

6. The Cabinet Secretary of Health, and the Nursing Council of Kenya to review the Codes of Conduct of Nurses, with a view towards bringing them in line with the provisions of the Constitution of Kenya, the Health Act 2017, and other relevant laws.

7. A review of the Kenya Medical Practitioners and Dentists Act with a view to providing for professional indemnity, and compensation of victims of medical negligence.

8. The Cabinet Secretary of Health in collaboration with relevant health regulatory bodies, propose mechanisms for the harmonization of the disciplinary mechanisms among the health professionals with a view towards improving indemnity and strengthening accountability;

9. The establishment of a sub-Committee of the Standing Committee on Health to follow-up on the implementation of the above recommendations and report back to the Senate within the period of six (6) months.

In light of the above, the Committee resolves that-

1. This report be dispatched to the Ministry of Health, Nairobi City County Government, the Council of Governors, the Kenya Bureau of Standards and the National Police Service for purposes of implementing the recommendations contained herein within **3 months** upon receipt of this report.

2. This report be dispatched to the Health Professionals Oversight Authority. the Kenya Medical Practitioners and Dentists Council, the Nursing Council of

Kenya and any other relevant regulatory body for the purposes of investigating the professional conduct of the health workers identified above, and recommending appropriate action **within 1 month** upon of receipt of this report.

3. This report be dispatched to the Ministry of Health and State Corporations Advisory Committee for purposes of investigating liability of the Chief Executive Officer and Board of Kenyatta University Teaching, Referral and Research Hospital contravening Article 43(2) of the Constitution which guarantees every person the right to emergency medical treatment; and sections 7(3) and 91 (b) of the Health Act **within 3 months** upon receipt of this report.