THIRTEENTH PARLIAMENT

THE SENATE

THE STANDING COMMITTEE ON HEALTH

REPORT ON THE PETITION REGARDING ALLEGED MEDICAL NEGLIGENCE AND STAFF INCOMPETENCY LEADING TO THE DEATH OF MS. ANNITA JEPKORIR AT MOI TEACHING AND REFERRAL HOSPITAL

Clerk's Chambers,
Parliament Buildings,
NAIROBI

April, 2025

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ABBREVIATION

COSECSA	College of Surgeons of East, Central and Southern Africa
KMPDC	Kenya Medical Practitioners and Dentists Council.
MTRH	Moi Teaching and Referral Hospital
NCIA	Nairobi Centre for International Arbitration
MoH	Ministry of Health

PRELIMINARIES

Establishment and Mandate of the Committee

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.*

Pursuant to Standing Order 228(4), the Committee is specifically mandated to-

1) *investigate, inquire into, and report on all matters relating to the mandate, management, activities, administration and operations of the Ministry of Health and its departments;*
2) *study the programme and policy objectives of the Ministry of Health and its departments, and the effectiveness of the implementation thereof;*
3) *study and review all legislation referred to it;*
4) *study, assess and analyse the success of the Ministry of Health 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 the 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 for 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 its mandate;* and
11) *follow up and report on the status of commitments made by the Cabinet Secretaries in their response to questions under Standing Order 51C*

Committee Membership

The Committee is comprised of the following members-

1.	**Sen. Jackson K. Mandago, EGH, MP**	**- Chairperson**
2.	**Sen. Mariam Sheikh Omar, MP**	**- Vice-Chairperson**
3.	Sen. Justice (Rtd.) Stewart Madzayo, EGH, MP	- Member
4.	Sen. Ledama Olekina, MP	- Member
5.	Sen. David Wafula Wakoli, MP	- Member
6.	Sen. Maureen Tabitha Mutinda, MP	- Member
7.	Sen. Joseph Githuku Kamau, MP	- Member
8.	Sen. Richard Momoima Onyonka, MP	- Member
9.	Sen. Hamida Ali Kibwana, MP	- Member

CHAIRPERSONS FOREWORD

The Petition concerning alleged medical negligence and staff incompetency at Moi Teaching and Referral Hospital (MTRH), which tragically led to the death of Ms. Annita Jepkorir was submitted by Ms. Mercy Cherono and reported to the Senate on 10th July, 2024. This Petition highlights critical issues in healthcare delivery and patient safety that demand urgent attention and action.

The Standing Committee on Health undertook a thorough inquiry into the matters raised in the Petition and held meetings with the petitioners and the key stakeholders including the Moi Teaching and Referral Hospital (MTRH) and the Kenya Medical Practitioners and Dentists Council (KMPDC). The Committee further sought written submissions from the Ministry of Health. These submissions were analysed during Committee meetings leading to preparation of this report.

This report underscores the importance of accountability, transparency and adherence to professional standards in healthcare institutions. The Committee observes that failure of medical procedures to locate or remove the ingested foreign body, later confirmed at post-mortem, reflects a critical diagnostic error and significant breach of duty of care. This is further compounded by systemic failures in adherence to clinical guidelines and standard operating procedures a clear contravention of both College of Surgeons of East, Central and Southern Africa (COSECSA) and the Kenya Medical Practitioners and Dentists Council (KMPDC) guidelines.

The Committee further observes that the attendant post-discharge complications were managed without consulting cardiothoracic surgeons which coupled with poor record keeping procedures and briefings violated multidisciplinary care principles and ethical standards and further obscured accountability.

It is the finding of the Committee that the Petitioner was denied fair hearing and their voice suppressed during dispute resolution; the Moi Teaching and Referral Hospital (MTRH) and the Kenya Medical and Dentists Practitioners Council (KMPDC) delayed in addressing the concerns raised in the matter as characterized by extended and inordinate delay between when the case was filled and when the decision was rendered.

With the foregoing, the Committee recommends that-

1. The Moi Teaching and Referral Hospital and Dr. Stephen Ondigo should be held liable for the untimely death of Ms. Annita Jepkorir. Consequently, the family of the late Ms. Annita Jepkorir should be compensated in the damages caused by the negligent acts of both Dr. Stephen Ondigo and the Moi Teaching and Referral Hospital;

2. The Kenya Medical Practitioners and Dentists Council should issue a caution or reprimand in writing to all medical practitioners involved in the untimely death of Ms. Annita Jepkorir in line with the provisions of Section 20 (6) (a);

3. The Moi Teaching and Referral Hospital should within three (3) months of tabling this report-
   1) establish clear protocols for surgical procedures that ensures all operations and critical medical procedures are conducted under the supervision of qualified medical specialists and all post-operative briefings are conducted by the lead surgeons to ensure accurate communication with patients and their families about the procedures and outcomes; and
   2) establish clear framework that is able to provide for a comprehensive documentation of all patient interactions, procedures, and follow-ups to ensure transparency and accountability. This should include detailed clinical notes on patient status, treatment plans, and any complications encountered during treatment;

4. The Kenya Medical Dentists and Practitioners Council (KMPDC) should within three (3) months of tabling this report-
   1) investigate the professional conduct of the officers in its legal department who were responsible for mismanaging and delaying investigations of issues raised in this petition and report on disciplinary and or administrative actions, if any, that will be taken to hold those culpable;
   2) review its disciplinary procedures to ensure full compliance with section 20 (6) (g) of the Medical Practitioners and Dentist Act, which requires fines to be imposed in addition to other appropriate disciplinary measures;
   3) create a formal patient advocacy program within healthcare facilities to assist families in navigating complaints and grievances related to medical care and provide support in understanding medical procedures, rights, and available recourse in cases of perceived negligence;
   4) develop standardized protocols for investigating medical negligence cases that outline the steps to be taken, timelines for investigations, and criteria for evaluating evidence;
   5) encourage hospitals to engage in mediation processes with families of patients who have experienced adverse outcomes, ensuring that these processes are facilitated by neutral third parties to promote fairness and transparency; and
   6) encourage healthcare facilities to adopt Continuous Quality Improvement (CQI) practices that regularly assess and enhance patient care standards. This could involve routine audits of surgical outcomes, patient feedback mechanisms, and interdisciplinary team reviews of complex cases.

On behalf of the Committee, I wish to extend my gratitude to the Committee members for their diligence, commitment and insightful contributions throughout this inquiry. I also thank the petitioner and all stakeholders who provided valuable input during our investigations. It is my hope that this report will serve as a catalyst for meaningful reforms in healthcare delivery and inspire confidence among citizens in the institutions entrusted with their health and well-being.

As I conclude, I wish to sincerely thank the Office of the Speaker and the Office of the Clerk of the Senate for the support extended to the Committee in execution of its mandate.

It is now my pleasant duty, pursuant to standing order 238 (2) of the Senate Standing Orders, to present the Report of the Standing Committee on Health on petition concerning alleged medical negligence and staff incompetency leading to the death of Ms. Annita Jepkorir at Moi Teaching and Referral Hospital (MTRH).

I thank you

Signed..... Date..14/4/2025

SEN. JACKSON K. ARAP MANDAGO, EGH, MP
CHAIRPERSON, STANDING COMMITTEE ON HEALTH

CHAPTER ONE

1. Introduction

1. Article 119 of the Constitution accords every person a right to petition Parliament on any matter within its authority including seeking enacting, amending or even repealing of legislation.

2. Every petition presented to the Senate stands committed to the relevant standing committee for consideration.

1.1. The Petition

3. The Petition by Ms. Mercy Cherono concerning the medical negligence and staff incompetency that led to the death of her daughter Annita Jepkorir at Moi Teaching and Referral Hospital was reported to the Senate at the sitting held on Wednesday, 10th July, 2024.

4. The Salient issues raised in the Petition are **that**-

   1) on 9th January, 2021, Annita Jepkorir ingested a black seed which choked her and she was rushed to Mediheal Hospital which referred her to Moi Teaching and Referral Hospital to have *Bronchoscopy* done to remove the seed that was stuck on her airway;

   2) at Moi Teaching and Referral Hospital, she was taken to theatre where a *Bronchoscopy* showed that there was no evidence of a foreign body in her airway and on 10th January, 2021 she was discharged. However, before she was cleared she developed respiratory distress necessitating her to be readmitted;

   3) on 13th January, 2021, the hospital performed a *Gastrografin* test but no abnormalities were found. Further, on 19th January, 2021, Annita underwent a *CT Chest Bronchogram* and the report indicated that there was a ring like foreign body in the right bronchi.

   4) on 22nd January, 2021, Annita was taken to theatre of which the parent consented for a *Bronchoscopy* procedure to remove the foreign body from her right Bronchi. The procedure was not successful and the medical team proceeded to perform a *Thoracotomy* procedure which the parents had not consented to;

   5) after receiving Annita at the theatre recovery room, Dr. Earnest Nshom explained to the parents that it was not seed that was stuck in her airway but it was actually a tooth;

   6) the parents realized that Annita had lost two of her upper incisors teeth while in theatre and upon inquiry, Dr. Nshom confided to them that he removed the two teeth as they were wobbly during *Bronchoscopy* procedure and so in total they had managed to remove three teeth including the one from the lung;

7) however, the parents could only find two teeth and upon inquiring on the third tooth which was supposedly taken from the lung, one Dr. Alfred Wanyonyi told them to stop asking questions and instead be grateful that their daughter was still alive and that if they kept asking for the foreign body that was removed, then the nurses might hear them and they could do something bad to their child;

8) on 28th January, 2021, Annita was discharged from hospital and the parents kept going back for checkups as her condition did not improve that much and she kept having bouts of fever and chest congestion. Between February and April, there were numerous hospital visits including one admission.

9) nonetheless, no follow-up CT Scan was done to confirm whether the procedures done were successful in removing the foreign object from the patient despite being readmitted to the hospital with the same symptoms of respiratory distress.

10) on 10th May, 2021, while playing outside, Annita had a long coughing episode in which she fainted and was rushed to hospital where she was pronounced dead on arrival. The parents were made to wait with the body of the deceased for over twelve (12hrs) which was very traumatizing before she was finally moved to the Moi Teaching and Referral Hospital Mortuary;

11) on 13th May, 2021, an autopsy of Annita was done by Dr. David Chumba and he found a seed in the right bronchi of the deceased as it was shown in the first *CT Chest* report which had indicated the presence of a foreign body in the right bronchi and the right lung had badly been damaged;

12) after the post mortem findings, the family launched a complaint with the hospital management on account of negligence given that the hospital staff lied about removing the foreign body from Annita which was not the case, causing her death;

13) the parents have made the best efforts to have these matters addressed by relevant authorities all of which have failed to give satisfactory response.

14) that none of the issues raised in the Petition is pending in any Court of Law, Constitutional or any other legal body.

1.2. Petitioners' Prayer

5. The Petitioners prayed that the Senate-

i. Investigates the happening at the hospital that led to the loss of a life and the doctors involved with a view to ensure that justice prevails for the deceased and the family; and

ii. Recommends the collaboration of Kenya Medical Practitioners and Dentists Council (KMPDC) and Moi Teaching and Referral Hospital (MTRH) authorities in order to address the apparent hesitation in addressing the unfortunate demise of Annita.

CHAPTER TWO

2. Committee Inquiry into the Petition

6. During consideration of the Petition, the Committee held four (4) meetings during which it sought information and reports on the issues raised in the petition from the petitioners, the Moi Teaching and Referral Hospital (MTRH), the Kenya Medical and Dentists Practitioners Council (KMPDC) and the Ministry of Health;

7. The Committee was informed that Ms. Annita Jepkorir, a daughter to MS. Mercy Jepkorir, ingested a black seed and got chocked and was rushed to a medical facility for urgent treatment where she was attended to and referred to MTRH for specialised procedures. Ms. Annita Jepkorir was admitted at MTRH on 9th January 2021 where she was treated and later on discharged on 26th January, 2021. During her stay in the hospital, a number of procedures were undertaken as part of treatment including *bronchoscopy* and *thoracotomy* procedures;

8. However, on 10th May, 2021, while playing outside, Jepkorir had a long coughing episode in which she fainted and was rushed to hospital where she was pronounced dead on arrival. Later, on 13th May, 2021, an autopsy revealed the cause of death as a black seed in the right bronchi of the deceased. After the post mortem findings, the family launched a complaint with the hospital management on account of negligence. However, the petitioners were unsatisfied with the manner the matter was being addressed by the MTRH and filled a complaint with the KMPDC;

9. The Chief Executive Officer of the MTRH informed the Committee that the late Ms. Jepkorir received the highest attainable healthcare service and caregivers included medical specialists in cardio-thoracic surgeons and consultant paediatricians. Further, after the unfortunate incident, MTRH management including the cardio-thoracic team, nurses, customer relations and communication officers held several meetings with the immediate and extended family to address their concerns and complaints. The hospital offered the family full psychological counselling and support for free;

10. KMPDC informed the Committee that its Disciplinary Committee found that the complaint against Dr. Stephen Ondigo and Moi Teaching and Referral Hospital had merit. Consequently, the KMPDC directed that Dr. Stephen Ondigo and MTRH mediate with the Estate of the late Jepkorir jointly with a view to making restitution and thereafter inform the Council within 90 days. The Committee was further informed that KMPDC Disciplinary Committee also directed Dr. Ondigo and MTRH to each pay a fine of Kshs. 200,000/- and Kshs 350,000/- respectively.

CHAPTER THREE

3. ANALYSIS OF SUBMISSIONS

3.1. Treatment and Management of the Patient.

1. The petitioner avers that when Ms. Annita Jepkorir, her six years old daughter, ingested a black seed and got chocked, she was rushed to a medical facility for urgent treatment where she was attended to and referred to Moi Teaching and Referral Hospital (MTRH) for specialised procedures. The MTRH recommended *bronchoscopy*[1] which found a mucus plug that was considered to be the cause of the obstructive symptoms. However, following breathing difficulties, a virtual bronchoscopy identified a ring-like foreign body stuck in her airway.

2. Ms. Jepkorir was admitted at MTRH on 9th January 2021 where she was treated and later on discharged on 26th January 2021. During her stay in the hospital, a number of procedures were undertaken as part of treatment including bronchoscopy and *thoracotomy*[2] procedure. MTRH submitted that they proceeded to thoracotomy after failing to retrieve the foreign body through bronchoscopy. At thoracotomy, a foreign body was palpated and retrieved by sharp dissection where an incisor tooth was removed.

3. MTRH further submitted that they extended the best medical treatment and care to the deceased performed by experienced medical practitioners including a cardiothoracic surgeon. The patient was reviewed on 4th February, 2021 and was found to have recovered well. She would later be re-admitted at the facility on 8th February, 2021 when chest CT Scan showed a bi-basal pneumonia and pleural thickening which were treated successfully and she was discharged on 14th February, 2021. She was seen again on 16th and 22nd April and thereafter was not seen again at MTRH.

4. Kenya Medical Practitioners and Dentists Council (KMPDC) in their inquiry into the issues raised by the family of the late Ms. Jepkorir found that after the first bronchoscopy, the patient continued to develop paroxysmal episodes of breathing difficulties which necessitated a second bronchoscopy. The KMPDU noted that after the second bronchoscopy, two incisor teeth were dislodged; one was retrieved from the oral cavity and other could not be accounted for.

5. A decision was therefore made to perform a right-sided thoracotomy and after palpation of the lung for the foreign body, they removed a tooth through sharp dissection. Efforts to locate the foreign body by palpation was futile and they therefore closed the chest.

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[1] **Bronchoscopy** is a procedure that lets doctors look at your lungs and air passages by passing a thin tube (Bronchoscope) through your nose or mouth, down your throat and into your lungs.

[2] **Thoracotomy** is a surgical procedure in which a cut is made between the ribs to see and reach the lungs or other organs in the chest or thorax.

6. KMPDC argues that it is not possible that the incisor tooth was the foreign body seen on the CT scan taken much earlier and the misplaced incisor tooth was a red herring. KMPDC further submitted that after the discharge, Ms. Jepkorir continued to demonstrate evidence of a retained foreign body. However, when she was re-admitted at the MTRH, there was no evidence that the cardiothoracic team was consulted or involved in the management of the patient.

7. KMPDC opined that had the cardiothoracic team been consulted, with her history and symptoms of retained foreign body in the airway, the course of management would have changed. They further highlight the failures of internal consultation within the hospital given such a complicated case that needed close follow-up and lack of proper documentation on instructions given to the patient both within clinical continuation notes and on the discharge summary.

8. KMPDC further observed that post-operative briefings in particular after the second procedure was done by practitioners who were not the lead surgeon nor anaesthesiologist contrary to good medical practice that the surgeon should conduct the post-operative briefing of either the patient or the guardian. KMPDC argued that the lead surgeon at the bronchoscopy and thoracotomy should have briefed the guardians of the findings intraoperatively, including the circumstances under which the teeth were dislodged and the management thereafter.

3.2. Loss of life; what was the possible cause?

9. The Petitioner informed the Committee that on 10th May, 2021; while playing outside, Ms. Jepkorir had a long coughing episode in which she fainted and was rushed to hospital where she was pronounced dead on arrival. On 13th May, 2021, an autopsy indicated a foreign body in the right bronchi and that the right lung had been badly damaged. However, the MTRH submitted that the post mortem established the cause of death was *asphyxia*[3] due to aspirated food particles.

10. The Petitioner argued that Ms. Jepkorir lost her life because of medical negligence and staff incompetence adding that after her discharge on 28th January, 2021, her condition never improved as she experienced bouts of fever and chest congestions, complications that resulted into numerous hospital visits including a hospital admission. She reiterated that the actual cause of Ms. Jepkorir death was the ingested black sunflower seed which the medical team did not successfully extract from her airway.

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[3] **Asphyxia** is the failure or disturbance of the respiratory process brought about by the lack or insufficiency of oxygen in the brain. The unconsciousness that results sometimes leads to death.

11. KMPDC informed the Committee that it was their finding that the failure to remove the foreign body led to accumulation of fluid distally. Sepsis set in leading to pneumonia and followed by *septicaemia*[4] leading to pus in the other organs found at post mortem. KMPDC noted that the foreign body in question was missed at the bronchoscopy and thoracotomy despite there being clinical evidence indicating the presence of a foreign body. This error led to the removal of a tooth rather than both the tooth and the foreign body.

3.3. Complaint and dispute resolution efforts.

12. Medical negligence is a human right issue that affects right to life and right to healthcare. Medical negligence complaints are usually received by the Kenya Medical Practitioners and Dentists Council (KMPDC) and a complaint may also be filed with the police. Such grievances are emotional expressions of customers due to mismatches in the acceptance of the quality of services or products offered[5] and are good momentum as input because they create an opportunity for organizations to identify deficiencies that exist so as to develop immediate strategies to improve quality service.

13. The Petitioner informed the Committee that she faced frustrations from the MTRH when she sought information about the procedures and the missing teeth. She narrated how she was asked to tone down by medical staff or her daughter would not be attended to as expected. She further wrote to MTRH asking the facility to admit liability and responsibility for the loss of her daughter, tender and apology and meet all medical and funeral expenses. The MTRH submitted that they secured a secluded room to talk to the family in privacy and had apologised for the hurt caused during the conversations. The Committee was informed that thoracotomy was a necessary procedure after unsuccessful bronchoscopy in order to remove the foreign body.

14. The Petitioner filed a complaint with KMPDC and enumerated particulars in support of an allegation of medical negligence, patient's mismanagement, intimidation and failure to follow up on second admission. The petitioners informed the Committee that during the process of launching the complaint with the KMPDC, they felt subjected to humiliation, harassment and intimidation by individuals some of whom work for KMPDC. They further alleged that the management of the MTRH, its leadership and individual doctors involved staff members from KMPDC to manipulate the process and intimidate the petitioner to abandon the matter.

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[4] **Sepsis** is a life-threatening condition that happens when the body's immune system has an extreme response to an infection, causing organ dysfunction

[5] Filip A. Complaint Management: A Customer Satisfaction Learning Process. Procedia – Soc Behav Sci. 2013 Oct 21;93:271-5

15. The Petitioner mentioned one Mr. Zablon Ogeto, an employee of the KMPDC and Mr. Isaac Obundo, a blogger as some of the individuals who posed challenges to the family during their quest for justice. They also highlighted an instance where Dr. Ondigo personally visited the family's rural home at Kapkitony in an attempt to invoke a cultural practice where a person who killed another sought forgiveness by tying a cow somewhere in the deceased's persons home or next to their grave. The Committee was further informed that Dr. Ondigo stalked the petitioners and attempted to coerce them to sign a prepared agreement to withdraw the complaint.

16. The KMPDC consequently referred the complaint to the Disciplinary and Ethics Committee as DC Case Number 43 of 2021 for consideration and determination. Whereas the matter was lodged on or about 12th July, 2021, the matter stalled at the KMPDC for fifteen (15) months before a hearing that took place on 12th October, 2022. In the intervening period, the petitioner had made several visits to KMPDC and informed the Committee that attempts had been made to convince her to withdraw the complaint and negotiate with MTRH. Despite the apologies for inordinate delay, the decision of the disciplinary committee was rendered seven (7) months after the hearing on 5th May, 2023.

17. The KMPDC Disciplinary Committee noted several instances where the petitioner made attempts to raise her grievances with the management of MTRH including a letter asking them to admit liability and responsibility for the loss of her daughter, an apology, and request to meet all the medical and funeral expenses that were incurred. On the other hand, MTRH submitted that in an attempt to address the complaints and disputes arising from the sudden death of Ms. Annita Jepkorir, the management held a meeting with the family on 8th June 2021 and the medical team together with the relatives of the deceased were present. In the meeting the MTRH management together with the medical team, offered a message of condolence to the family and took them through the management of the patient from her admission, management in the surgical wards, follow up in the cardiothoracic clinic and lastly admission and management in *Upendo* ward.

18. The Management of the MTRH reiterated to the family members of the long hours they took to manage their patient and appreciated the family's feedback, adding that the Hospital is open, transparent and committed in doing what is right and best for the its clients. The CEO further asked the family to state what kind of assistance they needed and advised the parents of the late Ms. Annita to be assisted with psychological counselling. The management of the hospital from the submissions assured the hospital of no medical negligence from his medical team comprised of experienced doctors and nurses.

19. Consequently, the KMPDC directed MTRH and the medical doctor mentioned to mediate with the Estate of the late Ms. Annita Jepkorir jointly with a view to making restitution and inform the council within 90 days. Further the MTRH and Dr. Stephen Ondigo were fined Ksh. 350,000/- and 200,000/- respectively.

KMPDC was informed by MTRH that the mediation process progress poorly since the petitioner Ms. Mercy Kiprono was not cooperative. MTRH sought the intervention and guidance of Nairobi Centre for International Arbitration (NCIA) as a mediator, however the mediation never proceeded. The CEO of MTRH through a letter dated 14th December 2023 informed the council that the mediation had not yielded any results and it was his opinion that the mediation had irretrievably collapsed.

20. The Committee notes that section 20 (6) of the Medical Practitioners and Dentists Act establishes specific punishments and remedies that the Kenya Medical Practitioners and Dentist Council may grant in matters of medical malpractice by its professional members. However, this does not extend to awarding damages to complainants even when finding merit in the cases before it. Nonetheless Section 20 (6) (g) of the Act prescribes that fines must be imposed in conjunction with other disciplinary sanctions, including but not limited to remedial training to the concerned medical practitioner, suspension from practice, removal of a medical practitioner's name from the register, or revocation of a licence.

CHAPTER FOUR

4. COMMITTEE OBSERVATIONS AND RECOMMENDATIONS

4.1. Committee Observations

21. Following extensive deliberations and analysis of the submissions on the issues raised in the Petition, the Committee **observes** that-

    1) The untimely death of Ms. Annita Jepkorir was largely caused by medical negligence by medical personnel at the Moi Teaching and Referral Hospital where she sought medical attention after ingesting a black seed;

    2) The failure of initial *bronchoscopy* and *thoracotomy* procedures to locate or remove the ingested foreign body, later confirmed at postmortem, reflects a critical diagnostic error and significant breach of duty of care by the MTRH. This is further compounded by systemic failures in adherence to clinical guidelines and standard operating procedures a clear contravention of both COSECSA and KMPDC guidelines;

    3) The misplaced tooth was a distraction by the medical practitioners from the failure to retrieve the actual foreign body. The failure by Dr. Ondigo and his medical team to revisit the CT-Scan results to confirm retrieval of the foreign object led to misdiagnosis, delayed outcomes and contributed to the demise of Ms. Annita Jepkorir;

    4) The post-operative briefings were done by medical practitioners who were not the lead surgeon nor anaesthesiologist in violation of good medical practice, professional standards and guidelines. Dr. Ondigo and the MTRH did not document information shared during different briefings with the patient, in the patients records for continuity of care nor were the procedures to locate the ingested foreign body recorded to allow for post-operative reviews to identify errors and complications;

    5) The attendant post-discharge complications were managed without consulting cardiothoracic surgeons which coupled with poor record keeping procedures and briefings violated multidisciplinary care principles and ethical standards and further obscured accountability;

    6) The Petitioner was denied fair hearing and their voice suppressed during dispute resolution; the MTRH and the KMPDC delayed in addressing the concerns raised in the matter as characterised by extended and inordinate delay between when the case was filed and when the decision was rendered. Further, the choice of Nairobi Center for International Arbitration as a mediator appears to have been made by MTRH and not mutually agreed;

7) The performance of the MTRH and the KMPDC during dispute resolution was inefficient and unprofessional. KMPDC appears to have violated the principles of confidentiality by sharing essential information and data received during investigations with third parties; and

8) Section 20 (6) (g) of the Act prescribes that fines must be imposed in conjunction with other disciplinary sanctions, including but not limited to remedial training to the concerned medical practitioner, suspension from practice, removal of a medical practitioner's name from the register, or revocation of a licence. Notwithstanding this statutory requirement, the Council decided to impose fines as a stand-alone punishment against Dr. Ondigo and the MTRH;

4.2. Committee Recommendations

22. Based on the analysis of the submissions presented the Committee makes the following **recommendations**-

1) That, the Moi Teaching and Referral Hospital and the medical practitiners involved in the medical procedures related to the late Ms. Annita Jepkorir should be held liable for the untimely death of Ms. Jepkorir. Consequently, the family of the late Ms. Jepkorir should be compensated for the damages caused by the negligent acts of both the medical practitioners and the Moi Teaching and Referral Hospital from the medical indemnity insurance;

2) That, the **Moi Teaching and Referral Hospital** should within three (3) months of tabling this report-

i. establish clear protocols for surgical procedures that ensures all operations and critical medical procedures are conducted under the supervision of qualified medical specialists and all post-operative briefings are conducted by the lead surgeons to ensure accurate communication with patients and their families about the procedures and outcomes; and

ii. establish a clear framework that provides for comprehensive documentation of all patient interactions, procedures, and follow-ups to ensure transparency and accountability. This should include detailed clinical notes on patient status, treatment plans, and any complications encountered during treatment;

3) That, the **Kenya Medical Dentists and Practitioners Council (KMPDC)** should within three (3) months of tabling this report-

i. issue a caution or reprimand in writing to all medical practitioners involved in the untimely death of Ms. Annita Jepkorir in line with the provisions of Section 20 (6) (a);

ii. investigate the professional conduct of the officers in its legal department who were responsible for mismanaging and delaying investigations of issues raised in this petition and report on disciplinary and or administrative actions, if any, that will be taken to hold those culpable;

iii. review its disciplinary procedures to ensure full compliance with section 20 (6) (g) of the Medical Practitioners and Dentist Act, which requires fines to be imposed in addition to other appropriate disciplinary measures;

iv. create a formal patient advocacy program within healthcare facilities to assist families in navigating complaints and grievances related to medical care and provide support in understanding medical procedures, rights and available recourse in cases of perceived negligence;

v. develop standardized protocols and mechanisms for investigating reported medical negligence cases that outline the steps to be taken, timelines for investigations and criteria for evaluating evidence. Further, that a decision on such cases should be rendered within six (6) months of reporting and investigations should involve independent oversight and families of the victims to ensure transparency and accountability;

vi. encourage hospitals to engage in mediation processes with families of patients who have experienced adverse outcomes, ensuring that these processes are facilitated by neutral third parties to promote fairness and transparency; and

vii. encourage healthcare facilities to adopt Continuous Quality Improvement (CQI) practices that regularly assess and enhance patient care standards. This could involve routine audits of surgical outcomes, patient feedback mechanisms and interdisciplinary team reviews of complex cases.

LIST OF ANNEXES

Annex 1: Minutes of the Committee Sittings
Annex 2: Copy of the Petition and Submissions from the Petitioner
Annex 3: Report from the Moi Teaching and Referral Hospital (MTRH)
Annex 4: Report from the Kenya Medical Dentists and Practitioners Council

Annex 1:

Minutes of the Committee sittings

13TH PARLIAMENT |4TH SESSION

MINUTES OF THE NINTH SITTING OF THE STANDING COMMITTEE ON HEALTH HELD ON THURSDAY, 13TH MARCH, 2025 AT COMMITTEE ROOM 7, BUNGE TOWERS, AT 10.00 AM

MEMBERS PRESENT

1. Sen. Jackson K. Arap Mandago, EGH, MP - **Chairperson**
2. Sen. Mariam Sheikh Omar, MP - **Vice - Chairperson**
3. Sen. David Wakoli, MP - Member
4. Sen. Richard Onyonka, MP - Member
5. Sen. Joseph Githuku Kamau, MP - Member

ABSENT WITH APOLOGY

1. Sen. Justice (Rtd.) Stewart Madzayo, EGH, MP - Member
2. Sen. Ledama Olekina, MP - Member
3. Sen. Tabitha Mutinda, MP - Member
4. Sen. Hamida Kibwana, MP - Member

SENATE SECRETARIAT

1. Mr. Humphrey Ringera - Senior Research Officer
2. Mr. David Ngamate - Clerk Assistant
3. Mr. Dennis Amunavi - Research Officer
4. Mr. Stanley Gikore - Media Relations Officer
5. Ms. Hawa Abdi - Serjeant- At -Arms
6. Mr. Francis Mugi - Intern - Audio Recording Officer
7. Purity Nginyi - Attaché - DSEC

MIN/SEN/SCH/43/2025 PRELIMINARIES

The Chairperson called the meeting to order at twenty-six minutes past ten o'clock and the proceedings commenced with a word of prayer said by the Chairperson.

MIN/SEN/SCH/44/2025 ADPOTION OF THE AGENDA

The agenda of the meeting was adopted after being proposed by Sen. David Wakoli, MP, and seconded by Sen. Joseph Githuku Kamau, MP, as listed below-

1) Prayers;
2) Adoption of the Agenda;
3) Confirmation of Minutes of the previous meetings;
   (1) Minutes of the 2nd sitting held on 27th February, 2025
   (2) Minutes of the 4th sitting held on 6th March, 2025

4) Consideration and Adoption of the Committee Report on the Petition regarding the alleged medical negligence and staff incompetency that led to the death Ms. Annita Jepkorir at Moi Teaching and Referral Hospital (*Committee Paper No. 108*);
5) Brief on the Decision of the High Court Ruling on an Interim Application in Hon. Abdi Ibrahim Hassan v the Senate and 4 others (Committee Paper No. 109);
6) Any other business; and
7) Adjournment/Date of the Next Meeting.

MIN/SEN/SCH/45/2025 **CONFIRMATION OF THE MINUTES OF THE PREVIOUS SITTINGS**

Minutes of the 4th Sitting of the Committee held on Thursday 6th March, 2025 were confirmed as true record of the proceedings after having been proposed by Sen. David Wakoli, MP and seconded by Sen. Richard Onyoka, MP.

MIN/SEN/SCH/46/2025 **CONSIDERATION ON THE PETITION REGARDING MEDICAL NEGLIGENCE AND STAFF INCOMPETENCY AT MOI TEACHING AND REFERAL HOSPITAL.**

1) The Secretariat presented the draft report on the petition regarding medical negligence and staff incompetence that led to the death of Ms. Annita Jepkorir at Moi Teaching and Referral Hospital (MTRH) for consideration and adoption;

2) The Committee **observed** that-
   a. The initial *bronchoscopy* and *thoracotomy* procedures failed to locate and or remove the ingested foreign body which was retained and later confirmed at autopsy indicating a diagnostic error. The attendant post-discharge complications were managed without consulting cardiothoracic surgeons which coupled with poor record keeping procedures and briefings obscured accountability;
   b. Whereas, MTRH maintains that medical procedures were led by specialists, there was no evidence adduced to confirm that they handled critical stages which suggest that surgeries may have been performed without supervision contravening both COSECSA and KMPDC guidelines;
   c. The post-operative briefings were conducted by junior staff which is a violation of ethical standards for transparency; and
   d. While the MTRH attributed the death to 'aspirated food particles' the autopsy report presented to the Committee confirmed a retained foreign body and sepsis from unresolved airway obstruction.

3) The Committee further observed that medical and diagnostic errors done during the procedures and concerns raised by the petitioners were not adequately addressed by the KMPDC which would indicate possible cover up.

4) Based on the analysis of the Submissions received the Committee made the following recommendations-

a. The Moi Teaching and Referral Hospital should within three (3) months of tabling this report-
   i. establish clear protocols for surgical procedures that ensures all operations and critical medical procedures are conducted under the supervision of qualified medical specialists and all post-operative briefings are conducted by the lead surgeons to ensure accurate communication with patients and their families about the procedures and outcomes; and
   ii. establish clear framework that is able to provide for a comprehensive documentation of all patient interactions, procedures, and follow-ups to ensure transparency and accountability. This should include detailed clinical notes on patient status, treatment plans, and any complications encountered during treatment;

b. The Kenya Medical Dentists and Practitioners Council (KMPDC) should within three (3) months of tabling this report-
   i. create a formal patient advocacy program within healthcare facilities to assist families in navigating complaints and grievances related to medical care and provide support in understanding medical procedures, rights, and available recourse in cases of perceived negligence;
   ii. develop standardized protocols for investigating medical negligence cases that outline the steps to be taken, timelines for investigations, and criteria for evaluating evidence. This will ensure consistency and thoroughness in handling complaints;
   iii. encourage hospitals to engage in mediation processes with families of patients who have experienced adverse outcomes, ensuring that these processes are facilitated by neutral third parties to promote fairness and transparency; and
   iv. encourage healthcare facilities to adopt continuous quality improvement (CQI) practices that regularly assess and enhance patient care standards. This could involve routine audits of surgical outcomes, patient feedback mechanisms, and interdisciplinary team reviews of complex cases

5) The Committee adopted the Report on the Petition with the proposed amendments after being proposed by Sen. Mariam Sheikh Omar, MP and seconded by Sen. Richard Onyonka, MP.

MIN/SEN/SCH/47/2025 **BRIEF ON THE DECISION OF THE HIGH COURT RULING ON AN INTERIM APPLICATION IN *HON. ABDI IBRAHIM HASSAN V THE SENATE AND 4 OTHERS***

The deliberation of this Agenda was pended to the next Committee meeting.

MIN/SEN/SCH/48/2025 **ANY OTHER BUSINESS**

The Committee was informed that the summons by the Cabinet Secretary, Ministry of Health to appear before the Committee had been served and she was expected to appear on Tuesday, 18th March, 2025.

MIN/SEN/SCH/49/2025 **ADJOURNMENT**

There being no other business, the meeting was adjourned at eleven o'clock. The next meeting will be on notice.

SIGNED:.....DATE: 8/9/2025

SEN. JACKSON K. ARAP MANDAGO, EGH, MP
(CHAIRPERSON, COMMITTEE ON HEALTH)

MINUTES OF THE ONE HUNDRED SIXTY SITTING OF THE STANDING COMMITTEE ON HEALTH HELD ON THURSDAY, 21ST NOVEMBER AT 10.00 A.M. IN COMMITTEE ROOM 1, BUNGE TOWER BUILDING.

MEMBERS PRESENT

1. Sen. Jackson K. Mandago, EGH, MP	-	**Chairperson**
2. Sen. Mariam Sheikh Omar, MP	-	**Vice-Chairperson**
3. Sen. Ledama Olekina, MP	-	Member
4. Sen. Esther Anyieni Okenyuri, MP	-	Member

ABSENT WITH APOLOGY

1. Sen. Abdul Mohamed Haji, CBS, MP	-	Member
2. Sen. Joe Nyutu, MP	-	Member
3. Sen. Erick Okong'o Mogeni, SC, MP	-	Member
4. Sen. Raphael Chimera, MP	-	Member
5. Sen. Hamida Kibwana, MP	-	Member

IN-ATTENDANCE

1. Sen. James Murango, MP	-	Friend of the Committee

SENATE SECRETARIAT

1. Mr. Humphrey Ringera	-	Senior Research Officer
2. Ms. Florence Waweru	-	Clerk Assistant
3. Mr. Mitchell Otoro	-	Legal Counsel
4. Mr. Ryan Injendi	-	Research Officer
5. Mr. Dennis Amunavi	-	Research Officer
6. Mr. Victor Kimani	-	Audio Recording Officer
7. Ms. Njeri Manga	-	Media Relations Officer
8. Ms. Swaluha Yusuf	-	Protocol Officer
9. Ms. Hawa Abdi	-	Sergeant- at-Arms

IN-ATTENDANCE

KENYA MEDICAL PRACTITIONERS AND DENTISTS COUNCIL (KMPDC)

1) Dr. David Kariuki	-	Chief Executive Officer
2) Mr. Michael Onyango	-	Ag. Company Secretary
3) Ms. Eunice Muriithi	-	Assistant Director, Disciplinary and Ethics

PETITIONERS

1) Ms. Mercy J. Kiprono - Mother to the deceased
2) Mr. Issac Kandie - Father to the deceased
3) Dr. Vincent Mutai - Advocate
4) Mr. David Mosonik - Relative

MIN/SEN/SCH/939/2024 **PRELIMINARIES**

The meeting was called to order at thirty minutes past ten and the proceedings commenced with a word of prayer said by the Chairperson, Sen. Jackson K. Mandago, EGH, MP.

MIN/SEN/SCH/940/2024 **ADOPTION OF AGENDA**

The agenda of the meeting was adopted with amendments after being proposed by Sen. Mariam Sheikh, MP and seconded by Sen. Esther Okenyuri, MP as follows-

1. Prayers;
2. Adoption of the Agenda;
3. Confirmation of the Minutes of the157th and 159th Committee Meetings;
4. Matters arising from the Minutes of Previous Committee Meetings;
5. Consideration of the petition regarding an alleged medical negligence and staff incompetency that led to the death of Ms. Annita Jepkorir at Moi Teaching and Referral Hospital (**Committee Paper No. 99**);
6. Any other business; and
7. Adjournment/Date of the Next Meeting.

MIN/SEN/SCH/941/2024 **CONFIRMATION OF THE MINUTES**

The agenda item was deferred following re-organization of the agenda.

MIN/SEN/SCH/942/2024 **MATTERS ARISING FROM THE MINUTES OF PREVIOUS COMMITTEE MEETINGS**

The agenda item was deferred following re-organization of the agenda.

MIN/SEN/SCH/943/2024 **CONSIDERATION OF THE PETITION REGARDING AN ALLEGED MEDICAL NEGLIGENCE AND STAFF INCOMPETENCY THAT LED TO THE DEATH OF MS. ANNITA JEPKORIR AT MOI TEACHING AND REFERRAL HOSPITAL**

1. The Committee Secretariat presented Committee Paper No. 99 on the petition regarding an alleged medical negligence and staff incompetency that led to the death of Ms. Annita Jepkorir at Moi Teaching and Referral Hospital;

2. The Committee was informed that the Petition by Ms. Mercy Cherono concerning the medical negligence and staff incompetency that led to the death of her daughter Annita Jepkorir at Moi Teaching and Referral Hospital was reported to the Senate at the sitting held on Wednesday, 10th July, 2024 and thereafter stood committed to the Committee for consideration.

3. The Committee was informed that at a Sitting of the Committee held on Thursday, 11th July, 2024 the Committee resolved to seek information from the following stakeholders- The Principal Secretary, State Department for Medical Services; The Chief Executive Officer, Moi Teaching and Referral Hospital (MTRH); and The Chief Executive Officer of the Kenya Medical and Dentists Practitioners Council (KMPDC);

4. The Committee was informed that at its meeting held on Thursday, 14th November, 2024, the Committee resolved to invite the Chief Executive Officer of the KMPDC to a meeting scheduled to be held on Thursday, 21st November, 2024 to deliberate on the issues raised in the Petition.

5. The Committee had requested the Chief Executive officer of the KMPDU to-

    1) submit a comprehensive report on dispute resolution mechanisms, highlighting the number of complaints received within the last five (5) years, the number of complaints resolved, the type of resolution reached, the timelines within which such disputes were resolved and the challenges, if any; and
    2) be accompanied by Ms. Eunice Muriithi, the Legal Services Manager at the Kenya Medical Practitioners and Dentists Council who had been mentioned earlier during the consideration of the petition.

Submission by Kenya Medical Practitioners and Dentists Council (KMPDC).

6. The Chief Executive Officer informed the Committee that the Kenya Medical and Dentists Practitioners Council (KMPDC) is a statutory body corporate established under section 3 of the Medical Practitioners and Dentists Act Chapter 253 of the Laws of Kenya. The Council is mandated to regulate the training and practice of medicine, dentistry, and community oral health within the Republic of Kenya and regulating all health institutions in the County;

7. The Committee was informed that the petitioners submitted a complaint against Dr. Stephen Mondego, Prof. Barasa Otsyula, Dr. Alfred Wanyonyi, Dr. Ernest Nshom and Moi Teaching and Referral Hospital (MTRH) alleging medical negligence, patient mismanagement, intimidation and follow-up on the second admission. The complaint was processed and assigned DC Case N0 43 of 2021 on 12th July, 2021;

8. The KMPDC constituted a Disciplinary and Ethics Committee which deliberated on the complaint and recommended a hearing be scheduled. The said hearing took place on 12th October, 2022 whereupon all parties were required to be present. Thereafter, the KMPDC Disciplinary Committee rendered its decision on 5th May, 2023;

9. The Committee was informed that KMPDC Disciplinary Committee held that the complaint had merit and presented its recommendations to the KMPDC at its meeting held in December, 2022 wherein the decision of the Committee was upheld.

10. The Committee was informed that KMPDC issued the following orders-

a. the complaint of negligence made against Dr. Ernest Nshom, Dr. Alfred Wanyonyi and Prof. Barasa Otsyula Khwa be dismissed;

b. Dr. Stephen Ondigo and MTRH to mediate with the Estate of the Late Anita Jepkorir jointly and severally with a view to making restitution and thereafter inform the Council after 90 days from the date thereof; and

c. Dr. Stephen Ondigo was directed to pay a fine of Kshs. 200,000/- and the MTRH was directed to pay a fine of Kshs. 350,000/- within fourteen days from 5th May, 2023.

11. The Committee was informed that through a letter dated 14th December, 2023, Dr. Wilson Aruasa, the then Chief Executive Officer of the MTRH, informed KMPDC that mediation efforts had not yielded any results allegedly because the petitioner had refused to participate and consequently the mediation process had collapsed;

12. The Committee was informed that since 1999, the KMPDC had received 1,599 cases of alleged medical negligence and highlighted that it faced challenges related to delays in receiving requisite documents from respondents, lack of full time Disciplinary and Ethics Committee members which hinders the frequency of meetings, Change of legal representation by parties mid-way through the process, budgetary constraints and limitations of its mandate;

13. The petitioners informed the Committee that during the process of launching the complaint with the KMPDC, they felt subjected to humiliation, harassment and intimidation by individuals some of whom work for the KMPDC. They mentioned one Mr. Zablon Ogeto, an employee of the KMPDC and a Mr. Isaac Obundo, a blogger as some of the individuals who posed challenges to the family during their quest for justice.

Committee observations

14. The Committee observed that-

a. there were discrepancies in the dates of the order of events as submitted by KMPDC compared to the dates indicated in the petitioner's submissions;

b. the performance of the KMPDC in dispute resolution was inefficient and there is need to instil professionalism in the conduct of front office personnel and officers tasked with the duty of receiving and making follow-up on the complaints raised by different stakeholders;

c. KMPDC should endeavour to conduct inspections to healthcare facilities and especially those with perennial reports of alleged malpractices in order to ascertain the levels of service delivery first-hand;

d. KMPDC should explore a collaborative framework with the Commission for University Education (CUE) in order to provide proper oversight to medical training institutions noting that there is a direct relationship between training and practice;

Committee resolutions.

15. The Committee **resolved**-

a) to consider all the submissions and evidence received on the petition on the alleged medical negligence and staff incompetence that led to the death of Ms. Annita Jepkorir at Moi Teaching and Referral Hospital so as to develop its report; and

b) that the Kenya Medical Practitioners and Dentists Council (KMPDC) should submit a comprehensive report on dispute resolution mechanisms, highlighting the number of complaints received within the last two (2) years, the number of complaints resolved and the type of resolution(s) reached;

MIN/SEN/SCH/944/2024 **ANY OTHER BUSINESS**

Members were informed that the Committee working retreat was scheduled to take place from 21st – 24th November. 2024 in Kiambu County to consider stakeholder submissions on the Tobacco Control (Amendment) Bill, 2024 (Senate Bills No. 35 of 2024).

MIN/SEN/SCH/945/2024 **ADJOURNMENT**

There being no other business, the meeting was adjourned at thirty minutes past one o'clock. The next meeting will be called on notice.

SIGNED: .....**DATE**.....14/11/2025.....

SEN. JACKSON K. ARAP MANDAGO, EGH, MP
(CHAIRPERSON, COMMITTEE ON HEALTH)

MINUTES OF THE ONE HUNDRED AND FIFTY-FIFTH SITTING OF THE STANDING COMMITTEE ON HEALTH HELD ON TUESDAY, 1ST OCTOBER IN MINI-CHAMBER- FIRST FLOOR- COUNTY HALL, PARLIAMENT BUILDING AT 10.00 A.M.

PRESENT

1. Sen. Jackson K. Mandago, EGH, MP - **Chairperson**
2. Sen. Mariam Sheikh Omar, MP - Vice-**Chairperson**
3. Sen. Abdul Mohamed Haji, MP - Member
4. Sen. Hamida Kibwana, MP - Member
5. Sen. Esther Anyieni Okenyuri, MP - Member

ABSENT WITH APOLOGY

1. Sen. Erick Okong'o Mogeni, SC, MP - Member
2. Sen. Ledama Olekina, MP - Member
3. Sen. Joe Nyutu, MP - Member
4. Sen. Raphael Chimera, MP - Member

IN ATTENDANCE

1. Hon. Geoffrey Mulanya, MP - Friend of the Committee

SECRETARIAT

1. Mr. Humphrey Ringera - Senior Research Officer
2. Ms. Florence Waweru - Clerk Assistant
3. Mr. Mitchell Otoro - Legal Counsel
4. Mr. Ryan Injendi - Research Officer
5. Mr. Dennis Amunavi - Research Officer
6. Mr. Victor Kimani - Audio Recording Officer
7. Ms. Njeri Manga - Media Relations Officer
8. Ms. Swaluha Yusuf - Protocol Officer
9. Ms. Hawa Abdi - Sergeant- at-Arms

INATTENDACE

1. Ms. Mercy J. Kiprono
2. Mr. Issac Kandie
3. Mr. Vincent Mutai

PETITTIONERS

- Mother to the deceased
- Father to the deceased
- Advocate to the Petitioners

MOI TEACHING AND REFERRAL HOSPITAL

1. Dr. Phillip Kirwa - Chief Executive Officer
2. Dr. Stepehen Odongo - Medical Specialist
3. Mr. Josphat Kirima - Head of Dispute Settlement Services

KENYA MEDICAL PRACTIONERS AND DENTISTS COUNCIL

1. Dr. David Kariuki - Chief Executive Officer
2. Mr. Michael Onyango - Ag. Company Secretary

MIN/SEN/SCH/908/2024 **PRELIMINARIES**

The meeting was called to order at thirty minutes past ten and the proceedings commenced with a word of prayer said by the Chairperson, Sen. Jackson K. Mandago, EGH, MP.

MIN/SEN/SCH/909/2024 **ADOPTION OF AGENDA**

The agenda of the meeting was adopted with amendments after being proposed by Sen. Abdul Mohamed Haji, MP and seconded by Sen. Mariam Sheikh Omar, MP as follows-

1. Prayers;
2. Adoption of the Agenda;
3. Consideration of the Petition regarding an alleged medical negligence and staff incompetency that led to the death of Ms. Annita Jepkorir at Moi Teaching and Referral Hospital (*Committee Paper No. 94*)
4. Any other business; and
5. Adjournment/Date of the Next Meeting.

MIN/SEN/SCH/910/2024 **CONSIDERATION OF THE PETITION REGARDING AN ALLEGED MEDICAL NEGLIGENCE AND STAFF INCOMPETENCE THAT LED TO THE DEATH OF MS. ANITTA JEPKORIR AT MOI TEACHING AND REFERAL HOSPITAL**

1. The Committee Secretariat presented Committee Paper No. 94 that highlighted the issues raised in the Petition and the Prayers sought by the Petitioner regarding an alleged medical negligence and staff incompetency that led to the death of Ms. Annita Jepkorir at Moi Teaching and Referral Hospital;

2. The Committee was informed that the petitioners had prayed that the Senate-
   a. Investigates the happenings at the hospital that led to the loss of life and the doctors involved with a view to ensure that justice prevails for the deceased and the family; and
   b. Recommends the collaboration of Kenya Medical Practitioners and Dentists Council (KMPDC) and Moi Teaching and Referral Hospital (MTRH) authorities in order to address the apparent hesitation in addressing the unfortunate demise of Ms. Anita.

3. The Committee was further informed at a Sitting of the Committee held on Thursday, 11th July, 2024 while considering the Petition, the Committee had resolved to seek responses from the following stakeholders and later on 19th September resolved to invite them to a meeting of the Committee to deliberate on the issues raised in the Petition-
   a. The petitioners
   b. The Ministry of Health;
   c. The Moi Teaching and Referral Hospital (MTRH); and
   d. The Kenya Practitioners and Dentists Council (KMPDC)

Submissions by the Petitioners

4. The petitioners narrated to the Committee the chronology of events from 9th January, 2021 when Ms. Anita Jepkorir is said to have ingested a black seek which chocked her until her unfortunate demise on 10th May, 2021, after a long coughing episode while playing;

5. The Committee was informed that-
   a. on 9th January, 2021, the late Ms. Anita Jepkorir ingested a black seed which choked her and she was rushed to *Mediheal Hospital* where she was referred to Moi Teaching and Referral Hospital (MTRH) for *bronchoscopy*. However, according to the MTRH, the *bronchoscopy* showed no evidence of a foreign body in her airway;
   b. on 10th January, she was discharged from the MTRH but before she had been cleared, developed respiratory distress necessitating her to be re-admitted. on 13th January, the hospital performed a *gastrografin* test to see if something was stuck in her esophagus, but no abnormalities were found;
   c. on, 19th January, she underwent a CT Chest Bronchogram and the report indicated that there was a ring like foreign body in the right bronchi. The parents then showed the medical team who were handling her case a sample of the seed which she had choked on so that they could be aware of what to look out for. on 22nd January, Ms. Anitta was taken to theatre for a bronchoscopy procedure to remove the foreign body from her right bronchi.
   d. after receiving Ms. Anitta at the recovery room, one Dr. Earnest Nshom, assistant anesthesiologist, explained to the parents that bronchoscopy was not successful and they had performed thoracotomy procedure. The parents (petitioners) were later informed that it was not a seed that had been stuck in her airway, it was a tooth;
   e. Dr. Nshom further confided to the parents that he had removed the two teeth as they were wobbly during the bronchoscopy procedure and so in total, they had managed to remove three teeth including the one from the lung. However, the parents could only find two teeth and upon inquiring on the third tooth which was supposedly taken from the lung, one Dr. Alfred Wanyonyi told them to stop asking questions and if they kept asking for the foreign body that was removed, then the nurses might hear them and they could do something bad to their child. The doctor kept threatening them further until they resigned from asking questions;

f. on 28th January, Ms. Annita was discharged from hospital and the parents kept going back for medical check-up as her condition did not improve and she kept having bouts of fever and chest congestion. Between February and April, 2021, there were numerous hospital visits including one admission;
g. on 10th May, 2021, while playing outside, Ms. Anita had a long coughing episode in which she fainted and was rushed to hospital where she was pronounced dead on arrival. Thereafter an autopsy conducted by Dr. David Chumba revealed a black seed in the right bronchi as was shown in the first CT Chest scan and her right lung was badly damaged;
h. after the postmortem findings, the parents launched a complaint with the MTRH and also made efforts to have the issues addressed by the Kenya Medical and Dentists Practitioners Council (KMPDC). Nonetheless, they felt subjected to humiliation, harassment and intimidation by individuals from these institutions to drop pursuit of justice and abandon the matter;
i. their petition to KMPDC lodged on 12th July, 2021 stalled until she posted her plight on social media in September and October 2022 when the matter was scheduled for mention and subsequent hearing on 12th October, 2022. However, the decision of the KMPD disciplinary committee was rendered seven (7) months after the hearing on 5th May, 2023.

6. Petitioners further informed the Committee that Ms. Anita Jepkorir death was largely caused by negligence of the attending doctors and consultants at the MTRH who allowed trainees to undertake such a delicate procedure and make critical decisions. The mother added that while at the recovery ward, her daughter was used by a Prof. Utsula, a cardio thoracic surgeon, during a training session with some of his students. However, the consultants and specialists at the institution continued to make efforts to cover up their actions.

7. The petitioner informed the Committee that she was concerned that one Dr. Ondigo, a cardio thoracic surgen, did not perform the operation but was taking blame on behalf of the hospital. She added that Dr. Ondigo personally visited the family's rural home where Ms. Anita is buried and convinced elders and community leaders that he went to seek forgiveness and tied a heifer near the grave.

8. The petitioners were further concerned by the insistence by the MTRH that Dr. Ondigo and Dr. Otsyla attended to the patient alongside Dr. Nshom and Dr. Wanyonyi while none of the two gentlemen ever appeared at the theatre. She argued that the hospital and the doctors involved should therefore tender an apology for the loss and pain caused to the family by misdiagnosis and unconsented thoracotomy surgery.

b) Submissions by Moi Teaching and Referral Hospital (MTRH)

9. The Chief Executive Officer of the MTRH on an oath informed the Committee that the late Ms. Anita Jepkorir received the highest attainable healthcare service and caregivers included medical specialists in cardio-thoracic surgeons and consultant pediatricians.

10. The Committee was further informed that-

a. the late Ms. Anitta Jepkorir was admitted at MTRH on 9th January, 2021 with respiratory distress and following a bronchoscopy procedure a mucus plug was noted and cleared out. The girl was then later taken to the ward for recovery. However, symptoms persisted between 10th January and 19th January, 2021, several investigations were done such as a gastrographin test, a virtual bronchoscopy and a CT scan which revealed a ring-like foreign body in the right bronchi;

b. the parents' consent was sought for a bronchoscopy procedure, plus/minus other procedures to remove the foreign the body. Consequently, on 22nd January, 2021, while in theatre the bronchoscopy procedure proved to be unsuccessful hence a thoracotomy was opted for direct removal of the object. However, during intubation the deceased upper two incisor- teeth got loose necessitating their removal. The two incisor teeth removed were presented to the parents and following recovery the girl was discharged on 27th January, 2021 and kept on having subsequent clinic- review visits;

c. on 8th February, 2021 the deceased was admitted and a CT-scan revealed bi-basal pneumonia and pleural thickening on both lungs. She was treated with antibiotics and later discharged on 14th February, 2021. However, on 10th May, 2021, while playing with other children at home Anita collapsed and she was pronounced dead on arrival at the MTRH. The postmortem investigations revealed the immediate cause of death to be asphyxia due to food particles up the terminal bronchi.

d. after the unfortunate incident MTRH management including the cardio-thoracic team, nurses, customer relations and communication officers held several meetings with the immediate and extended family to address their concerns and complaints. The hospital offered the family full psychological counselling and support for free.

e. on 28th June, 2021, Ms. Mercy Kiprono, mother of the deceased filed a case against MTRH at the Kenya Medical Practitioners and Dentists Council (KMPDC). The case was heard and determined on 5th May, 2023 where MTRH was directed to mediate with the estate of the late Anita with a view of making restitution and thereafter inform the Council. However, MTRH faced resistance from the family of the deceased which derailed the mediation talks;

f. on, 2nd June, 2023 the MTRH received a letter from MS/ Tarigo Kiptoo & Co Advocates informing them about a change in advocates and demanding a neutral mediation ground and mediator. This led to the hospital's request to the Nairobi Center for International Arbitration to guide the mediation process being the statutorily mandated body. However, the mediation talks collapsed and the efforts to resolve the matter through mediation of quantum damages as ordered by KMPDC had been met with hostility and stalled.

c) Submissions by Kenya Medical Practitioners and Dentists Council (KMPDC)

11. The KMPDC presented written submissions and informed the Committee that a decision was issued on 5th May, 2023 having heard all the parties and interrogated the evidence presented before it.

12. KMPDC informed the Committee that-
    a. KMPDC Disciplinary Committee found that the complaint against Dr. Stephen Ondigo and Moi Teaching and Referral Hospital had merit. Consequently, the KMPDC had directed that Dr. Stephen Ondigo and MTRH mediate with the Estate of the late Annita jointly and severally with a view to making restitution and thereafter inform the Council within 90 days; and
    b. KMPDC Disciplinary Committee also directed Dr. Ondigo and MTRH to each pay a fine of Kshs. 200,000/- and Kshs 350,000/- respectively.

Committee deliberations.

13. During deliberations, the Committee observed that-
    a. there was no evidence produced by the MTRH and the KMPDC to confirm that a consent was sought to perform thoracotomy following the failure of the virtual bronchoscopy to retrieve the foreign body;
    b. the intubation process may have been carried out unprocedurally leading to the loss of two upper incisors teeth and subsequent pushing one of them through to the airway to the lungs necessitating thoracotomy;
    c. whereas, scans showed presence of ring-like object further examinations were not carried out following removal of a tooth during thoracotomy; and
    d. there is needed for KMPDC to prepare and submit to the Committee a comprehensive report on dispute resolutions mechanisms, highlighting the number of complaints received within the last five years, the number of complaints resolved, the type of resolution reached, the timelines within which such disputes were resolved, and challenges if any, facing dispute resolution mechanisms.

MIN/SEN/SCH/911/2024 **ANY OTHER BUSINESS**

There was no other business.

MIN/SEN/SCH/912/2024 **ADJOURNMENT**

There being no other business, the meeting was adjourned at thirty minutes past two. The next meeting will be by notice.

SIGNED: .....**DATE**.....08/11/24.....

SEN. JACKSON MANDAGO, EGH, MP
(CHAIRPERSON, COMMITTEE ON HEALTH)

MINUTES OF THE A HUNDRED AND FORTY-EIGHTH-HYBRID- SITTING OF THE STANDING COMMITTEE ON HEALTH HELD ON THURSDAY, 11TH JULY, 2024, AT 10.00 A.M IN COMMITTEE ROOM 4, BUNGE TOWER BUILDING.

PRESENT

1.	Sen. Jackson K. Mandago, EGH, MP	-	**Chairperson**
2.	Sen. Mariam Sheikh Omar, MP	-	**Vice-Chairperson**
3.	Sen. Joe Nyutu, MP	-	Member
4.	Sen. Raphael Chimera, MP	-	Member
5.	Sen. Esther Anyieni Okenyuri, MP	-	Member

ABSENT WITH APOLOGY

1.	Sen. Erick Okong'o Mogeni, SC, MP	-	Member
2.	Sen. Ledama Olekina, MP	-	Member
3.	Sen. Abdul Mohamed Haji, MP	-	Member
4.	Sen. Hamida Kibwana, MP	-	Member

SECRETARIAT

1.	Mr. Humphrey Ringera	-	Senior Research Officer
2.	Ms. Florence Waweru	-	Clerk Assistant
3.	Mr. Mitchell Otoro	-	Legal Counsel
4.	Mr. Victor Kimani	-	Audio Officer
5.	Mr. Ryan Injendi	-	Research Officer
6.	Mr. Dennis Amunavi	-	Research Officer
7.	Ms. Lilian Onyari	-	Fiscal Analyst
8.	Mr. David Muthuri	-	DSEC-Intern
9.	Ms. Hawa Abdi	-	Sergeant- at-Arms

MIN/SEN/SCH/859/2024 **PRELIMINARIES**

The meeting was called to order at thirty minutes past ten and the proceedings commenced with a word of prayer said by the Chairperson, Sen. Jackson K. Mandago, EGH, MP

MIN/SEN/SCH/860/2024 **ADOPTION OF AGENDA**

The Agenda of the meeting was adopted after being proposed by Sen Mariam Sheikh Omar, MP and seconded by Sen. Raphael Chimera, MP as follows-

1. Prayers
2. Adoption of the Agenda
3. Confirmation of the Minutes of the *125th;131st. 132nd; 134th; 144th; 145th* and *146th* Committee Meetings;
4. Matters arising from Minutes of Previous Committee Meetings;
5. Consideration of the Committee Brief on the Social Health Insurance (General) Regulations (Legal Notice No.49 2024) and the Social Health Insurance (Tribunal Procedures Rules 2024) (Legal Notice No. 48 of 2024) (*Committee Paper* No. 85);
6. Consideration of a Petition to the Senate by Mercy Cherono concerning an alleged medical negligence and staff incompetency that led to the death of Ms. Annita Jepkorir at Moi Teaching and Referral Hospital (*Committee Paper No. 86*);
7. Any other business; and
8. Adjournment/Date of the Next Meeting.

MIN/SEN/SCH/861/2024 **CONFIRMATION OF MINUTES**

1) Minutes of the 132nd sitting held on Monday, 20th May, 2024 at 10.00 a.m. were confirmed to be a true record of the deliberations having been proposed by Sen Mariam Sheikh Omar, MP and seconded by Sen. Esther Okenyuri, MP;

2) Minutes of the 134th sitting held on Thursday, 23rd May, 2024 at 10.00 a.m were confirmed to be a true record of the deliberations having been proposed by Sen Mariam Sheikh Omar, MP and seconded by Sen. Raphael Chimera, MP;

3) Minutes of the 144th sitting held on Tuesday, 26th June, 2024 at 10.00 a.m. were confirmed to be a true record of the deliberations having been proposed by Sen. Joe Nyutu, MP and seconded by Sen. Mariam Sheikh Omar, MP;

4) Minutes of the 145th sitting held on Tuesday, 2nd July, 2024 at 10.00 a.m. were confirmed to be a true record of the deliberations having been proposed by Sen. Mariam Sheikh Omar, MP and seconded by Sen. Joe Nyutu, MP; and

5) Minutes of the 146th sitting held on Thursday, 4th July, 2024 at 10.00 a.m. were confirmed to be a true record of the deliberations having been proposed by Sen. Joe Nyutu, MP and seconded by Sen. Mariam Sheikh Omar, MP.

MIN/SEN/SCH/862/2024 **MATTERS ARISING FROM MINUTES OF PREVIOUS COMMITTEE MEETINGS**

There were no matters arising.

MIN/SEN/SCH/863/2024 **CONSIDERATION OF THE COMMITTEE BRIEF ON THE SOCIAL HEALTH INSURANCE REGULATIONS**

1) The Committee Secretariat presented Committee Paper No. 85 on the consideration of the Committee Brief on the Social Health Insurance (General) Regulations (Legal Notice No.49 2024) and the Social Health Insurance (Tribunal Procedures Rules 2024) (Legal Notice No. 48 of 2024); and

2) Members observed that the Motion on the Report of the Select Committee on Delegated Legislation on its consideration of the Social Health Insurance (General) Regulations, 2024 and the Social Health Insurance (Tribunal Procedures Rules 2024) (Legal Notice No. 48 of 2024) had been debated in the House and the mover had been called to reply, therefore the matter had been concluded.

MIN/SEN/SCH/863/2024 **CONSIDERATION OF A PETITION TO THE SENATE ON THE ALLEGED MEDICAL NEGLIGENCE AND STAFF INCOMPETENCY LEADING TO THE DEATH OF MS. ANNITA JEPKORIR AT MOI TEACHING AND REFERAL HOSPITAL.**

1. The Committee Secretariat presented Committee Paper No. 86 on a Petition to the Senate by Mercy Cherono concerning an alleged medical negligence and staff incompetency leading to the death of Ms. Annita Jepkorir at Moi Teaching and Referral Hospital.
2. The Committee considered the Petition and the prayers therein and resolved to seek information from the following stakeholders-
   a. *The Cabinet Secretary, Ministry of Health;*
   b. *The Chief Executive Officer, Kenya Medical Practitioners and Dentists Council (KMPDC); and*
   c. *The Chief Executive Officer, Moi Teaching and Referral Hospital*

MIN/SEN/SCH/865/2024 **ANY OTHER BUSINESS**

1. The Committee observed that Senate Resolutions on the matters falling under its mandate should be continuously followed up and the attendant Ministries, Departments and Agencies should be filling periodic reports for consideration;
2. The Committee resolved to seek clarification and supplementary information on the-
   a. All pending NHIF remittances to healthcare facilities countrywide;
   b. Status of account of NHIF contributions; and
   c. Detailed information on all payouts to healthcare facilities in the FY 2023/24
3. The Committee directed the Secretariat to develop a Committee work plan on activities to be undertaken during the Senate *Mashinani* scheduled to be held in Busia County in September, 2024.

MIN/SEN/SCH/866/2024 **ADJOURNMENT**

There being no other business, the meeting was adjourned at fifteen minutes past noon. The next meeting will be by notice.

SIGNED: .....

(CHAIRPERSON, SEN. JACKSON MANDAGO, EGH, MP)

DATE: 18/11/2024

Annex 2:

Copy of the Petition and submissions from the petitioner.

Petition To The Senate By Mercy Cherono Concerning The Medical Negligence And Staff Incompetency That Led To The Death Of Her Daughter Ms. Annita Jepkorir At Moi Teaching And Referral Hospital

The Clerk of the Senate
Parliament Buildings
P.O. Box 41842 – 00100
NAIROBI
Email: clerk.senate@parliament.go.ke

RE: PETITION TO THE SENATE CONCERNING THE MEDICAL NEGLIGENCE AND STAFF INCOMPETENCY THAT LED TO THE DEATH OF MS. ANNITA JEPKORIR AT MOI TEACHING AND REFERRAL HOSPITAL

I, Mercy Jepchirchir the undersigned,

Citizen of the Republic of Kenya, and resident of Annex estate, Eldoret Town, Uasin Gishu County;

DRAW the attention of the Senate to the following:

1. *On 9th January 2021, Annita Jepkorir ingested a black seed which choked her and she was rushed to Mediheal hospital which then referred her to Moi Teaching and Referral Hospital to have a bronchoscopy done to remove the seed that was stuck in her airway.*

1.1 THAT, at Moi Teaching and Referral Hospital, she was taken to theatre where they did a bronchoscopy which showed that there was no evidence of a foreign body in her airway according to the report by Dr. Oloo;

1.2 THAT, on 10th January2021, Annita was discharged from the hospital but even before she had been cleared, she developed a respiratory distress necessitating her to be readmitted;

1.3 THAT, on 13th January 2021, the hospital performed a gastrografin test to see if something was stuck in her esophagus but no abnormalities were found;

1.4 THAT, on 19th January 2021, Annita underwent a CT Chest Bronchogram and the report indicated that there was a ring like foreign body in the right bronchi. The parent showed the medical team who were handling her case a sample of the seed which she had choked on so that they could be aware of what to look out for.

2. *On 22nd January 2021, Annita was taken to theatre of which the parent consented for a Bronchoscopy procedure to remove the foreign body from her right bronchi. The bronchoscopy procedure was not successful and the medical team*

3.5 THAT, after the postmortem findings, we launched a complaint with the hospital management on account of negligence given that the hospital staff lied about removing the foreign body from Annita which was not the case. This case of neglect subsequently caused her death which could have been avoided if due diligence was followed.

4. THAT, the parents have made the best efforts to have these matters addressed by the relevant authorities all of which have failed to give a satisfactory response.

5. THAT, none of these issues raised in this Petition is pending in any court of Law, Constitutional or any other legal body.

WHEREFORE, your humble petitioner prays that the Senate-

1. Investigates the happenings at the hospital that led to the loss of a life and the doctors involved with a view to ensure that justice prevails for the deceased and the family.

2. Recommends the collaboration of Kenya Medical Practitioners and Dentists Council (KMPDC) and Moi Teaching and Referral Hospital (MTRH) authorities in order to address the apparent hesitation in addressing the unfortunate demise of Anita.

Dated this 22nd day of May, 2024.

No	NAME	ADDRESS	I.D. No.	SIGNATURE
1.	Mercy Jepchirchir	P.O Box 9266, Eldoret	22381620	

Counter signed by Senator Hamida Kibwana, Nominated Senator.

Sen. Hamida Kibwana, MP
Nominated Senator

SUBMISSIONS BY MERCY JEPKORIR KIPRONO ON HER PETITION CONCERNING MEDICAL NEGLIGENCE AND STAFF INCOMPETENCE THAT LED TO PREVENTABLE DEATH OF SIX (6) YEAR OLD ANNITA JEPKORIR CHIRCHIR ON 10TH MAY 2021

The Humble submissions of Mercy Jepkorir Kiprono shows as follows:

Introduction

1. The Petitioner is mother to the late Annita Jepkorir Chirchir. Annita was born on 17th January 2015, and would now be aged 9 years and 9 months but for the negligent acts of staff at Moi Teaching Referral Hospital (MTRH) who rendered inept care that led to her death on 10th May 2021 while aged only 6.

Summary points

2. This Petition proves four points:

   (a). Annita's death was largely caused by the negligence of the attending doctors and consultants at Moi Teaching and Referral Hospital (MTRH) where the parents of the little girl had sought medical attention arising from a minor accident where she had aspirated a flower seed. In particular, MTRH and the Consultants allowed trainee doctors to undertake a delicate procedure and make critical decisions when they were not qualified to do so.

   (b). Once it was discovered that the trainee doctors had messed up, the consultants who should have supervised them, and been with them while undertaking critical decisions actively lied about what had happened in an attempt to cover up their misdeeds.

   (c). When this cover-up did not work, MTRH, its leadership, individual doctors involved and staff at the Medical Practitioners and Dentists Council (KMPDC) engaged in high stakes manipulation to influence the Petitioner to abandon this matter.

   (d). The KMPDC is largely unaccountable to the public, unlike courts or other tribunals. As such the KMPDC does not care about the welfare of people who have been hurt through negligence and would rather protect medical practitioners than render justice. There is clear need for a regulatory overhaul of the KMPDC so that it operates openly in the same way as other tribunals and be under the stewardship of the judiciary.

Facts

3. On 9th January 2021, the Petitioner took her daughter to MTRH after her daughter complained that she was being choked by a seed that she had inhaled. A cardiothoracic

review was done by Dr. Oloo who saw no distress and discharged the girl at 12.30 pm. **(See Continuation sheet dated 9th January 2021 marked as Document 1).**

4. However, at 6pm, the Petitioner noted that the girl was having respiratory distress and so took her back to MTRH. She was admitted and a bronchoscopy was performed by Dr. Oloo at 11.43 pm. Dr. Oloo only removed a mucus plug and reported not finding the seed. **(See Operation Notes dated 9th January 2021 marked as Document 2 and Discharge Summary dated 10th January 2021, marked as Document 3).**

5. A discharge was recommended and was to happen on 10th January 2021 but even before the Petitioner left the hospital premises, the girl developed respiratory distress and had to be re-admitted. She stayed in hospital until 28th January. **(See Discharge Summary of 28th January 2021 marked as Document 4).** The following transpired between 10th and 28th January.

   (a). On 13th January 2021, MTRH undertook a gastrograffin study and a virtual bronchoscopy and apparently found no foreign body.

   (b). On 19th January 2021, MTRH performed a CT Chest Bronchogram and this time, the test established that there was a "ring-like" foreign body in the right bronchi. **(See the Radiologist's report dated 19th January 2021 marked as Document 5).**

   (c). MTRH scheduled a procedure for removal of the foreign body and on 22nd January 2021, the child was wheeled into the theatre at 9.30 am. Before that procedure, the Petitioner showed the 2 doctors involved – Dr Ernest Nshom and Dr. Alfred Wanyonyi a sample of the seed that was lodged in the girl's lungs so they could better appreciate what to look for.

   (d). The doctors performed a second bronchoscopy at 9.50 am but they were unable to retrieve the object. They decided, without informing the parents or seeking their consent, to do a thoracotomy – a surgical opening up of the thoracic space, to gain access to the lungs – so to apparently remove the foreign body. They purported to have retrieved a tooth, which they assumed was the foreign body.

   (e). When the girl was wheeled into the recovery room, Dr. Nshom informed the Petitioner that they did not find the seed in the girl's lungs but a tooth. He also said that during the procedure, they extracted some 2 upper incisor teeth. He indicated that the tooth removed from the lungs and the 2 they extracted were in the two bandages strapped to the girl's leg – a blue bandage with 2 extracted teeth and a white bandage with the tooth removed from the lungs (as the foreign body).

(f). Upon checking the bandages, the Petitioner found that each had one tooth only. This did not add up and so she asked the nurses about a third tooth. This inquiry invited the wrath of Dr. Wanyonyi who directed the Petitioner and her husband to a room where he proceeded to dress them down with words to the following effect:

> **"Can't you appreciate what we have done? Stop asking me for the foreign body you have wasted my time, my fuel and other patients in the theatre. So you think I did not remove the foreign body, appreciate that Annita did not go to I.C.U. You are the type of people that removes the money in bank and goes home without counting, then you start complaining later. Take care if these nurses hear you asking for the foreign body again they might do something bad to your child".**

(g). Dr. Wanyonyi kept up with his threats including making the proposition that he would bill the parents for the extraction of the teeth if they persisted. The threats had the desired effect since the parents, feeling intimidated, tendered their profuse apologies and left the room.

(h). Even though the girl continued to cough, the parents were advised that this was a normal post-operative occurrence they should not worry about.

(i). On 25th January 2021, one Professor Khwa' Otsyula came to the ward accompanied by Dr. Nshom and Dr. Wanyonyi and they proceeded to discuss some x-rays that had just been taken. Dr. Otsyula recommended that the tube attached to the girl's chest be removed. (**See Continuation Sheet dated 25th January 2021 marked as Document 6.**)

(j). The girl was discharged on 28th January 2021 and taken home.

6. However, her cough persisted despite continued use of the prescribed medication. The parents took her to the MTRH Clinic on 4th February 2021 for a scheduled check-up. She was seen and allowed to go home. (**See treatment notes dated 4th February 2021 marked as Document 7**).

7. On 8th February 2021, she started vomiting, ran a fever and exhibited general weakness and illness. She was admitted at MTRH once more and a CT chest scan was undertaken. However, the investigation done and medications prescribed were for severe pneumonia. There was no attempt to revisit the girl's history on the foreign body. (**See Continuation Sheet dated 8th February 2021 marked as Document 8**).

8. While there, the Petitioner informed the attending consultants – Professor Otsyula and Dr. Ondigo - that the girl had been re-admitted and that they should make haste and check her again since the Petitioner thought that Dr. Nshom and Dr. Wanyonyi had not been forthright about what happened in the theatre. The consultants – Dr. Otsyula and Dr. Ondigo – looked at the CT scan slides and the report and stated affirmatively that the girl was OK but was only suffering from post-thoracotomy pneumonia.

9. Even though the girl was discharged to go home on 15th February 2021 (**see Discharge Summary dated 15th February 2021 marked as Document 9**), her condition did not improve as she continued to run fevers and cough. The fever forced the parents to take her to Mediheal Hospital out-patient clinic on 5th March 2021. They made another visit to Mediheal on 6th April 2021 again on account of fevers.

10. The parents took her back to MTRH on 16th April because of coughing, vomiting and fevers. (**See Continuation Sheet dated 16th April 2021 marked as Document 10**). MTRH prescribed medicines and sent them home. They followed up with another visit on 22nd April 2021 and again she was seen as an outpatient and sent home with some more medication. (**See continuation sheet dated 22nd April 2022 marked Document 11.**)

11. On 10th May 2021, while the girl was playing, she had a long coughing bout, fainted and fell down. The parents rushed her to MTRH where she was pronounced dead on arrival. At first MTRH refused to admit her body to their mortuary urging the Petitioner to look for a morgue outside the hospital. Eventually they admitted the girl to the morgue around 8 pm (note she had died at 9 am).

12. An autopsy conducted by Dr. Chumba on 13th May 2021 found a seed in the right bronchi confirming the radiological finding on 19th January 2021 which had shown the presence of a foreign body in the right main bronchi. The foreign body had caused an infection of the lungs. (**See autopsy report by Dr. Chumba dated 13th May 2021 marked as Document 12 and Certificate of Death marked as Document 13**).

The aftermath

13. Since it was apparent that MTRH had somehow failed to deal with the foreign object that they themselves had found on 19th January 2021 and especially in view of the history of the patient as narrated by the Petitioner, the relatives sought audience with the relevant officials. MTRH's deputy CEO was antagonistic and accused the parents of negligence.

14. The Petitioner went to the CEO's office and her persistence secured her a date for a meeting. The meeting was held on 25th May 2021 but from the word go, it was clear that MTRH had less than noble objectives to achieve. MTRH was

not interested in coming clean with what happened but wanted the matter to be hushed down. (**See minutes of the meeting held on 25th May 2021 marked as Document 14.**)

MTRH's intransigence and impunity

15. First off, the Petitioner had her family were kept waiting and then made to see the Deputy CEO. The CEO showed up well into the evening for a meeting that was to start early in the morning.

16. Second, MTRH refused to hand over the patient's file to the Petitioner and her husband raising spurious arguments about confidentiality.

17. Third, MTRH kept insisting that Dr. Ondigo and Dr. Otsyula attended to the patient alongside Dr. Nshom and Dr. Wanyonyi. Clearly this was a lie since the Petitioner and her relatives were present all along during the procedure on 22nd January and none of those gentlemen ever appeared in the theatre. The idea here was to shield the MTRH from being blamed for allowing registrars to perform delicate care procedures in the hospital without supervision.

18. Fourth, Dr. Ondigo and Dr. Nshom came up with a new theory – they alleged that two teeth were accidentally pushed into the patient's mouth, one was recovered but that one was aspirated into the patient's lungs, where it bypassed the seed and lodged at the bottom. This was a clear contradiction.

19. Fifth, when the Petitioner filed a complaint with the KMPDC (Disciplinary Case No. 43 of 2021) (**see Complaint lodged on 28th June 2021 marked as Document 15**), a concerted effort was made to reach out to family members while bypassing the Petitioner here. Indeed, Dr. Ondigo personally visited the family's rural home at Kapkitony where their little girl was buried and convinced elders and community leaders that he went to seek forgiveness, paid the elders some money, then tied a heifer near the girls grave! This was an insidious attempt to invoke an old Keiyo cultural practice where a person who killed another sought forgiveness by tying a cow somewhere in the deceased's person home or next to their grave. Culturally, when this was done, the victim's family would have to agree to a meeting with the perpetrator to allow the latter to ask for forgiveness. The idea was to make the Petitioner's parents to persuade the Petitioner to attend a meeting of reconciliation. The meeting was held sometimes in October 2021 at Kapkitony. Dr. Ondigo gave out money and milk to the elders present. However, he completely refused to accept his wrongdoing and so the Petitioner did not agree to withdraw her case.

20. When it became apparent that the Petitioner would not budge, Dr. Ondigo begun stalking her, going to her house on 24th October 2021 and attempting to coerce her to sign a pre-prepared agreement to withdraw her complaint. (**See copy of the agreement dated 24th October 2021 marked as Document 16**).

21. From correspondence by the CEO MTRH, it is apparent that even as Dr. Ondigo was making overtures to the Petitioner, MTRH was never prepared to own up to the misdeeds of its doctors. (**See letter dated 17th June 2021 by the family – marked as Document 17.**) The notes made on it by Dr. Aruasa are clearly indicative of an arrogant and unapologetic person. (**See also the formal response dated 22nd June 2021 –marked as Document 18**) which was equally dismissive and unapologetic.

KMPDC's complicity

22. The Petitioner lodged her complaint with KMPDC on or about 12th July 2021. KMPDC never took any action at all for over 8 months. The Petitioner wrote many email inquiries all of which were studiously ignored. (**See copies of emails marked as Document 19**). The Petitioner instructed an advocate who wrote a demand letter dated 8th February 2022 which the KMPDC again ignored. (**See demand letter marked as Document 20**).

23. The Petitioner made several visits to KMPDC offices in Nairobi to no avail. During these visits, KMPDC's Legal Services Manager, one Eunice Muriithi attempted to convince the Petitioner to withdraw the Complaint and negotiate with MTRH.

24. The matter continued to stall until the Petitioner posted her plight on social media in September and October 2022. (**See copies of social media posts marked as document 21**). Soon thereafter, the matter was scheduled for mention on 20th September and a hearing on 12th October 2022. After the hearing, and before delivery of decision, KMPDC apologised to the Petitioner for the manner it had handled her complaint. (**See email dated 17th October 2022 marked as Document 22.**)

25. Despite the apology, the decision of the disciplinary committee was rendered 7 months after the hearing, on 5th May 2023. This was close to 2 years since the complaint was lodged and 5 days shy of the 2nd anniversary of the demise of the Petitioner's child. (**See the decision of the Council marked as Document 23.**)

Prayers

26. In view of the foregoing, the Petitioner prays that Senate:

    (a). Publicly censures MTRH for ineptitude that led to the demise of Annita Jepkorir Chirchir

    (b). Publicly censures MTRH for allowing trainee students to undertake delicate and complicated medical surgeries without supervision which led to the death of Annita Jepkorir Chirchir.

(c). Censures the KMPDC for inefficiency and lack of concern for the plight of the Petitioner herein and other Complainants whose claims have taken years before resolution.

(d). Orders KMPDC to present a comprehensive report of all complaints received in the last 5 years, complaints resolved, the type of resolution reached and the timelines during which those complaints were resolved together with a list of backlogs and reasons thereof.

(e). Recommends appropriate legislative reforms that will enhance the complaints handling procedure within the KMPDC. Complaints of patient mismanagement could perhaps be removed from the KMPDC and handed over to a tribunal under the Judiciary. It will be easier to devolve complaints handling to counties to avoid a situation such as the Petitioner's who had to travel over 600 kilometres (round trip) many times just to pursue this matter.

DATED this ..... 27th ..... day of ..... September..... 2024

SIGNED: ISAAC KANDIE .....

ID NUMBER: 22432018

PHONE: 0720322296

MERCY JEPKORIR KIPRONO:.....

ID NUMBER: 22386020

PHONE: 0720496205

PETITION REGARDING MEDICAL NEGLIGENCE AND STAFF INCOMPETENCE LEADING TO THE DEATH OF MS. ANNITA JEPKORIR AT MOI TEACHING AND REFERAL HOSPITAL

TO

THE CLERK, SENATE

FOR AND ON BEHALF OF MERCY JEPKORIR KIPRONO AND ISAAC KANDIE (THE PARENTS)

SIGNED: ISAAC KANDIE .....

ID NUMBER: 22432018

PHONE: 0720322296

MERCY JEPKORIR KIPRONO:.....

ID NUMBER: 22386020

PHONE: 0720496205

BY

MUTAI ODUOR & COMPANY ADVOCATES (MOCA) LLP,

KVDA PLAZA, 7TH FLOOR, OLOO STREET,

P.O. BOX 10768-30100,

ELDORET,

Email address: mutaioduor@gmail.com

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PETITION AS TABLED IN SENATE

Petition To The Senate By Mercy Cherono Concerning The Medical Negligence And Staff Incompetency That Led To The Death Of Her Daughter Ms. Annita Jepkorir At Moi Teaching And Referral Hospital

The Clerk of the Senate
Parliament Buildings
P.O. Box 41842 – 00100
NAIROBI
Email: clerk.senate@parliament.go.ke

RE: PETITION TO THE SENATE CONCERNING THE MEDICAL NEGLIGENCE AND STAFF INCOMPETENCY THAT LED TO THE DEATH OF MS. ANNITA JEPKORIR AT MOI TEACHING AND REFERRAL HOSPITAL

I, Mercy Jepchirchir the undersigned,

Citizen of the Republic of Kenya, and resident of Annex estate, Eldoret Town, Uasin Gishu County;

DRAW the attention of the Senate to the following:

1. *On 9th January 2021, Annita Jepkorir ingested a black seed which choked her and she was rushed to Mediheal hospital which then referred her to Moi Teaching and Referral Hospital to have a bronchoscopy done to remove the seed that was stuck in her airway.*

1.1 THAT, at Moi Teaching and Referral Hospital, she was taken to theatre where they did a bronchoscopy which showed that there was no evidence of a foreign body in her airway according to the report by Dr. Oloo;

1.2 THAT, on 10th January2021, Annita was discharged from the hospital but even before she had been cleared, she developed a respiratory distress necessitating her to be readmitted;

1.3 THAT, on 13th January 2021, the hospital performed a gastrografin test to see if something was stuck in her esophagus but no abnormalities were found;

1.4 THAT, on 19th January 2021, Annita underwent a CT Chest Bronchogram and the report indicated that there was a ring like foreign body in the right bronchi. The parent showed the medical team who were handling her case a sample of the seed which she had choked on so that they could be aware of what to look out for.

2. *On 22nd January 2021, Annita was taken to theatre of which the parent consented for a Bronchoscopy procedure to remove the foreign body from her right bronchi. The bronchoscopy procedure was not successful and the medical team*

proceeded to perform a thoracotomy procedure which the parents had not consented to.

2.1 THAT, after receiving Annita at the theatre recovery room, Dr. Ernest Nshom explained to us that it was not a seed that was stuck in her airway and it was actually a tooth;

2.2 THAT, the parents realized that Annita had lost two of her upper incisors teeth while in theatre and upon further questioning, Dr. Nshom confided to us that he removed the two teeth as they were wobbly during the bronchoscopy procedure and so in total they had managed to remove three teeth including the one from the lung;

2.3 THAT, the parents could only find two teeth and upon inquiring on the the third tooth which was supposedly taken from the lung, one Dr. Alfred Wanyonyi told them to stop asking questions and instead be grateful that that their daughter was still alive and that if they kept asking for the foreign body that was removed, then the nurses might hear them and they could do something bad to their child. The doctor kept threatening them further until they resigned from asking questions;

3. On 28th Jan 2021, Annita was discharged from hospital and the parents kept going back for checkups as her condition didn't improve that much as she kept having bouts of fever and chest congestion. Between February and April, there were numerous hospital visits including one admission;

3.1 THAT, no follow up CT Scan was done to show whether the procedures done were successful in removing the foreign object from the patient despite being readmitted to the hospital with the same symptoms of respiratory distress;

3.2 THAT, on 10th May 2021, while playing outside, Annita had a long coughing episode in which she fainted and was rushed to hospital where she was pronounced dead on arrival;

3.3 THAT, the parents were made to wait with the body of the deceased for over 12hrs which was very traumatizing before she was finally moved to the Moi Teaching and Referral Hospital Mortuary;

3.4 THAT, on 13th May 2021, an autopsy of Annita was done by Dr. David Chumba and he found a seed in the right bronchi of the deceased as it was shown in the first CT Chest report which had indicated the presence of a foreign body in the right bronchi and the right lung had badly been damaged.

3.5 THAT, after the postmortem findings, we launched a complaint with the hospital management on account of negligence given that the hospital staff lied about removing the foreign body from Annita which was not the case. This case of neglect subsequently caused her death which could have been avoided if due diligence was followed.

4. THAT, the parents have made the best efforts to have these matters addressed by the relevant authorities all of which have failed to give a satisfactory response.

5. THAT, none of these issues raised in this Petition is pending in any court of Law, Constitutional or any other legal body.

WHEREFORE, your humble petitioner prays that the Senate-

1. Investigates the happenings at the hospital that led to the loss of a life and the doctors involved with a view to ensure that justice prevails for the deceased and the family.

2. Recommends the collaboration of Kenya Medical Practitioners and Dentists Council (KMPDC) and Moi Teaching and Referral Hospital (MTRH) authorities in order to address the apparent hesitation in addressing the unfortunate demise of Anita.

Dated this 22nd day of May, 2024.

No	NAME	ADDRESS	I.D. No.	SIGNATURE
1.	Mercy Jepchirchir	P.O Box 9266, Eldoret	22381620	

Counter signed by Senator Hamida Kibwana, Nominated Senator.

Sen. Hamida Kibwana, MP
Nominated Senator

SENATE INVITATION

REPUBLIC OF KENYA

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PARLIAMENT
OFFICE OF THE CLERK OF THE SENATE

Ref. SEN/DSEC/SCH/368/2024 **20th September, 2024**

Ms. Mercy Cherono,
P.O. Box 9266-30100,
ELDORET.

Dear Madam,

RE: PETITION REGARDING THE ALLEGED MEDICAL NEGLIGENCE AND STAFF INCOMPETENCE LEADING TO THE DEATH OF MS. ANNITA JEPKORIR AT MOI TEACHING AND REFERAL HOSPITAL

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

The Committee is presently considering a Petition on the alleged medical negligence and staff incompetence that led to the death of Ms. Annita Jepkorir at Moi Teaching and Referral Hospital.

This is to inform you that at its sitting held on Tuesday, 17th September, 2024, the Committee resolved to invite you to a meeting of the Committee to deliberate on the issues raised in the Petition.

The purpose of this letter is to invite you to a meeting of the Committee to be held on **Tuesday, 1st October, 2024** in **Committee Room 4, First Floor, Bunge Tower,** at **10.00 a.m.**

Mr. Humphrey Ringera, Senior Research Officer **(Cell phone: +254 722 985 682; email:** humphrey.ringera@parliament.go.ke) is the Clerk to the Committee and is responsible for all arrangements relating to this matter.

Yours faithfully,

For: EG

J. M. NYEGENYE, CBS,
CLERK OF THE SENATE.

DOCUMENT 1

CONTINUATION SHEET DATED 9TH JANUARY 2021

C.T. C
Richard Ole Kaw
22/07/2021

0720 322 296. (T)

22 JUL 2021

An ISO 9001:2015 Certified Hospital

MOI TEACHING AND REFERRAL HOSPITAL

Priority wing

CONTINUATION SHEET

Name: Anita Chepkoni DOB: 2016 Age: 5yrs Sex: F Hosp No: 10025

Residence: Annex Date: 9/7/21

12.00pm

Informant: Paternal cousin

T - 11.52.
T - 36.5
Wt - 22kg

c/o: chocked on a seed x ½

HPI.

5yrs girl who was well at home when she chocked on a flower. Seed. Immediately developed drooling & vomiting. Had a mild cough. Reports that the symptoms have improved over the past half a hour. Had notable ~~Not noted~~ DIB we have slightly improved

PMHx

No previous admis

N/KFDA.

GE: Fairly Stable
P° S° C° D°

RS: Not in obvious distress
Normal quality, transmitted sounds more on the (R) side.

CVS: Warm peripheries, Capp refill immediate.
S1 S2 heard.

CNS: (R) UPJ
Cooperative.

P/A: NWR, normal fullness soft, non tender.

Impression: FB esophagus
? Expelled vs swallowed.
Ddx: FB bronchus

REX CXR: No obvious FB (? Tracheobronchial)

Plan

1. Cardiothoracic review.
Dr. Mark Olou consulted, will come review
Dr. Chelulu.

05/01/2021

Reports to have had some foreign body.
Vomited at some point
Currently breathing well
No respiratory issues right now

Plan

Allow home
TCA if she has any new issues

Dr. Mark Olou

1627 PM

Child comes back with respiratory distress

Informed Dr Olou CBC
Said Dr will
1 Hour prepare
Dr explanation
Bronchoscopy

DOCUMENT 2

OPERATION NOTES DATED 9TH JANUARY 2021

C.T.C
Richard Ole Kwyo
22/07/2024

22 JUL 2021

An ISO 9001:2015 Certified Hospital

MOI TEACHING AND REFERRAL HOSPITAL
ELDORET

OPERATION NOTES

Date: 09.01.2021

Name: Anita Chepkoir Age 2016 Sex F / Hosp No. 1002542 Ward Facility

Surgeon: Dr Oloo Ass. Surgeon:

Anaesthetist: Dr. Ebner Type of Anaesthesia: GA

Scrub Nurse: Susan Diagnosis: FB Bronchus.

Operation: Bronchoscopy Incision:

PROCEDURE

Patient was placed under GA. Cleaned & draped. Size 5 Bronchoscope used Large mucus plug noted in the carina. Both Bronchioles clear & suctioned off.

Plan
- Admit to Facility
- Rx as per Ticket
- Regular diet
- Monitor vitals

Dr Mark Oloo

10/1/21

Tachypnoeic
Dyspnoea
- patient drowsy
P.O.D #1 following

Bronchoscopy
& Suction of mucus plug
- Had hypopharyngeal aspiration of food seed. (brown/chewed)

Today: has no issue
- Requests discharge

O/E- FCP
- RBBT - clear
- Breath sound are normal

Plan Blocked
① Allow home - antibiotics

Dr. Ikhsan

11/1/2021

MMR. PROF-O-Hay Wa
DR. ONASIGO
DR. OLOO

DX: ? Recurrent aspiration
- Bronchoscopy done = no FB

DDX: = R/o fistula TOF

Plan
① Do. virtual Bronchoscopy
② gastrografin swallow
- review c LOS

Dr. Ikhsan

12/1/2021

Today again had episodes of choking/cough c DVB
- Plan
① do the gastrografin swallow today
② & virtual Bronchoscopy

Dr. Ikhsan

DOCUMENT 3

DISCHARGE SUMMARY DATED 10TH JANUARY 2021

An ISO 9001:2015 Certified Hospital

MOI TEACHING AND REFERRAL HOSPITAL

P.O. BOX 3, ELDORET
TEL: (+254) 053-2033471/2/3/4; FAX: 053 -2061749 ; Email:ceo@mtrh.go.ke ; Website: www.mtrh.go.ke

DISCHARGE SUMMARY FORM

Patient's Name: ANITA CHEPKURUR
DOB 2016 Sex: F Weight (kg) .....
Date of admission: 9/1/2021
Date of Discharge: .....

Hospital No 100254/2
Ward: PADIATRIC Division CHRISTO
Firm: ..... Ward Doctor DR. ISMAIL
Consultant I/C DR. OLOO

Presenting complaints: FB - Aspiration
Provisional Diagnosis (on admission): - ? FB Aspiration
Discharge Diagnosis: FB - Bronchus
Other Problems Noted: -

Operations/ Procedures: Bronchoscopy

Clinical and Management Summary: Patient reported to have accidentally aspirated a chewed white seed developed respiratory distress on/07 - Bronchoscopy and brushes upon suction done (mucus plug documented) no evidence of seed as in the airway. Done well post-Bronchoscopy in the last 24hrs

Laboratory Investigations Done: CBC, UEC

Radiology Investigations Done:

Discharge Medications: (1) Augmentin syr. 457 mg BD x 7/7

...ge Care Plan and Instructions: To come back if symptoms recur

...ame of Discharging Doctor ... 10/1/2021 Date ...

DOCUMENT 4

DISCHARGE SUMMARY DATED 28TH JANUARY 2021

D. code
117.9

4 Q13

An ISO 9001:2015 Certified Hospital

MOI TEACHING AND REFERRAL HOSPITAL
P.O. BOX 3, ELDORET

TEL: (+254) 053-2033471/2/3/4; FAX: 053 -2061749 ; Email:ceo@mtrh.go.ke ; Website: www.mtrh.go.ke

DISCHARGE SUMMARY FORM

Patient's Name: Anita Chepkorir
DOB: 2016 Sex: F Weight (kg) .....
Date of admission: 9/01/2021
X Date of Discharge: 28/01/2021

Hospital No 100254
Ward: Paediatric Division Cardiothoracic
Firm: ..... Ward Doctor: Dr Ismail
Consultant I/C Prof Ohuma, Dr Evelyn Below

Presenting complaints: Sudden onset of DIB
Provisional Diagnosis (on admission): Foreign body bronchus
Discharge Diagnosis: POD 4 Bronchospy + Thoracotomy + Extraction of FB
Other Problems Noted: —

Operations/ Procedures: Bronchoscopy + thoracotomy

Clinical and Management Summary: She had history of sudden onset of DIB. Hx of playing with seeds in the mouth - suspected that she had aspirated the seeds. Bronchoscopy was done but not successfully as Patient noted to have DIB in recovery. She was scheduled for 2nd bronchospy visualized the FB - tooth like tooth. but not able to grasp. She therefore underwent thoracotomy and extraction of the FB. Has no fever. Tolerating POD 4 day well, chest tube removed no DIB, wound w/clean

Laboratory Investigations Done: CBC,

Radiology Investigations Done: CT scan Chest with Bronchoscopy reconstruction

Discharge Medications: Tem 250mg/5ml Syrup 1.0 TDS
- Zinnat 250mg/5ml 2.0 TDS BD x5/7
FBC in cardiothoracic clinic

Discharge Care Plan and Instructions: The child should not go to school for 1/52 until seen in the Clinic If she develop DIB should report to hospital immediately. FBC in thoracic clinic in 1/52

Name of Discharging Doctor | Date | Signature of Discharging Doctor

DOCUMENT 5

RADIOLOGY REPORT DATED 19TH JANUARY 2021

As ISO 9001 2015 Certified Hospital

MOI TEACHING AND REFERRAL HOSPITAL

Email: dirmtrh@mtrh.or.ke
Telephone: 053 2033471/2/3
Fax: 053 2061749

NANDI ROAD
P.O. BOX 3
ELDORET, KENYA

Our Ref:
DATE: 1/19/2021 9:27:04 AM
PATIENT NAME: ANITA CHEPKORIR
D.O.B: 1/1/2016
HOSPITAL NO.: 1002542
CLINIC/WARD:
INVESTIGATION: CT CHEST BRONCHOGRAM
INDICATION:

CHEST FINDINGS

- A hyperdense ring like foreign body is noted in the proximal right main bronchi/It measures 0.76cm x 0.64cm around 0.46cm from the carinal bifurcation.
- Both lung fields are clear.
- There are no pulmonary nodules seen.
- There is no pleural effusion.
- Normal pleura, no thickening.
- The heart and the great mediastinal vessels are normal.
- There is no hilar adenopathy.
- No mediastinal adenopathy.
- The vertebral bones and other bony structures are normal.
- Normal subcutaneous tissues

IMPRESSION

1. Right ring like foreign body in the proximal right main bronchi.
2. Lung fields are normal

DR. TARUS F.K
CONSULTANT RADIOLOGIST

All correspondence should be addressed to the Chief Executive Officer
Visit our Website: www.mtrh.go.ke
TO BE THE LEADING MULTI-SPECIALTY HOSPITAL FOR HEALTHCARE, TRAINING AND RESEARCH IN AFRICA

DOCUMENT 6

CONTINUATION SHEET DATED 25TH JANUARY 2021

An ISO 9001:2015 Certified Hospital

MOI TEACHING AND REFERRAL HOSPITAL

CONTINUATION SHEET

Name: Brida Cherotich DOB..... Age..... Sex..... Hosp No: 100294/2

Residence:..... Date.....

25/01/21

Ward Pod Cicula, Dr. Codige

Post op day 3; Bronchoscopy + Thoracotomy
- FB Foreign body RT bronchus

C/C - No new complains,
- Patient doing well

O/E - Fair P/S C/L

Plan

1. Physiotherapy (Posturing)
2. Remove chest tube.
3. Encourage mobilization

Clavian medic.

FB

DWR 26thJan

1

Dx - PUD 4p Bronchoscopy + Thoracotomy + FB extracted

2° to FB bronchus - Right (both)

Issue no new complaints
Chest tube removed, ha.
Client has gone to school.

CHO

1

DOCUMENT 7

TREATMENT NOTES DATED 4TH FEBRUARY 2021

4/2/2021

was seen thoracotomy in Jan 2021
F/B. tooth was extracted.

Wound - Rt. chest
Charlotte site

Plan:
- CT dacity cleaning and dressing
- Angle ap pectoris
- TCA in 2/12

B Nichen

C.T.C
Richard Oke Kuye
22/07/2021

14

DOCUMENT 8

CONTINUATION SHEET DATED 8TH FEBRUARY 2021

C.T.C
Richard Ole Kuyo
22/07/2021

An ISO 9001:2015 Certified Hospital

MOI TEACHING AND REFERRAL HOSPITAL

22 JUL 2021

CONTINUATION SHEET

Name: ANITA CHEPKIRUI DOB 2015 Age 5YRS Sex F Hosp No: 150 2542

Residence: ANGATA Date 8.2.2021

10:30pm.

T- 37.8°C

Pressure T - 39-2

Wt - 20-8kg

SPO2 97%

C/O - Abdominal pains x Few hrs ago.
- Cough x 2/7

?Abdo. H/o Worms of body occasionally. PR-99/

- Pt done FB removal 2/52 ago & done Surgery successful & done dressing (Bronchoscopy + Thoracic + Extraction of FB.
- H/o vomiting x2 - Contained food contents.
- H/o cough

Remedi: nil.

O/E - Fluc, pallor ++, Febrile, Clinically dyspnoeic ++
ENT - Tonsils enlarged
- FAM+, ICR+, SLR+
R/S - Fine basal crepts bilaterally
Rhonchi
CVS - S1 S2 heard, No murmurs

P.T.O

P/V. Alab. S/f. epigastric tenderness + organomegaly Bowel sounds

Inf- S. B' pneumonia post Thoracotomy.

Plan: ① Admit under.

① CBC, BS, U/R E's

② O_2 via nasal prongs 1L/min + Dressing of wound.

④ Iv X-pen

⑤ Iv Pantoprazole

⑥ Iv Dexamethasone

⑦ Pleads review/ Cardiac review.

Cardiology review - 12.20 hrs 9.2.2021

Informed Dr Okwe on phone and suggested pt to be admitted in medical ward.

Dr. Okwe

13/02/21 DWR - Dr. Yakubu.

Dx - S. pneumonia / part thoracotomy for FB.

Today - Stable
- Completed course of antibiotics

OE FGC P° J° C_4° O° $Dc.H_2O$°

Temp - 36.5°C

SPO$_2$ - 96% RA

GNS
CVS
RS
PA
} (N)

Plan

① ⓓ Home on orals

Dr. Atan
MOL.

DOCUMENT 9

DISCHARGE SUMMARY DATED 15TH FEBRUARY 2021

An ISO9001: 2015 Certified Hospital

MOI TEACHING AND REFERRAL HOSPITAL

P.O. BOX 3, ELDORET

TEL: (+254) 053-2033471/2/3/4; FAX: 053-2061749; Email: ceo@mtrh.go.ke ; Website: www.mtrh.go.ke

DISCHARGE SUMMARY FORM

Patient's Name: ANITA CHEPKORIR

DOB: 2015 Sex: F Weight (kg):

Date of admission: 5/2/21

Date of Discharge: 15/02/21

Hospital No: 1003542

Ward: UHM Kids Division: PAEDS

Firm: II Ward Doctor: DR NATION

Consultant I/C: DR CHEMUTAI

Presenting complaints: RIB / Cough / Fever / 3/7

Provisional Diagnosis (on admission): S. Pneumonia post thoracotomy for FB / r/o tuberculosis / r/o lung abscess

Discharge Diagnosis: S. Pneumonia.

Other Problems Noted: Abdominal pain & vomiting (port - tumour)

Operations/ Procedures: None

Clinical and Management Summary: Pt managed for the above complaints with 4 hourly nebulization with 2.5ml Duolin / IV Piperacillin & Tazobactam 2g TDS x 1/52 / IV Vancomycin 200mg 6/D x 1/52 / IV Fluconazole 200mg OD / Multivitamin Inj 1Dml OD / Daily cleaning & dressing of the thoracotomy site (since 1 day) / PCM 1g 200mg TDS x 3/7

Laboratory Investigations Done: BS - No sugar seen / FBC Hb 14.3 g/dl 5530, WBC 21.55 / Malaria parasites +ve / CBC (n)

Radiology Investigations Done: CT Chest - Bibasal pneumonia & left pleural thickening.

Discharge Medications: (b) Home oral Ciprofloxacin 200mg TDS x 1/52

Discharge Care Plan and Instructions:

Dr. Nation — Name of Discharging Doctor

15/02/21 — Date

Signature of Discharging Doctor

DOCUMENT 10

CONTINUATION SHEET DATED 16TH APRIL 2021

C.T.C Richard Ole Kaeg 22/07/2021

22 JUL 2021

An ISO 9001:2015 Certified Hospital

MOI TEACHING AND REFERRAL HOSPITAL

8:30 A — 9:30 A

CONTINUATION SHEET

Name: Anita Chepkirui Kopuri DOB 1/6 Age Sex F Hosp No: 1002542

Residence: Annex Date 16/7/2021 9:28am

Informant: father

T 8:17 A

T 36.8°C

Wt 21.6 K

C/C: Cough x 4/7.
Runny nose x 4/7.

HPI:

- A Keylo girl ... was well until 4days ago when he developed above complains of cough which is non-productive of sputum. The cough is worse during the Morning and evening, also father also reported of runny nose which is on and off worse during cold season. no hx of Difficulty in breathing, father also reported of on and off hot of body.

MSHX:

Of Previous admission 2021 due to Pneumonia.
Hx of Previous blood transfusion
Hx of Surgical operation.

DA.

E: Fgc P° S° cy° clellbO°.

Is: chest is clear.

RS: S_1, S_2 heard, no murmur.

N: (A)VPU

ENT - Normal fullness, no tenderness, no organomegaly.

ENT - Normal.

Imp: URTI

Plan:

1. ~~Augmentin~~ Augmentin 375mg BD x5/7.
2. P.O Cetirizine 5mg nocte x5/7.
3. Pc Paracetamol ~~250mg~~ 500mg tds x5/7.

Sgd

DOCUMENT 11

CONTINUATION SHEET DATED 22ND APRIL 2021

An ISO 9001:2015 Certified Hospital

MOI TEACHING AND REFERRAL HOSPITAL

22 JUL 2021

CONTINUATION SHEET

Name: Anita Cherkoin DOB 2016 Age: Sex: F Hosp No: 100254

Residence: Date 22/04/21

- Has a persistent dry cough.
- Has ↓ appetite
- On & off fevers

Plan

Mucosolvan
Multivitamin
Amoxiclav.

Dr. M. Olwo

DOCUMENT 12

AUTOPSY REPORT

An ISO 9001:2015 Certified Hospital

MOI TEACHING AND REFERRAL HOSPITAL

FAREWELL HOME

RE: AUTOPSY REPORT OF DECEASED

ANITA JEPKORIR KANDIE - 5 YEARS

My full name is Dr. David K. Chumba. I am legally qualified pathologist, registered by the Kenya Medical Practitioners and Dentist Board and currently working as a Senior Lecturer Department of Human Pathology and Forensic Medicine Department and College of Health Sciences-Moi University.

My physical address is:
Department of Histopathology and Forensic Medicine, Moi University, P.O. Box 4606
Eldoret- Kenya.
Telephone: dchumba@yahoo.com
Cell Phone 0722-247909
My Qualification are:
MBcHB (UoN 1994)
MMEd (Human Pathology UoN 2006)
Diploma Forensic Pathology (Durban SA)

On13.05.2021 at MTRH Farewell, I performed an autopsy on the body of Anita Jepkorir Kandie according to the request of the relative

1. Isaac Kandie - Father
2. Lucas Kiprop- Uncle

DECEASED BACKGROUND
History of fall and become weak.

Usual residence: Annex

Occupation: child

Date of Death: 10.05.2021

Place of Death: MTRH

Place of Post Mortem: MTRH Farewell Home

Date of Autopsy 13.05.2021

Death certificate Number: 1729358

EXTERNAL EXAMINATION
The body is that of young girl measuring 80cm. Mild peripheral cyanosis. No external injuries.

POST MORTEM CHANGES

Post mortem changes are not prominent, rigor mortis was poorly established in all skeletal muscles. The body feels cold due to refrigeration. Signs of medical intervention noted.

Head and Neck
Normal
Chest
Normal
Abdomen:
External genitalia;
Upper and lower limbs:

Central Nervous System:

INTERNAL EXAMINATION

Cardiovascular: The pericardial sac contained of yellowish translucent fluid.

Heart is: Normal

Respiratory System;

- Right lung has multiple abrasions
- The hyoid and thyroid cartilage are intact. Food particles up to terminal bronchi. Few particle seed block in colon in the right bronchi.

Digestive System:

- The gall bladder was thin-walled and distended by bile. The pancreas was grey in colour, congested and edematous. Normal

Genitourinary

- The kidneys were enlarged. Their capsules could not easily be stripped. The cortex and medulla were reddish in colour and cartico-medullary definition is seen. Left kidney measured 6 by 5.5 cm and right 6 by 5cm.

Hemopoetic System:

- The spleen was mild enlarged. The spleen tissues is soft dark red in colour. The lymph nodes are not enlarged. soft spleen with features of septicemia

Endocrine Glands:

- The adrenals and the thyroid are grossly unremarkable.

Central Nervous System:

- Brain shows enlargement with features intracranial pressure.

CONCLUSION

- Asphyxia due to aspirated food- foreign object in right bronchi with multiple abscesses.
- Samples for histology taken: Portion of lung, liver and spleen.

13/5/2021

DR. DAVID CHUMBA
PATHOLOGIST AND FORENSIC SPECIALIST.
Date: 13 May, 2021

DOCUMENT 13

CERTIFICATE OF DEATH

REPUBLIC OF KENYA

CERTIFICATE OF DEATH

ELDORET EAST RIFT VALLEY 1532516

Death in the ..... District in the ..... Province

Entry No.	1442102125	Name and Surname of Deceased	Annita Jepkorir Chirchir		
Sex	Female	Age	6yrs	Occupation	Pupil
Date of Death	10/05/2021	Place of Death	M.T.R.H	Residence	Kesses
Cause of Death	Asphyxia Due to Foreign Body In Lung				
Name and Description of Informant	Pathologist- Chuma	Name of Registering Officer	K.K.KEMBOI	Date of Registration	19/05/2021

K.K.KEMBOI

I, Eldoret East ..... District/Assistant Registrar for ..... District, hereby certify that this certificate is compiled from an entry/return in the Register of Deaths in the District.

EE/CA NO.20259 OF 22/05/2023

District/Assistant Registrar

Given under the Seal of the Director of Civil Registration on the 22TH day of May, 20

This certificate is issued in pursuance of the Births and Deaths Registration Act (Cap. 149) which provides that a certified copy of any entry any register or return purporting to be sealed or stamped with the Seal of the Director of Civil Registration shall be received as evidence of dates and facts therein contained without any or other proof of such entry.

PK (SP) 7384 —8.62m Bks.—06-2019

DOCUMENT 14

MINUTES OF THE MEETING HELD ON 25TH MAY 2021

C.T.C
Richard Ole Kwayo
22-07-2021

22 JUL 2021

An ISO 9001:2015 Certified Hospital

MOI TEACHING AND REFERRAL HOSPITAL

MINUTES OF MEETING BETWEEN MOI TEACHING AND REFERRAL HOSPITAL (MTRH) MANAGEMENT TEAM AND THE FAMILY OF THE LATE ANITA CHEPKORIR IP. NO. 1002542 ON TUESDAY 25TH MAY, 2021 AT LILY BOARDROOM

MOI TEACHING AND REFERRAL HOSPITAL

1. Dr. Wilson K. Aruasa, *EBS*	–	Chief Executive Officer	–	Chairing
2. Dr. Philip Kirwa	–	Senior Director, Clinical Services	–	Secretary
3. Dr. Stephen Ondigo	–	Cardiothoracic Surgeon		
4. Dr. David K. Chumba	–	Consultant Pathologist – Moi University, School of Medicine		
5.. Dr. Alfred Wanyonyi	–	Registrar, COSECSA		
6. Dr. Nshom Ernest Bah	–	Registrar, Anaesthesia		

Chairperson/CEO 07/06/2021

Secretary 8/6/21

40

FAMILY OF THE LATE ANITA CHEPKORIR

1.	Mercy Kiprono	–	Mother
2.	Mr. Isaac Kipchirchir	–	Father
3.	Mr. Stanley Moiy	–	Grandfather
4.	Mrs. Julia Moiy	–	Grandmother
5.	Mr. Lukas Kiprop	–	Family member
6.	Priscilla Kandie	–	Aunt
7.	Beatrice Sawe	–	Aunt
8.	Amos Kimebur	–	Family friend and a neighbor

IN-ATTENDANCE

1.	Consolata Rop	–	Head, Corporate Communications
2.	Doreen Mutegi	–	Customers Relations Nurse Co-ordinator

ITEM	AGENDA	ACTION
MIN. 01/25/05/21	PRELIMINARY	
Introduction	• The meeting was called to order at 10:00 a.m. and a word of prayer was said by Doreen Mutegi. • The Chair welcomed members and introduced to the agenda of the day which was a family conference with Moi Teaching and Referral Hospital (MTRH) on management of the Late Anita Chepkorir.	

Chairperson/CEO _____ 07/06/2021

Secretary _____ SH/21

	▪ The Chair then went through management of the patient from 9th January, 2021 admission, management in surgical wards, follow-up in Cardiothoracic Clinic, and lastly admissions and management in Upendo ward. ▪ After giving an overview of all the management done to the late Anita he informed the family that MTRH is committed to quality healthcare. ▪ He added that MTRH is open & transparent and is committed in doing what is right and best for its clients. ▪ He informed family members that the team that managed Late Anita was determined to give the best and was hoping for the best outcome.	
MIN. 02/25/05/21	CONCERNS/COMPLAINS FROM ANITA'S PARENTS AND FAMILY MEMBERS	
Concerns/Complains	▪ The number of teeth wrapped up on Anita's leg were two contrary to their expectations which was three. That is one which was removed from the bronchus (foreign body) and two which were accidentally extracted during the procedure. ▪ If the Doctor was not competent to remove the foreign body (FB), he could have referred the patient instead of cheating that the FB was a tooth. They felt that the tooth was a "low hanging fruit " after missing the intended foreign body. ▪ The operation was done by a student Dr. Wanyonyi and not by a Consultant, Dr. Ondigo. ▪ Dr. Wanyonyi called the family and locked them in one of the room and talked to them rudely when they demanded for the third tooth. ▪ Dr. Wanyonyi informed them that if they continued complaining about the tooth, the	

Chairperson/CEO 07/06/2021

Secretary 8/6/21

	nurses could harm their child. ▪ That Anita stayed in the ward from 9th to 20th without any investigations. ▪ Anita was admitted in Upendo ward with pneumonia with the initial signs/ symptoms which she had presented with, meaning FB had not been removed. ▪ Demanded to be explained what the repeat CT Scan chest revealed. ▪ During the postmortem a seed similar to what the mother had given history about and similar to the report of CT Scan chest was found in the lungs. ▪ On coming from the postmortem they felt a need to raise a complaint and they were linked to Customer Care Officer called Doreen Mutegi. Doreen took a short history of the illness and learning that Anita had first been brought to Hospital on 9th January, 2021 and it was already in May 2021 concluded that this probably could be another FB. ▪ They wanted to know if the relative signed a consent for CT Scan chest with contrast.	
MIN 03/25/05/21	RESPONSE FROM DR. STEPHEN ONDIGO - CARDIOTHORACIC SURGEON	
Response from Dr. Stephen Ondigo	▪ Dr. Stephen Ondigo started by registering his condolences to the family. ▪ He said that he has been a Cardiothoracic Surgeon for fifteen (15) years. ▪ He then explained the usual process of managing a foreign body (FB) in the lungs. The first step is usually a bronchoscopy but sometimes a thoracotomy may be done if the foreign body cannot be removed with the bronchoscope. ▪ The family was taken through the management of Anita in detail. ▪ The late Anita was in the ward for some time in the ward with complaints of having	

	inhaled a FB. She was taken to theatre for bronchoscopy but no foreign body was visualized. After this the child remained in the ward for treatment and observation. ▪ On 13/1/2021 Gastrographin studies were done to rule out Thoraco-eosophageal Fistula. The results were normal - No fistula. ▪ On 20/1/2021 a virtual bronchoscopy was done (CT Scan chest with contrast). ▪ Dr Ondigo informed them that we don't usually take written but a verbal consent when doing CT Scan with contrast. ▪ On 22/1/2021 patient was taken to theatre for bronchoscopy were the foreign body could not be seen/reached. He decided to do a Thoracotomy. ▪ He palpated a hard object and when he made an incision what was found as an incisor tooth. ▪ After removal of the foreign body the lung was inflated, there was no lung collapse and he was sure that he had removed the foreign body. ▪ After the procedure the patient was managed in Fadhili ward for three days with great improvement. Then she was discharged. ▪ The Cardiothoracic team later saw the patient twice in the clinic and was doing well. ▪ The patient was later admitted to Upendo wall. A repeat CT scan done in the ward showed bi-basal pneumonia.	
MIN: 04/25/05/21	RESPONSE FROM DR. ERNEST NSHOM – REGISTRAR, ANAESTHESIA	
Response from Dr. Ernest Nshom	▪ Dr. Ernest Nshom registered his condolences also to the family. ▪ He was the Assistant Anesthesiologist with Dr. Kimani Mbugua.	

Chairperson/CEO 07/06/2021

Secretary 8/6/21

	▪ Reported that the anesthesia process was uneventful and can confirm that the Surgeon removed a tooth from the lungs during thoracotomy. ▪ He said he later met the mother of Anita along Riley Mother and Baby Hospital. The mother asked him about the number of teeth and he only remembered telling her that they were two. But didn't engage much because he was rushing to theatre.	
MIN 05/25/05/21	RESPONSE FROM DR. ALFRED WANYONYI – REGISTRAR COSECS	
Response from Dr. Alfred Wanyonyi	▪ Dr. Alfred Wanyonyi said he was the Assistant Surgeon and surgery went as explained above. ▪ He said that later after surgery, the nurse from Fadhili ward called him to come and talk to the family on the issues they had raised. ▪ He was not in the Hospital then but drove back to meet the family. ▪ He secured an office to talk to them for privacy/confidentiality purpose. This was not ill intended. ▪ He denied threatening them or talking to them rudely. ▪ He apologized for any form of hurt that he may have caused during their conversation.	
MIN 06/25/05/21	RESPONSE FROM DOREEN MUTEGI – CUSTOMERS RELATIONS NURSE CO-ORDINATOR	
Response from Doreen Mutegi	▪ Doreen started by registering her condolences to the family. ▪ Doreen apologized to the relatives for being hurt during the conversation.	

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	▪ She promised to be a good listener and not to rush into conclusion. ▪ She said after taking the history she informed the relatives that she was to organize a meeting with the family members, surgeons who did the operation and clinical team who managed the late Anita. ▪ The surgeon would explain to the family the issue of the foreign body.	
MIN. 07/25/05/21	RESPONSE FROM DR. DAVID K. CHUMBA, CONSULTANT PATHOLOGIST – MOI UNIVERSITY, SCHOOL OF MEDICINE	
Response from Dr. David K. Chumba	▪ Dr. David K. Chumba said that as he was continuing with the postmortem when he made an incision on the right lung, he found a hard seed and the relatives shouted at him to stop the procedure. ▪ He wondered why. ▪ So he asked for the history of which they narrated to him some relatives moved out but he continued with the postmortem. ▪ The brain and liver had some abscess-like areas from which he took samples for histological confirmation.	
MIN. 08/25/05/21	REMARKS FROM THE GRANDFATHER	
Remarks from the Grandfather	▪ He said that Anita had passed on. ▪ No form of efforts would bring her to life again. ▪ He added that he believes that no doctor had an intention to kill because if any clinical person would plan this, it would be a matter of a few seconds.	

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	▪ According to him he felt the Hospital should apologize and put measures into place to prevent any other patient to undergo such.	
MIN. 08/25/05/21	REMARKS FROM MR. AMOS KIMEBUS (FAMILY FRIEND AND A NEIGHBOUR)	
Remarks from Mr. Amos Kimebus (Family friend and a neighbour)	▪ He was happy for the audience given to the family. ▪ He said he understands what the family is undergoing because he also had a similar issue recently. ▪ He said that the family wasn't taking any legal actions in this issue; what they wanted was to know the truth. ▪ He asked MTRH Chief Executive Officer (CEO) to see how the Hospital can assist or do to this particular family.	
MIN. 09/25/05/21	REMARKS FROM DR. WILSON K. ARUASA, *EBS* - CHIEF EXECUTIVE OFFICER, MTRH	
Conclusion	▪ The CEO started by registering his condolences to the family. ▪ He appreciated the family for their feedback and assured them that MTRH is open and transparent in everything being done. As an organization, we working hard to improve our services and any shortcoming identified is used as an opportunity for improvement. ▪ He informed the family that he has gone through the file and found out that much was done to the Late Anita and all was geared toward the best outcome.	

Chairperson/CEO _____ 07/06/2021

Secretary _____ 5/6/21

	▪ The two operations took some time and nobody can take all that time if he/ she intended to do evil. ▪ He informed them that he's been in MTRH for many years and that Dr. Ondigo is our Cardiothoracic Surgeon who has long experience with very good professional standards. ▪ He assured the family that there was no professional negligence at all. ▪ He informed the family that Dr. Wanyonyi is a Registrar and a student working under consultants and that he wrote the theatre notes under instructions of Dr. Ondigo as he was an Assistant Surgeon. ▪ He informed them that he will look into the issues they raised about Dr. Wanyonyi administratively. ▪ On asking Mr. Amos Kimebur, the family friend and a neighbour what kind of assistance family wished MTRH to do for them, he said the Hospital to decide and also the family will discuss further and revert. ▪ He then advised the parents of Anita to be assisted with psychological counselling as soon as possible. ▪ He asked the family members to book an appointment any time later and be free to share more.	Action: Consolata to coordinate

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Secretary 8/6/21

There being no any other business for discussion, the meeting was adjourned at 4:45 p.m with a word of prayer from Dr. Philip Kirwa.

07 JUN 2021

SIGN

MINUTES APPROVED FOR CIRCULATION

CHAIRPERSON _____ DATE 07/06/2021

DR. WILSON K. ARUASA, *EBS*
CHIEF EXECUTIVE OFFICER

SECRETARY _____ DATE 08/6/2021

DR. PHILIP KIRWA
SENIOR DIRECTOR, CLINICAL SERVICES

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Chairperson/CEO_____ Secretary _____

DOCUMENT 15

PETITIONER'S KMPDC COMPLAINT

FORM – LDI

REPUBLIC OF KENYA
KENYA MEDICAL PRACTITIONERS AND DENTISTS COUNCIL

APPLICATION FOR LODGING A COMPLAINT
Pursuant to the Medical Practitioners and Dentists Act (CAP 253 – Laws of Kenya)

FOR OFFICIAL USE ONLY:	Allocated Case Number				Date of Receipt of the Complaint
	CASE NO		OF		
	Complaint Category:				

A. DETAILS OF THE COMPLAINANT/REPRESENTATIVE	
Name of Complainant/Representative:	Mercy J. Kiprono/Isaak Kandie
Identity/Passport Number:	22381620 / 22432018
Nationality:	Kenyan
Postal Address:	P.O Box 9266 Eldoret
Physical Address:	Annex Eldoret
County:	Uasin Gishu
Mobile Number:	0720496205 / 0720322296
E-Mail Address:	chiriMercy80@gmail.com
(Fill in this section if the representative is from an institution e.g. a law firm, a company, a non-governmental organization)	
Name of Institution:	
Postal Address:	P.O Box 2179-20100 Nakuru
Physical Address:	Murimy, Nduma, Mbago & Muchela advocate
Name of Contact Person:	Muchela Aston Ori'enge
Mobile Number:	0723356135
E-Mail Address:	Muchas211@yahoo.com
If the above institution is a law form, attach a 'Notice of Appointment' to this application.	

B. DETAILS OF THE PATIENT *(Fill in this section if the patient is not the complainant in 'A' above)*	
Name of Patient:	Annita Jepkorir chuchir Kandie
Identity/Passport Number:	
Nationality:	Kenyan
Relationship to the patient: *(You are the patient's e.g. father, mother, sister, guardian)*	Mother and Father

DETAILS OF THE RESPONDENT(S)
Fill in either Section 'C' or 'D' or both depending on the nature of your complaint

C. DETAILS OF THE PRACTITIONER(S) BEING COMPLAINED AGAINST

Name primary doctor/dentist:	Dr Ondiko Stephen | Prof Otiysula
Name of Health Facility:	MTRH
County:	Uasin Gishu
Postal Address:	P.O Box 3 Eldoret
Physical Address:	Eldoret
Mobile Number:	
E-Mail Address:	
Names of other practitioners being complained against:	Dr Alfred Wanyonyi, Dr Oloo Dr Ernest Nshom. Dr Ismael Dr Ouma, V.

D. DETAILS OF THE HEALTH FACILITY BEING COMPLAINED AGAINST

Name of Health Facility:	MTRH
County:	Uasin Gishu
Postal Address:	p.o Box 3 Eldoret
Physical Address:	Eldoret.
Name of Contact Person:	Dr WILSON ARUASAN
Mobile Number:	0727415377 | 053-2033471/2/34
E-Mail Address:	Ceo @ mtrh.go.ke
Names of other health facilities being complained against:	

E. BRIEF NATURE OF THE COMPLAINT

Medical negligence/
Patient mismanagment/
Intimidation, and
No follow up on
second admission

F. DOCUMENTS TO BE ATTACHED

1.	Attach a double spaced typed narrative explaining the background history of the matter in detail *(*Mandatory)*
2.	List of copies of relevant documents attached:
i.	Autopsy report
iii.	Two Ct chest reports & Slio
iii.	3 discharge summaries
iv.	Photographs i.e Bandages on Amputa leg seed and Amputa Mouth

G. DECLARATION

I solemnly and sincerely declare that the information given above is true to the best of my knowledge and belief.

Signature of Complainant/Representative:		Date:	28-06-2021

REPUBLIC OF KENYA

IN THE DISCIPLINARY/ETHICS COMMIITEE/ COUNCIL/ TRIBUNAL SITTING AT KENYA MEDICAL PRACTITIONERS & DENTIST COUNCIL AT NAIROBI.

STATEMENT BY THE COMPLAINANT

(PARENTS TO THE LATE ANNITA CHEPKORIR).

On 9th January 2021, Annita Chepkorir complained that she was being chocked by a black, circular shaped seed. We rushed her to Mediheal where we were referred to Moi Teaching and Referral Hospital because of bronchoscopy procedure. At MTRH she was taken to theatre and they did a bronchoscopy which showed there was no evidence of seed in her airway according to Dr. Oloo bronchoscopy report.

On 10th January 2021, we were discharged, but even before we were cleared, she developed respiratory distress and we were readmitted.

On 13th January 2021, they did Gastrografin studies. No abnormality was found

On 19th January 2021, Annita underwent CT Chest Bronchogram and they found a ring like FB in the right bronchi. CT Chest Bronchogram.

We did show a sample of seed to the doctors and On 22/01/2021, before going to the theatre I (Annita's Mother) showed Dr. Ernest Nshom a sample of the seed (herein after referred to as FB (Foreign Body) again. Annita underwent thoracotomy and bronchoscopy (as per the discharge summaries).

On receiving Annita at theatre recovery room, Dr. Ernest Nshom said it was NOT a seed according to what Annita had said and her mother, but Dr. Ernest said that they found a tooth. He added that he had also pulled 2 teeth from Annita's mouth 2 upper incisors in the theatre which deemed loss in child's mouth according to his (Dr. Ernest) analysis. So Annita had two fresh teeth gaps after the operation.

He showed me (Annita's Mother) two bandages (blue and white) on Annita's left leg, saying the **blue** strapped bandage was carrying two (2) teeth pulled out from the child's mouth in the theatre and **white** bandages carrying one teeth which was extracted from the right lung i.e. total 3 teeth. I didn't see the real teeth because they had been covered with a strapped bandage on the left leg. Dr. Wanyonyi at the theatre recovery room asked me if I had any question but I said no and thanked him.

Later, on removing the bandages we found that each bandage carried one tooth i.e. 2 teeth in total equivalent to the bleeding gaps in Annita's mouth.

We asked the nurse for the third teeth they had extracted from the lungs because 2 teeth matched with 2 bleeding gaps in Annita's mouth. Immediately Dr. Alfred Wanyonyi arrived took us (Annita's parents) to a room while the patient remained with her grandmother.

In the room Dr. Alfred Wanyonyi told us not to ask for any question instead we should appreciate what he had done. **"Can't you appreciate what we have done? Stop asking me for the FB you have wasted my time, my fuel and other patients in the theatre. So you think I did not remove the FB, appreciate that Annita did not go to I.C.U. You are the type of people that removes the money in bank and goes home without counting, then**

you start complaining later. Take care if these nurses hear you asking for the FB again they might do something bad to your child", Dr. Alfred Wanyonyi said.

I inquired of our mistake in asking but he said," it is not wrong to ask but the protocol of asking".

The doctor continued threatening us that if we continue asking questions that he will even charge us for the teeth extraction.

And because we felt intimidated and threatened we thanked him and apologized, then we left the room.

Annita continued coughing but not as much as previously and every time we asked Dr. Ishmael (Ward Doctor) he said coughing was a process of recovery.

Prof. Otysula one day came to the ward with the students' doctors and we heard him talking about the extraction of teeth from the lungs showing the students the x-ray slide which we had taken in the morning that day before he came. He told the doctor ward to remove the tube from Annita and to continued dressing the wound.

On 28th Jan 2021, we were discharged.

Annita continued having chest congestion while at home and we continued giving her medicines. On 4th February 2021, we took her for checkup according to clinic card.

On 8th February 2021, she started vomiting, DIB, fever and became weak. We went back to MTRH and we were admitted again at Upendo PAEDs WARD and the doctors at the ward included Dr. Yatich, Dr. Chumba and Dr. Ataro.

They requested for CT Chest scan and after which were given 3 slides.

As Annita continued with medication, we thought it was necessary to inform Dr. Ondiko and Professor Otysula as did ward round on Fadhili ward (cardiac) that we were admitted again and that they should check the patient since we felt Dr. Alfred Wanyonyi had cheated thus intimidated us in order to cover up.

After Dr. Ondiko and Prof. Otysula checked the CT Chest slides and the report and they said Annita was okay and its only pneumonia and post thoracotomy.

On 15th February 2021 we were discharged with medication but still at home Annita was not that well, she had fever and was coughing.

On 5th March 2021 we took her to Mediheal because of fever (out-patient).

On 6th April 2021 we took her again to Mediheal because she had fever(out-patient).

On 16th April 2021 we went back to MTRH since the child was coughing, vomiting and had fever and they gave her medicines(out-patient).

On 22nd April 2021 we brought her back to MTRH for checkup and still we were given medicine after being served in the outpatient section.

On 10th May 2021 Annita when playing, she coughed for long and fainted, we rushed her to MTRH. She was pronounced death.

On 13th May 2021 an autopsy was done by Dr.David Chumba and they found a seed in the right bronchi as it was stated in first CT Chest report i.e. right bronchi. The right lung had been badly damaged.

Immediately, after the postmortem the uncle and aunt went to MTRH deputy CEO's office to report on the negligence but it was shocking to be accused of negligence by the hospital customer care personnel Doreen mutegi.

I (Annita's Mother) went back again to launch a complaint and finally we were given a meeting date as a family with MTRH CEO, Deputy CEO and some doctors. The meeting was psychologically frustrating. After much insisting, Annita's file was brought, but it refused us to check. The doctor was summoned after we continuously demand for his presence in the meeting. We requested that we be give the patient's file and we be allowed to read the same but our requests fell on deaf ears.

The said meeting took 7 hours without a break wearing us out. Dr. Alfred Wanyonyi admitted to have intimidated us on 22nd January 2021 while Dr.Steven Ondiko and Dr. Ernest Nshom admitted to have pulled out the 2 teeth during the operation.

They said one of the tooth they had pulled from Annita's mouth went to the right bronchi passed by the seed and went down to the lung. Thus TWO FB, they neither informed us about this accident nor stated on the discharge summary. This statement totally contradicts the statement he made after the operation (as mentioned in Page1). Which shows that they clearly knew that they did not remove the FB.

We thus note that the doctors and hospital that were handling the Late Annita Chepkorir's case were negligent and the patient's death was therefore preventable

PARTICULARS OF NEGLIGENCE

1. Failing to not the presence of a seed in the patient's airway
2. Failing to conduct a proper bronchoscopy procedure
3. Failing to properly interpret the results of the bronchoscopy
4. Misdiagnosis of the patient's condition
5. Leaving a foreign object in the patient's airway/lungs
6. Conducting the wrong procedure when the patient was in theater.
7. Extracting the patient's teeth when the same were not due for extraction.
8. Misinforming that the patient had swallowed a tooth when such was not the case.
9. Misdiagnosing the patient with pneumonia when she was brought back for a further check
10. Failing to exercise proper skill and care required of the doctor.
11. Failing to reveal the truth to the patient's parents

By the death of my daughter, I have suffered loss, pain and damages knowing well that my daughter was a loving girl, cheerful and full of life. Her life was indeed cut short by the sheer negligence of the doctors. Despite their actions, the doctors refused to own up to their mistakes and instead turned their anger and rudeness towards me the parent.

I thus seek that the council do consider this case and indeed find justice for the late Annita.

Signed.....

Mercy Jepchirchir

An ISO 9001:2015 Certified Hospital

MOI TEACHING AND REFERRAL HOSPITAL

FAREWELL HOME

RE: AUTOPSY REPORT OF DECEASED

ANITA JEPKORIR KANDIE - 5 YEARS

My full name is Dr. David K. Chumba. I am legally qualified pathologist, registered by the Kenya Medical Practitioners and Dentist Board and currently working as a Senior Lecturer Department of Human Pathology and Forensic Medicine Department and College of Health Sciences-Moi University.

My physical address is:
Department of Histopathology and Forensic Medicine, Moi University, P.O. Box 4606
Eldoret- Kenya.
Telephone: dchumba@yahoo.com
Cell Phone 0722-247909
My Qualification are:
MBcHB (UoN 1994)
MMEd (Human Pathology UoN 2006)
Diploma Forensic Pathology (Durban SA)

On13.05.2021 at MTRH Farewell, I performed an autopsy on the body of Anita Jepkorir Kandie according to the request of the relative

1. Isaac Kandie - Father
2. Lucas Kiprop- Uncle

DECEASED BACKGROUND
History of fall and become weak.

Usual residence: Annex

Occupation: child

Date of Death: 10.05.2021

Place of Death: MTRH

Place of Post Mortem: MTRH Farewell Home

Date of Autopsy 13.05.2021

Death certificate Number: 1729358

EXTERNAL EXAMINATION
The body is that of young girl measuring 80cm. Mild peripheral cyanosis. No external injuries.

POST MORTEM CHANGES

Post mortem changes are not prominent, rigor mortis was poorly established in all skeletal muscles. The body feels cold due to refrigeration. Signs of medical intervention noted.

Head and Neck

Normal

Chest

Normal

Abdomen:

External genitalia;

Upper and lower limbs:

Central Nervous System:

INTERNAL EXAMINATION

Cardiovascular: The pericardial sac contained of yellowish translucent fluid.

Heart is: Normal

Respiratory System;

- Right lung has multiple abrasions
- The hyoid and thyroid cartilage are intact. Food particles up to terminal bronchi. Few particle seed block in colon in the right bronchi.

Digestive System:

- The gall bladder was thin-walled and distended by bile. The pancreas was grey in colour, congested and edematous. Normal

Genitourinary

- The kidneys were enlarged. Their capsules could not easily be stripped. The cortex and medulla were reddish in colour and cartico-medullary definition is seen. Left kidney measured 6 by 5.5 cm and right 6 by 5cm.

Hemopoetic System:

- The spleen was mild enlarged. The spleen tissues is soft dark red in colour. The lymph nodes are not enlarged. soft spleen with features of septicemia

Endocrine Glands:

- The adrenals and the thyroid are grossly unremarkable.

Central Nervous System:

- Brain shows enlargement with features intracranial pressure.

CONCLUSION

- Asphyxia due to aspirated food- foreign object in right bronchi with multiple abscesses.
- Samples for histology taken: Portion of lung, liver and spleen.

13/5/2021

DR. DAVID CHUMBA

PATHOLOGIST AND FORENSIC SPECIALIST.

Date: 13 May, 2021

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MOI TEACHING AND REFERRAL HOSPITAL

Email: director@mtrh.or.ke
Telephone: 053 2033471/2/3
Fax: 053 2061749

NANDI ROAD
P.O. BOX 3
ELDORET, KENYA

Our Ref:
DATE: 1/19/2021 9:27:04 AM
PATIENT NAME: ANITA CHEPKORIR
D.O.B: 1/1/2016
HOSPITAL NO.: 1002542
CLINIC/WARD:
INVESTIGATION: CT CHEST BRONCHOGRAM
INDICATION:

CHEST FINDINGS

- A hyperdense ring like foreign body is noted in the proximal right main bronchi/It measures 0.76cm x 0.64cm around 0.46cm from the carinal bifurcation.
- Both lung fields are clear.
- There are no pulmonary nodules seen.
- There is no pleural effusion.
- Normal pleura, no thickening.
- The heart and the great mediastinal vessels are normal.
- There is no hilar adenopathy.
- No mediastinal adenopathy.
- The vertebral bones and other bony structures are normal.
- Normal subcutaneous tissues

IMPRESSION

1. Right ring like foreign body in the proximal right main bronchi.
2. Lung fields are normal

DR. TARUS F.K
CONSULTANT RADIOLOGIST

All correspondence should be addressed to the Chief Executive Officer
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Email: ceo@mtrh.go.ke/directorsofficemtrh@gmail.com
Telephone: 053 2033471/2/3
Fax: 053 2061749

Nandi Road
P.O. Box 3
ELDORET, KENYA

Our Ref: ELD/MTRH/CLIN.4/42/VOL.III/2016 DATE: 11th February, 2021

PATIENT NAME	:	ANITA CHEPKORIR
D.O. B	:	2015
HOSPITAL NO.	:	1002842
CLINIC/WARD	:	UPENDO
INVESTIGATION	:	CT SCAN CHEST

FINDINGS

- Normal, symmetrical lung volumes seen.
- Bibasal, ill-defined reticulo-nodular lung infiltrates are seen; Predominantly within right lower lobe subpleural areas and scattered peripherally on the left.
- Note interstitial thickening.
- Right posterior lateral pleural based focal consolidation seen.
- Associated right pleural thickening. No effusion.
- No chest wall overt defect or surgical emphysema.
- Midline structures are unremarkable.

IMPRESSIONS

1. Bibasal pneumonia.
2. Pleural thickening ?post-surgical ?inflammatory process.

DR. OUMA V.
CONSULTANT RADIOLOGIST

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P.O. BOX 3, ELDORET

TEL: (+254) 053-2033471/2/3/4; FAX: 053 -2061749 ; Email:ceo@mtrh.go.ke ; Website: www.mtrh.go.ke

DISCHARGE SUMMARY FORM

Patient's Name: ANITA CHEPKURUR

DOB: 2016 Sex: F Weight (kg):

Date of admission: 9/1/2021

Date of Discharge:

Hospital No 1002542

Ward: FADHILI Division: CARDIO

Firm: - Ward Doctor: DR. ISAAC

Consultant I/C: DR. DAN

Presenting complaints: FB - Aspiration

Provisional Diagnosis (on admission): - Acute FB Aspiration

Discharge Diagnosis: FB - Bronchus

Other Problems Noted: -

Operations/ Procedures: Bronchoscopy

Clinical and Management Summary: Patient reported to have accidentally aspirated a chewed water seed. developed respiratory distress on/OE - Bronchoscopy and bronchos aspir suction done (mucus plug documented) no evidence of seed as in the airway. done well post Bronchoscopy in the last 24hours

Laboratory Investigations Done: CBC, UEC

Radiology Investigations Done:

Discharge Medications: (1) Augmentin syr: 457 mg BD x 7/7

Discharge Care Plan and Instructions: To come back if symptoms return

Name of Discharging Doctor: [signature] Date: 10/1/2021 Signature: [signature]

D. code
T 17.9

4 RB

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TEL: (+254) 053-2033471/2/3/4; FAX: 053 -2061749 ; Email:ceo@mtrh.go.ke ; Website: www.mtrh.go.ke

DISCHARGE SUMMARY FORM

Patient's Name: Anita Chepkirir

DOB. 2016 Sex: 2F Weight (kg) .....

Date of admission: 9/01/2021

X Date of Discharge: 28/01/2021

Hospital No 1002542

Ward: Paediatric Division Cardiothoracic

Firm: ..... Ward Doctor. Dr Isaac

Consultant I/C. Prof Obonyo, Dr Onchiri, Dr Olac

Presenting complaints: Sudden onset of DIB

Provisional Diagnosis (on admission): Foreign body bronchus

Discharge Diagnosis: POD 4 Bronchospy + Thoracotomy + Extraction of FB

Other Problems Noted: -

Operations/ Procedures: Bronchoscopy + thoracotomy

Clinical and Management Summary: She had history of sudden onset of DIB. Hx of playing with seeds in the mouth - suspected that she had aspirated the seeds. Bronchoscopy was done first but not successfully as Patient noted to have DIB in theatre. She was scheduled for 2nd bronchospy visualized the FB - tooth like tooth. but not able to grasp. She therefore underwent thoracotomy and extraction of the FB. Tooth. Tolerated POD 4 day well, chest tube removed no DIB, wound w clean

Laboratory Investigations Done: CBC,

Radiology Investigations Done: CT scan Chest with Bronchoscopy reconstruction

Discharge Medications: - Pcm 250mg 5ml Syrup 5 TDS

- Zinnat 250mg 5ml 2x0 TDS BD x5/7

Review in Cardiothoracic Clinic

Discharge Care Plan and Instructions: The child should not go to school for 1/52/12 until seen in the Clinic If she develop DIB should report to hospital immediately. Review in Thoracic Cardiothoracic Clinic in 4/52/12

Name of Discharging Doctor Date Signature of Discharging Doctor

S. 1002
J18.9

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P.O. BOX 3, ELDORET

TEL: (+254) 053-2033471/2/3/4; FAX: 053 -2061749 ; Email:ceo@mtrh.go.ke ; Website: www.mtrh.go.ke

DISCHARGE SUMMARY FORM

Patient's Name: ANITA CHEPKORIR
DOB. 2015 Sex: F Weight (kg) .....
Date of admission: 08/02/21
Date of Discharge: 15/02/21

Hospital No 1002542
Ward: UPENDO Division: PAEDS
Firm: II Ward Doctor: DR · YATICH
Consultant I/C: DR · CHUMBA

Presenting complaints: DIB / Cough / Fever x 2/7
Provisional Diagnosis (on admission): S. Pneumonia post thoracotomy for FB / r/o bronchial stenosis r/o Lung abscess
Discharge Diagnosis: S. Pneumonia.
Other Problems Noted: Abdominal pain & Vomiting (post-tussive)

Operations/ Procedures: None

Clinical and Management Summary:
P4 managed for the above complaints with 4 hourly nebulization with 2.5ml Duolin / IV Piperacillin & Tazobactam 2g TDS x 1/52 / IV Vancomycin 200mg QID x 1/52 / IV Esomeprazole 20mg OD / Multivitamin syr 10ml OD / Daily cleaning & dressing of the thoracotomy site (clean & dry) / PCM syr 200mg TDS x 3/7

Laboratory Investigations Done: BS → No mps seen / FHG Hb 14.3 @ Plt 583↑, WBC 21.55↑ (Neutrophilia 89%) / UEC (N)

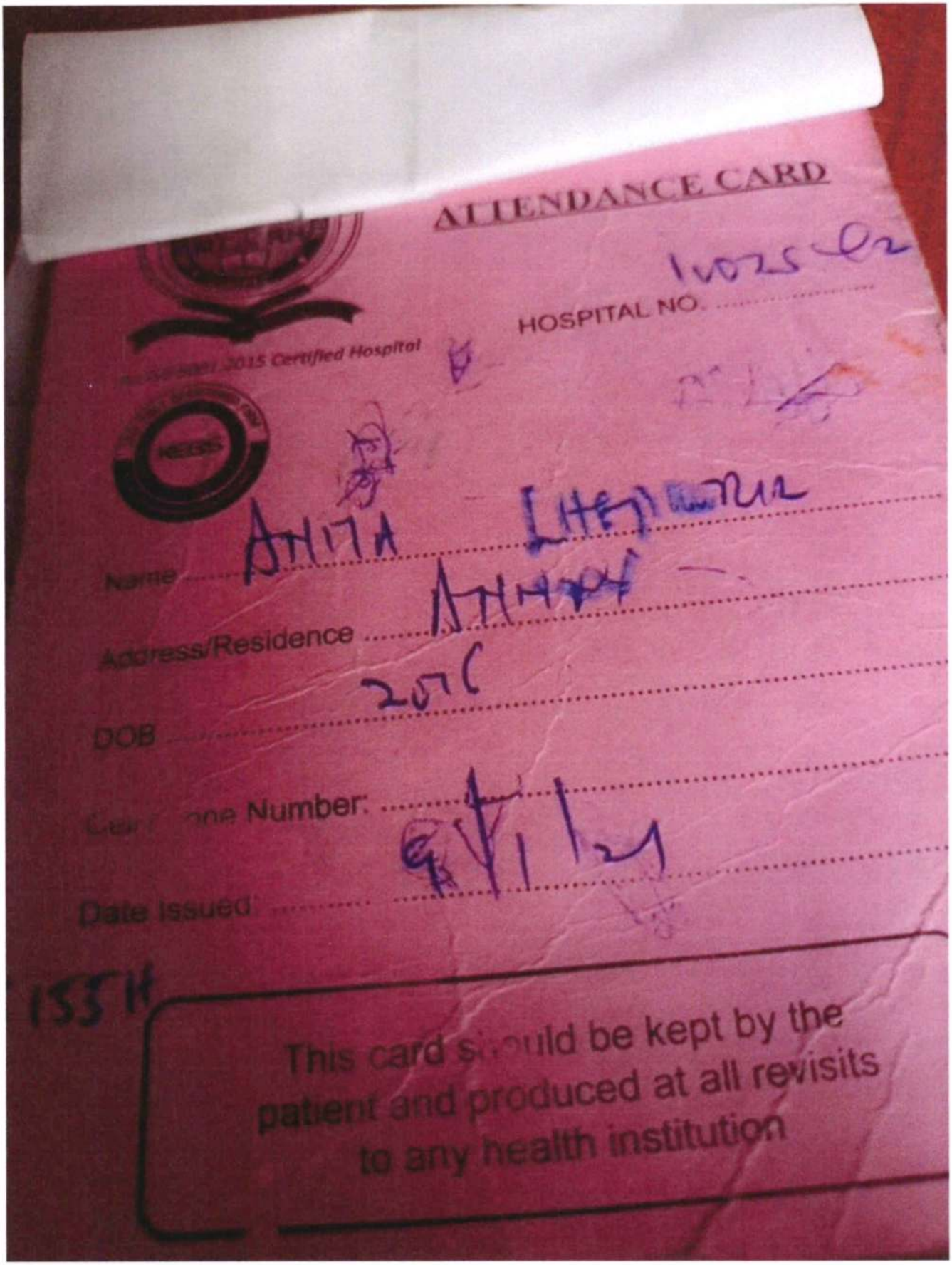
Radiology Investigations Done: CT Chest → Bibasal pneumonia & Left pleural thickening.

Discharge Medications: (b) home on @ Lincamycin 200mg TDS x 1/52

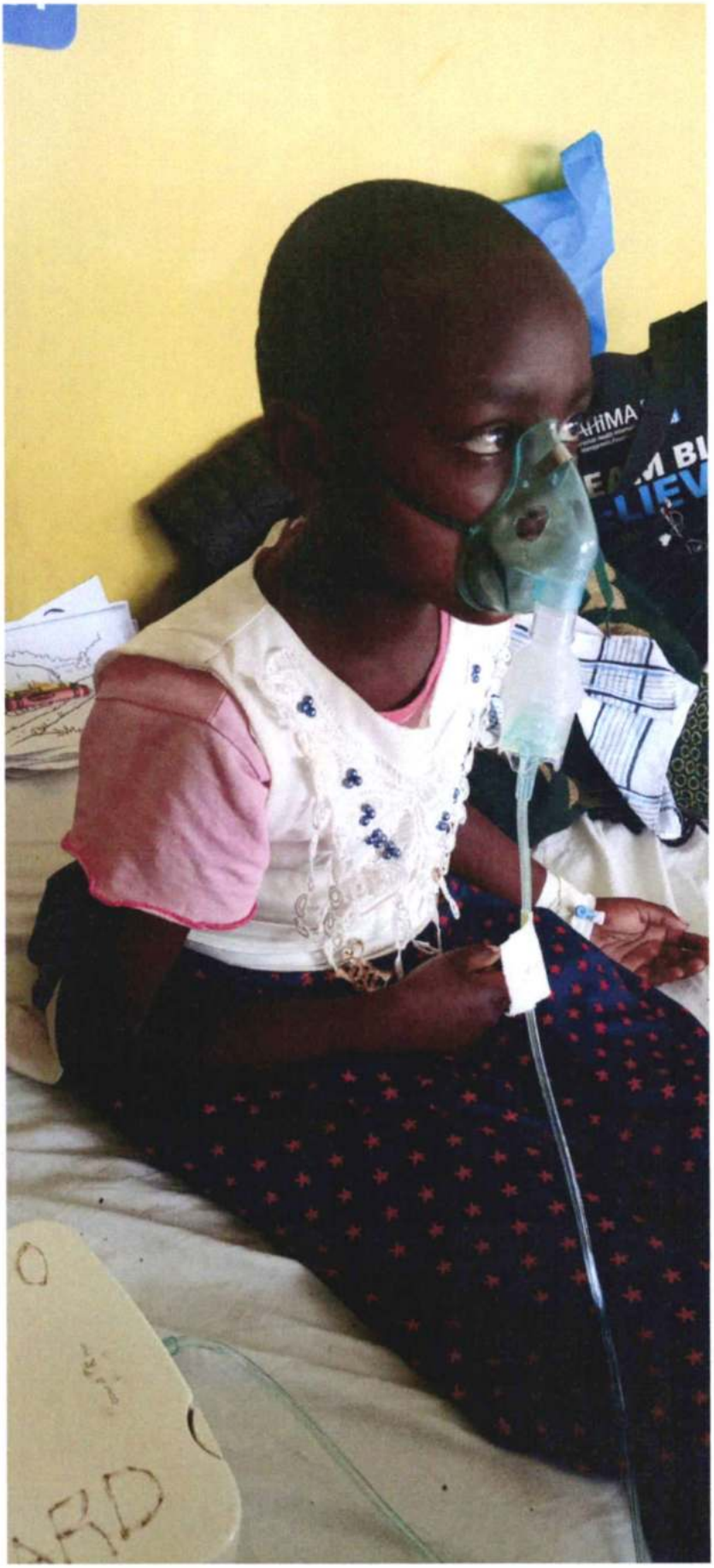
Discharge Care Plan and Instructions:

Dr · Atau — 14/02/21 — Signature of Discharging Doctor

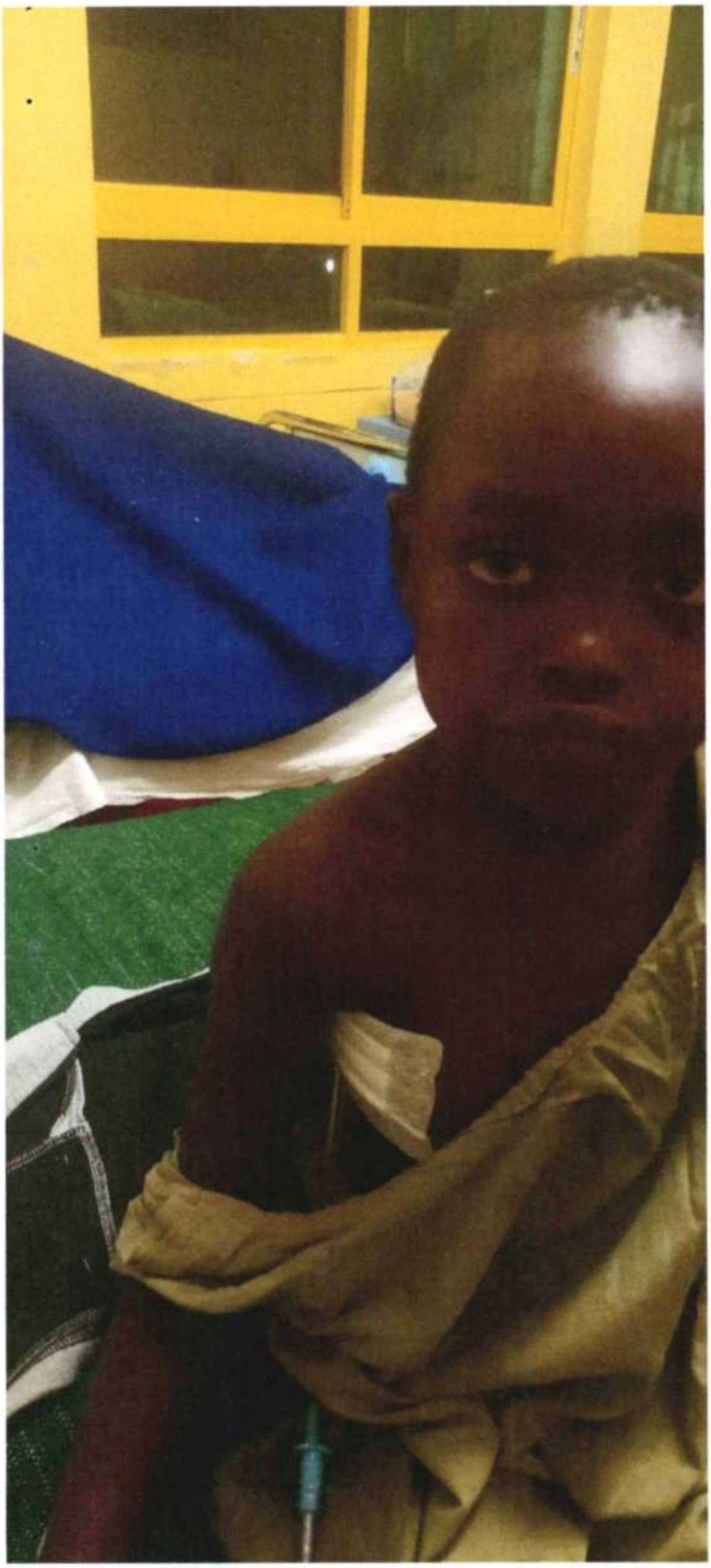
Name of Discharging Doctor — Date

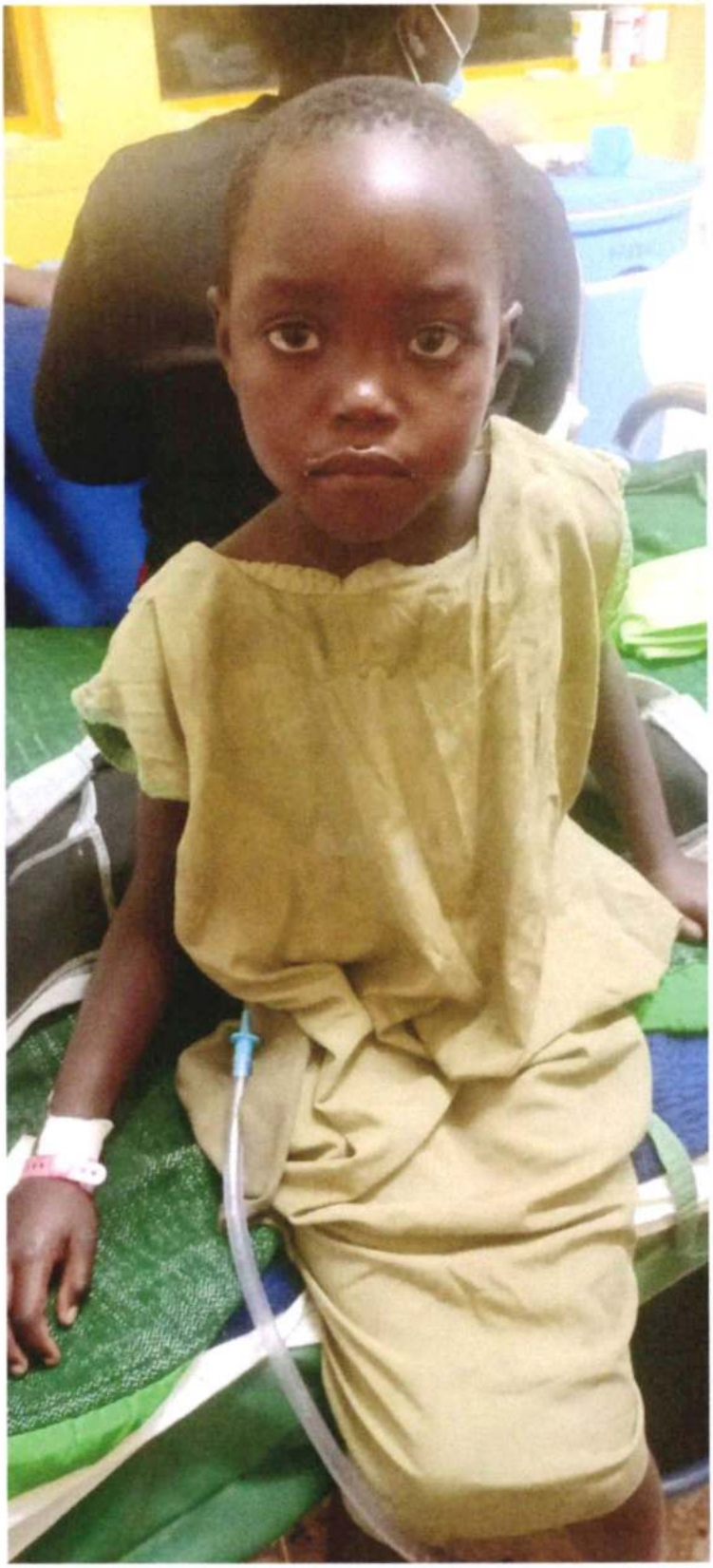


ANITA'S CLINIC CARD

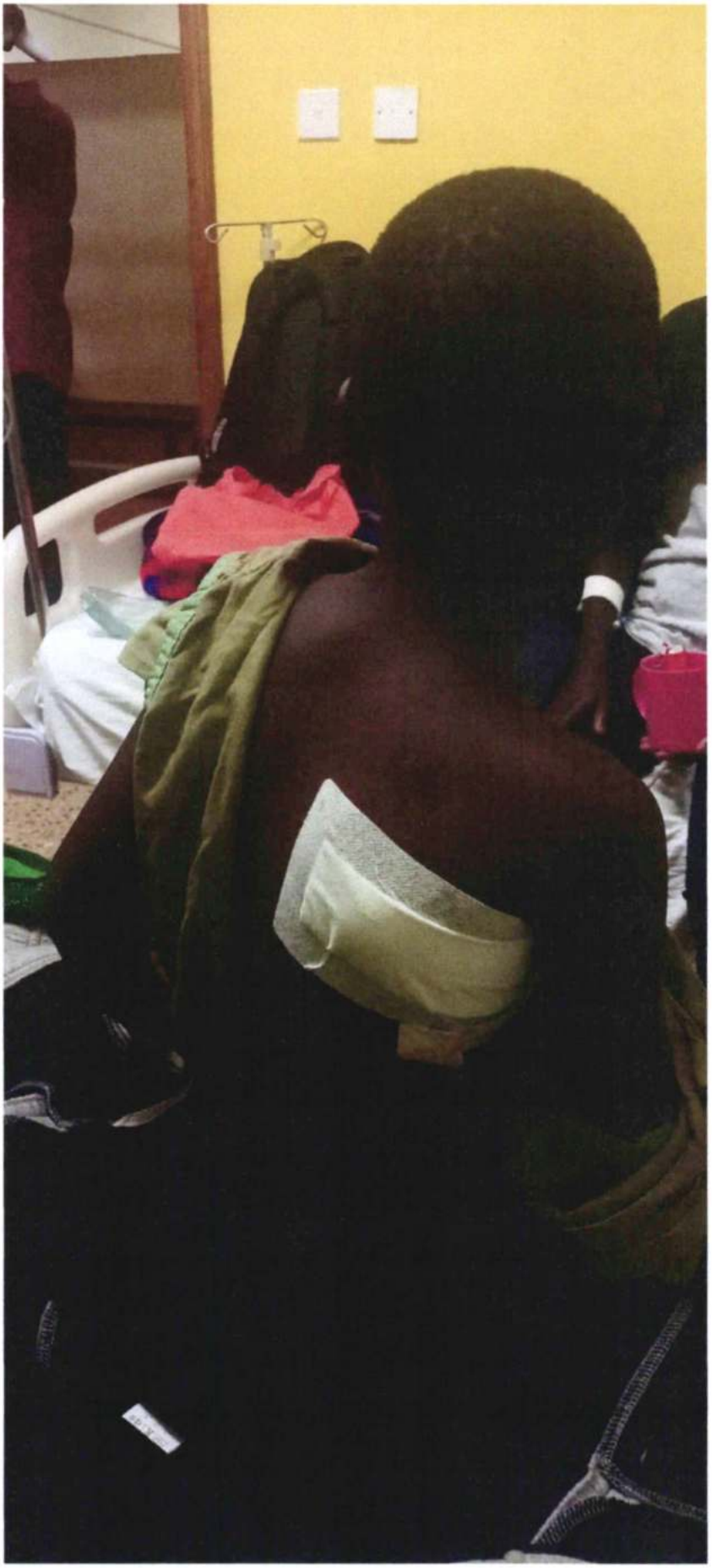


ON 2ND ADMISSION

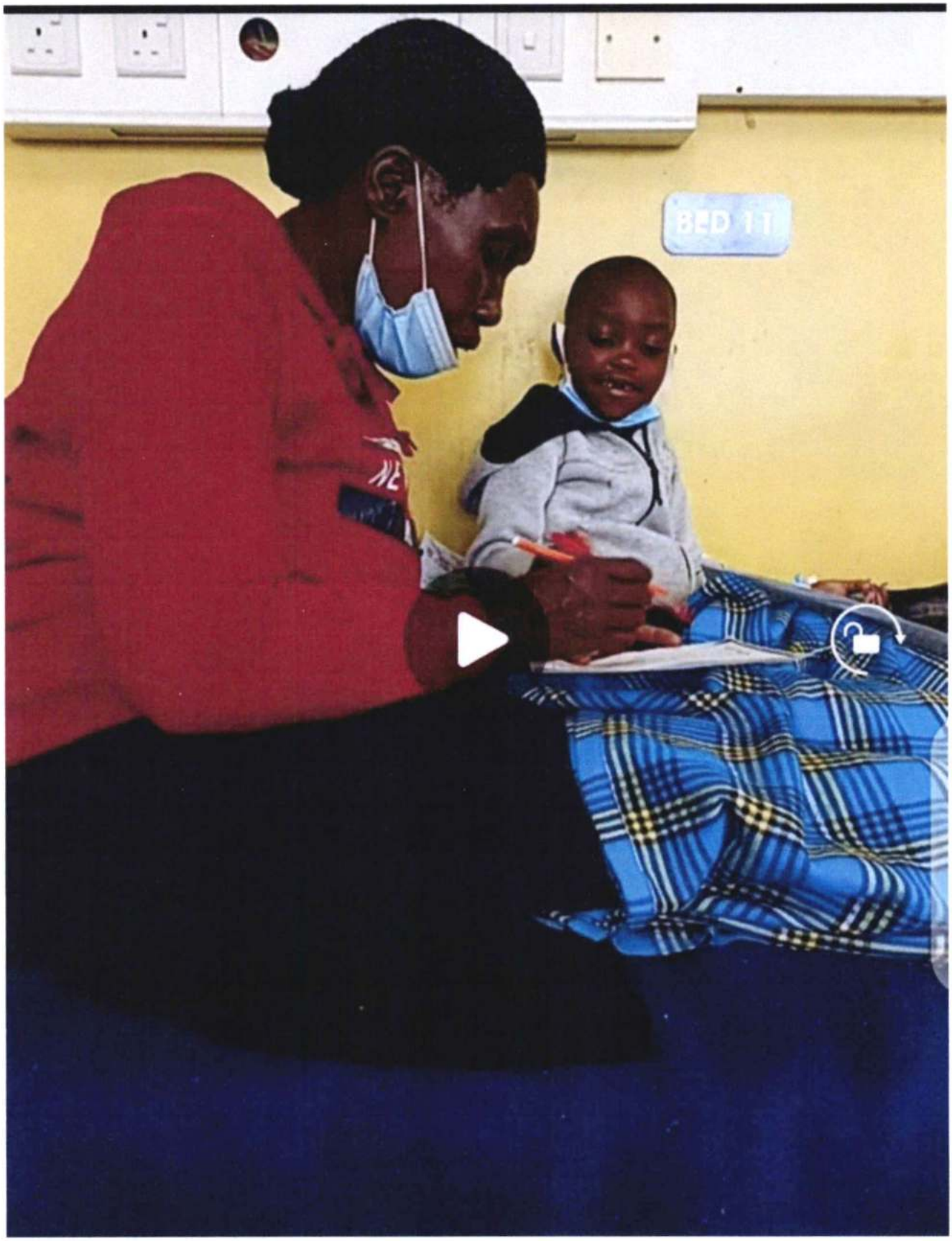




AT FADHILI WARD AFER THE THEATRE

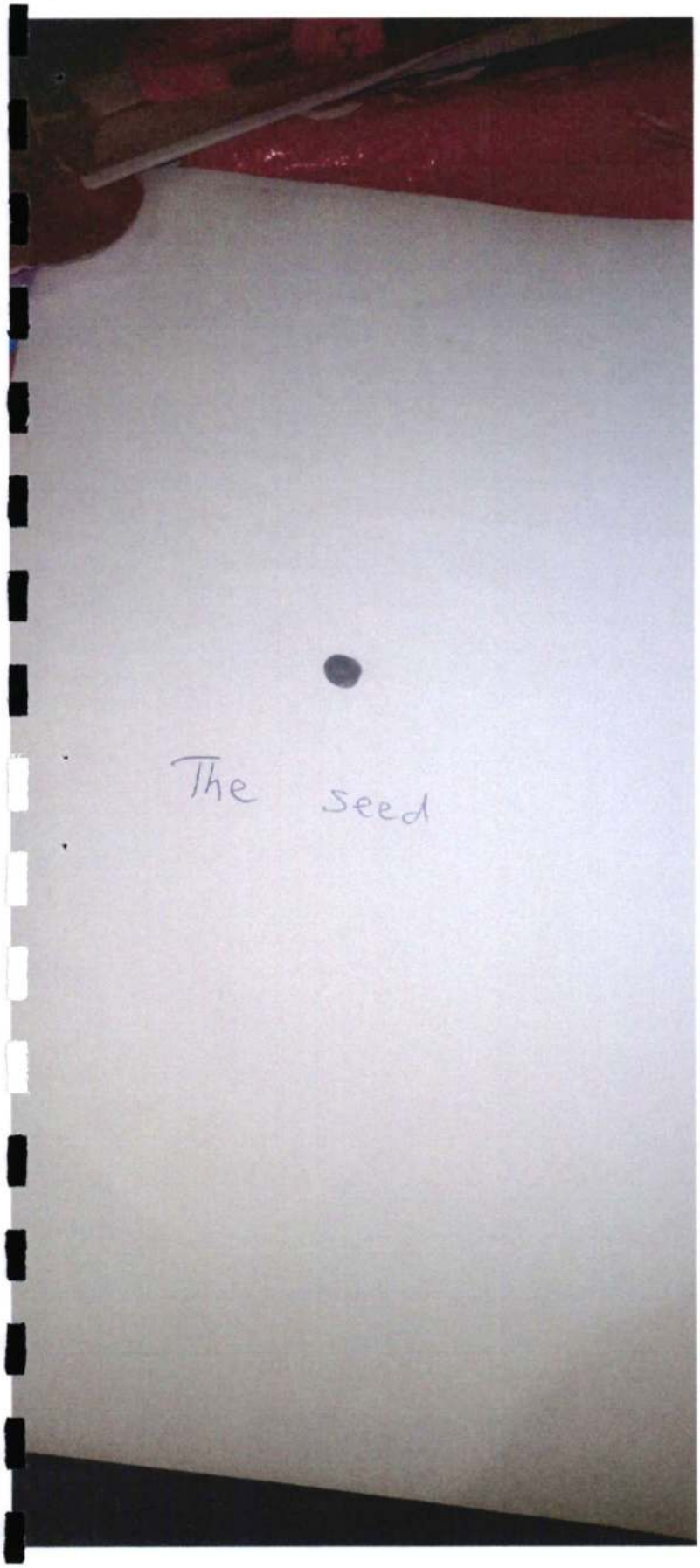


OPERATED PART AND THE TUBE



THE TOOTH GAPS ON MOUTH

AT THE RECOVERY ROOM



THE FB AFTER THE POST MORTEM (THE SEED)

WHITE AND BLUE BANDAGES ON THE LEFT LEG

DOCUMENT 16

DRAFT AGREEMENT

REPUBLIC OF KENYA

MEMORANDUM OF UNDERSTANDING

THIS MEMORANDUM OF UNDERSTANDING ENTERED INTO THIS 22ND DAY OF OCTOBER, 2021 between MERCY JEPCHIRCHIR KIPRONO ID No. 22381620 of P.O. Box 9266 -30100 ELDORET (hereinafter referred to as the 1st party) on one part and DR.STEPHEN ONDIGO holder of ID/NO.11236610 and of P.O box 4836-30100 ELDORET AND (hereinafter referred to as the 2nd Party) of the second part.

WHEREAS:-

a) The 1st Party is the COMPLAINANT in DC CASE NO,43 OF 2021 before THE MEDICAL PRACTITIONERS AND DENTISTS COUNCIL(MP&DB)

b) The 2nd Party is a RESPONDENT in DC CASE NO,43 OF 2021 before THE MEDICAL PRACTITIONERS AND DENTISTS COUNCIL(MP&DB).

NOW THESE PRESENTS WITNESSETH AS FOLLOWS:-

1. THAT the 1st party has today on 22ND day of OCTOBER, 2021, agreed to withdraw all the charges against the 2nd parties as filed in DC CASE NO,43 OF 2021,MERCY J KIPRONO ON BEHALF OF ANNITA JEPKORIR (DECEASED) AGAINST DR.ERNEST NSHOM,DR.ALFRED WANYONYI,PROF BARASA OTSYULA, DR STEPHEN ONDIGO &MOII TEACHING &REFERRAL HOSPITAL before THE MEDICAL PRACTITIONERS AND DENTISTS COUNCIL(MP&DB).

2. That the parties herein have been undergoing mediation and 1st party states that she is satisfied with her decision to withdraw the said charges against the respondents and will not revisit and or review the charges again whatsoever.

3. That the 1st party confirms that she has not been put under any duress, coerced, allured and or forced in any manner to withdraw the said charges but has done so willingly following a successful mediation process.

4. The Parties have entered into this memorandum of understanding at their own will and confirm having capacity to so enter into the agreement.

5. The parties undertake to be bound by the terms of this memorandum of understanding.

6. That the parties have mutually agreed to have this agreement adopted by the MEDICAL PRACTITIONERS AND DENTISTS COUNCIL (MP&DP) if it may deem fit to do so.

IN WITNESS WHEREOF both parties have here set their respective hands and signature the day and year herein above mentioned.

SIGNED by the said COMPLAINANT

MERCY JEPCHIRCHIR KIPRONO)

ID No. 22381620)

)

In the Presence of)

)

)

SIGNED by the said "RESPONDENT:-)

DR.STEPHEN ONDIGO)

ID/NO. ----------)

)

In the Presence of)

)

WITNESS

ISAAK KANDIE

ID,22432013

BONIVENTURE BARAZA

ID,)

)

DRAWN & FILED BY

MANYONI ORINA & COMPANY ADVOCATES,

BARNGETUNY PLAZA 2ND FL, RM 7

P O BOX 4500-30100

Email- manyoniorinaadvocates@yahoo.com

Phone No. 0723-441-804

ELDORET.

DOCUMENT 17

FAMILY'S LETTER

(21)

Richard Ole Kamuo
Ag Director
MTRH

22 JUL 2021

MR.ISACK CHIRCHIR/MERCY CHIRCHIR.
P.O BOX 347-30100
ELDORET
17/06/2021

THE DIRECTOR.
MTRH.
ELDORET.

CHIEF EXECUTIVE OFFICER
MOI TEACHING & REFERRAL HOSPITAL
RECEIVED
17 JUN 2021

We Mr ISACK CHIRCHIR, AND MRS CHIRCHIR MERCY, as the parents of our late daughter ANITA JEPKORIR. Are writing this letter in pain to raise and forward our complain to your office. This is due to the medical operations and negligence that was done by your doctors (1). Dr. Ondiko, (2) Prof Otysula (3) Dr Wanyonyi. Your office is very much aware that at the end it resulted to the death of our lovely daughter. Through our knowledge, observations and even the pathology results it clearly indicated that there was professional failures and medical malpractice and the doctors involved should be held responsible for the loss. We as a family and the parents of our late daughter Anita Jepkorir have the following demands.

(1) The responsible person should admit the mess in writing. no one has any liability.

(2) To register a word of sorrow and apology in whichever form. we already did in our meeting with the whole family

(3.) Should be ready to negotiate and to meet all the medical and funeral expenses that were incurred due to the incident, the loss of child's expectations. The pain of suffering of the kids and the general damages. NO!. We are not culpable for the child's death, must as we embole with family. NO to any form of liability.

We are therefore giving your office a duration of 7 (seven) days starting from this date to respond to this matter. Failure to do so we shall proceed to seek legal advice and redress in a court of law.

Thank you.

Yours. Mercy Chirchir.
And Isack Chirchir.
0720322296/0720496205

Copy to: Prof Otysula
Dr Ondiso S.

Scan to:
SD-S Dr. King
HODCC Cordelia
Dr Eyd Sylvia
SLO King

Draft a response for my approval. Along above lines no MTRH office is/was culpable as we upheld the Standard of Care. We event went beyond the Standard of Care by all the reviews, investigations and treatment we offered our the late Anita Jepkorir.
17/06/2021

DOCUMENT 18

RESPONSE BY CEO MTRH

c.t.c
Richard Okenyo
24 07 2021

22 JUL 2021

An ISO 9001:2015 Certified Hospital

MOI TEACHING AND REFERRAL HOSPITAL

Telephone: (+254)-0532033471/2/3/4
Fax: 0532061749
Email: ceo@mtrh.go.ke/ceosoffice@mtrh.go.ke

NANDI ROAD
P.O. BOX 3-30100
ELDORET,KENYA

Ref: ELD/MTRH/ADMIN/1/15/VOL.111/2018

22nd June, 2021

Mr Isack Chirchir/Mercy Chirchir
P.O. Box 347 – 30100
ELDORET

Dear Isaac and Mercy,

DEMAND LETTER FOR COMPENSATION ON BEHALF OF THE ESTATE OF ANITA JEPKORIR (DECEASED)

This is in reference to your letter dated 17th June, 2021.

Moi Teaching and Referral Hospital (MTRH) is the leading Multi-Specialty Referral Hospital in the region with a coverage spanning the western half of Kenya, eastern Uganda, South Sudan amongst other areas. MTRH is committed to quality healthcare provided in an open, transparent and accountable manner as dictated by its Core Values.

In the course of providing this service, MTRH had a privilege attending to the late Anita Jepkorir. Following passing on of the patient, your family contacted and met a few officers of MTRH, finally leading to a meeting between MTRH Management, the family and medical caregivers.

A day-long meeting was held between yourselves and MTRH Management on 25th May 2021. Your family members who were present were Isaac Kipchirchir, Mercy Kiprono, Stanley Moiy, Julia Moiy, Lukas Kiprop, Priscilla Kandie, Beatrice Sawe, Amos Kimebus. On the MTRH side were Dr. Wilson K. Aruasa, *EBS* (Chief Executive Officer (CEO), Chairing the afternoon session), Dr. Philip Kirwa (Senior Director, Clinical Services (SDCS), chairing the morning session), Dr. Stephen Ondigo, Dr. David Chumba, Dr. Alfred Wanyonyi, Dr. Ernest Nshom, Doreen Mutegi, and Consolata Rop.

During the meeting, your team was taken through Anita's treatment steps as follows;

- That patient Anita was admitted on 9th January, 2021 with a history of having inhaled a foreign body (FB) a few days earlier with associated history of cough and shortness of breath.

22/06/2021

- That the patient was taken to theatre on 10th January, 2021 for bronchoscopy where no foreign body was not visualized but a large mucus plug was washed out.
- On 13th January, 2021 a gastrographin test was done due occasional shortness of breath to rule out trachea-oesophageal fistula. No abnormality was found.
- On 18th January, 2021 a virtual bronchoscopy (by CT scan) was ordered and done the next day. This confirmed a presence of a foreign body in the right bronchus.
- On 22nd January, 2021 the patient taken to theatre were a bronchoscopy was done in an attempt to view and remove the foreign body. This was not successful as the foreign body was not visualized hence converted to a thoracotomy for direct removal of FB.
- During the thoracotomy, a foreign body was palpated on the right lung and removed by sharp dissection. This was found to be an incisor tooth. The lung was then inflated and found to fully expand.
- Post-operatively, the patient had uneventful recovery and went home on the 27th January, 2021.
- The patient was reviewed in the cardiothoracic outpatient clinic and found to be in good health and hence discharged from follow-up.
- The patient was admitted to the paediatric ward on 8th February, 2021 with features of pneumonia were a CT scan done showed bi-basal pneumonia and pleural thickening post thoracotomy. The patient recovered after treatment with antibiotics. Was discharged home on 15th February, 2021.
- Following Anita's passing on 10th May, 2021 a post mortem was done where the findings were peripheral cyanosis, food particles in the trachea, features of increased intracranial pressure in the brain, lung had multiple abscesses with a foreign body in the right bronchus.

From the above patient management, we met and exceeded the Standard of Care required each time. During the meeting on 25th May, 2021 MTRH Management, medical team who managed the patient and other employees present condoled with you. One staff, who you had accused of using unfriendly language unreservedly apologized for any hurt this might have caused to the family. Hence your assertion that MTRH did not condole with your family is untrue.

At the end of the meeting, it was succinctly stated by your representatives (Jepkorir's Grandfather) that no doctor had an intention to kill Anita and if they did it would have been a matter of seconds and that the family only wanted to know the truth of the matter and get its closure accordingly. On the part of MTRH, we had given a true reflection of the patient's management and demonstrated that there was no ill intent on our part. Also remember that it was more than four months from the time Anita aspirated the foreign body on 9th January, 2021 to her death on 10th May, 2021. The MTRH doctors and care fraternity had done their best all along to ensure Anita recovered from her medical problem.

During conclusion of the meeting, it was agreed that MTRH would support Anita's parents with psychological counselling and any other assistance which they may require during this time. The family was free to book an appointment anytime with the Chief Executive Officer (CEO) for any further discussions.

MTRH reached you on 2nd June, 2021 for the psychological counseling support as agreed but you indicated that you were not interested in the sessions and needed to see the CEO. We scheduled another meeting for Friday 4th June, 2021 but efforts to reach you for the same were futile as you later indicated that the notice was short. Further, another meeting was planned for Wednesday 23rd June, 2021 but before then, we received the demand letter dated 17th June, 2021.

22/06/2021

It is therefore utterly surprising to receive your demand letter imputing ill motive on the part of MTRH and its employees. This has left in doubt your sincerity during all our engagements/meetings with yourselves.

Kindly understand that the said discussions were held without prejudice and do not in any way imply MTRH acceptance of any liability or admission of medical negligence in management of Late Anita Jepkorir.

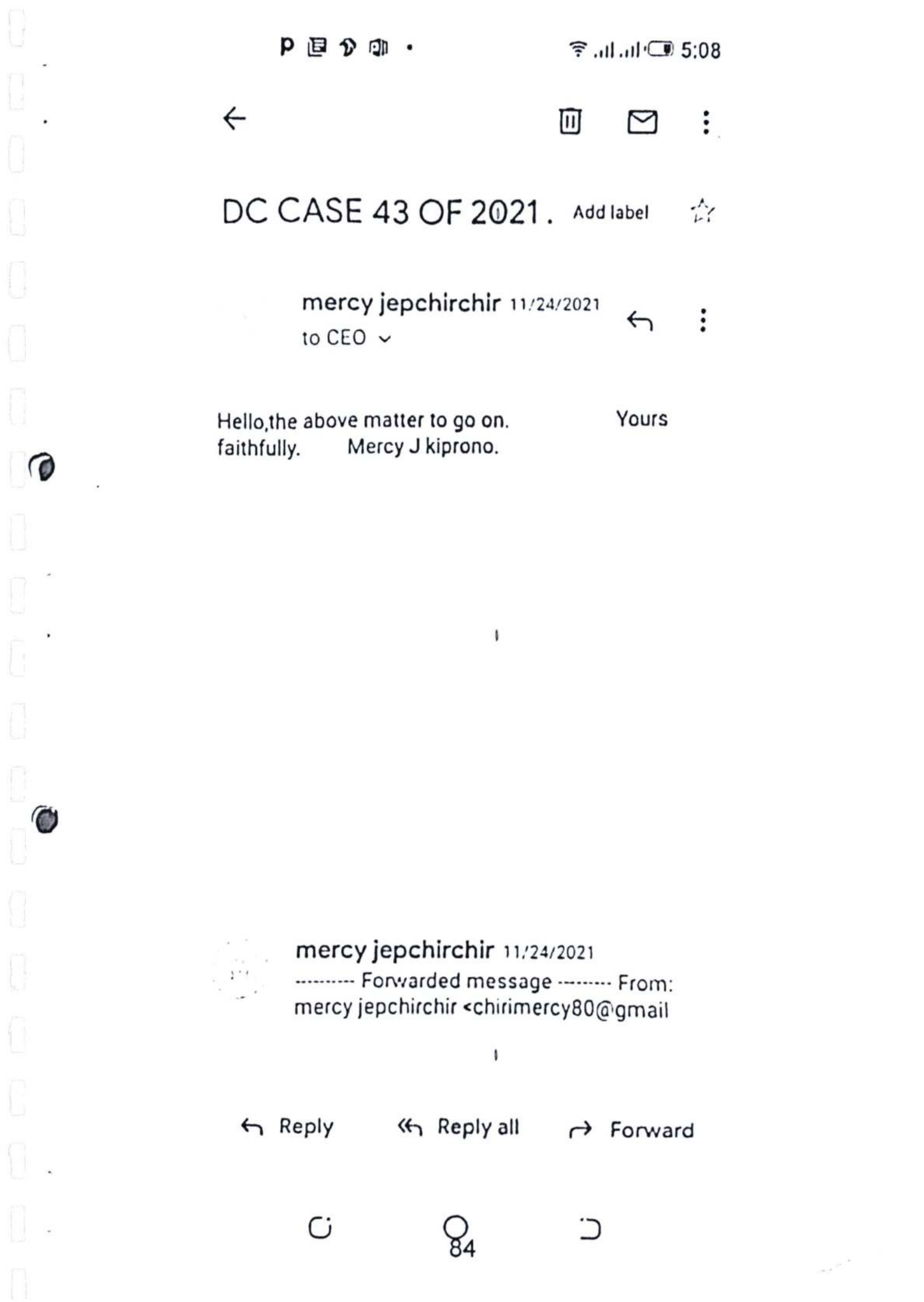
Yours Sincerely,

MOI TEACHING AND REFERRAL HOSPITAL
C.E.O
APPROVED
22 JUN 2021
SIGN.....
P. O. Box 3 - 30100, ELDORET

22/06/2021
DR. WILSON K. ARUASA, *EBS*
CHIEF EXECUTIVE OFFICER

DOCUMENT 19

EMAILS


5:08
DC CASE 43 OF 2021 .
Add label
mercy jepchirchir 11/24/2021
to CEO
Hello,the above matter to go on. Yours faithfully. Mercy J kiprono.
mercy jepchirchir 11/24/2021
--------- Forwarded message --------- From: mercy jepchirchir <chirimercy80@gmail
Reply
Reply all
Forward

DC case 43 2021. Add label

mercy jepchirchir 11/1/2021
to e.muriithi

I did not receive all the MTRH response letters from your office.Your office sent some.

Reply Reply all Forward

DC case 43 of 2021

Add label

mercy jepchirchir 11/12/2021

to legal

Hello.I am still waiting for MOI TEACHING AND REFERRAL HOSPITAL responses from your office.
Regards Mercy Kiprono.

Reply Reply all Forward

DOCUMENT 20

DEMAND LETTER FROM ADVOCATE

KIPKOSGEI & C'
ADVOCA

ADVOCATE:
KIPKOSGEI ABEL,
LL.B (HONS) MOI, DIP IN LAW (KSL)
CELL: 0724090229,
kipkosgeiadvocates@gmail.com

OUR REF: GEN 88/2022 YOUR

TO:
THE KENYA MEDICAL PRACTITIONERS
AND DENTISTS COUNCIL,
P.O BOX 44839-00100,
NAIROBI.

Dear Sir/Madam

RE: DC CASE NO. 43 OF 2021

We refer to the above matter,

Our client (Mercy Jepchirchir) is the complainant in the above case suing on behalf of her daughter(deceased) and has instructed us to address you as follows;

That you are a legal entity/body established under Section 3 of the Medical Practitioners and Dentists Act, and your roles, duties and functions are well stated therein.

That our client in search of justice for her daughter lodged a Medical Negligence complaint on her behalf in July, 2021, facts of the case are well within your records.

That contrary to Article 50 of the Constitution of Kenya, 2010 on fair hearing and exchange of documents before trial, you have without any justifiable reason declined to supply our client with all the responses/defenses from the Medical practitioners/defendants in the case, this despite an earlier formal assurance that the said documents would be supplied to her within Fourteen(14) days after registration. Further, you have not only failed to set the matter for hearing since July, 2021 but also you have declined to give any updates pertaining status of the case and/or the reasons for the delay.

That our client out of frustration and in desperation has gone out of her way and made several requests for the said responses and also to be informed of the status of the case but her requests have all gone unresponded to, safe for the standby auto generated responses acknowledging receipt. (Attached are sample emails dated 1/11/2021 and 12/11/2021.)

That we are aware that on 18/11/2021, you misquoted our client and her intentions regarding withdrawal of the case and went ahead to issue her with a Seven(7) day notice to confirm or rescind withdrawal. First, the notice was too short considering our client is a lay-person who rarely checks e-mails. Secondly the same was made on unfounded facts and information which did not reflect our client's intentions thus ill motivated.

Nevertheless, our client managed to respond to the above said notice on withdrawal within the Seven day timeline given and confirmed that the case should not be withdrawn and it should proceed.(attached is an email dated 24/11/2021)

That since our client gave the go ahead for the case to continue, you have never set the matter or hearing or for pre trial preparations and you no longer respond to any of her emails which are basically reminders, requests and or questions regarding her case.

We now demand from you, information on the status of the case DC CASE 43/2021, and specifically, whether the same was withdrawn despite our client rescinding withdrawal? if Yes, the reasons for the same. If not withdrawn, why has there never been any communication to our client on the status and progress of her case?

You are a body entrusted with hearing complaints from citizens and the manner this case has been handled is contrary to that trust, duty and obligations the public has bestowed you. Be informed that your acts have caused our client pain, suffering and emotional anguish.

You have breached our client's Constitutional Right to fair hearing under Article 50 of COK, Right to fair administrative Action under Article 47 of COK and Fair Administrative Act and Right to information under Article 35 of COK.

TAKE NOTICE that we demand from you, which we hereby do that you give us a prompt response to all the issues raised above within the **NEXT SEVEN (7) DAYS** from the date hereof failure of which we shall institute legal proceedings including Judicial Review action against you at your own risk as to costs and other consequences that will arise therefrom.

Yours Faithfully,

KIPKOSGEI & COMPANY
ADVOCATES
KIPKOSGEI & CO. ADVOCATES
P. O. BOX 2166
Email kipkosgeiadvocates@

KIPKOSGEI A.

CC.

CLIENT

C.E.O KMPDC

DOCUMENT 21

SOCIAL MEDIA POSTS

← Post

Mercy Kiprono @MercyKiprono80 · 01 Oct 22
#RotInMTRH,get #JusticeForAnnita and be the voice to other victims.After a long struggle to get help & justice from @MTRHofficial & @KmpdcOfficial I opted for Twitter and Eunice acted, thus gave me Mention and Hearing dates. 20th August 2022 & 12th October 2022 respectively.

2 9 19

Mercy Kiprono @MercyKiprono80 · 01 Oct 22
DO WE HAVE TO TWEET TO BE HEARD?
WHY IS JUSTICE BEING COMPROMISED IN EVERY STEP?
HOW SURE AM I THAT I'LL GET JUSTICE WITH ALL THESE ROT?
#RotInMTRH #JusticeForAnnita

1 9 21

Mercy Kiprono @MercyKiprono80 · 01 Oct 22
@MikeSonko @Osama_otero @Kimuzi_ @Onorpik @DennisOkari @LynnNgugiShow @bonifacemwangi @MOH_Kenya

4 13

Yells @Yells_O · 04 Oct 22
Replying to @MercyKiprono80 @DCI_Kenya and 4 others
💔🐶

Rigathi bodyguard 001 @BONFA... · 07 Nov 22
Replying to @MercyKiprono80 @DCI_Kenya and 4 others
@_CrazyNairobian hii story isukume

Post your reply

← Post

Mercy Kiprono @MercyKiprono80 · 01 Oct 22

Autopsy was finally done,the results showed that the seed was NEVER REMOVED,which they got rid of during the autopsy.We tried reaching out to MTRH administration,held meeting but all were in vain. #RotInMTRH #JusticeForAnnitaJepkorir

1 6 18

Mercy Kiprono @MercyKiprono80 · 01 Oct 22

Launching the complain with the @KmpdcOfficial, they behaved like the respondent. EUNICE MURITHI, DANIEL YUMBYA & HILDA KARANGA took me rounds.Eunice wanted us to resolve the issue traditionally but I never accepted that because, i wanted the Law to take its course and expose the

1 10 21

Post your reply

The Doctors who handed my daughter to the students without supervision are: Prof.Otysula Baraza, Dr.Ondigo,Dr.Oloo,Dr.Kimani,Dr.Ouma. On enquiry why all these happened, Wanyonyi intimidated us. #RotInMTRH #JusticeForAnnitaJepkorir

1 9 17

Mercy Kiprono @MercyKiprono80 · 01 Oct 22

We took Annita back & forth to the hospital for nearly 5months without any improvement.Eventually, my daughter passed away.The hospital NEVER wanted her to be admitted in their mortuary or autopsy done. #RotInMTRH #JusticeForAnnitaJepkorir

Post your reply

1 12 16

Mercy Kiprono @MercyKiprono80 · 01 Oct 22

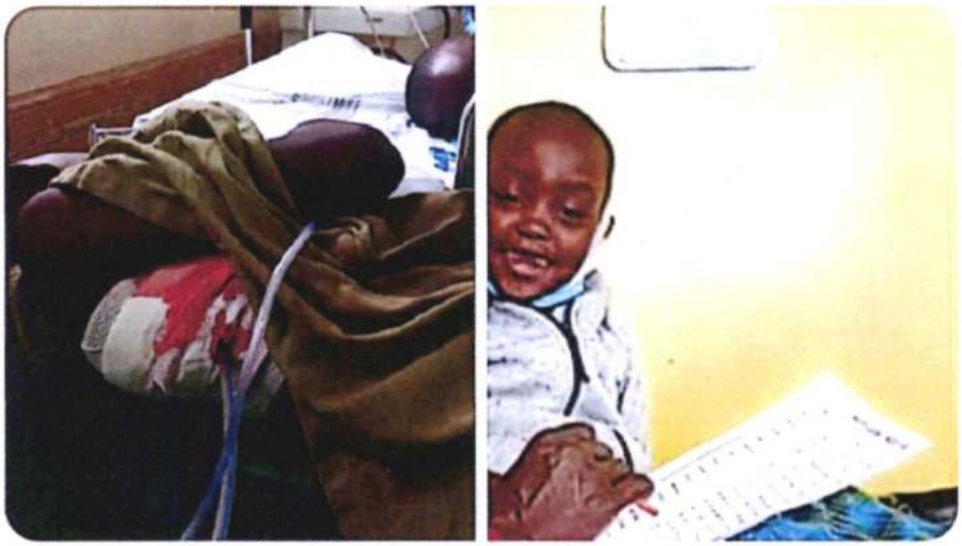
Nshom told me that they found 1 tooth in the bronchi and that the foreign body was not the seed & the 2 upper teeth were loose hence they assisted in removing.I was handed back my daughter with 2teeth bandaged on her leg #RotInMTRH #JusticeForAnnitaJepkorir

1 7 13

Post your reply

Mercy Kiprono @MercyKiprono80 · 01 Oct 22
Replying to @MercyKiprono80

She was attended by two 2nd year COSECSA students who were claiming to be consultants(Alfred Wanyonyi & Ernest Nshom-Cameroonian).They did multiple operations and failed to remove the seed but instead removed 2 incisor teeth from the upper jaw #RotInMTRH #JusticeForAnnitaJepkorir



3 11 19

Mercy Kiprono @MercyKiprono80 · 01 Oct 22

This is where questions arise:
1.Why did they operate between the right side ribs without removing the seed as per the CT scan?
2.Why did they remove 2 teeth from her upper jaw?
3.Why lie to me that they found one of the tooth in the bronchi #RotInMTRH #JusticeForAnnitaJepkorir

Post your reply

← Post

Mercy Kiprono
@MercyKiprono80

#RotInMTRH #JusticeForAnnitaJepkorir
Late Annita was chocked by a flower seed and rushed to Mediheal then referred to Moi Teaching & Referral Hospital,Eldoret.The CT Scan showed that the seed was lodged in the RIGHT BRONCHI @DCI_Kenya @MOH_Kenya @thekhrc @EACCKenya @KituoSheria

20:40 · 01 Oct 22

280 Reposts **22** Quotes **196** Likes **6** Bookmarks

Post your reply

DOCUMENT 22

KMPDC EMAIL

---------- Forwarded message ---------
From: **mercy jepchirchir** <chirimercy80@gmail.com>
Date: Mon, Oct 2, 2023, 8:57 PM
Subject: Re: COMPLAINT AGAINST THE DEPARTMENT
To: <campoprinters@gmail.com>

On Mon, Oct 17, 2022, 9:42 AM Eunice Muriithi <e.muriithi@kmpdc.go.ke> wrote:

Morning Ms. Mercy Jepchirchir,

I hope this email finds you well.

On behalf of the entire department, I would like to apologize for the experience which you had when you were lodging and following up on your complaint.

We take every complaint seriously and would like to assure you that it is not the intention of any member of the department to make any processes more difficult.

Once again we sincerely apologize for your experience.

We welcome your invaluable feedback on how to improve our processes.

Kind regards,

E. Muriithi

DOCUMENT 23

RULING OF KMPDC

REPUBLIC OF KENYA

THE KENYA MEDICAL PRACTITIONERS AND DENTISTS COUNCIL

INQUIRY BY THE

DISCIPLINARY AND ETHICS COMMITTEE

(PURSUANT TO THE PROVISIONS OF THE MEDICAL PRACTITIONERS AND DENTISTS

ACT, CHAPTER 253 LAWS OF KENYA

DC CASE NO 43 OF 2021

MERCY JEPCHIRCHIR KIPRONO ON BEHALF OF
ANNITA JEPKORIR CHIRCHIR (DECEASED).....COMPLAINANT

AND

DR. ERNEST NSHOM.....1ST RESPONDENT
DR. ALFRED WANDEBA WANYONYI .....2ND RESPONDENT
PROF. BARASA OTSYULA KHWA.....3RD RESPONDENT
DR. STEPHEN ONDIGO.....4TH RESPONDENT
MOI TEACHING & REFERRAL HOSPITAL.....5TH RESPONDENT

RULING

A. INTRODUCTION

1. The Complaint leading to this inquiry was lodged before the Kenya Medical Practitioners and Dentists Council, hereinafter referred to as **"the Council"**, by **Mercy J. Kiprono** on behalf of The Late Annita Jepkorir, hereinafter referred to as **"the Complainant"** against **Dr Ernest Nshom** hereinafter referred to as **"Dr Nshom"** or **"1st Respondent"**, **Dr Alfred Wandeba Wanyonyi**, hereinafter referred to as **"Dr Wanyonyi"** or **"the 2nd Respondent"**,

Prof. Barasa Otsyula Khwa hereinafter referred to as **"Prof. Otsyula"** or **"the 3rd Respondent"**, **Dr Stephen Ondigo** hereinafter referred to as **"Dr Ondigo"** or **"the 4th Respondent"** and **Mol Teaching & Referral Hospital** hereinafter referred to as **"the Hospital"** or **"MTRH"** or **"the 5th Respondent"**

2. The Complainant submitted to the Council a signed Application for Lodging Complaint dated 28th June 2021. She attached thereto a statement that gave the chronology of events leading to the complaint, a copy of an autopsy report drawn by Dr David Chumba dated 13th May 2021, a copy of a CT scan Chest Bronchogram report from the Respondent Institution dated 19th January 2021, a copy of CT scan report dated 11th February 2021, a copy of a discharge summary dated 10th January 2021, a copy of a discharge summary from the Respondent Institution dated 14th February 2021, a colour picture of a black seed placed on a white paper and yellow glove, picture of a hospital attendance card issued on 9th January 2021, and several pictures of the Deceased while in Hospital.

3. The Council served the Respondents with a copy of the complaint through a letter dated 21st July 2021 and requested for a comprehensive report addressing the allegations raised by the Complainant, certified, and paginated copy of the patient's file, statements from the medical personnel who managed the patient and any other documents that would assist in the investigations.

4. In response thereto, the 5th Respondent through a letter by the Chief Executive Officer dated 30th July 2021, submitted to the Council an executive summary drawn by Dr Philip Kirwa, Senior Director, Clinical Services dated 30th July 2021, a statement by Prof. Otsyula dated 29th July 2021, a statement by Dr Wandeba dated 29th July 2021, a statement by Dr Ondigo dated 30th July 2021, a statement by Dr Mark Oloo dated 30th July 2021, a statement by Dr Ismail Mohamed dated 29th July 2021, a statement Dr Nshom dated 29th July 2021, a statement by Dr Victor Ouma, a copy of the autopsy report by Dr David Chumba dated 26th May 2021, and a copy of the patient's file.

5. The genesis of the complaint herein arises from the treatment and management of Annita Jepkorir Chirchir, hereinafter referred to as **"the Patient"** or **"the Deceased"** by the 1st to 4th Respondents and the 5th Respondent Institution. The Complainant in the Application for lodging a Complaint at Section E indicated the brief nature of the complaint as;

> ***"Medical negligence, patient's mismanagement, intimidation, and no follow up on second admission"***.

In the statement accompanying the application for lodging a complaint, on page 6, the Complainant enumerated the particulars of negligence as;

(i) Failing to note the presence of a seed in the patient's airway;

(ii) Failing to conduct a proper bronchoscopy procedure;

(iii) Failing to properly interpret the results of the bronchoscopy;

(iv) Misdiagnosis of the patient's condition;

(v) *Leaving a foreign object in the patient's airway/lung;*

(vi) *Conducting the wrong procedure when the patient was in theatre;*

(vii) *Extracting the patient's teeth when the same was not due for extraction;*

(viii) *Misinforming that the patient had swallowed a tooth when such was not the case;*

(ix) *Misdiagnosing the patient with pneumonia when she was brought back for further check;*

(x) *Failing to exercise proper skill and care required of the doctor; and*

(xi) *Failing to reveal the truth to the patient's parents.*

B. INQUIRY BY THE COMMITTEE

6. The Council referred the complaint to the Disciplinary and Ethics Committee, hereinafter referred to as **"the Committee"**, as **DC Case Number 43 of 2021**. Section 4A (1) (b) provides that the mandate of the Committee shall include:

(i) *Conducting inquiries into complaints submitted to it;*

(ii) *Regulating professional conduct;*

(iii) *Ensuring fitness to practice and operate;*

(iv) *Promoting mediation and arbitration between the parties; and*

(v) *At its own liberty, recording and adopting mediation agreements or compromise between parties, on the terms agreed.*

Section 20 of the Act further provides in subsection (1) that; "*Any person who is dissatisfied with the professional serviced offered or alleges a breach of standards by a registered or licensed person under this Act, may lodge a complaint in the prescribed manner to the Council*".

7. The Committee being cognisant of its mandate as provided in Section 4 A (1) (b) of the Act, considered the application for lodging a complaint and the documents submitted by the Complainant, documents submitted by the Respondent, the patient's files and all the documents before it and found that they were insufficient to make a determination. Consequently, the Committee recommended that the matter proceeds for hearing. The Council served the parties with a notice for mentions dated 7th September 2022. On 20th September 2022, mentions for directions were held at the Council offices wherein in the absence of the Respondents, the hearing was confirmed for 12th October 2022.

8. On 12th October 2022, the Committee held its sitting at the Kenya Medical Practitioners and Dentists Council offices, at Nairobi where the Complainant appeared in person, and was presented by learned Counsel Prof. Kiama Wangai. The Respondents were also present and were represented by Learned Counsel Mr Josphat Mutuma Kurima.

9. **Ms Mercy Jepchirchir Kiprono, ("Ms Mercy")** the Complainant was the first to testify before the Committee. She was led in her evidence by learned counsel Prof. Kiama Wangai. She stated that she is the mother to the Late Annita She adopted her signed statement as evidence in chief.

10. It was her evidence that she took her daughter to the hospital for treatment. She was six years old at the time she took her to MTRH as she had difficulty in breathing. She said that she had been choked by a sunflower seed that she could identify. She stated that they were referred to MTRH from Mediheal. They first went to Mediheal, but she began recovering and was discharged. However, within a short period before they left Mediheal, she experienced distress and they rushed her to MTRH.

11. She stated that they were advised to go to MTRH for Bronchoscopy. This was on 9th January 2021. At the Hospital, she was referred for surgery and booked for theatre the same night. At the theatre, she was received by Dr Ernest Nshom who informed her that they wanted to perform the procedure to check. When they left the theatre, she was informed that they did not see anything, and they remained admitted to the hospital. They stayed in the hospital until 19th January 2021 when a CT scan was done which revealed a ring-shaped foreign body in the right bronchus. Surgery was recommended and she was taken to theatre on 22nd January 2021. After the surgery, Dr Nshom informed them that they had found a tooth in the bronchus. Annita had already lost her lower incisor teeth. However, when she was brought back from theatre, she had two missing

upper incisor teeth. Dr Nshom informed her that they had removed the two upper incisor teeth after finding a tooth in the lungs. He also informed her that the white bandage had the tooth, that was removed from the right bronchus, while the blue bandage had the two teeth they assisted to remove since they were loose.

12. It was her evidence that while on the ward, she removed the bandage and found two teeth, one in the white and another in the blue bandage. She stated that Dr Nshom told her that they performed a thoracotomy because the bronchoscopy failed. The Deceased had a chest tube on the side where they had made an incision. She stated that she had consented for bronchoscopy and not the thoracotomy. On the ward, when they queried about the missing teeth, and after speaking to Dr Nshom, Dr Wanyonyi called her and her husband and directed them to a room at the nurses' station. He wanted to address the issue she had raised regarding the 3rd missing tooth which he claimed they removed in theatre. She claimed he was rude in addressing them and they apologized. She also claimed that he told them not to complain as their child was well. At the time the child was coughing like there was still a blockage.

13. Ms Mercy testified that they were advised to do another x-ray to check the status of the tube that had been inserted. Prof. Otsyula came to the ward, and she heard him telling the students that teeth were extracted, and one was removed from the lung. He also advised that they would be

discharged because the wound had dried. On 28th January, they were discharged on medication and advised to go for dressing of the wound. On 8th February, the Deceased began vomiting with a fever, so they returned to MTRH. On arrival, they were informed that her oxygen was low, she was nebulized and admitted to the ward. A CT scan was performed, and the diagnosis was pneumonia post-thoracotomy procedure was made. She was treated and they were discharged on 15th February.

14. On 6th March 2021, they took her back to the hospital for cough, vomiting, and fever. They also went back to MTRH on 16th April 2021 when she was treated at outpatient. On 22nd April, they went back to MTRH for a check-up, and they were given medicine at outpatient. On 10th May 2021, while playing, she coughed for a long and fainted. They rushed her to MTRH, and she was pronounced dead on arrival. On 13th May 2021, an autopsy was done by Dr David Chumba, and they found a seed in the right bronchus.

15. She testified that her complaint was that it was evident that the seed was the issue from the Deceased's description and the scan which revealed the same and yet they removed teeth. When they tried to get an explanation, they only met with students. They did not get an explanation from Dr Ondigo, Prof. Otsyula, or Dr Oloo.

16. On cross-examination by counsel for MTRH Mr Kurima, she confirmed that she consented to the procedures done on the 9th and 22nd of January 2021. She confirmed that she noticed the fresh upper tooth gaps after the

theatre. She also confirmed that there was a meeting held between MTRH and the family. She stated that she was not going to MTRH for any counselling.

17. **Dr Alfred Wandeba Wanyonyi**, the 1st Respondent, was the next person to testify before the Committee. He stated that he was registered in 2001, was currently undertaking a Fellowship in General Surgery (COSECSA) and was in his second year of residency. During the said case he was undertaking his rotation in the cardiothoracic surgery department. He adopted his statement dated 29th July 2021 as his evidence in chief.

18. Dr Wanyonyi testified that he first met Anita on 11th January 2021 during a major ward round. On a review, she had been admitted on 9th January 2021 to the cardiothoracic surgical unit with a cough and vomiting following a history of having inhaled a seed and choking on the same. She had undergone a bronchoscopy on the day of admission. During the ward round, a decision was made to conduct a gastrograffin study and virtual bronchoscopy to assess the child because she was drooling saliva to rule out an oesophageal fistula that might have occurred. Under the guidance of Dr Oloo, Dr Ismael(MO), and Dr Kibos (Resident in general surgery). On 13th January, the child was reported to have episodes of chocking and dyspnoea and a decision was made to follow up gastrograffin study which involved giving an oral contrast and taking an x-ray, to check if there is an abnormal connection with oesophagus and trachea. On the 14th the plan was to follow up on the gastrograffin study.

On 16th January 2021 the gastrograffin study was done and there was no such abnormal connection.

19. It was his testimony that his next interaction with the Patient was on 19th January 2021, during another major ward round under Prof. Otsyula, Dr Ondigo, Dr Oloo, and Dr Ismael. At that point, the decision was to conduct a CT bronchoscopy(3D reconstruction) because she still experienced difficulty in breathing. On 20th January 2021, the report of bronchoscopy was received, and it revealed a ring-like lesion in the right proximal bronchi, and a decision was made to undertake elective bronchoscopy with possible thoracotomy.

20. On 22nd January 2021, the Patient was taken to theatre. During bronchoscopy, two deciduous teeth came off, one was recovered and but the other was not. Intraoperatively, rigid bronchoscopy was done by Dr Ondigo as the main surgeon, but it was not possible to retrieve the foreign body and therefore necessitating a change to thoracotomy. A right thoracotomy was done during which he participated as the assistant surgeon. The main surgeon was Dr Ondigo, and the anaesthetist was Dr Nshom.

21. On cross-examination by Prof. Kiama, Counsel for the Complainant, he clarified that he first met the Deceased on 11th January 2021. The plan of management was to do bronchoscopy and gastrograffin, but his name doesn't appear on the records. In reference to the operation notes of 9th

January 2021, findings of which were confirmed, he stated that it is not indicated whether the foreign body was removed. They found a mucus plug which was removed.

22. It was his testimony that a review of the CT scan was done on 20th January and a decision for elective bronchoscopy with possible thoracotomy was made. He confirmed that the consent was for explorative bronchoscopy. He reiterated that the consent form indicates consenting for such further operations that may be found necessary intraoperatively. He stated that during the bronchoscopy, two upper incisors came out and one of the teeth was retrieved from the mouth and the other one could not be retrieved. The purpose of the thoracotomy was to completely check for the tooth that had not been retrieved which he opined because he was in surgery. He submitted that when they performed the thoracotomy, they palpated the lungs, felt a hard mass, and when they did the sharp dissection, they found a tooth.

23. On the issue of any family discussions, he confirmed that after the operation, he was called to explain the intra-operative findings which he clearly explained to the parents. He informed them that there was one tooth retrieved from the mouth and the other from the sharp dissection of the lung. He stated that when he gave them the explanation, it was not palatable to them, and it was one of the reasons for the unfair accusations. He stated that he could not make up a story of what they found in theatre.

24. About the post-mortem report dated 13th May 2021, he confirmed that it has the logo of the Hospital and that the pathologist was Dr David Chumba. Further, Dr Chumba concluded that the cause of death was asphyxia due to aspirated food-a foreign object in the right bronchus with multiple abscesses, and samples for histology were taken. He stated that he could not change the pathology report and that he noted the findings as indicated. On his opinion of the foreign body found at post-mortem, he stated that according to Hill's criteria on causality, there are several factors that need to be considered. One of them is timelines, events preceding an outcome. From the post-mortem, it is indicated that the child died due to asphyxia due to aspirated food. In terms of Hill's criteria, he could not directly link surgery and aspiration. He opined that the Deceased received standard care available at the hospital.

25. On cross-examination by Committee, about the episodes of difficulty in breathing, he stated that they did not have any associated or aggravating factors. The justification for the gastrograffin test was based on the child's presentation. The child was also reported to be drooling and based on the history of choking on a foreign body which was not retrieved in the first bronchoscopy. He confirmed that a tooth did not fit the description of a ring-enhancing lesion, but the thick mucus plug would appear like it. He confirmed they anticipated finding a foreign body. He also confirmed that the tooth which they removed was what the Patient had aspirated in theatre. He stated that the finding of a tooth did not mark the end of their

search. After sharp dissection, they palpated both sides of the lung and inflated the lungs, and they expanded well and there were no areas of collapse. He submitted that there was no step that they missed in trying to retrieve the foreign body. On the bronchoscope used, he submitted that they used a rigid bronchoscope.

26. On the question of when the CT scan was done and whether there was possibly another report before they went to theatre? He stated that the scan was done before they went to theatre. On whether the right bronchotomy was opened following the CT scan, he stated that a bronchotomy was not done and that they did rigid bronchoscopy. That the CT scan images don't correlate with the report.

27. Further cross-examination by the Committee, he indicated that the operation notes were written by him immediately after the operation. He confirmed that he was the assistant surgeon. He confirmed that his operation notes failed to indicate the issue of the missing teeth that came off during intubation which he mentioned in his statement. He further confirmed that he missed indicating the issue of the missing teeth in his operation notes. On when the teeth were lost, he stated that the teeth were lost during bronchoscopy which was being undertaken by Dr Ondigo. He explained that teeth can be lost during bronchoscopy(rigid) during either the initial introduction or during the manipulation of the bronchoscope. He confirmed that the operation notes do not make mention of where the foreign body was. He confirmed that he was called by the attending nurse

to explain to the relatives. He clarified that he first spoke to the Patient's mother and grandmother who told him to wait and appraise the father too, which he did. He stated that the rude Dr Wanyonyi whom the Complainant described was not him. He stated that he was not in any way rude and that his interactions with people are always cordial.

28. **Dr Stephen Ondigo,** the 4th Respondent was the next person before the Committee. He adopted his signed statement dated 30th July 2021 as his evidence in chief. He stated that he is a cardiothoracic surgeon working at MTRH. He has an MMed degree in Surgery and a Fellowship in Cardiothoracic surgery and had been doing cardiothoracic work for the last 11 years together with Prof. Otsyula. He stated that the Patient was admitted on 9th January 2021 with a history of choking on a flower seed. Had drooling of saliva, vomiting, and mild cough. At the time of admission, the symptoms had improved. An impression of foreign body oesophagus with a differential diagnosis of foreign body bronchus was made and the cardiothoracic team was consulted. He submitted that he first saw the patient on 11th January 2021 during a major ward round with Prof. Otsyula and Dr Oloo. The child was stable, but they requested for gastrograffin study to assess if the child could be having an oesophageal foreign body or tracheo-oesophageal fistula (TOF).

29. On cross-examination by Prof. Kiama, Dr Ondigo confirmed that he was involved in the management of the patient while she was in the ward. He clarified that he is the one who indicated to the mother that they would

perform the bronchotomy with the possibility of thoracotomy but that the consent was signed by Dr Ismael.

30. On cross-examination by the Committee, he clarified that intraoperatively, they still looked for the foreign body by palpating the lung. They looked for the seed intraoperatively, but they did not locate it. They did a CT Bronchogram to give an indication and better level of accuracy at 67% of where the foreign body might have been. After they could not retrieve the seed, they had to monitor the patient and then subsequently repeat the CT scan. On why they did a bronchogram the first time and a normal CT scan the 2nd time, he stated that he was not involved in the decision to conduct the normal CT scan the second time in February but that the bronchogram is ideally more accurate. He stated that they advised the parents to go back to the hospital in case of any incidences. Further, at the time of her demise, the child was not in their custody.

31. On the post-mortem finding of a seed. He stated that he could not explain the same. He confirmed that they did an audit of the case. It was his evidence that at the time of discharge, the Patient was stable. When she was readmitted to the medical ward, a CT scan found pneumonia.

32. On further cross-examination by the Committee, Dr Ondigo stated that at the two-week follow-up after discharge from the surgical ward, the Patient did not present with any symptoms.

33. On the CT scan findings, he stated that he was informed by radiology that they saw a ring-like structure that was radiolucent in the right main bronchus. During the thoracotomy, they opened the right main bronchus as per the said CT scan. He confirmed that at Post-mortem the foreign body was found in the right bronchus. He submitted that literature postulates that 30% of foreign bodies can be ejected even without surgery.

34. Dr Ondigo confirmed that he was the team leader in the 2nd operation. On the contents of the operation notes, he confirmed that there was no mention of the teeth dislodgement. He stated that the teeth dislodged during bronchoscopy. He confirmed that during the procedure he did not remove the bronchoscope. He also confirmed that one tooth was found in the oral cavity, but he did not find the other tooth and he did not see the tooth while pushing in the bronchoscope. He stated that at the time they did not have tubes for lung isolation. He admitted that there was a possibility of having pushed the tooth with the bronchoscope or ET tube. He further stated that on using forceps he did not find any foreign body and on palpation, they did not feel any foreign body.

35. On whether a meeting was held at the hospital, he confirmed that the family meeting took about 10 hours because of arguments on whether the foreign body was removed or not.

36. On re-examination, he stated that when doing a major ward round and they would have explained to the parent what needs to be done, consent can be taken by any other doctor and not necessarily the consultant. On

the standard for removal of a foreign body, he stated thoracotomy is standard to be performed once an expected foreign body was not retrieved through bronchoscopy. On the findings at post-mortem, he stated that food particles were found in the airway and that is what the child had aspirated. Further, the foreign body was not the immediate cause of death.

37. **Prof. Barasa Otsyula Khwa,** the 3rd Respondent was the next person before the Committee. He adopted his statement dated of 29th July 2021 as his evidence in chief. It was his evidence that he saw the Patient three times. On all occasions, it was during the major ward round. He stated that on 11th January 2021, it was reported that the child had developed drooling of saliva, vomiting, and mild cough after choking on a flower seed on 9th January 2021. At bronchoscopy that evening, a mucus plug was found. The plug was suctioned out. At the review on 11th January, the child was reported to have had episodes of cough since the bronchoscopy. During the major ward round, he requested for a virtual bronchoscopy and gastrograffin swallow. On 18th January 2021, the child had no complaint. The gastrograffin swallow had been done and it was normal. They decided to wait for the virtual bronchoscopy.

38. It was his further statement that the virtual bronchoscopy done on 19th January 2021 was reported to show a *"right ring-like foreign body in the right main bronchus"*. The child had a repeat bronchoscopy and right thoracotomy on 22nd January 2021. An incisor tooth was found and removed. On 25th January 2021, the chest tube, which was in place, was not

bubbling or draining and they decided to remove the tube and continue with physiotherapy.

39. Prof. Otsyula stated that he did not see the child again. He was not aware that the child had been admitted to the paediatric ward and he did not see the second CT scan. He learned of the demise of the child sometime in May 2021 after the family complained.

40. On cross-examination by Prof. Kiama, he stated that the doctors who operated stated that they found a tooth and no other foreign body was retrieved. He confirmed that the circumstances of the two teeth were brought to his attention and that they came out during bronchoscopy. On his opinion on the foreign body being found on the post-mortem, he stated that he did not dispute the finding at the post-mortem however, due diligence was done, and the child was well managed by the department.

41. On cross-examination by the Committee, he stated that when the Patient was readmitted, she should have been sent to the cardiothoracic surgical unit and they would have assessed her differently.

42. On re-examination, he stated that the cause of death as per post-mortem was not in doubt, the immediate cause of death was asphyxia due to aspirated food particles.

43. **Dr Ernest Nshom**, the 1st Respondent was the next person before the Committee. He stated that he qualified as a medical practitioner in 2013, and presently is a Resident in Anaesthesia and Critical Care at MTRH. He adopted his statement dated 29th July 2021 as his evidence in chief. It was his evidence that he was part of the management of the Deceased as part of the anaesthesia team in both procedures. He stated that on 9th January 2021 the main anaesthesia provider was a Clinical Officer anaesthetist who was leading the team but there was an anaesthesiologist on call.

44. During the 2nd procedure, the team leader was an anaesthesiologist assisted by a Clinical Officer anaesthetist and he was assisting. In response to the complaint against him for instructing the team, he stated that he was not in a position to instruct the team considering his role. Regarding the accusation of interaction with the mother after the procedure, he stated that he met the Complainant before the procedure and later at the entrance to the children's hospital when she enquired about what transpired intra-operatively (in an informal setup), he informed her of what he saw. He told her that they retrieved one tooth from thoracotomy.

45. On cross-examination by Prof. Kiama, he confirmed that at the theatre receiving area on 9th January 2021, the Complainant showed him the sample of the seed that the Deceased had indicated had swallowed. Further, after theatre, he denied that he told her that the seed she showed him was not what they found. Dr Nshom clarified that he only informed the Complainant of two teeth and denied telling her about three teeth in the

bandages. He stated that the lead anaesthesiologist was Dr Kimani Mbugua. He confirmed that he was present in both procedures. He also confirmed that his name was missing from the operation notes because the surgeon only indicate qualified practitioners. He stated that the role he played was that of a student assisting the lead anaesthesiologists.

46. **Dr Phillip Kirwa, ("Dr Kirwa")** the Senior Director, Clinical Services at MTRH, was the next person before the Committee. He adopted the executive case summary dated 30th July 2021 as his evidence in chief.

47. On cross-examination by Counsel for the Complainant, he confirmed that the Complainant expressed that the child was not managed well. He stated that they held a meeting with the family and the mother was very emotional. He stated that they offered the Complainant counselling because she was distressed and for emotional support. He confirmed that Dr Chumba works at MTRH, and his qualifications are known and acknowledged.

48. The last person to appear before the Committee was Dr Wilson Aruasa, **("Dr Aruasa")** the Chief Executive Officer of MTRH. Dr Aruasa submitted on behalf of the hospital. he adopted his statement of 4th October 2022 as his evidence in chief. It was his testimony that when the complaint was filed, he forwarded all the documents requested to the Council. He submitted that the hospital has invested heavily in the cardio-thoracic surgical unit; where they have an adult and paediatric ward, three well-trained surgeons and

equipment. They have several COSESCA trainees who get good training. That they hold clinical and mortality audits to improve the quality of care. In terms of the filing system, they have a robust system currently having an electronic system acting parallel to their existing manual system. They also started to migrate to fully electronic health records. Every patient has one file only which is easily retrievable. The same file used in the surgical ward would equally be used in the medical ward.

49. It was his testimony that they held a meeting with the family from 10 am to 4 pm, to go through the steps of management through all admissions. The meeting was partly chaired by Dr Kirwa and then by himself. In the meeting, there was some progress and a lot of back and forth. He stated that the Patient was taken to the funeral home on the day of the demise therefore they did not perform resuscitation. The food particles seen at post-mortem indicate that the cause of death was asphyxia due to aspirated food particles. It was his submission that the hospital provided the best care to the child. It was his further submission that while the case was lawfully before the Council, it was continually prosecuted on social media.

50. On cross-examination, he confirmed that Dr Wanyonyi was issued with a warning letter and the family was informed.

C. ISSUES FOR DETERMINATION

51. Upon careful evaluation and lengthy deliberation of the matter, the Committee notes that the substantive issue for determination are as hereunder: -

(i) Whether the Respondents owed the patient a duty of care and what is the expected standard of care;

(ii) Whether the 5th Respondent can be held liable for the acts or omissions of its servants/agents; and

(iii) Whether the 1st- 4th Respondents and 5th Respondent through its servants/agents were negligent in the treatment and management of the Patient.

D. FINDINGS

52. The Committee carefully considered the complaint as lodged before the Council, the statements and documents submitted by the parties herein to enable it to determine the matter fairly and judiciously. On careful evaluation and lengthy deliberation of the matter, the Committee notes that the complaint hinges on the treatment and management of the Deceased at the 5th Respondent Hospital.

53. The first issue for determination is whether the Respondents owed the patient a duty of care, and what is the expected standard. The Committee notes that duty of care is a legal obligation imposed on individuals or persons, requiring adherence to a standard of care while performing any acts that could foreseeably harm others. This means that hospitals and practitioners

shall be held to a particular standard when it comes to treating and managing patients who will fall under their care.

54. In the case of **Richard Njoki Wahome (suing as the administrator of the Estate of Wahome Mutahi (deceased) –vs- Attorney General & 2 others (2015) eKLR**, where the Court relied on the case of **Jimmy Paul Semenye -vs- Aga Khan Hospital & 2 others (2006) eKLR**, it was stated that;

> ***"There exists a duty of care between the patient and the doctor, hospital or health provider".***

55. On the expected standard, it can be stated that the standard will not be of an ordinary man but shall be a standard of the peers. Thus, a reasonable man can is substituted with "reasonable professional". **McNair J** in **Bolam vs Friern Hospital Management (1957) 2 All E.R**, explained the law on the test of professional negligence as;

> ***"but where you get a situation which involves the use of some special skill or competence, then the test whether there has been negligence or not is not the test if a man on the Chapman omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill at the risk of being found negligent.... It is sufficient is he exercises the ordinary skill of an ordinary competent man exercising that particular art."***

The Committee considered the case of **Nevill and Another -vs- Cooper and Another (1958) EA 594** it was held that;

> ***"if he professes an art, he must be reasonably skilled at it. He must also be careful but the standard of care which the law requires is not an insurance against accidental slips. It is such a degree of care as a normally skilful member of the profession may reasonably be expected to exercise in the actual circumstances that may present themselves for urgent attention...."***

It is judicious to emphasize that the standard of care in medicine is that which is already laid out in established international, regional, and country standards and guidelines, books, and peer-reviewed scientific journals.

56. In **Herman Nyangala Tsuma vs- The Nairobi Hospital and 2 others**, Odunga J stated that;

> ***"it is accepted in the medical profession that there is no objective test for determining the negligence of a doctor. Whereas doctors are supposed to operate within certain known parameters of the diagnosis the profession is not straight-jacketed to the extent that all doctors must respond in exactly the same way when confronted with a set of circumstances. As long as the doctor does not go outside the well-known medical procedures, it is accepted that there may be variation in approaches to particular cases".***

Consequently, in determining whether the duty has been discharged by not only a doctor but by a health care professional, regard must be given to whether the professional observed or followed universally accepted standards, guidelines, and protocols.

57. Having established that indeed a duty of care was owed to the Patient, and the expected standard of care, the question then becomes whether the 5th Respondent can be held liable for the acts or omissions of its servants/agents. The courts have pronounced themselves in this regard. The Committee considered **Hellen Kiramana –vs- PCEA Kikuyu Hospital Nairobi HCCC No. 54 of 2013**, where the Court quoted and relied on the case of **M (A Minor) vs- Amulega & Another (2001) KLR 420**, where it was held that;

> ***"Authorities who own a hospital are in law under the safe-same duty as the humblest of doctors. Whenever they accept a patient for treatment, they must use reasonable care and skill to cure him of his ailment. The hospital authorities cannot of course do it by themselves. They must do it by the staff whom they employ and if the staff is negligent in giving the treatment, they are just as liable for the negligence as is anyone else who employs others to do duties for him...it is established that those conducting a hospital are under a direct duty of care to those admitted as patients at the hospital. They are liable for the negligent acts of the member of staff, which constitutes a breach of that duty of care owed by him to the patient thus there has been acceptance from the courts that hospital***

authorities are in fact liable for the breach of duty by members of its staff. It is trite law that a medical practitioner owes a duty of care to his patients to take all due care, caution, and diligence in the treatment."

58. In the instant case, the Committee guided by the above precedents holds that a hospital is responsible for all those in whose charge the patient is placed, and the Respondent can be held liable for the acts of its servants/agents.

59. The Committee considered the final issue for determination, whether the 1st-4th Respondents and 5th Respondent through its servants/agents were negligent in the treatment and management of the Patient. Black's Law Dictionary 9th Edition defines negligence as;

"a failure to exercise the standard of care that a reasonably prudent person would have exercised in a similar situation: Any conduct that falls below the legal standard established to protect others against unreasonable risk of harm, except for conduct that is intentionally, wantonly, or willfully disregardful of other rights. The term denotes culpable carelessness".

60. The Court in the case of **Hellen Kiramana –vs- PCEA Kikuyu Hospital Nairobi HCCC No. 54 of 2013**, quoted the case of **Dr Laxman Balkrishna Joshi V. Trimbark Babu God Bole and another; AIR 1969 SC 128 and A.S Mittal V state of U.P; AIR 1989 SC 1570,** where it was held that when a doctor is consulted by a patient, the doctor owes to his patient certain duties which are (a) duty

of care in deciding whether to undertake the case(b) duty of care in deciding what treatment to give, and (c) duty of care in the administration of that treatment. A breach of any of the above duties may give a cause of action for negligence and a patient may on that basis recover damages from his doctor. In this case, the Supreme Court of India observed, inter alia, that negligence has many manifestations.

61. When a patient generally approaches a doctor or a hospital, his or her expectations are twofold; that the doctor and the hospital will provide medical treatment with all the knowledge and skill at their command, and secondly, that they will not do anything to harm the patient in any manner either because of their negligence, carelessness, or reckless attitude of their staff.

62. The Committee considered the treatment and management of the Deceased and notes that the Late Anita Jepkorir six years of age presented at MTRH on 9th January 2021 with a histpry of having aspirated a seed. Upon evaluation, Dr Oloo a Thoracic and Cardiovascular surgeon was consulted. He reviewed the child and on finding her relatively stable, discharged her with advice to return in case of any problems. She returned later in the evening of the same day with complaints of difficulty in breathing. A decision was made to perform a bronchoscopy, although they entertained the possibility of the seed being in the oesophagus. The Patient was prepared and taken to theatre. During bronchoscopy, a mucus plug was

found and suctioned out. This was at the time considered to be the cause of the obstructive symptoms.

63. The child was returned to the ward where she continued to develop paroxysmal episodes of breathing difficulties. Based on this and upon review in the major ward round, a decision was made to conduct a CT Bronchogram, it demonstrated a ring-like foreign body in the proximal right main bronchus. On the strength of this finding, the Patient was scheduled for a repeat bronchoscopy.

64. The Committee notes that there is no evidence that consent was sought for thoracotomy, however, this finding notwithstanding, it was in the best interest of the Patient to perfume the thoracotomy where bronchoscopy is unsuccessful. The Committee finds that two incisor teeth were dislodged at the second bronchoscopy. One was retrieved from the oral cavity, and the other could not be accounted for. Having failed to locate the second tooth, Dr Ondigo introduced the bronchoscopy, and he visualized the foreign body. He, however, did not give details of the same. At that point, a decision was made to perform a right-sided thoracotomy and through it and after palpation of the lung for the foreign body, they removed a tooth through sharp dissection. Their effort to locate the foreign body by palpation was futile and they, therefore, closed the chest and sent the Patient back to the ward. Notably, during cross-examination by the Committee, Dr Wanyonyi stated that they closed the lung with Vicryl® suture. In the ward, the Patient

improved and was discharged to be followed up in the surgical outpatient clinic.

65. The Committee finds that at the second bronchoscopy, the misplaced incisor tooth was a red herring, and Dr Ondigo should have revisited the CT scan results before the incisor tooth dislodged. It is not possible to remove, an incisor tooth lost at bronchoscopy a few minutes earlier and claim it is the foreign body seen on the CT scan taken much earlier.

66. The Committee notes that after discharge the Patient was seen at both MTRH and Mediheal during which there was continued evidence of a retained foreign body and was finally admitted to the MTRH paediatrics ward with a pneumonic process. The Committee finds that there is no evidence that during this admission, the cardiothoracic team was consulted or involved in the management of the Patient. The Committee opines that had the cardiothoracic team been consulted, with her history and symptoms of a retained foreign body in the airway, the course of management would have changed, including consideration of a repeat CT bronchogram rather than a plain CT scan of the chest that only picked a pneumonic process and missed the seed that was eventually found at post-mortem examination. This further highlights the failures of internal consultation within the hospital given such a complicated case that needed close follow-up and lack of proper documentation on instructions given to the patient both within clinical continuation notes and on the discharge summary. If such instructions were clear on the discharge

summary, a copy of the same usually in the patient's file, the caregivers in the paediatric ward would have come across the information and consulted the thoracic surgical unit.

67. The Committee also finds that the failure to remove the foreign body "*black seed*", led to the accumulation of fluid distally. Sepsis set in leading to pneumonia and followed by septicaemia leading to the pus in the other organs found at post-mortem. The foreign body in question was missed at the first bronchoscopy as well as at the second bronchoscopy/thoracotomy. There was clinical evidence indicating the presence of a foreign body. Further, at thoracotomy, the clinical evidence was not interrogated critically. This error led to the removal of a tooth rather than both the tooth and the foreign body.

68. The Committee also considered the submissions made by the Complainant and the Respondents on the post-operative briefings in particular after the second procedure. The Committee notes that from the evidence, the briefings were done by Dr Nshom and Dr Wanyonyi, who were not the lead surgeon nor anaesthesiologist. It is good medical practice that the surgeon should conduct the post-operative briefing of either the patient or the guardian. Consequently, Dr Ondigo as the lead surgeon at the bronchoscopy and thoracotomy should have briefed the Patient's guardians of the findings intraoperatively, including the circumstances under which the teeth were dislodged and the management thereafter.

69. The Committee also considered the complaint made against Dr Wanyonyi on his conduct towards the Complainant. The Committee notes that from the submissions made by Dr Aruasa, Dr Wanyonyi was issued with a written warning letter, which action the Committee finds sufficient.

E. DETERMINATION

70. Given the above findings, the Committee holds that the complaint lodged by the complainant against the 4th and 5th Respondents has merit. The Committee presented its findings, as set out herein above, and its recommendations to the Kenya Medical Practitioners and Dentists Council in its meeting held in December 2022 wherein the decision of the Committee was upheld. Consequently, the Committee hereby issues the following orders;

(i) The complaint of negligence made against Dr Ernest Nshom, Dr Alfred Wanyonyi and Prof. Barasa Otsyula Khwa be and is hereby dismissed.

(ii) Dr Stephen Ondigo and MTRH be and are hereby directed to mediate with the Estate of the Late Anita Jepkorir jointly and severally with a view of making restitution and thereafter inform the Council within Ninety (90) days from the date hereof.

(iii) Dr Stephen Ondigo be and is hereby directed to pay a fine of Kenya shillings Two Hundred Thousand (KSh. 200,00/-) within fourteen (14) days from the date hereof.

(iv) Moi Teaching and Referral Hospital be and is hereby directed to pay a fine of Kenya Shillings Three Hundred and Fifty Thousand Shillings (KSh. 350,000/-) within fourteen days (14) from the date hereof.

(v) In the event of non-compliance with orders (ii), (iii) and (iv) above, the Council shall be at liberty to issue any such further orders as it deems fit.

Dated at Nairobi this 5th day of MAY, 2023

KENYA MEDICAL PRACTITIONERS AND DENTISTS COUNCIL
05 MAY 2023
P O Box 44839, NAIROBI

DR. TIMOTHY THEURI
CHAIR
DISCIPLINARY AND ETHICS COMMITTEE

PETITION CONCERNING MEDICAL NEGLIGENCE AND STAFF INCOMPETENCE THAT LED TO PREVENTABLE DEATH OF SIX (6) YEAR OLD M/S ANNITA JEPKORIR CHIRCHIR ON 10TH MAY 2021

WE, the undersigned herein have appointed the firm of **MUTAI ODUOR & COMPANY ADVOCATES (MOCA) LLP** to act for us in these proceedings.

Our address for service for the purpose of these proceedings shall henceforth be **c/o MUTAI ODUOR & COMPANY ADVOCATES (MOCA) LLP, KVDA PLAZA, 7TH FLOOR, OLOO STREET, P.O. BOX 10768-30100, ELDORET,** and **email address:** mutaioduor@gmail.com

DATED at ELDORET this.....27th.....day of.....September.....2024

SIGNED: ISAAC KANDIE .....

ID NUMBER: 22432018

PHONE: 0720322296

MERCY JEPKORIR KIPRONO:.....

ID NUMBER: 22386020

PHONE: 0720496205

MUTAI ODUOR & COMPANY ADVOCATES (MOCA) LLP
ADVOCATES FOR THE PETITIONERS

DRAWN
Mutai Oduor & Company Advocates (MOCA) LLP
KVDA Plaza, 7th Floor,
P.O. Box 10768-30100
ELDORET
mutaioduor@gmail.com

Annex 3:

Report from the Moi Teaching and Referral Hospital (MTRH)

An ISO 9001:2015 Certified Hospital

MOI TEACHING AND REFERRAL HOSPITAL

Email: ceo@mtrh.go.ke
Telephone: 053 2033471/2/3
Fax: 053 2061749

NANDI ROAD
P.O. BOX 3
ELDORET, KENYA

Ref: ELD/MTRH/ADMIN/1/15/VOL.II/2007(4) **Date:** 26 August 2024.

To.
J.M. Nyegenye CBS,
Clerk of the Senate,
Clerks Chambers,
Parliament Buildings,
P. O. Box 41842 – 00100,
Nairobi
Email clerk.senate@parliament.go.ke and healthcommittee.senate@parliament.go.ke

Dear Clerk,

PETITION REGARDING THE ALLEGED MEDICAL NEGLIGENCE AND STAFF INCOMPETENCEY LEADING TO THE DEATH OF MS. ANNITA JEPKORIR AT MOI TEACHING AND REFERRAL HOSPITAL.

Reference is made to the above matter and your letter dated 17th July 2024, the attached petitions together with the Hansard Report of the plenary session of the Senate held on Wednesday, 10th July 2024 and wish to respond as follows.

Moi Teaching & Referral Hospital offered the late Anita Chepkorir the highest attainable health care services. Her caregivers included not only medical specialists in Cardio-thoracic surgery, Consultant paediatricians but also a Professor in Cardio-thoracic surgery. Below is the chronology of events.

On 9th of January 2021 the late Annita Jepkorir was admitted at Moi Teaching and Referral Hospital herein referred to as MTRH. She was treated and discharged on 28th January 2021. She was re-admitted on 8th February and discharged on 14th February 2021. She passed on while

playing with other children more than 2months after the surgery. The post-mortem established that cause of death was asphyxia due to aspirated food particles (that is according to autopsy report "immediate cause of death: food particles up to the terminal bronchi") and not due to airway obstruction by a Foreign Body (F.B) as alleged by the complainant.

It is further explained that the child was playing with other children when she collapsed and died and that no cardiopulmonary resuscitation was done since the child was taken to MTRH when already dead. She was taken straight to the mortuary.

After the unfortunate incident MTRH management including the Cardio-thoracic team, nurses and customer relations and communication officers held several meetings including a daylong one on 25th May 2021 (signed by Chairperson/CEO on 07/06/20221 and 8/6/2021 by Secretary) with the extended family (including grandparents, aunts, family friends and neighbours) of the late Anita Chepkorir to address their concerns and complaints. During the meeting her grandfather remarked that "she had passed on and no effort could bring her to life again. That he believed that, no doctor had an intention to kill her; because if any clinical person would plan to kill, it would be a matter of few seconds." Which MTRH concurred with. Considering she passed on while playing with other children more than two and months after surgery (i.e. from 22nd January 2021 when she was operated to 10th May 2021 when she passed on) it is not possible to connect the cause of death with the surgery. ***(Please see the attached letter from Mercy and Isack Chirchir dated 17th June 2021, as well as MTRH response to Isack and Mercy dated 22nd June 2021,)***

In response to Mr. Amos Kimebur, the family neighbour and friend MTRH offered the family, full psychological counseling and support free of charge. ***(The minutes for 25th May 2021 are attached here for ease of reference).***

On 28th June 2021 her Mother Mercy J. Kiprono filed a case MTRH against MTRH Ref No. MPDC/DEC.1283/43/2021/02 at the Kenya Medical Practitioners and Dentist Council Disciplinary and Ethics Committee herein referred to DC case Number 43 of 2021. It was heard and determined on 5th May 2023. MTRH was directed to mediate with the estate of the late Anita Jepkorir with a view of making restitution and thereafter inform the Council. The whole process was full of drama from Mercy J. Kiprono ***(Attached Please find a letter from KMPDC to MTRH dated 21st July 2021, MTRH executive case summary dated 30th July 2021 sent to KMPDC, autopsy report dated 26th May 2021 KMPDC, MTRH further letter to KMPDC dated 4th October 2022 and the annexures thereto, MTRH written submissions to KMPDC dated 26th October 2022 and KMPDC ruling dated 5th May 2023)***

It is noteworthy that Mercy J Kiprono was represented at the KMPDC DEC by an Advocate Named Professor Peter Kiama Wangai please see page 6 paragraph numbered 9 of the ruling. Therefore, after the ruling Counsel for MTRH Mr. Josphat Mutuma Kirima contacted him to

kick start the negotiation for quantum for damages. It was agreed that the quantum will be based on case law/precedence. This was not to be.

On 2nd June MTRH received a letter from M/S Tarigo Kiptoo & Co Advocates informing it about change of advocates and demanding mediation in a neutral ground and a neutral mediator. MTRH obliged and requested the Nairobi Centre for International Arbitration to guide the mediation process since it is the statutorily mandated body. However, Mercy frustrated the process by arbitrary changing her advocates, blaming everyone including her advocates, the NCIA, KMPDC, MTRH and its staff members and refusing to attend any meetings. The mediation collapsed.

It is MTRH submissions that it finds itself in this unenviable position of being accused of all manner of misdeeds not because of any fault committed by itself or it employees. We humbly request this honourable house to hold and find that MTRH has demonstrated that it did everything possible to resolve complaint, but it remains unresolved. In the circumstances it could only wait for next opportunity to resolve the dispute as guided by the law including the Kenya Medical Practitioners Dentist Act. Hopefully this honourable house will finally bring it to closure.

It is MTRH's further submission that Anita was timeously diagnosed with FB bronchus and all the necessary medical experts involved in her treatment, also all necessary investigations where conducted and that at no time did it or its employees demonstrate ill motive or abdicate their duty of care, including during its efforts to mediate quantum of damages as ordered by KMPDC.

Yours Sincerely

DR. PHILIP K. KIRWA
Ag CHIEF EXECUTIVE OFFICER

(21)

MR.ISACK CHIRCHRI/MERCY CHIRCHIR.
P.O BOX 347-30100
ELDORET

17/06/2021

THE DIRECTOR.
MTRH.
ELDORET.

We Mr ISACK CHIRCHIR, AND MRS CHIRCHIR MERCY, as the parents of our late daughter ANITA JEPKORIR. Are writing this letter in pain to raise and forward our complain to your office. This is due to the medical operations and negligence that was done by your doctors (1). Dr. Ondiko, (2) Prof Otysula (3) Dr Wanyonyi. Your office is very much aware that at the end it resulted to the death of our lovely daughter. Through our knowledge, observations and even the pathology results it clearly indicated that there was professional failures and medical malpractice and the doctors involved should be held responsible for the loss. We as a family and the parents of our late daughter Anita Jepkorir have the following demands

(1) The responsible person should admit the mess in writing.

(2) To register a word of sorrow and apology in whichever form.

(3.) Should be ready to negotiate and to meet all the medical and funeral expenses that were incurred due to the incident, the loss of child's expectations. The pain of suffering of the kids and the general damages.

We are therefore giving your office a duration of 7 (seven) days starting from this date to respond to this matter. Failure to do so we shall proceed to seek legal advice and redress in a court of law.

Thank you.

Yours. Mercy Chirchir.

And Isack Chirchir.

0720322296/0720496205

(22)

An ISO 9001:2015 Certified Hospital

MOI TEACHING AND REFERRAL HOSPITAL

Telephone: (+254)-0532033471/2/3/4
Fax: 0532061749
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NANDI ROAD
P.O. BOX 3-30100
ELDORET,KENYA

Ref: ELD/MTRH/ADMIN/1/15/VOL.111/2018

22nd June, 2021

Mr Isack Chirchir/Mercy Chirchir
P.O. Box 347 – 30100
ELDORET

Dear Isaac and Mercy,

DEMAND LETTER FOR COMPENSATION ON BEHALF OF THE ESTATE OF ANITA JEPKORIR (DECEASED)

This is in reference to your letter dated 17th June, 2021.

Moi Teaching and Referral Hospital (MTRH) is the leading Multi-Specialty Referral Hospital in he region with a coverage spanning the western half of Kenya, eastern Uganda, South Sudan mongst other areas. MTRH is committed to quality healthcare provided in an open, transparent and accountable manner as dictated by its Core Values.

1 the course of providing this service, MTRH had a privilege attending to the late Anita Jepkorir. Following passing on of the patient, your family contacted and met a few officers of MTRH, finally ading to a meeting between MTRH Management, the family and medical caregivers.

A day-long meeting was held between yourselves and MTRH Management on 25th May 2021. Your nily members who were present were Isaac Kipchirchir, Mercy Kiprono, Stanley Moiy, Julia oiy, Lukas Kiprop, Priscilla Kandie, Beatrice Sawe, Amos Kimebus. On the MTRH side were Dr. Wilson K. Aruasa, *EBS* (Chief Executive Officer (CEO), Chairing the afternoon session), Dr. ilip Kirwa (Senior Director, Clinical Services (SDCS), chairing the morning session), Dr. phen Ondigo, Dr. David Chumba, Dr. Alfred Wanyonyi, Dr. Ernest Nshom, Doreen Mutegi, and Consolata Rop.

ring the meeting, your team was taken through Anita's treatment steps as follows;

- That patient Anita was admitted on 9th January, 2021 with a history of having inhaled a foreign body (FB) a few days earlier with associated history of

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- That the patient was taken to theatre on 10th January, 2021 for bronchoscopy where no foreign body was not visualized but a large mucus plug was washed out.
- On 13th January, 2021 a gastrographin test was done due occasional shortness of breath to rule out trachea-oesophageal fistula. No abnormality was found.
- On 18th January, 2021 a virtual bronchoscopy (by CT scan) was ordered and done the next day. This confirmed a presence of a foreign body in the right bronchus.
- On 22nd January, 2021 the patient taken to theatre were a bronchoscopy was done in an attempt to view and remove the foreign body. This was not successful as the foreign body was not visualized hence converted to a thoracotomy for direct removal of FB.
- During the thoracotomy, a foreign body was palpated on the right lung and removed by sharp dissection. This was found to be an incisor tooth. The lung was then inflated and found to fully expand.
- Post-operatively, the patient had uneventful recovery and went home on the 27th January, 2021.
- The patient was reviewed in the cardiothoracic outpatient clinic and found to be in good health and hence discharged from follow-up.
- The patient was admitted to the paediatric ward on 8th February, 2021 with features of pneumonia were a CT scan done showed bi-basal pneumonia and pleural thickening post thoracotomy. The patient recovered after treatment with antibiotics. Was discharged home on 15th February, 2021.
- Following Anita's passing on 10th May, 2021 a post mortem was done where the findings were peripheral cyanosis, food particles in the trachea, features of increased intracranial pressure in the brain, lung had multiple abscesses with a foreign body in the right bronchus.

From the above patient management, we met and exceeded the Standard of Care required each e. During the meeting on 25th May, 2021 MTRH Management, medical team who managed the ent and other employees present condoled with you. One staff, who you had accused of using unfriendly language unreservedly apologized for any hurt this might have caused to the family. ice your assertion that MTRH did not condole with your family is untrue.

At the end of the meeting, it was succinctly stated by your representatives (Jepkorir's Grandfather) no doctor had an intention to kill Anita and if they did it would have been a matter of seconds that the family only wanted to know the truth of the matter and get its closure accordingly. r the part of MTRH, we had given a true reflection of the patient's management and onstrated that there was no ill intent on our part. Also remember that it was more than four ths from the time Anita aspirated the foreign body on 9th January, 2021 to her death on 10th a 2021. The MTRH doctors and care fraternity had done their best all along to ensure Anita ered from her medical problem.

g conclusion of the meeting, it was agreed that MTRH would support Anita's parents with ological counselling and any other assistance which they may require during this time. The y was free to book an appointment anytime with the Chief Executive Officer (CEO) for any r discussions.

H reached you on 2nd June, 2021 for the psychological counseling support as agreed but you ed that you were not interested in the sessions and needed to see the CEO. We scheduled r meeting for Friday 4th June, 2021 but efforts to reach you for the same were futile as you indicated that the notice was short. Further, another meeting was planned for Wednesday 23rd 021 but before then, we received the demand letter dated 17th June, 2021.

It is therefore utterly surprising to receive your demand letter imputing ill motive on the part of MTRH and its employees. This has left in doubt your sincerity during all our engagements/meetings with yourselves.

Kindly understand that the said discussions were held without prejudice and do not in any way imply MTRH acceptance of any liability or admission of medical negligence in management of Late Anita Jepkorir.

Yours Sincerely,

MOI TEACHING AND REFERRAL HOSPITAL
CEO
APPROVED
22 JUN 2021
SIGN.....
P. O. Box 3 - 30100, ELDORET

22/06/2021
DR. WILSON K. ARUASA, *EBS*
CHIEF EXECUTIVE OFFICER

An ISO 9001:2015 Certified Hospital

MOI TEACHING AND REFERRAL HOSPITAL

MINUTES OF MEETING BETWEEN MOI TEACHING AND REFERRAL HOSPITAL (MTRH) MANAGEMENT TEAM AND THE FAMILY OF THE LATE ANITA CHEPKORIR IP. NO. 1002542 ON TUESDAY 25TH MAY, 2021 AT LILY BOARDROOM

MOI TEACHING AND REFERRAL HOSPITAL

1. Dr. Wilson K. Aruasa, *EBS*	–	Chief Executive Officer	–	Chairing
2. Dr. Philip Kirwa	–	Senior Director, Clinical Services	–	Secretary
3. Dr. Stephen Ondigo	–	Cardiothoracic Surgeon		
4. Dr. David K. Chumba	–	Consultant Pathologist – Moi University, School of Medicine		
5.. Dr. Alfred Wanyonyi	–	Registrar, COSECSA		
6. Dr. Nshom Ernest Bah	–	Registrar, Anaesthesia		

Chairperson/CEO 07/06/2021

Secretary 8/6/21

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FAMILY OF THE LATE ANITA CHEPKORIR

1. Mercy Kiprono – Mother
2. Mr. Isaac Kipchirchir – Father
3. Mr. Stanley Moiy – Grandfather
4. Mrs. Julia Moiy – Grandmother
5. Mr. Lukas Kiprop – Family member
6. Priscilla Kandie – Aunt
7. Beatrice Sawe – Aunt
8. Amos Kimebur – Family friend and a neighbor

IN-ATTENDANCE

1. Consolata Rop – Head, Corporate Communications
2. Doreen Mutegi – Customers Relations Nurse Co-ordinator

ITEM	AGENDA	ACTION
MIN. 01/25/05/21	PRELIMINARY	
Introduction	▪ The meeting was called to order at 10:00 a.m. and a word of prayer was said by Doreen Mutegi. ▪ The Chair welcomed members and introduced to the agenda of the day which was a family conference with Moi Teaching and Referral Hospital (MTRH) on management of the Late Anita Chepkorir.	

Chairperson/CEO 07/06/2021

Secretary 8/6/21

	▪ The Chair then went through management of the patient from 9th January, 2021 admission, management in surgical wards, follow-up in Cardiothoracic Clinic, and lastly admissions and management in Upendo ward. ▪ After giving an overview of all the management done to the late Anita he informed the family that MTRH is committed to quality healthcare. ▪ He added that MTRH is open & transparent and is committed in doing what is right and best for its clients. ▪ He informed family members that the team that managed Late Anita was determined to give the best and was hoping for the best outcome.	
MIN: 02/25/05/21	CONCERNS/COMPLAINS FROM ANITA'S PARENTS AND FAMILY MEMBERS	
Concerns/Complains	▪ The number of teeth wrapped up on Anita's leg were two contrary to their expectations which was three. That is one which was removed from the bronchus (foreign body) and two which were accidentally extracted during the procedure. ▪ If the Doctor was not competent to remove the foreign body (FB), he could have referred the patient instead of cheating that the FB was a tooth. They felt that the tooth was a "low hanging fruit " after missing the intended foreign body. ▪ The operation was done by a student Dr. Wanyonyi and not by a Consultant, Dr. Ondigo. ▪ Dr. Wanyonyi called the family and locked them in one of the room and talked to them rudely when they demanded for the third tooth. ▪ Dr. Wanyonyi informed them that if they continued complaining about the tooth, the	

	nurses could harm their child. ▪ That Anita stayed in the ward from 9th to 20th without any investigations. ▪ Anita was admitted in Upendo ward with pneumonia with the initial signs/ symptoms which she had presented with, meaning FB had not been removed. ▪ Demanded to be explained what the repeat CT Scan chest revealed. ▪ During the postmortem a seed similar to what the mother had given history about and similar to the report of CT Scan chest was found in the lungs. ▪ On coming from the postmortem they felt a need to raise a complaint and they were linked to Customer Care Officer called Doreen Mutegi. Doreen took a short history of the illness and learning that Anita had first been brought to Hospital on 9th January, 2021 and it was already in May 2021 concluded that this probably could be another FB. ▪ They wanted to know if the relative signed a consent for CT Scan chest with contrast.	
MIN 03/25/05/21	RESPONSE FROM DR STEPHEN ONDIGO - CARDIOTHORACIC SURGEON	
Response from Dr. Stephen Ondigo	▪ Dr. Stephen Ondigo started by registering his condolences to the family. ▪ He said that he has been a Cardiothoracic Surgeon for fifteen (15) years. ▪ He then explained the usual process of managing a foreign body (FB) in the lungs. The first step is usually a bronchoscopy but sometimes a thoracotomy may be done if the foreign body cannot be removed with the bronchoscope. ▪ The family was taken through the management of Anita in detail. ▪ The late Anita was in the ward for some time in the ward with complaints of having	

	inhaled a FB. She was taken to theatre for bronchoscopy but no foreign body was visualized. After this the child remained in the ward for treatment and observation. ▪ On 13/1/2021 Gastrographin studies were done to rule out Thoraco-eosophageal Fistula. The results were normal - No fistula. ▪ On 20/1/2021 a virtual bronchoscopy was done (CT Scan chest with contrast). ▪ Dr Ondigo informed them that we don't usually take written but a verbal consent when doing CT Scan with contrast. ▪ On 22/1/2021 patient was taken to theatre for bronchoscopy were the foreign body could not be seen/reached. He decided to do a Thoracotomy. ▪ He palpated a hard object and when he made an incision what was found as an incisor tooth. ▪ After removal of the foreign body the lung was inflated, there was no lung collapse and he was sure that he had removed the foreign body. ▪ After the procedure the patient was managed in Fadhili ward for three days with great improvement. Then she was discharged. ▪ The Cardiothoracic team later saw the patient twice in the clinic and was doing well. ▪ The patient was later admitted to Upendo wall. A repeat CT scan done in the ward showed bi-basal pneumonia.	
MIN. 04/25/05/21	RESPONSE FROM DR ERNEST NSHOM – REGISTRAR ANAESTHESIA	
Response from Dr. Ernest Nshom	▪ Dr. Ernest Nshom registered his condolences also to the family. ▪ He was the Assistant Anesthesiologist with Dr. Kimani Mbugua.	

Chairperson/CEO [signature] 07/06/2021

Secretary [signature] 8/6/21

	▪ Reported that the anesthesia process was uneventful and can confirm that the Surgeon removed a tooth from the lungs during thoracotomy. ▪ He said he later met the mother of Anita along Riley Mother and Baby Hospital. The mother asked him about the number of teeth and he only remembered telling her that they were two. But didn't engage much because he was rushing to theatre.	
MIN. 05/25/05/21	RESPONSE FROM DR. ALFRED WANYONYI – REGISTRAR, COSECSA	
Response from Dr. Alfred Wanyonyi	▪ Dr. Alfred Wanyonyi said he was the Assistant Surgeon and surgery went as explained above. ▪ He said that later after surgery, the nurse from Fadhili ward called him to come and talk to the family on the issues they had raised. ▪ He was not in the Hospital then but drove back to meet the family. ▪ He secured an office to talk to them for privacy/confidentiality purpose. This was not ill intended. ▪ He denied threatening them or talking to them rudely. ▪ He apologized for any form of hurt that he may have caused during their conversation.	
MIN. 06/25/05/21	RESPONSE FROM DOREEN MUTEGI – CUSTOMERS RELATIONS NURSE CO-ORDINATOR	
Response from Doreen Mutegi	▪ Doreen started by registering her condolences to the family. ▪ Doreen apologized to the relatives for being hurt during the conversation.	

Chairperson/CEO 09/06/2021

Secretary 8/6/21

	▪ She promised to be a good listener and not to rush into conclusion. ▪ She said after taking the history she informed the relatives that she was to organize a meeting with the family members, surgeons who did the operation and clinical team who managed the late Anita. ▪ The surgeon would explain to the family the issue of the foreign body.	
MIN: 07/25/05/21	RESPONSE FROM DR. DAVID K. CHUMBA, CONSULTANT PATHOLOGIST – MOI UNIVERSITY SCHOOL OF MEDICINE	
Response from Dr. David K. Chumba	▪ Dr. David K. Chumba said that as he was continuing with the postmortem when he made an incision on the right lung, he found a hard seed and the relatives shouted at him to stop the procedure. ▪ He wondered why. ▪ So he asked for the history of which they narrated to him some relatives moved out but he continued with the postmortem. ▪ The brain and liver had some abscess-like areas from which he took samples for histological confirmation.	
MIN: 08/25/05/21	REMARKS FROM THE GRANDFATHER	
Remarks from the Grandfather	▪ He said that Anita had passed on. ▪ No form of efforts would bring her to life again. ▪ He added that he believes that no doctor had an intention to kill because if any clinical person would plan this, it would be a matter of a few seconds.	

	▪ According to him he felt the Hospital should apologize and put measures into place to prevent any other patient to undergo such.	
MIN. 08/25/05/21	REMARKS FROM MR. AMOS KIMEBUS (FAMILY FRIEND AND A NEIGHBOUR)	
Remarks from Mr. Amos Kimebus (Family friend and a neighbour)	▪ He was happy for the audience given to the family. ▪ He said he understands what the family is undergoing because he also had a similar issue recently. ▪ He said that the family wasn't taking any legal actions in this issue; what they wanted was to know the truth. ▪ He asked MTRH Chief Executive Officer (CEO) to see how the Hospital can assist or do to this particular family.	
MIN. 09/25/05/21	REMARKS FROM DR. WILSON K. ARUASA, *EBS*, CHIEF EXECUTIVE OFFICER, MTRH	
Conclusion	▪ The CEO started by registering his condolences to the family. ▪ He appreciated the family for their feedback and assured them that MTRH is open and transparent in everything being done. As an organization, we working hard to improve our services and any shortcoming identified is used as an opportunity for improvement. ▪ He informed the family that he has gone through the file and found out that much was done to the Late Anita and all was geared toward the best outcome.	

Chairperson/CEO 07/06/2021

Secretary 8/6/21

12

	▫ The two operations took some time and nobody can take all that time if he/ she intended to do evil. ▫ He informed them that he's been in MTRH for many years and that Dr. Ondigo is our Cardiothoracic Surgeon who has long experience with very good professional standards. ▫ He assured the family that there was no professional negligence at all. ▫ He informed the family that Dr. Wanyonyi is a Registrar and a student working under consultants and that he wrote the theatre notes under instructions of Dr. Ondigo as he was an Assistant Surgeon. ▫ He informed them that he will look into the issues they raised about Dr. Wanyonyi administratively. ▫ On asking Mr. Amos Kimebur, the family friend and a neighbour what kind of assistance family wished MTRH to do for them, he said the Hospital to decide and also the family will discuss further and revert. ▫ He then advised the parents of Anita to be assisted with psychological counselling as soon as possible. ▫ He asked the family members to book an appointment any time later and be free to share more.	Action: Consolata to coordinate

Chairperson/CEO 07/06/2021

Secretary 8/6/21

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There being no any other business for discussion, the meeting was adjourned at 4:45 p.m with a word of prayer from Dr. Philip Kirwa.

MINUTES APPROVED FOR CIRCULATION

HGH TEACHING AND REFERRAL HOSPITAL
APPROVED
07 JUN 2021
SIGN

CHAIRPERSON _____ DATE 07/06/2021

DR. WILSON K. ARUASA, *EBS*
CHIEF EXECUTIVE OFFICER

SECRETARY _____ DATE 07/6/2021

DR. PHILIP KIRWA
SENIOR DIRECTOR, CLINICAL SERVICES

Chairperson/CEO_____ Secretary _____

REPUBLIC OF KENYA

Telephone: +254 020 2724994/2711478/2728752
0720 771478/0738 504112
Fax: +254 020 2724938
Email Address: info@kmpdc.go.ke
Email Address: ceo@kmpdc.go.ke
Website: www.kmpdc.go.ke
Twitter: @KmpdcOfficial
When replying please quote:

MEDICAL PRACTITIONERS
AND DENTISTS COUNCIL
MP & DB HOUSE,
WOODLANDS RD, OFF LENANA RD
P.O BOX 44839 - 00100 - NAIROBI

21-7-2021

Ref No: MPDC/DEC/283/43/2021/02

Date: 21st July, 2021

Dr. Ernest Nshom *(1st Respondent)*
Moi Teaching & Referral Hospital
P.O Box 3- 30100
ELDORET
Tel: 0727109526
E-Mail: admince o@mtrh.go.ke

<Advance Copy via E-mail>

Dr. Alfred Wanyonyi Wandeba *(2nd Respondent)*
Moi Teaching & Referral Hospital
P.O Box 3- 30100
ELDORET
Tel: 0727109526
E-Mail: wandeba@gmail.com

<Advance Copy via E-mail>

Prof Barasa Otsyula Khwa *(3rd Respondent)*
P.O Box 5450- 30100
ELDORET
Tel.: 0733808367
E-Mail: barasaotsyula@yahoo.com

<Advance Copy via E-mail>

Dr. Stephen Ondigo *(4th Respondent)*
P.O Box 4836-30100
ELDORET
Tel.: 0722472319
E-Mail: stephenondigo@yahoo.com

<Advance Copy via E-mail>

Dr. Wilson K. Aruasa *(5th Respondent)*
Chief Executive Officer
Moi Teaching & Referral Hospital
P.O Box 3- 30100
ELDORET
Tel.: 0727415377
E-Mail: ceo@mtrh.go.ke
directorsofficemtrh@gmail.com
aruasaw@gmail.com

<Advance Copy via E-mail>

: DC CASE NO. 43 OF 2021
MERCY J. KIPRONO ON BEHALF OF ANNITA JEPKORIR(DECEASED) AGAINST
DR. ERNEST NSHOM, DR. ALFRED WANYONYI, PROF BARASA OTSYULA,
DR. STEPHEN ONDIGO & MOI TEACHING & REFERRAL HOSPITAL

refer to the above matter.

15

The Council is in receipt of a complaint from Mercy J Kiprono on behalf of Annita Jepkoir against yourselves dated 29th June, 2021 (copy attached for ease of reference). The complainant in the application for lodging a complaint and statement attached alleges that you misdiagnosed the patient, leaving a foreign object in the patient's airways/ lungs which eventually caused the demise of the patient.

You are hereby required to submit the following to the Council on or before 4th August, 2021;

(a) A statement by all the Respondents addressing the allegations made by the Complainant in the complaint form and statement as follows;

i). Conducting the wrong procedure when the patient was in theatre

ii). Extracting the patient's teeth when the same was not due for extraction.

iii). Misdiagnosing the patient with pneumonia when she was brought back for a further check and ;

iv). Failing to exercise proper skill and care required of a doctor.

(b) The 5th Respondent to provide statements from the medical personnel adversely mentioned in the complainant's statement ie. Dr Oloo, Dr. Ismael, Dr. Ouma;

(c) Certified and paginated copy of the entire patient's file to be submitted by the 5th Respondent.

(d) Any other relevant document (s) or information that may assist the Disciplinary and Ethics Committee of the Council in its investigations.

Do endure that the above listed documents are received within the specified period.

Eunice Muraihi
LEGAL SERVICES MANAGER
MEDICAL PRACTITIONERS AND DENTISTS COUNCIL

Cc: Mercy J Kiprono
P.O Box 9266
ELDORET
Tel: 0720 496205
E-mail: chirimercy80@gmail.com

/kw

DETAILS OF THE RESPONDENT(S)

Fill in either Section 'C' or 'D' or both depending on the nature of your complaint

C. DETAILS OF THE PRACTITIONER(S) BEING COMPLAINED AGAINST

Name primary doctor/dentist	Dr Ondiko Stephen Prg Ojesola
Name of Health Facility	MTRH
County	Uasin Gishu
Postal Address:	P.O Box 3 Eldoret
Physical Address:	Eldoret
Mobile Number:	
E-Mail Address:	
Names of other practitioners being complained against:	Dr Aldrid Wanyonyi, Dr Oloo Dr Ernest Nshom, Dr Ismael Dr Ouma V.

D. DETAILS OF THE HEALTH FACILITY BEING COMPLAINED AGAINST

Name of Health Facility	MTRH
County	Uasin Gishu
Postal Address	P.O Box 3 Eldoret
Physical Address:	Eldoret
Name of Contact Person	Dr WILSON ARUASA
Mobile Number:	0721415377 / 0534203347/1152
E-Mail Address	ceo@mtrh.go.ke
Names of other health facilities being complained against	

E. [illegible]

Medical negligence
Failure management
[illegible]
Poor doctor-patient
Medical admission

F. DOCUMENTS TO BE ATTACHED

1. Attach a double spaced typed narrative explaining the background history of the matter in detail *(Mandatory)*
2. List of copies of other documents attached.
   - i. Autopsy report
   - ii. Two CT chest reports 3 slides
   - iii. 3 discharge summaries
   - iv. Photographs of injuries (Bandages on head and left Arm, leg)

G. DECLARATION

I solemnly and sincerely declare that the information given above is true to the best of my knowledge and belief.

Signature of Complainant/Representative	[signature]	Date:	25-06-2021

An ISO 9001:2015 Certified Hospital

MOI TEACHING AND REFERRAL HOSPITAL

ANITA CHEPKORIR

IPNO - 1002542

DOB - 2016

EXECUTIVE CASE SUMMARY

Anita Chepkorir was a 5-year-old girl who was first seen on 9th January, 2021 at 12.00 noon with history of choking on a seed. Her symptoms then were vomiting, drooling, cough and respiratory distress.

The Impression was foreign body bronchus. She was subsequently done bronchoscopy in theatre that evening. In theatre only a mucus plug was noted at carina and was cleared out.

The next day on 11th January, 2021, she was stable but was kept for observation. She was noted be doing well but getting occasional dyspnea.

On the 12th January 2021, gastrografin studies were done to rule out any trachea-oesophageal fistula. This came out as normal.

On 18th January, a virtual bronchoscopy was requested. This showed a ring like foreign body in the proximal right main bronchus.

She was then planned for elective bronchoscopy and possibly thoracotomy, which was done on 22nd January,2021. The bronchoscopy was not successful in retrieving the foreign body and hence proceeded to thoracotomy. At thoracotomy, a foreign

30/01/2021

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body was palpated and retrieved by sharp dissection where an incisor tooth was removed.

Post operatively, the patient recovered well and was discharged on 26th January 2021.

She was reviewed in OPD on 4th February, 2021 and was found to have recovered well with no new complaints.

The patient was seen and treated on 8th February, 2021 for abdominal pain, fever, dyspnea and bilateral basal crepitations.

She was admitted to Pediatric Medical Wards and treated for bronchopneumonia post thoracotomy on 8th February 2021. She was also done a chest CT scan which showed a bi-basal pneumonia and pleural thickening. She was treated successfully and discharged on the 14th February 2021.

She was seen on 16th and 22nd April in OPD Clinic and treated for URTI. After that the patient was not seen again in MTRH.

Following the demise of the patient a meeting was held at the request of the family with the hospital management and the care-givers on 25th May 2021. This was to condole with the family, support them during the grieving period and to listen and answer any questions they had. The meeting was chaired by the senior director from 10:00 am to 3:00 pm then by the CEO from 3:00 pm to 5:30 pm. In the meeting, most issues raised were answered and explained appropriately. We agreed to further support the family emotional through counselling and further future meetings if they so desired.

From the above chronology of interventions, the patient was managed as per the standard of care. There was no ill-will or intent to harm the patient from any of the care-givers. We value our clients and will always strive to improve the outcomes and experiences as we give them highest possible quality healthcare in a friendly and conducive environment.

30/07/21

19

DR. PHILIP KIRWA
SENIOR DIRECTOR, CLINICAL SERVICES

30/04/2021

20

ANITA CHEPKORIR/DC CASE NO 43 OF 2021.

DOCUMENTS PROVIDED

1. Forwarding letter from CEO, Dr. Wilson Aruasa, EBS
2. Executive summary by SDCS, Dr. Phillip Kirwa
3. Statements from
    - Prof. B. O. Khwa-Otsyula
    - Dr. Ondigo Stephen
    - Dr. Mark Oloo
    - Dr. Alfred Wanyonyi
    - Dr. Ismael Mohammed
    - Dr. Ernest Nshom
    - Dr. Victor Ouma
4. Certified copy of patient's file
5. Two CT Scan CDs (the reports are inside the copy of the file.
6 Autopsy report

30/8/2021

21

An ISO 9001:2015 Certified Hospital

MOI TEACHING AND REFERRAL HOSPITAL

FAREWELL HOME

RE: AUTOPSY REPORT OF DECEASED

ANITA JEPKORIR KANDIE - 5 YEARS

My full name is Dr. David K. Chumba. I am legally qualified pathologist, registered by the Kenya Medical Practitioners and Dentist Board and currently working as a Senior Lecturer Department of Human Pathology and Forensic Medicine Department and College of Health Sciences-Moi University.

My physical address is:
Department of Histopathology and Forensic Medicine, Moi University, P.O. Box 4606
Eldoret- Kenya.
Telephone: dchumba@yahoo.com
Cell Phone 0722-247909
My Qualification are:
MBcHB (UoN 1994)
MMEd (Human Pathology UoN 2006)
Diploma Forensic Pathology (Durban SA)

On13.05.2021 at MTRH Farewell, I performed an autopsy on the body of Anita Jepkorir Kandie according to the request of the relative

1. Isaac Kandie - Father
2. Lucas Kiprop- Uncle

DECEASED BACKGROUND
History of fall and become weak.

Usual residence: Annex

Occupation: child

Date of Death: 10.05.2021

Place of Death: MTRH

Place of Post Mortem: MTRH Farewell Home

Date of Autopsy 13.05.2021

Death certificate Number: 1729358

EXTERNAL EXAMINATION
The body is that of young girl measuring 80cm. Mild peripheral cyanosis. No external injuries.

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POST MORTEM CHANGES

Post mortem changes are not prominent, rigor mortis was poorly established in all skeletal muscles. The body feels cold due to refrigeration. Signs of medical intervention noted.

Head and Neck
Normal
Chest
Normal
Abdomen:
External genitalia;
Upper and lower limbs:

Central Nervous System:

INTERNAL EXAMINATION

Cardiovascular: The pericardial sac contained of yellowish translucent fluid.

Heart is: Normal

Respiratory System;

- Right lung has multiple abscesses
- The hyoid and thyroid cartilage are intact. Food particles up to terminal bronchi. Foreign body in the right bronchi black measuring about 0.5 cm

Digestive System:

- The gall bladder was thin-walled and distended by bile. The pancreas was grey in colour, congested and edematous. Normal

Genitourinary

- The kidneys were enlarged. Their capsules could not easily be stripped. The cortex and medulla were reddish in color and cartico-medullary definition is seen. Left kidney measured 6 by 5.5 cm and right 6 by 5cm.

Hemopoetic System:

- The spleen was mild enlarged. The spleen tissues is soft dark red in colour. The lymph nodes are not enlarged. soft spleen with features of septicemia

Endocrine Glands:

- The adrenals and the thyroid are grossly unremarkable.

Central Nervous System:

- Brain shows enlargement with features raised intracranial pressure.

Histology Report:

Lung: Sections form the lung show multiple abscess and exudate in the surrounding lung tissue. A few thrombosed blood vessels noted.

Brain: Sections show edematous brain tissue. No evidence of malaria

Spleen: The spleen show enlargement of the red pulp but its architecture is preserved

Liver: Sections of the liver show normal liver tissue

CONCLUSION

Immediate cause of death: Asphyxia due to aspirated food particles

Underlying cause of death: Septicemia

Other important conditions identified: Multiple lung abscess due to foreign body lodged in the right lower bronchus.

DR. DAVID CHUMBA
PATHOLOGIST AND FORENSIC SPECIALIST.
Date: 26th May, 2021

24

An ISO 9001:2015 Certified Hospital

MOI TEACHING AND REFERRAL HOSPITAL

Email: ceo@mtrh.go.ke
Telephone: 053 2033471/2/3
Fax: 053 2061749

NANDI ROAD
P.O. BOX 3-30100
ELDORET, KENYA

Ref: ELD/MTRH /ADMIN/1/VOL.11/2007

Date: 4th October 2022

Assistant Director Disciplinary & Ethics,
Kenya Medical Practitioners & Dentists Council.
P.O. Box 44839 - 00100
Nairobi.

Email info@kmpdc.go.ke ceo@kmpdc.go.ke

KENYA MEDICAL PRACTITIONERS
AND DENTISTS COUNCIL
DISCIPLINARY AND ETHICS DEPARTMENT
RECEIVED
P.O Box 446393 - 00100 NAIROBI

Dear Sir,

Further statement DC case no. 43 of 2021 Mercy J Kiprono v MTRH.

1. I am Dr Wilson K. Aruasa MBS, EBS Chief Executive Officer at Moi Teaching & Referral Hospital (MTRH) the 5th Respondent as per your letter Ref No. MPDC/DEC.1283/43/2021/02 dated 21/07/2021. Further to Dr. Philip Kirwa's statement, I would like to state as follows:

2. Moi Teaching & Referral Hospital offered the late Anita Chepkorir the highest attainable health care services. Her caregivers included not only medical specialists in Cardio-thoracic surgery, Consultant paediatricians but also a Professor in Cardio-thoracic surgery.

3. That, after the unfortunate incident MTRH management including the Cardio-thoracic team, nurses and customer relations and communication officers held several meetings including a daylong one on 25th May 2021 with the extended family (including grandparents, aunts, family friends and neighbours) of the late Anita Chepkorir to address their concerns and complaints. During the meeting her grandfather remarked that "she had passed on and no effort could bring her to life again. That he believed that, no doctor had an intention to kill her; because if any clinical person would plan to kill, it would be a matter of few seconds." Which I concurred with. Considering she passed on while playing with other children more than two and months after surgery i.e. from 22nd January 2021 when she was operated to 10th May 2021 when she passed on, it is not possible to connect the cause of death with the surgery.

4. In response to Mr. Amos Kimebur, the family neighbour and friend I offered the family, MTRH full psychological counselling and support free of charge. The minutes for 25th May 2021 are attached here for ease of reference.

5. At post-mortem on 13th May 2021 it was established that the cause of death was asphxia due to aspirated food particles. It is not therefore true that the cause of death was surgery. In any case the FB was in one of the bronci which means one lung was patent and medically people are known to live with one lung.

6. Surprisingly Mercy Kiprono mother of the late Anita Chepkorir has been maligning MTRH at every opportunity. She has not only been heard talking evil of MTRH which amounts to crime in the law of tort of Defamation known as "slander" punishable by imprisonment or

04/10/2022

25

payment of damages which can be in millions of shillings but also writing defamatory articles in print and social media. I have attached here some printouts of the Weekly Citizen and twitter messages. The messages are not only defamatory to MTRH but also Kenya Medical Practitioners and Dentist Board/Council and the medical specialists who treated Anita.

7. The above publications in print and social media amount to a crime in the law of tort of Defamation known as "libel" and similarly punishable as slander above. However, MTRH and its medical specialists have restrained themselves from taking any legal action against her. MTRH still believes Mercy Kiprono is being misled that there was negligence and that she can make monetary gain out of it.

Yours Sincerely

04/10/2022
DR. WILSON K. ARUASA, *MBS, EBS*
CHIEF EXCUTIVE OFFICER

MOI TEACHING AND REFERRAL HOSPITAL
C.E.O
ARCHIVED
04 OCT 2022
SIGN.....
P. O. Box 3-30100, ELDORET

26.

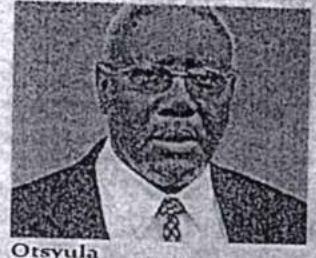
Moi Teaching and Referral Hospital doctors linked to patient's death

Our Investigative Team

A family is accusing Eldoret-based Moi Teaching and Referral Hospital doctors of causing death by negligence and with the administration trying to cover up the issue by dillydallying in the case filed against the medics.

Mercy J Kiprono is accusing Dr Ernest Nashom, Dr Alfred Wanyonyi, Prof Barasa Otsyula, Dr Stephene Ondigo of negligence that led to the death of her daughter Annita Jepkorir.

Documents Weekly Citizen has show the hospital council has been in communication with the family on the matter. At one time, the council wrote a missive to the mourning family that read in part: "The council is in receipt of a complaint from Mercy J. Kiprono on behalf of Annita Jepkorir against yourselves dated June 29 2021 (copy attached for ease of reference). The complainant in the application for lodging a complaint and statement attached alleges that you misdiagnosed the patient, leaving a foreign object in the patient's airways/lungs which eventually



Otsyula

caused the demise of the patient."

In the detailed complainant affirmation, the family claims doctors who operated on the girl extracted her tooth even though they were notified that the child had swallowed a sunflower seed and was detrimental to her health. The family has an audio record as part of the evidence in the case.

The family is also accusing Ogendo of conflict in the case by protecting the doctors implicated in the death. They want Ogendo to step aside from the matter, and must not chair the council review on the case.

The late Jepkorir's family is also reading mischief the way Eunice Muriithi, the deputy director in charge of disciplinary service, is handling the case. To them, Muriithi has not been cooperative but arrogant on them.

Weekly Citizen is informed that Muriithi was the one who allocated the case to Ogendo after holding talks with the doctors at the centre of the storm

Ogendo represents universities at Kenya Medical and Dentist Practitioners Council.

According to a family member, the tribunal like a jury, should be independent and should look at all the facets of the case. Eunice and Yumbya have already been compromised by the doctors. Ogendo as a council member should not be a case reviewer because he oversees the management.

We have since established that at one time, the council asked the implicated doctors not to share their reports on what happened but a year has elapsed without any reply.

They were required to submit the following to the council on or before August 4, 2021;

(a) A statement by all the respondents addressing the allegations made by the complainant in the complaint form and statement states as follows;

i). Conducting the wrong procedure when the patient was in theatre

ii). Extracting the patient's teeth when the same was not due for extraction.

iii). Misdiagnosing the patient with pneumonia when she was brought back for a further check and;

iv). failing to exercise proper skill and care required of a doctor.

(b) The 5 respondents to provide statements from the medical personnel adversely mentioned in the complainant's statement ie Dr Oloo, Dr Ismael, and Dr Ouma;

(c)Certified and paginated copy of the entire patient's file to be submitted by the 5 respondent.

(d) Any other relevant document (s) or information that may assist the Disciplinary and Ethics Committee of the Council in its investigations.

The letter's parting shot was: "do ensure that the above listed documents are received within the specified period".

12:10

Thread

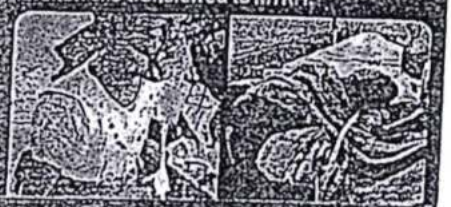
Blanca™
@Biancawamu2

Whatever happens at Moi Teaching & Referral Hospital (MTRH) can only be explained and understood by the DEVIL himself. I believe this hospital engage in Human Body Parts trafficking! A child has swallowed sunflower seed, instead of removing the seed they remove teeth. THREAD

19:43 · 26 Sep 22 · Twitter for Android

5 Retweets · 22 Quote Tweets · 959 Likes

Blanca™ @Biancawamu2 · 2d
Replying to @Biancawamu2
Anita, @MercyKiprono80's daughter complained of being chocked by a sunflower seed she has swallowed accidentally, the family rushed her to Mediheal Hospital, but later on she transferred to MTRH.



Tweet your reply

12:10

Thread

Blanca™ @Biancawamu2 · 2d
Instead of removing the seed stuck in Anita as per the X rays and CT scan. The two removed Anita's teeth to cover up what they should have done. The post-moterm results showed that they never removed the seed but instead did several surgeries on Anita's other body parts.

4 · 39 · 103

Blanca™ @Biancawamu2 · 2d
Surgeries were not related to Anita's ailments. Anita's family has faced a lot of challenges, frustration and Humiliation in pursued of justice for Anita. They went to Kenya Medical Practitioners and Dentistry because it a concerned administration. However, they

1 · 44 · 117

Blanca™ @Biancawamu2 · 2d
Never did anything to follow up on t issue. As family, they've been chased away several times by KMPDC people led by Eunice Murithi Assistant Director Disciplinary and Ethics together with Daniel M. Yumbya, Chief Executive Officer at KMPDC.

3 · 48 · 110

Blanca™ @Biancawamu2 · 2d
Mercy is in Pain and desperate mother seeking to have answers and help because of what she has been going through mentally, physically and emotionally.
Hey folks, help mercy get justice by retweeting. @hellenjeriKe, @Onorpiki,

our reply

12:11

Thread

Abdulmo'amen KIBET @AbdulmoKib · 2d
Replying to @Biancawamu2
@MTRHofficial is a fertile ground for harvesting patients by its own Doctor employees. The 'harvested' patients are hoodwinked to seek 'superior' medication from mushrooming private medical facilities around MTRH conspicuously owned by the same doctors. Too sad.

7 · 43

NGETICH HSC @Kipkorir_Denno · 2d
Replying to @Biancawamu2
@MTRHofficial mkuje hapa si kuzuri

1 · 7

Kiprotich Rop @Kiprotich38809222 · 2d
Replying to @Biancawamu2
@MTRHofficial If this is true this individuals must be prosecuted

2

Blanca™ @Biancawamu2 · 2d
@MOH_Kenya, @thekhrc, @KenyaOmbudsman, @DCI_Kenya

1 · 17 · 35

Job wasonga @wasonga_job · 2d
Replying to @Biancawamu2
Thank God you Voted them in. What do you expect from an institution that is 100% Kalenjins. Na Bado ngoma central bank. Mtatii

Tweet your reply

12:11

Thread

Job wasonga @wasonga_job · 2d
Replying to @Biancawamu2
Thank God you Voted them in. What do you expect from an institution that is 100% Kalenjins. Na Bado ngoma central bank. Mtatii

7 · 4

Abel @ItsAbelKE · 1d
But the names of all the medics mentioned say otherwise, in fact I saw your fellow luo

Show replies

gasura @Pius542 · 2d
eplying to @Biancawamu2
MTRHofficial
@HonOscarSudi
GvnMandago

2

Nk @karugu_nicholas · 2d
Replying to @Biancawamu2
m not defending anybody but the tooth might ave been removed during intubation which is a procedure done to patients to secure their airway during surgery which involves General anesthesia

2

EEK-O @CheekODread · 2d
ubate to remove a seed stuck in the throat, same throat you now fit said intubation

12:11

Thread

phillip_momanyi @nursemomanyi · 2d
Replying to @Biancawamu2
As far as I sympathize with mercy I have two crucial questions I will ask.
If the problem was just a swallowed seed, why could mediheal refer this patient, we know mediheal has capacity to handle this situation.
Second before surgery did mercy not sign consent?

2 · 9

Baetho @Fal_Karanja · 2d
Who are these questions addressed to?

1 · 3

Show replies

Followed by some Twoetors you follow

John gakunju @johngakunju · 2d
Replying to @Biancawamu2
I think its sad but one side of the story ,organ harvesting is not like movies ,there are compatability tests many of them ,a needy receivor and its urgent so how many transplants are done in kenya still far so I think something happened ,hear both sides of story

1 · 2

CHEEK-O @CheekODread · 2d
Maybe you should read up on how long an organ is viable after removal then read up on recipient lists.
Ergo the term "Organ Harvesting".

12:11

Thread

CHEEK-O @CheekODread · 2d
Maybe you should read up on how long an organ is viable after removal then read up on recipient lists.
Ergo the term "Organ Harvesting".
There's already demand, & sure not nowhere near enough supply.

2

Kap10 🇰🇪 @KaptenMwendwa · 2d
Replying to @Biancawamu2 and @NixonAiro
@MTRHofficial can you respond?

Eng. صالح ابن صالح @SalihIbnSwaleh · 1d
Replying to @Biancawamu2
Back in 2009 when staying in Bungoma we took there three patients very healthy only to come back home in coffins 🙏

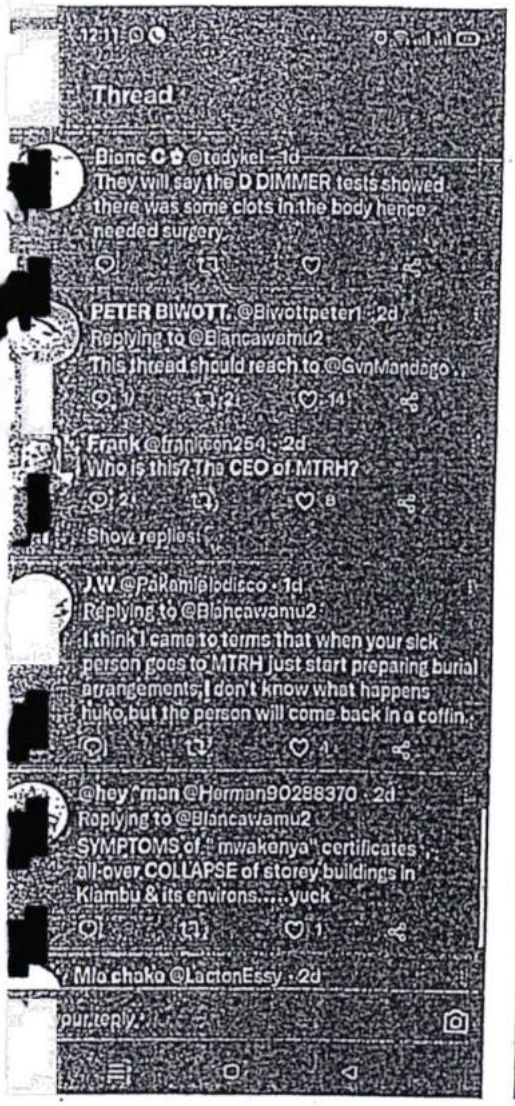
1

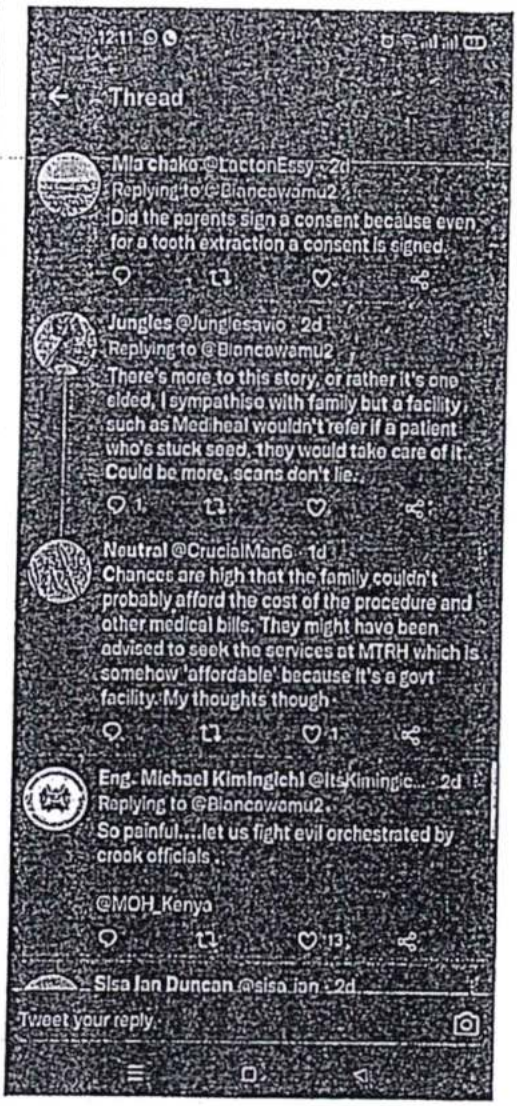
Oslov @geoffrey_osoro · 1d
Very healthy patients??
Oxymoronic much, don't you think?

kimaru Nahashon @NahashonKimaru · 2d
Replying to @Biancawamu2
Some patients can cook their stories let listen to doctor's side then we conclude

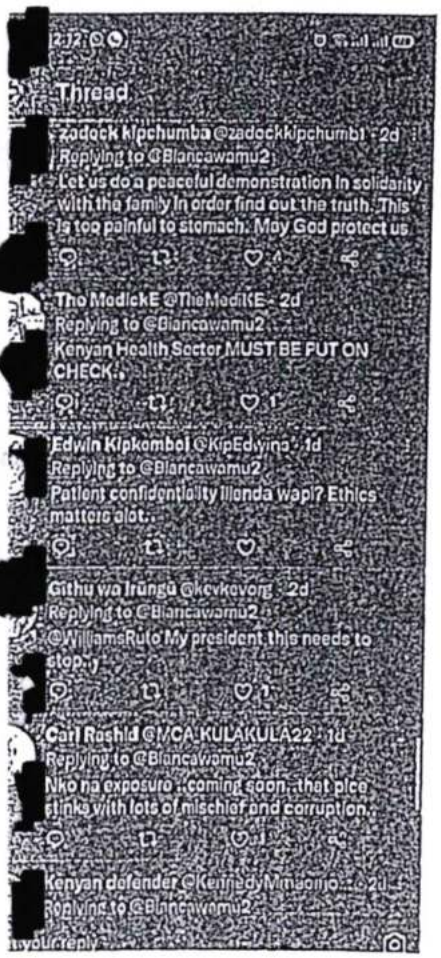
5 · 8

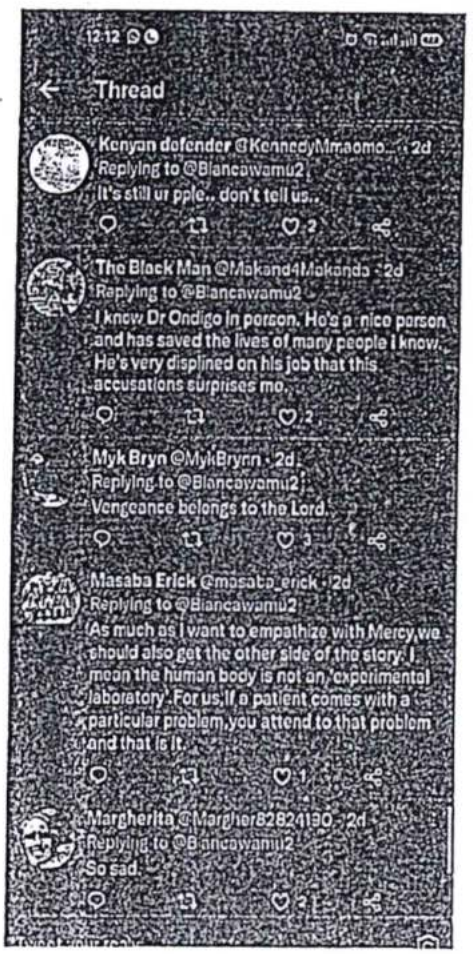
28


Thread
They will say the D DIMMER tests showed there was some clots in the body hence needed surgery.
PETER BIWOTT @Biwottpeter1 · 2d
Replying to @Blancawamu2
This thread should reach to @GvnMandago
Frank @frankcon254 · 2d
Who is this? The CEO of MTRH?
Show replies
J.W @Pakamigodisco · 1d
Replying to @Blancawamu2
I think I came to terms that when your sick person goes to MTRH just start preparing burial arrangements, I don't know what happens huko but the person will come back in a coffin.
@heyyman @Herman90288370 · 2d
Replying to @Blancawamu2
SYMPTOMS of "mwakenya" certificates all over.COLLAPSE of storey buildings in Kiambu & its environs.....yuck
Mla chako @LactonEssy · 2d
Tweet your reply

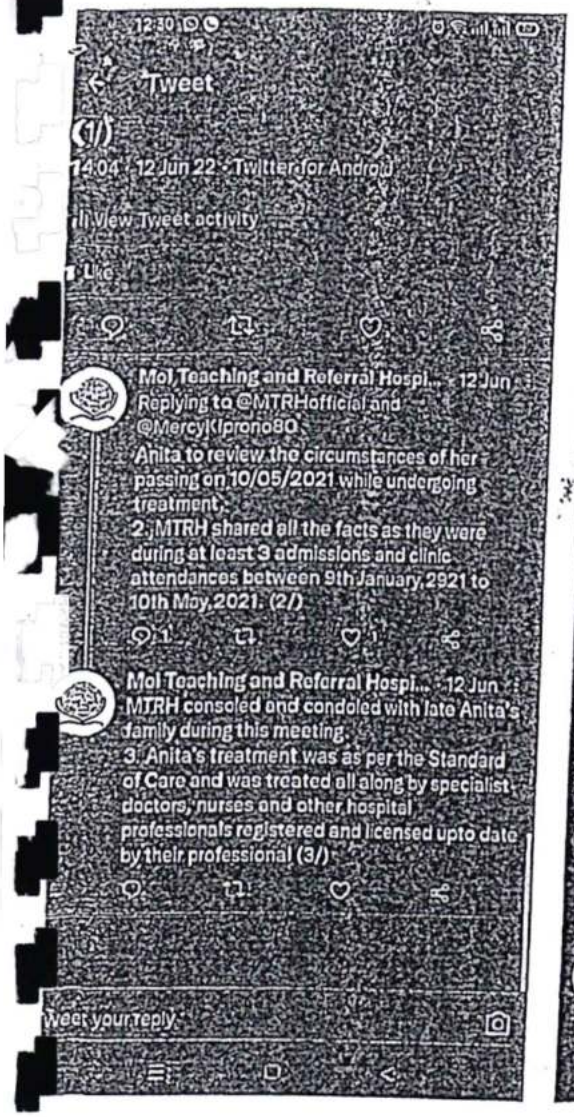

Thread
Mla chako @LactonEssy · 2d
Replying to @Blancawamu2
Did the parents sign a consent because even for a tooth extraction a consent is signed.
Jungles @Junglesavio · 2d
Replying to @Blancawamu2
There's more to this story, or rather it's one sided, I sympathise with family but a facility such as Mediheal wouldn't refer if a patient who's stuck seed. they would take care of it. Could be more, scans don't lie.
Neutral @CrucialMan6 · 1d
Chances are high that the family couldn't probably afford the cost of the procedure and other medical bills. They might have been advised to seek the services at MTRH which is somehow 'affordable' because it's a govt facility. My thoughts though
Eng. Michael Kimingichi @ItsKimingic... · 2d
Replying to @Blancawamu2
So painful....let us fight evil orchestrated by crook officials.
@MOH_Kenya
Sisa Ian Duncan @sisa_ian · 2d
Tweet your reply

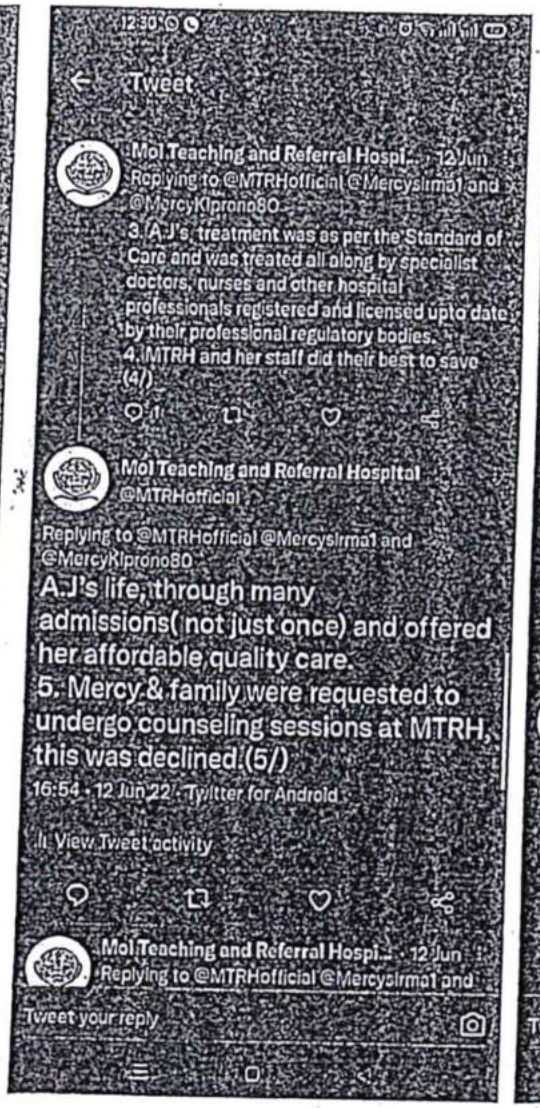

Thread
Sisa Ian Duncan @sisa_ian · 2d
Replying to @Blancawamu2
Where is the report of 22nd March, 2022?
MD @JamesNyawira3 · 1d
How did I miss the movie 😂... Residents wameitwa nn.. weh
Show replies
Junior @OngusoN · 1d
Replying to @Blancawamu2
Prayers for the family attached to this. Is why we needed ...//BabaCarol)
Silla B Dibba @GhostOtili · 1d
Replying to @Blancawamu2
Another one is Karen Hospital, Was forcing Us to Do CS with no clear intentions to why. Nitalipa blogger awaanike.
Helsenborgd @DrJuma_M · 2d
Replying to @Blancawamu2
This is one side of the story.Now tell us the other side
zadock kipchumba @zadockkipchumb1 · 2d
Replying to @Blancawamu2
Tweet your reply

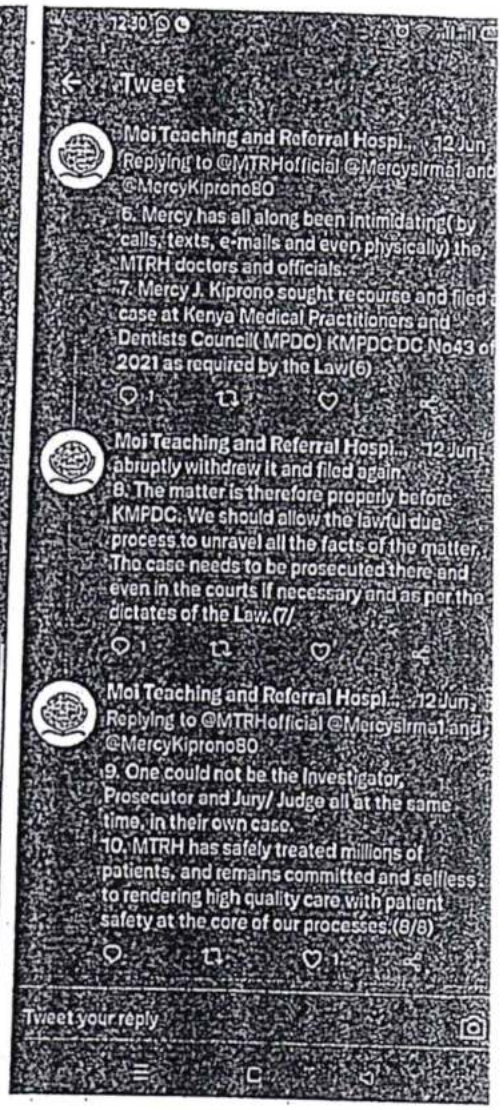

Thread
zadock kipchumba @zadockkipchumb1 · 2d
Replying to @Blancawamu2
Let us do a peaceful demonstration in solidarity with the family in order find out the truth. This is too painful to stomach. May God protect us.
The ModlckE @TheModlKE · 2d
Replying to @Blancawamu2
Kenyan Health Sector MUST BE PUT ON CHECK!.
Edwin Kipkombol @KipEdwina · 1d
Replying to @Blancawamu2
Patient confidentiality Ilionda wapi? Ethics matters alot.
Githu wa Irungu @kevkevorg · 2d
Replying to @Blancawamu2
@WilliamsRuto My president this needs to stop.
Carl Rashid @MCA_KULAKULA22 · 1d
Replying to @Blancawamu2
Nko na exposure ..coming soon..that place stinks with lots of mischief and corruption.
Kenyan defender @KennedyMmaomo... · 2d
Replying to @Blancawamu2

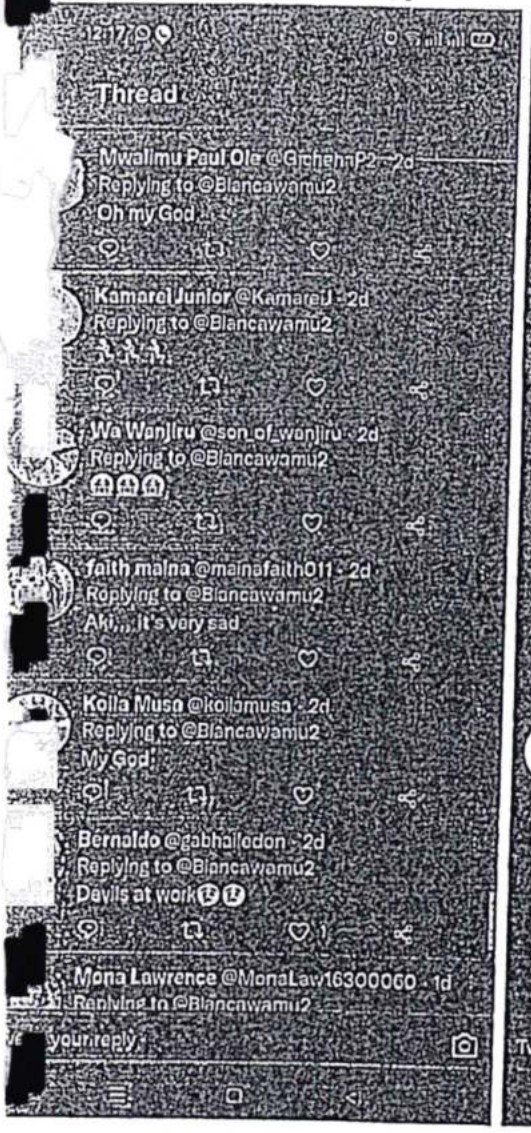

Thread
Kenyan defender @KennedyMmaomo... · 2d
Replying to @Blancawamu2
It's still ur pple.. don't tell us..
The Black Man @Makand4Makanda · 2d
Replying to @Blancawamu2
I know Dr Ondigo in person. He's a nice person and has saved the lives of many people I know. He's very displined on his job that this accusations surprises mo.
Myk Bryn @MykBrynn · 2d
Replying to @Blancawamu2
Vengeance belongs to the Lord.
Masaba Erick @masaba_erick · 2d
Replying to @Blancawamu2
As much as I want to empathize with Mercy,we should also get the other side of the story. I mean the human body is not an experimental laboratory. For us, if a patient comes with a particular problem,you attend to that problem and that is it.
Margherita @Margher82824190 · 2d
Replying to @Blancawamu2
So sad.

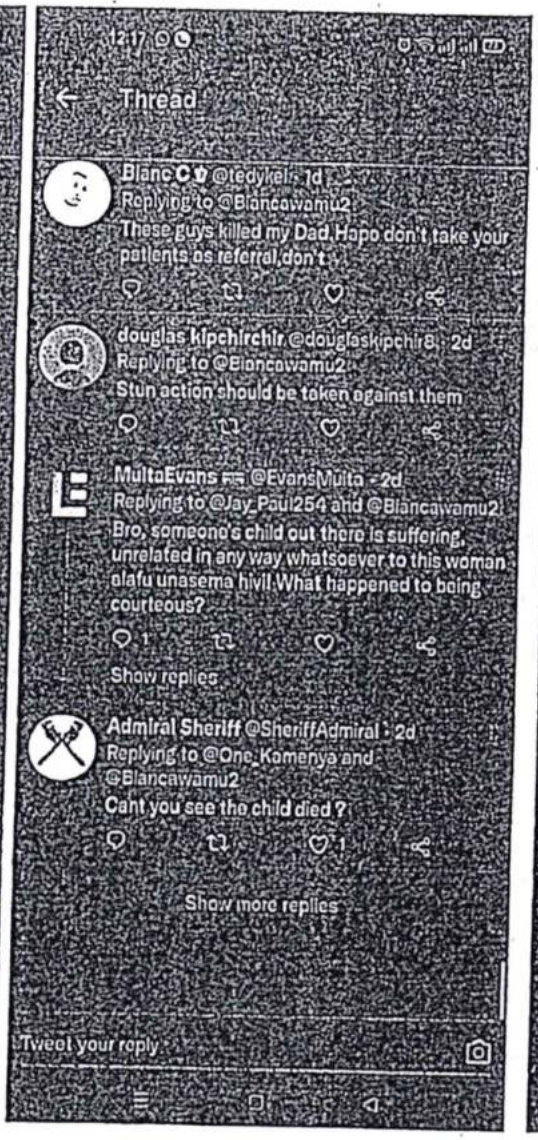

Thread
Margherita @Margher82824190 · 2d
Replying to @Blancawamu2
So sad.
Moneymaker @kimoneyjnr · 2d
Replying to @Blancawamu2
Finally, this lady has been seeking Justice for more than 1½ years now
Sir Jim Kitch @SirJimKitchKE · 2d
Replying to @Blancawamu2
Hey this is so sad.
Leng'al @PlainsDecendant · 2d
Replying to @Blancawamu2
X-rays showing a seed
BmJ @bmj251 · 2d
Replying to @Blancawamu2
It unfortunate that No justice will be served
zadock kipchumba @zadockkipchumb1 · 2d
Replying to @Blancawamu2
I can't think of a befitting punishment for such a gruesome act


Tweet
(1/)
14:04 · 12 Jun 22 · Twitter for Android
View Tweet activity
Like
MoI Teaching and Referral Hospi... · 12 Jun
Replying to @MTRHofficial and @MercyKiprono80
Anita to review the circumstances of her passing on 10/05/2021 while undergoing treatment.
2. MTRH shared all the facts as they were during at least 3 admissions and clinic attendances between 9th January,2021 to 10th May,2021. (2/)
MoI Teaching and Referral Hospi... · 12 Jun
MTRH consoled and condoled with late Anita's family during this meeting.
3. Anita's treatment was as per the Standard of Care and was treated all along by specialist doctors, nurses and other hospital professionals registered and licensed upto date by their professional (3/)
Tweet your reply

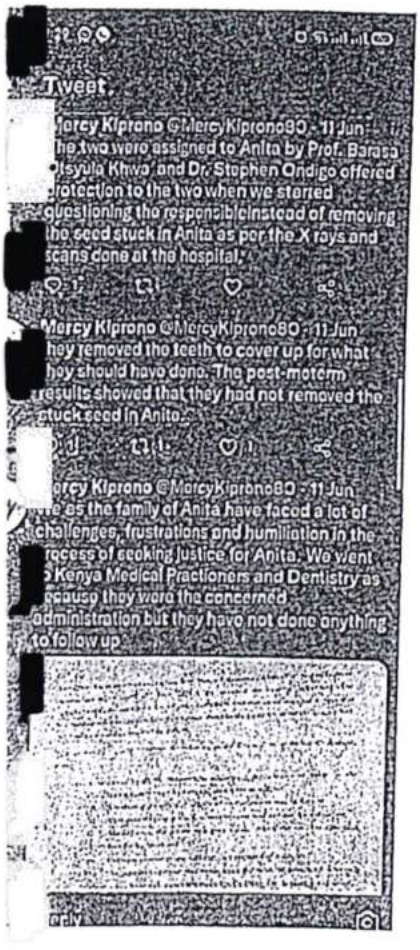

Tweet
MoI Teaching and Referral Hospi... · 12 Jun
Replying to @MTRHofficial @MercysIrma1 and @MercyKiprono80
3. A.J's treatment was as per the Standard of Care and was treated all along by specialist doctors, nurses and other hospital professionals registered and licensed upto date by their professional regulatory bodies.
4. MTRH and her staff did their best to save (4/)
MoI Teaching and Referral Hospital
@MTRHofficial
Replying to @MTRHofficial @MercysIrma1 and @MercyKiprono80
A.J's life, through many admissions(not just once) and offered her affordable quality care.
5. Mercy & family were requested to undergo counseling sessions at MTRH, this was declined.(5/)
16:54 · 12 Jun 22 · Twitter for Android
View Tweet activity
MoI Teaching and Referral Hospi... · 12 Jun
Replying to @MTRHofficial @MercysIrma1 and
Tweet your reply

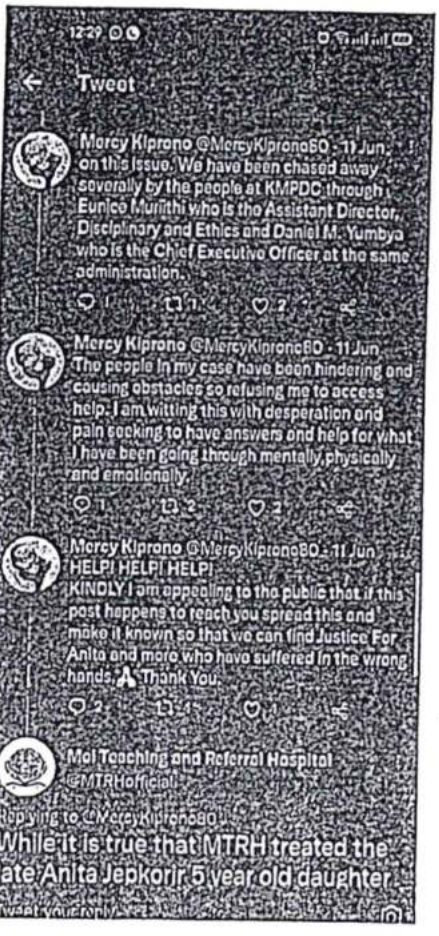

Tweet
MoI Teaching and Referral Hospi... · 12 Jun
Replying to @MTRHofficial @MercysIrma1 and @MercyKiprono80
6. Mercy has all along been intimidating(by calls, texts, e-mails and even physically) the MTRH doctors and officials.
7. Mercy J. Kiprono sought recourse and filed a case at Kenya Medical Practitioners and Dentists Council(MPDC) KMPDC DC No43 of 2021 as required by the Law(6)
MoI Teaching and Referral Hospi... · 12 Jun
abruptly withdrew it and filed again.
8. The matter is therefore properly before KMPDC. We should allow the lawful due process to unravel all the facts of the matter. The case needs to be prosecuted there and even in the courts if necessary and as per the dictates of the Law.(7/
MoI Teaching and Referral Hospi... · 12 Jun
Replying to @MTRHofficial @MercysIrma1 and @MercyKiprono80
9. One could not be the Investigator, Prosecutor and Jury/ Judge all at the same time, in their own case.
10. MTRH has safely treated millions of patients, and remains committed and selfless to rendering high quality care with patient safety at the core of our processes.(8/8)
Tweet your reply


Thread
Mwalimu Paul Ole @GichehaP2 · 2d
Replying to @Blancawamu2
Oh my God
Kamarel Junior @KamarelJ · 2d
Replying to @Blancawamu2
Wa Wanjiru @son_of_wanjiru · 2d
Replying to @Blancawamu2
faith maina @mainafaith011 · 2d
Replying to @Blancawamu2
Aki... it's very sad
Kolla Musa @kollamusa · 2d
Replying to @Blancawamu2
My God
Bernaldo @gabhalledon · 2d
Replying to @Blancawamu2
Devils at work
Mona Lawrence @MonaLaw16300060 · 1d
Replying to @Blancawamu2
your reply

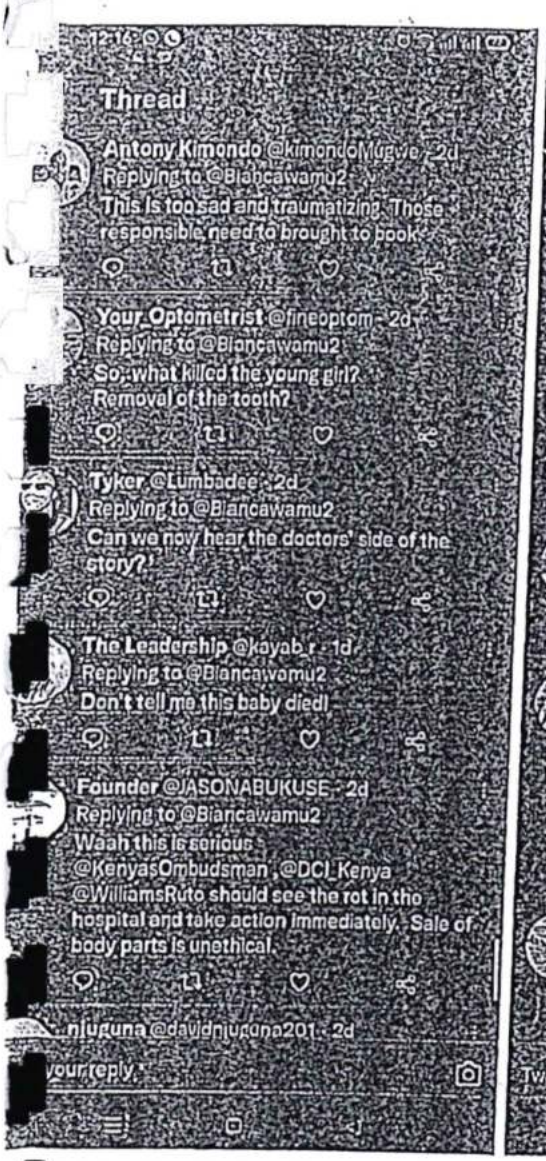

Thread
Blanc C @tedykel · 1d
Replying to @Blancawamu2
These guys killed my Dad.Hapo don't take your patients as referral,don't
douglas kipchirchir @douglaskipchir8 · 2d
Replying to @Blancawamu2
Stun action should be taken against them
MultaEvans @EvansMulta · 2d
Replying to @Jay_Paul254 and @Blancawamu2
Bro, someone's child out there is suffering, unrelated in any way whatsoever to this woman olafu unasema hivil.What happened to being courteous?
Show replies
Admiral Sheriff @SheriffAdmiral · 2d
Replying to @One_Kamenya and @Blancawamu2
Cant you see the child died ?
Show more replies
Tweet your reply


Tweet
This Tweet was deleted by the Tweet author. Learn more
Mercy Kiprono @MercyKiprono80 · 11 Jun
I Mercy Kiprono mother to the late Anita Jepkorir is writing this post with a lot of pain because of what happened to my daughter at Moi Teaching Referral (MTRH).
My daughter was complaining of being chocke and we rushed her to Mediheal Hospital then later transfered to
Mercy Kiprono @MercyKiprono80 · 11 Jun
MTRH where the unexpected happened to my daughter. Anita was not provided medical attention or treated for the ailments she had. She was being attended to by two inexperienc COSECSA who were students in the second year at Moi Teaching and Referral Hospital.The two doctors were
Mercy Kiprono @MercyKiprono80 · 11 Jun
Dr. Ernest Nzomo and Alfred Wanyonyi who claimed they were Consultants Cardiac department at MTRH
Mercy Kiprono @MercyKiprono80 · 11 Jun
The two were assigned to Anita by Prof. Barasa Otsyula Khwa and Dr. Stephen Ondigo offered protection to the two when we started
Tweet your reply


Tweet
Mercy Kiprono @MercyKiprono80 · 11 Jun
the two were assigned to Anita by Prof. Barasa Otsyula Khwa and Dr. Stephen Ondigo offered protection to the two when we started questioning the responsibleinstead of removing the seed stuck in Anita as per the X rays and scans done at the hospital.
Mercy Kiprono @MercyKiprono80 · 11 Jun
they removed the teeth to cover up for what they should have done. The post-moterm results showed that they had not removed the stuck seed in Anita.
Mercy Kiprono @MercyKiprono80 · 11 Jun
we as the family of Anita have faced a lot of challenges, frustrations and humiliation in the process of seeking justice for Anita. We went Kenya Medical Practioners and Dentistry as because they were the concerned administration but they have not done anything to follow up


Tweet
Mercy Kiprono @MercyKiprono80 · 11 Jun
on this issue. We have been chased away severally by the people at KMPDC through Eunice Murithi who is the Assistant Director, Disciplinary and Ethics and Daniel M. Yumbya who is the Chief Executive Officer at the same administration.
Mercy Kiprono @MercyKiprono80 · 11 Jun
The people in my case have been hindering and causing obstacles so refusing me to access help. I am witting this with desperation and pain seeking to have answers and help for what I have been going through mentally,physically and emotionally.
Mercy Kiprono @MercyKiprono80 · 11 Jun
HELP! HELP! HELP!
KINDLY I am appealing to the public that if this post happens to reach you spread this and make it known so that we can find Justice For Anita and more who have suffered in the wrong hands. Thank You
Moi Teaching and Referral Hospital @MTRHofficial
Replying to @MercyKiprono80
While it is true that MTRH treated the late Anita Jepkorir 5 year old daughter

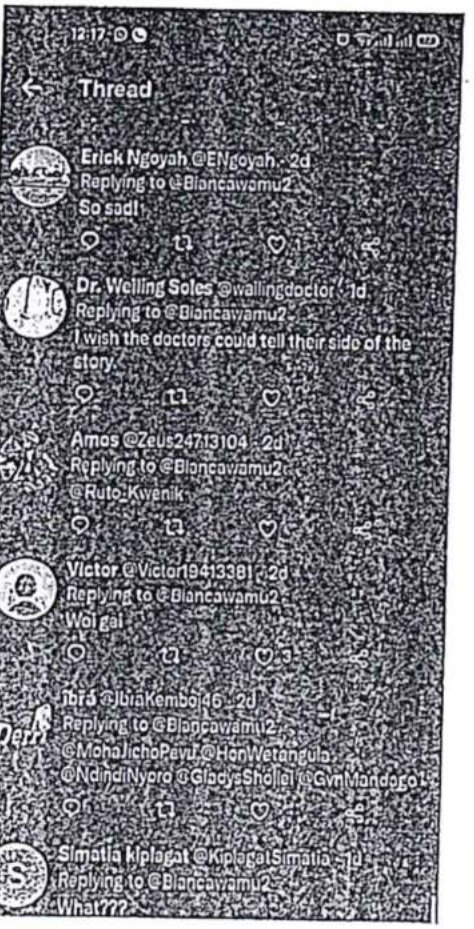

Tweet
Moi Teaching and Referral Hospital @MTRHofficial
Replying to @MercyKiprono80
While it is true that MTRH treated the late Anita Jepkorir 5 year old daughter of Mercy Kipronoh, the facts are as follows:
1. On 25/05/2021 MTRH led by its CEO, Senior Director Clinical Services, relevant Doctors, Nurses held a daylong meeting with the family of late (1/)
14:01 · 12 Jun 22 · Twitter for Android
View Tweet activity
1 Like
Moi Teaching and Referral Hospi... · 12 Jun
Replying to @MTRHofficial and @MercyKiprono80
Anita to review the circumstances of her passing on 10/05/2021 while undergoing treatment.
2. MTRH shared all the facts as they were during at least 3 admissions and clinic


Thread
Antony Kimondo @kimondoMugwe · 2d
Replying to @Biancawamu2
This is too sad and traumatizing. Those responsible need to brought to book.
Your Optometrist @fineoptom · 2d
Replying to @Biancawamu2
So, what killed the young girl? Removal of the tooth?
Tyker @Lumbadee · 2d
Replying to @Biancawamu2
Can we now hear the doctors' side of the story?
The Leadership @kayab_r · 1d
Replying to @Biancawamu2
Don't tell me this baby died!
Founder @JASONABUKUSE · 2d
Replying to @Biancawamu2
Waah this is serious.
@KenyasOmbudsman , @DCI_Kenya
@WilliamsRuto should see the rot in the hospital and take action immediately. Sale of body parts is unethical.
njuguna @davidnjuguna201 · 2d
your reply


Thread
njuguna @davidnjuguna201 · 2d
Replying to @Biancawamu2 and @JenniferKatusya
Ndindi Nyoro I hope you have not exited Twitter, do something we know you are so close to the President.
Amoo K Rutoh @AmooRutoh · 2d
Replying to @Biancawamu2
So sad, we can't allow that... Justice for the child
Endgen22 @Endgen22 · 1d
Replying to @Biancawamu2
Yes, name these hospitals
clinton okoth @clinton81719760 · 2d
Replying to @Biancawamu2
I know everything going on In line with dynasties from grass roots, the Most High God made me His servant and is revealing all to me. Human and body parts trafficking will stop asap
Trichomoniasis @ToshClinton002 · 1d
Replying to @Biancawamu2
This is a lie. Total crap
Tweet your reply


Thread
Nutr.Faith @Faith_Nutr · 22h
Replying to @Biancawamu2
The day a medic will be vindicated someone please call me. The games, humiliation and no care attitudes by the fraternity is heartbreaking. Sina maoni mimi
Josiah munyanya @Jowdawg · 2d
Replying to @Biancawamu2
That hospital is extremely pathetic I recently lost my sister to their negligence and indifference to patients the whole north rift is absolutely terrible in terms of health care
Mutongoi Nzamba @mu2nga13 · 1d
Replying to @Biancawamu2
So sad and painful.
Ahmed Abdi @AhmedAb17416700 · 2d
Replying to @Biancawamu2
Sad
Gk Mkenya @GkMkenya1 · 2d
Replying to @Biancawamu2
@Onorpik
Masaba Erick @masaba_erick · 2d
Tweet your reply


Thread
Masaba Erick @masaba_erick · 2d
Replying to @Biancawamu2
We are guided by the principle that we are not supposed to do no harm. In any case there's always a consent form provided before any procedure is done to a patient after thorough explanation. In this case the mother would have to sign it because the patient is a
Cornelius Ngetich @NgetichNget17 · 2d
Replying to @Biancawamu2
Very sad
@Eunice 01 @Eunice034975617 · 2d
Replying to @Biancawamu2
Bahati Hari Moses @harimoses · 2d
Replying to @Biancawamu2
@kenya_itan · 2d


Thread
Erick Ngoyah @ENgoyah · 2d
Replying to @Biancawamu2
So sad!
Dr. Welling Soles @wallingdoctor · 1d
Replying to @Biancawamu2
I wish the doctors could tell their side of the story
Amos @Zeus24713104 · 2d
Replying to @Biancawamu2
@Ruto_Kwenik
Victor @Victor19413381 · 2d
Replying to @Biancawamu2
Woi gai
Ibra @IbraKemboi46 · 2d
Replying to @Biancawamu2
@MohaJichoPeyu @HonWetangula @NdindiNyoro @GladysShollai @GvnMandago
Simatia kiplagat @KiplagatSimatia · 1d
Replying to @Biancawamu2
What???


Thread
Simatia kiplagat @KiplagatSimatia · 1d
Replying to @Biancawamu2
What???
Masaba Erick @masaba_erick · 2d
Replying to @Biancawamu2
Minor
Chemu Kirui @KiruiChemu · 1d
Replying to @Biancawamu2
So serious @ChangeOrgKE
wastol @wacikus · 2d
Replying to @Biancawamu2
Oh my God
RONJOS @Dr_SouUay · 2d
Replying to @Biancawamu2
@GKudaka
Captain Dominic Omondi @Dominic... · 2d
Replying to @Biancawamu2
This is serious

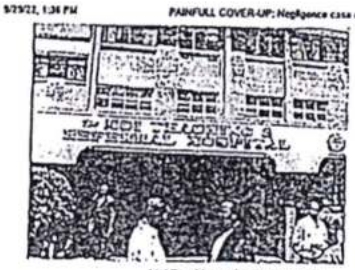
NEWS

PAINFULL COVER-UP: Negligence Case Against Moi Teaching And Referral Hospital

By Kaecha Kamaris
Published September 15, 2022 - 16:13

Trending

1. Insiders Reveal How Patrick Ijisrage Was Complicit In Outgoing Government's Malpractices
2. CBK Governor Patrick Ijisrage Tasked With Explaining The Irregular Enlisting Of Police Officers Who Stripped DP Gachagua Naked
3. Greedy Procurement Officer Abusing Power At The State Department For Culture And Heritage
4. Questions Raised Over NGAAF CEO Sasaka Telewa's Irregular Appointment



Moi Teaching and Referral Hospital

A couple of doctors at the Moi Teaching And Referral Hospital are accused of causing death by negligence.

Mercy J Kiprono, alleges that Dr. Ernest Nashom, Dr. Alfred Wanyonyi, Prof. Barasa Otsyula, Dr. Stephene Ondigo's negligence led to the demise of her daughter Annita Jepkorir.

"The Council is in receipt of a complaint from Mercy J Kiprono on behalf of Annita Jepkorir against yourselves dated 29th June, 2021 (copy attached for ease of reference). The complainant in the application for lodging a complaint and statement attached alleges that you misdiagnosed the patient, leaving a foreign object in the patient's airways/ lungs which eventually caused the demise of the patient," a document form the hospital's council said in part.

The doctors that operated on Annita extracted her tooth even though they were

5. CITAM Kenya Records Sh2.53Bn Income
6. CBK Workers Unhappy With Governor Ijisrage's Leadership
7. Corporate Insurance Facing Cash Flow Problems
8. Former TV Girl Jacque Maribe Lands New Job In The Office Of The Deputy President
9. Actor Paul Ogola Blasts Oprah Oyugi For Stealing His Original Script For "Country Queen" – Kenya's First Homegrown Netflix Series
10. Kilimani Man Loses Phones, Laptop To Mchele Terrorists Ferried From Brew Bistro Lounge

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- KeMRA Staff Left Without Medical Cover After Liaison Group Bungled Insurance Brokerage Tender
- SGA Guards Protest Pay Disparity
- Kenyan Girl Killed In Egypt For Refusing To Have Sex With Employer's Son
- Prestab Cleaning Services Underpaying Workers
- Unfairly Terminated Employee Reveals How Mwananchi Credit CEO Dennis Mombo, Nahrald DCIO Have Colluded To Deny Him Justice In Assault Case

notified that the child had swallowed a sunflower seed and was detrimental to her health.

The audio attached below summarises the case.

The victim's family says that justice has been delayed and therefore denied.

They claim that the hospital's management, a Prof. Ogendo is conflicted and must not chair the council review on the case.

Annita Jepkorir's family also believe that Eunice Muriithi, the deputy director in charge disciplinary service, has been compromised. She is the one who allocated the case to Prof. Ogendo.

Prof. Ogendo represents universities at KMDPC.

"The tribunal like a jury should be independent and should look at all the facets of the case. Eunice and Yumbya have already been compromised by the doctors. Prof Ogendo as a council member should not be a case reviewer because he oversees the management", an anonymous person interested in the case told cnyakundi.com

Kilimani Man Loses Phones, Laptop To Mchele Terrorists Ferried From Brew Bistro Lounge

The council had asked the above negligent doctors to share their reports on what happened. The deadline was a year ago, but up to now, nothing has happened.

You are hereby required to submit the following to the Council on or before 4th August, 2021;
(a) A statement by all the Respondents addressing the allegations made by the Complainant in the complaint form and statement as follows;
i). Conducting the wrong procedure when the patient was in theatre
ii). Extracting the patient's teeth when the same was not due for extraction.
iii). Misdiagnosing the patient with pneumonia when she was brought back for a further check and ;
iv). Failing to exercise proper skill and care required of a doctor.
(b) The 5th Respondent to provide statements from the medical personnel adversely mentioned in the complainant's statement i.e. Dr Oloo, Dr. Ismael, Dr. Ouma;
(c) Certified and paginated copy of the entire patient's file to be submitted by the 5th Respondent.
(d) Any other relevant document (s) or information that may assist the

> *Disciplinary and Ethics Committee of the Council in its investigations. Do ensure that the above listed documents are received within the specified period.*

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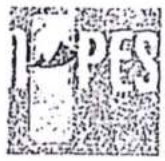

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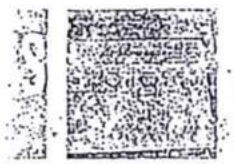

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Zawan254 · September 12, 2022 - 21:26

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35

17:45

← Tweet

Mercy Kiprono
@MercyKiprono80

Replying to @SammyymmaZ and @Biancawamu2

The operation was done by two student doctors ,who pretended like consultants during all this 5 months,

7:41 · 28 Sep 22 · Twitter for Android

2 Likes

SammyLFC @SammyymmaZ · 2d
Replying to @MercyKiprono80 and @Biancawamu2

Sorry for what happened. May you find justice

Tweet your reply

36

17:45

← Tweet

Mercy Kiprono
@MercyKiprono80

Replying to @MercyKiprono80 @s_nakhumicha and @s

These students handled my daughter without supervision,they claimed that they were consultant,autopsy from MTRH is clear evidence .kmpdc ,ombudsman's ,MOH have case but kmpdc led by Eunice Muriithi,Daniel Yumbya ,Hilda karanga are the worst hypocrites bedding with MTRH .

18:28 · 28 Sep 22 · Twitter for Android

3 Likes

Tweet your reply

37

17:44

← Tweet

Mercy Kiprono
@MercyKiprono80

Replying to @s_nakhumicha

Welcome madam @s-nakhumicha plis ,i am kneeling,safe us from the mess in MTRH Eldoret,its becoming level 6 HELLunder the watch of Dr wilson kiprotich Aruasa,the cardiac professors allowing the Cosecsa students from Cameroon quack Dr Ernest nshom and Alfred wanyonyi from kenya .

18:19 · 28 Sep 22 · Twitter for Android

4 Likes

Mercy Kiprono @MercyKipron... · 1d

Replying to @MercyKiprono80 @s_nakhumicha and @s

These students handled my daughter without supervision,they claimed that they were consultant,autopsy from MTRH is clear evidence .kmpdc ,ombudsman's ,MOH

Tweet your reply

38

← Tweet

Mercy Kiprono
@MercyKiprono80

Replying to @DrSusanWafula @WilliamsRuto and 2 others

Kmpdc Eunice Muriithi ,Daniel Yumbya ,Hilda karanga ,MTRH Dr wilson Aruasa,proff Otysula,Olo o,Auma,Ondigo ,kimani,Cosecsa students Alfred wanyonyi,Ernest nshom sustains themselves on the blood of innocent patients. My late daughter suffered on the hands of these students.

18:47 · 28 Sep 22 · Twitter for Android

3 Likes

Tweet your reply

17:44

← Tweet

Mercy Kiprono
@MercyKiprono80

Replying to @DonaldBKipkorir and @MOH_Kenya

Better that one trying to get money through forcing pple to buy mask,the worst is MTRH which allow students to handle patients on cardiac operations and claim that they are consultants.only to learnt after autopsy that my daughter was made to be a research specimen. I saw hell

20:54 · 29 Sep 22 · Twitter for Android

5 Likes

Tweet your reply

17:44

← Tweet

Mercy Kiprono
@MercyKipróno80

Replying to @DonaldBKipkorir and @MOH_Kenya

@MOH_Kenya if MTRH has permission from kmpdc Eunice Muriithi and Daniel yumbya to use human beings like rats ,don't we have a right to be told?should it allow Cosecsa student to handle patients without supervision?safe us.my child carried the FB for 5ms in lung

21:11 · 29 Sep 22 · Twitter for Android

3 Likes

Tweet your reply

41

← Thread

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Learn more

Mercy Kiprono
@MercyKiprono80

2MTRH COSECSA DOCTORS FROM HELL.
1/9 It was so unbelievable that the people we entrust the lives of our people turns out to be the heartless butchers student doctors.
#JusticeForAnnita

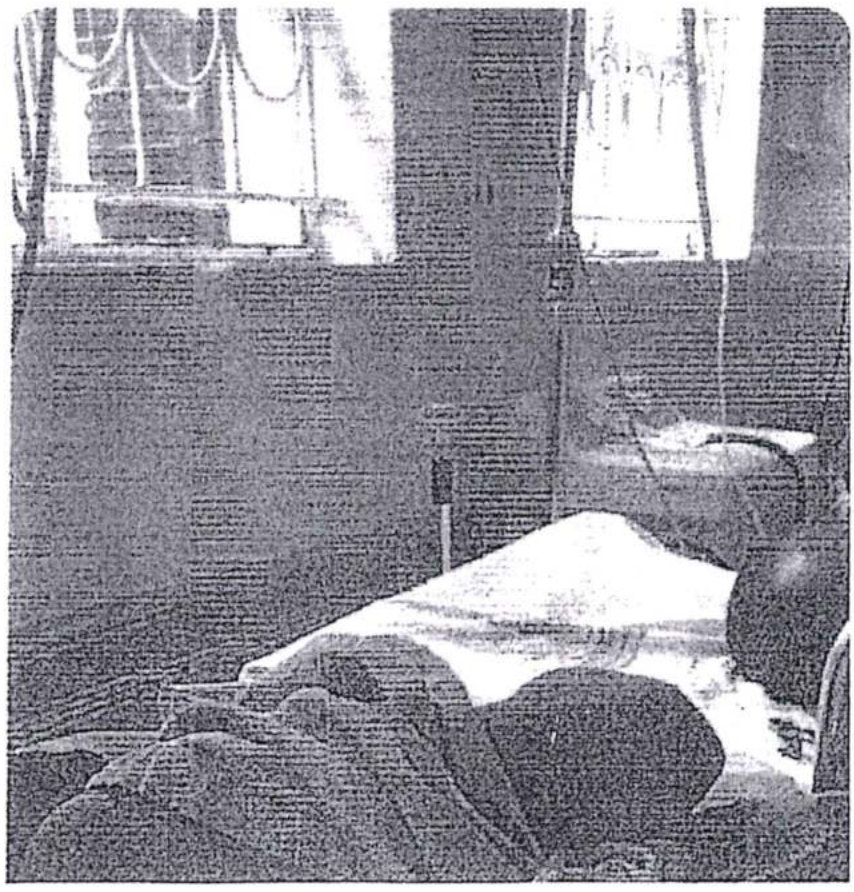
Tweet your reply

17:48

← Thread

Mercy Kiprono
@MercyKiprono80

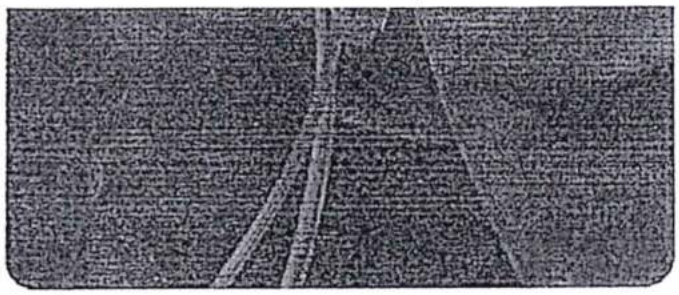
2/9 Annita was choked by a black ring like seed that went down to the right brochi.ct chest scan confirmed. At the theatre, the two students Dr Alfred Wadeba Wanyonyi and Dr Ernest Nshom did a thoracotomy but did not remove the seed.



Tweet your reply

17:48

← Thread



1 2

Mercy Kiprono
@MercyKiprono80

3/9 They only made sure that the tube reaches the seed, I think because they knew that their Prof. Otysula would only check the tube. 2 upper incisor teeth from her mouth were removed and sticked them separately in her left leg so that I couldn't see the number of the teeth

19:11 · 19 Jun 22 · Twitter for Android

2 Retweets **2** Likes

Mercy Kiprono @MercyKip... · 19 Jun
Replying to @MercyKiprono80
4/9 They later insisted that they found

Tweet your reply

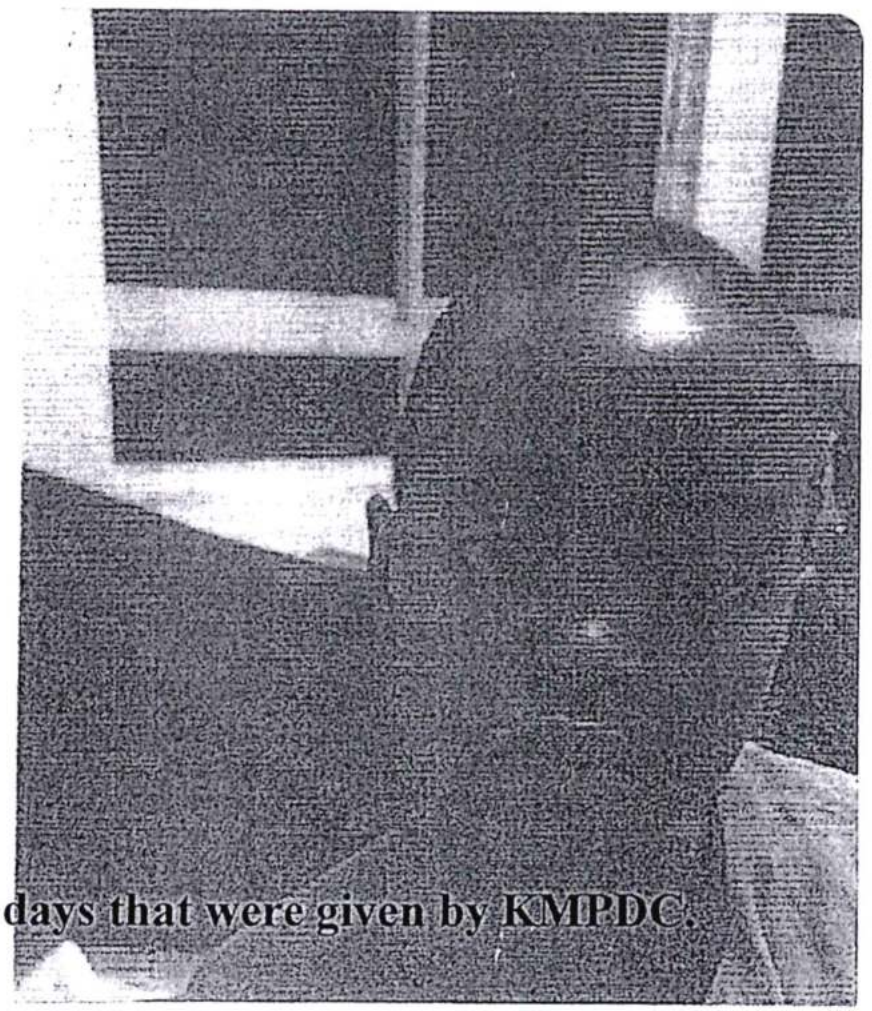
44

17:49

← Thread

Mercy Kiprono
@MercyKiprono80

7/9 Finally, we were in and out of the hospital as out-patients untill the day Annita died while playing at home. Postmortem showed that the seed was never removed. It stayed for nearly five months in the lung.



ation after 90 days that were given by KMPDC.

Tweet your reply

cy jepchirchir 16 Aug 2023, 13:39

An ISO 9001:2015 Certified Hospital

MOI TEACHING AND REFERRAL HOSPITAL

Email: ceo@mtrh.go.ke
Telephone: 053 2033471/2/3
Fax: 053 2061749

NANDI ROAD
P.O. BOX 3
ELDORET, KENYA

Our Ref: ELD/MTRH/ADMIN/1/15/VOL.II/2007(4) **Date:** 26th October 2022

The Assistant Director Disciplinary & Ethics,
Kenya Medical Practitioners and Dentists Council,
KMP & DC House,
Woodlands RD, off Lenana RD
P O Box 44839 – 00100
Nairobi

Dear Madam -

Mercy J. Kiprono on Behalf of Anita Jepkorir (deceased) against MTRH Eldoret and 4 others
DC case number 43 of 2021

Reference is made to your invitation letter Ref: KMPDC/DEC/HEARING.NOTICE/10/2022 dated 20th September 2022 and the hearing held between Disciplinary & Ethics Committee of the Council (herein referred to as the Council) sitting at the Kenya Medical Practitioners and Dentists Council Office Complex, Committee Room. Between Mercy J. Kiprono and the Moi Teaching & Referral hospital Represented by its C.E.O & Senior Director Clinical Services (herein referred to as MTRH), Professor Barasa Otsyula Khwa, Dr. Stephen Ondigo, Dr. Alfred Wanyonyi Wandeba and Dr. Ernest Nshom (herein referred as "the team of Doctors") on 12th October 2022. The complainant and MTRH were allowed 7 days apart to file it written submissions. MTRH hereby tenders its written submissions.

The issue before you for determination is whether MTRH met the standard of care it owed to the late Annita Jeplorir when it treated her between 9th January 2021 to 26th January 2021 and later on from 8th February 2021 and 14th February 2021, that is, whether MTRH neglected its duty of care to her.

26/10/22

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The case is summarised as misdiagnosis and leaving a foreign object (that is a Foreign Body herein referred to as an F.B) in the patient's airway/lung which eventually caused the demise of the patient. Further the complaint form and the complainant's statement include the following allegations; conducting the wrong procedure when the patient was in theatre; extracting the patient's teeth when the same was not due for extraction; misdiagnosing the patient with pneumonia when she was brought back for a further check and; failing to exercise proper skill and care required of a doctor. The KMP & DC letter dated 20th September 2022 invited the Dr. Wilson K. Aruasa the C.E.O MTRH, Professor Otsyula Khwa, Dr. Ondigo, Wanyonyi and Nshom for the hearing.

On 30th July 2021 MTRH responded to complainant's allegations through the Council and informed her that its health care services met and even exceeded the standard of care required of it. That at no time did any of its staff members have any ill intent or were negligent in any way. The executive summary by Dr. Philip Kirwa Senior Director Clinical Services dated 30th July 2021 highlighted all that was done for the late Annita. Which included not only the medical care but also a daylong meeting between MTRH management and the family members that was held on 25th May 2021. It was demonstrated that MTRH not only condoled with the family, but also offered it further emotional support through counselling and future meetings if they so desired. It further reiterated that there was no ill-will or intent to harm the patient from any of the care givers. That MTRH values its clients and will always strive to improve the outcomes and experience as it gives them the highest possible quality of healthcare in a friendly and conducive environment.

MTRH through Dr. Wilson K. Aruasa, MBS, EBS its C.E.O, filed a further statement dated 4th October 2022 in response to KMP & DC letter dated 21st July 2021. He reiterated that MTRH offered the late Anita Chepkorir the highest attainable health care services. That her caregivers included not only medical specialists in cardiothoracic surgery and paediatrics but also a renowned Professor in cardiothoracic surgery. The further statement also reiterated the previous statement including the meeting between MTRH & the family members and the words of the key members including the Anita's grandfather (minutes of the meeting where attached to the further statement). It also demonstrated that the patient passed on while playing with other children more than 2months after the surgery and that the post-mortem had established that the cause of death was asphyxia due to aspirated food particles (that is "immediate cause of death: food particles up to the terminal bronchi") and not due to airway obstruction by a Foreign Body (herein referred to as FB/s) in the right bronchus measuring about 0.5cm) as alleged by the complainant.

It was further explained that the child was playing with other children when she collapsed and died and that no cardiopulmonary resuscitation was done since the child was brought to MTRH when already dead and taken straight to mortuary. That, that size of the FB found on Post-mortem cannot obstruct even one bronchus, that air entry was not obstructed since the right bronchus as a diameter of 9 to 10 millimeters (0.9 to 1 Centimeter) according to the attached medical journal article (please see table 1 & 2 highlighted). That medically people are known to live with one lung. On examination in Chief and on whether a FB in a bronchus would cause fibrosis Professor Otsyula submitted that it does not. That there are reported incidences where FB's have been found in the bronchi ten (10) years later without any fibrosis. Which means a doctor can miss an FB in the bronchus. Therefore, missing an FB does not amount to misdiagnosis or failure to exercise proper skill and care required of a doctor. It was also explained that an FB seen on radiological investigations can be coughed out before patient is taken to theatre. Therefore, if it cannot be found on bronchoscopy and thoracotomy

26/10/22

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a reasonable cardiothoracic surgeon can conclude it was coughed out. That the patient was treated in Mediheal Hospital Eldoret on 5th March 2021 and on some other occasions but nothing was found wanting with the care offered at MTRH.

That despite the above facts, the further statement and the attached print out of the Weekly Citizen and twitter messages therein have amply demonstrated that Mercy Kiprono the complainant herein has been maligning MTRH and its employees as well as KMP & DC. It is much easier to find fault than to appreciate what has been done. It is also easy to be critical. That the complainant is clearly querulous, censorious and hypercritical, someone who finds fault in every body she interacts with or seeks services from. This is best demonstrated by her response on cross-examination. When she was asked whether MTRH had offered her any support after the death. She retorted that "I went to MTRH for treatment not to be counseled". On the other hand, MTRH, KMP & DC and their affected employees, including the doctors and medical specialist have remained magnanimous despite the caustic and vitriolic maligning and defamation. None has taken any legal action against Mercy.

It is MTRH humble submissions that it finds itself in this unenviable position of being accused of all manner of misdeeds not because of any fault committed by itself or it employees, but due the natural inclination of the complainant to find fault in everyone. Apparently the complainant is led by an ulterior motive. It cannot be ruled out that all her actions are geared towards monetary compensation out of this unfortunate incidence. Considering that medicine is not an exact science, it would unconscionable for the council to condemn health care institutions and their employees for missed diagnosis and failed treatments where it is demonstrated that all efforts were made to offer the highest standard of attainable health care. I therefore, urge the council to hold and find that, not all missed diagnosis are misdiagnosis, neither are all failed treatments medical negligence or failure to exercise proper skill and care required of a doctor.

It is also MTRH humble submissions that no wrong procedure was conducted on the patient while in theatre. That the extraction of the patient teeth during bronchoscopy or laryngoscopy was not intentional but occasioned by the loose milk teeth. This is known to occur as early as at the age of 4 years. Actually during the hearing, the complainant herself confirmed that the late Anita had already started shedding her milk teeth (her mother had removed two lower teeth) before she was admitted to MTRH. That all medical procedures/treatments have inherent risk of complication despite the degree of care provided. Therefore, the extraction of the patient's teeth during bronchoscopy or laryngoscopy did not amount to conducting the wrong procedure when the patient was in theatre. That the family of the complainant was availed with all this information and explanation during the family meeting with MTRH and they all accepted it only for the complainant to turn around and embark on her maligning campaign for monetary gain.

I refer to *Bolam v Friern Hospital Management Committee (1957) 2ALL E.R. 118 at 122* (The "Bolam test") for the proposition that "A doctor (health care professional) is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a **responsible body of medical men (in this caseKMP & DC and Mediheal Hospital where Anita was treated after discharge from MTRH)** skilled in that art". I will hasten to add that on further treatment a month before the demise of the patient at Mediheal Hospital Eldoret the medical specialists there did not find any fault

26/10/2022

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with what was done at MTRH. If there was any graring professional misconduct, malpractice or any breach of standard which had occurred at MTRH then it would have been noted and rectified.

It is MTRH humble further submission that no ill will has been demonstrated on it part or its employees, since extraction of loose teeth during bronchoscopy and laryngoscopy can reasonably occur and are documented to occur, the doctrine of "voleni non-fiti injuria" (voluntary assumption of the risk by the patient) applies.

It is MTRH humble submission that Anita was timeously diagnosed with FB bronchus and all the necessary medical experts involved in her treatment, also all necessary investigations were conducted and that at no time did it or its employees demonstrate ill motive or abdicate their duty of care. That MTRH exceeded the Standard of Care for management of Foreign Bodies in the Bronchus, which is to do Bronchoscopy. While in Anita case MTRH did more than that, it even did Bronchotomy therefore, all its healthcare staff went beyond the call of duty at every point they were managing her.

CONCLUSION

It is MTRH humble submissions that the cause of death has been ascertained by post-mortem report as asphyxia due to aspirated food particles more than 2 months from the date of surgery.

That MTRH made a timeous diagnosis and availed all resources including several medical specialists, investigations and best treatment options applied in managing Anita. That no professional misconduct, malpractice or breach of standard occurred at MTRH.

That the complainant is a person who finds fault in everyone she interacts with no matter how well they treat her.

Yours

26/10/2022.

Josphat Mutuma Kirima
In-house counsel and
Advocate for the Respondents

REPUBLIC OF KENYA

THE KENYA MEDICAL PRACTITIONERS AND DENTISTS COUNCIL

INQUIRY BY THE

DISCIPLINARY AND ETHICS COMMITTEE

(PURSUANT TO THE PROVISIONS OF THE MEDICAL PRACTITIONERS AND DENTISTS

ACT, CHAPTER 253 LAWS OF KENYA

DC CASE NO 43 OF 2021

MERCY JEPCHIRCHIR KIPRONO ON BEHALF OF
ANNITA JEPKORIR CHIRCHIR (DECEASED).....COMPLAINANT

AND

DR. ERNEST NSHOM.....1ST RESPONDENT
DR. ALFRED WANDEBA WANYONYI .....2ND RESPONDENT
PROF. BARASA OTSYULA KHWA.....3RD RESPONDENT
DR. STEPHEN ONDIGO.....4TH RESPONDENT
MOI TEACHING & REFERRAL HOSPITAL.....5TH RESPONDENT

RULING

A. INTRODUCTION

1. The Complaint leading to this inquiry was lodged before the Kenya Medical Practitioners and Dentists Council, hereinafter referred to as **"the Council"**, by **Mercy J. Kiprono** on behalf of The Late Annita Jepkorir, hereinafter referred to as **"the Complainant"** against **Dr Ernest Nshom** hereinafter referred to as **"Dr Nshom"** or **"1st Respondent"**, **Dr Alfred Wandeba Wanyonyi**, hereinafter referred to as **"Dr Wanyonyi"** or **"the 2nd Respondent"**,

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Prof. Barasa Otsyula Khwa hereinafter referred to as **"Prof. Otsyula"** or **"the 3rd Respondent"**, **Dr Stephen Ondigo** hereinafter referred to as **"Dr Ondigo"** or **"the 4th Respondent"** and **Moi Teaching & Referral Hospital** hereinafter referred to as **"the Hospital"** or **"MTRH"** or **"the 5th Respondent"**

2. The Complainant submitted to the Council a signed Application for Lodging Complaint dated 28th June 2021. She attached thereto a statement that gave the chronology of events leading to the complaint, a copy of an autopsy report drawn by Dr David Chumba dated 13th May 2021, a copy of a CT scan Chest Bronchogram report from the Respondent Institution dated 19th January 2021, a copy of CT scan report dated 11th February 2021, a copy of a discharge summary dated 10th January 2021, a copy of a discharge summary from the Respondent Institution dated 14th February 2021, a colour picture of a black seed placed on a white paper and yellow glove, picture of a hospital attendance card issued on 9th January 2021, and several pictures of the Deceased while in Hospital.

3. The Council served the Respondents with a copy of the complaint through a letter dated 21st July 2021 and requested for a comprehensive report addressing the allegations raised by the Complainant, certified, and paginated copy of the patient's file, statements from the medical personnel who managed the patient and any other documents that would assist in the investigations.

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4. In response thereto, the 5th Respondent through a letter by the Chief Executive Officer dated 30th July 2021, submitted to the Council an executive summary drawn by Dr Philip Kirwa, Senior Director, Clinical Services dated 30th July 2021, a statement by Prof. Otsyula dated 29th July 2021, a statement by Dr Wandeba dated 29th July 2021, a statement by Dr Ondigo dated 30th July 2021, a statement by Dr Mark Oloo dated 30th July 2021, a statement by Dr Ismail Mohamed dated 29th July 2021, a statement Dr Nshom dated 29th July 2021, a statement by Dr Victor Ouma, a copy of the autopsy report by Dr David Chumba dated 26th May 2021, and a copy of the patient's file.

5. The genesis of the complaint herein arises from the treatment and management of Annita Jepkorir Chirchir, hereinafter referred to as **"the Patient"** or **"the Deceased"** by the 1st to 4th Respondents and the 5th Respondent Institution. The Complainant in the Application for lodging a Complaint at Section E indicated the brief nature of the complaint as;

> ***"Medical negligence, patient's mismanagement, intimidation, and no follow up on second admission"***.

In the statement accompanying the application for lodging a complaint, on page 6, the Complainant enumerated the particulars of negligence as;

(i) *Failing to note the presence of a seed in the patient's airway;*

(ii) *Failing to conduct a proper bronchoscopy procedure;*

(iii) *Failing to properly interpret the results of the bronchoscopy;*

(iv) *Misdiagnosis of the patient's condition;*

(v) *Leaving a foreign object in the patient's airway/lung;*

(vi) *Conducting the wrong procedure when the patient was in theatre;*

(vii) *Extracting the patient's teeth when the same was not due for extraction;*

(viii) *Misinforming that the patient had swallowed a tooth when such was not the case;*

(ix) *Misdiagnosing the patient with pneumonia when she was brought back for further check;*

(x) *Failing to exercise proper skill and care required of the doctor; and*

(xi) *Failing to reveal the truth to the patient's parents.*

B. INQUIRY BY THE COMMITTEE

6. The Council referred the complaint to the Disciplinary and Ethics Committee, hereinafter referred to as **"the Committee"**, as **DC Case Number 43 of 2021**. Section 4A (1) (b) provides that the mandate of the Committee shall include:

(i) *Conducting inquiries into complaints submitted to it;*

(ii) *Regulating professional conduct;*

(iii) *Ensuring fitness to practice and operate;*

(iv) *Promoting mediation and arbitration between the parties; and*

(v) *At its own liberty, recording and adopting mediation agreements or compromise between parties, on the terms agreed.*

Section 20 of the Act further provides in subsection (1) that; *"Any person who is dissatisfied with the professional serviced offered or alleges a breach of standards by a registered or licensed person under this Act, may lodge a complaint in the prescribed manner to the Council".*

7. The Committee being cognisant of its mandate as provided in Section 4 A (1) (b) of the Act, considered the application for lodging a complaint and the documents submitted by the Complainant, documents submitted by the Respondent, the patient's files and all the documents before it and found that they were insufficient to make a determination. Consequently, the Committee recommended that the matter proceeds for hearing. The Council served the parties with a notice for mentions dated 7th September 2022. On 20th September 2022, mentions for directions were held at the Council offices wherein in the absence of the Respondents, the hearing was confirmed for 12th October 2022.

8. On 12th October 2022, the Committee held its sitting at the Kenya Medical Practitioners and Dentists Council offices, at Nairobi where the Complainant appeared in person, and was presented by learned Counsel Prof. Kiama Wangai. The Respondents were also present and were represented by Learned Counsel Mr Josphat Mutuma Kurima.

9. **Ms Mercy Jepchirchir Kiprono, ("Ms Mercy")** the Complainant was the first to testify before the Committee. She was led in her evidence by learned counsel Prof. Kiama Wangai. She stated that she is the mother to the Late Annita She adopted her signed statement as evidence in chief.

10. It was her evidence that she took her daughter to the hospital for treatment. She was six years old at the time she took her to MTRH as she had difficulty in breathing. She said that she had been choked by a sunflower seed that she could identify. She stated that they were referred to MTRH from Mediheal. They first went to Mediheal, but she began recovering and was discharged. However, within a short period before they left Mediheal, she experienced distress and they rushed her to MTRH.

11. She stated that they were advised to go to MTRH for Bronchoscopy. This was on 9th January 2021. At the Hospital, she was referred for surgery and booked for theatre the same night. At the theatre, she was received by Dr Ernest Nshom who informed her that they wanted to perform the procedure to check. When they left the theatre, she was informed that they did not see anything, and they remained admitted to the hospital. They stayed in the hospital until 19th January 2021 when a CT scan was done which revealed a ring-shaped foreign body in the right bronchus. Surgery was recommended and she was taken to theatre on 22nd January 2021. After the surgery, Dr Nshom informed them that they had found a tooth in the bronchus. Annita had already lost her lower incisor teeth. However, when she was brought back from theatre, she had two missing

upper incisor teeth. Dr Nshom informed her that they had removed the two upper incisor teeth after finding a tooth in the lungs. He also informed her that the white bandage had the tooth, that was removed from the right bronchus, while the blue bandage had the two teeth they assisted to remove since they were loose.

12. It was her evidence that while on the ward, she removed the bandage and found two teeth, one in the white and another in the blue bandage. She stated that Dr Nshom told her that they performed a thoracotomy because the bronchoscopy failed. The Deceased had a chest tube on the side where they had made an incision. She stated that she had consented for bronchoscopy and not the thoracotomy. On the ward, when they queried about the missing teeth, and after speaking to Dr Nshom, Dr Wanyonyi called her and her husband and directed them to a room at the nurses' station. He wanted to address the issue she had raised regarding the 3rd missing tooth which he claimed they removed in theatre. She claimed he was rude in addressing them and they apologized. She also claimed that he told them not to complain as their child was well. At the time the child was coughing like there was still a blockage.

13. Ms Mercy testified that they were advised to do another x-ray to check the status of the tube that had been inserted. Prof. Otsyula came to the ward, and she heard him telling the students that teeth were extracted, and one was removed from the lung. He also advised that they would be

discharged because the wound had dried. On 28th January, they were discharged on medication and advised to go for dressing of the wound. On 8th February, the Deceased began vomiting with a fever, so they returned to MTRH. On arrival, they were informed that her oxygen was low, she was nebulized and admitted to the ward. A CT scan was performed, and the diagnosis was pneumonia post-thoracotomy procedure was made. She was treated and they were discharged on 15th February.

14. On 6th March 2021, they took her back to the hospital for cough, vomiting, and fever. They also went back to MTRH on 16th April 2021 when she was treated at outpatient. On 22nd April, they went back to MTRH for a check-up, and they were given medicine at outpatient. On 10th May 2021, while playing, she coughed for a long and fainted. They rushed her to MTRH, and she was pronounced dead on arrival. On 13th May 2021, an autopsy was done by Dr David Chumba, and they found a seed in the right bronchus.

15. She testified that her complaint was that it was evident that the seed was the issue from the Deceased's description and the scan which revealed the same and yet they removed teeth. When they tried to get an explanation, they only met with students. They did not get an explanation from Dr Ondigo, Prof. Otsyula, or Dr Oloo.

16. On cross-examination by counsel for MTRH Mr Kurima, she confirmed that she consented to the procedures done on the 9th and 22nd of January 2021. She confirmed that she noticed the fresh upper tooth gaps after the

theatre. She also confirmed that there was a meeting held between MTRH and the family. She stated that she was not going to MTRH for any counselling.

17. **Dr Alfred Wandeba Wanyonyi**, the 1st Respondent, was the next person to testify before the Committee. He stated that he was registered in 2001, was currently undertaking a Fellowship in General Surgery (COSECSA) and was in his second year of residency. During the said case he was undertaking his rotation in the cardiothoracic surgery department. He adopted his statement dated 29th July 2021 as his evidence in chief.

18. Dr Wanyonyi testified that he first met Anita on 11th January 2021 during a major ward round. On a review, she had been admitted on 9th January 2021 to the cardiothoracic surgical unit with a cough and vomiting following a history of having inhaled a seed and choking on the same. She had undergone a bronchoscopy on the day of admission. During the ward round, a decision was made to conduct a gastrograffin study and virtual bronchoscopy to assess the child because she was drooling saliva to rule out an oesophageal fistula that might have occurred. Under the guidance of Dr Oloo, Dr Ismael(MO), and Dr Kibos (Resident in general surgery). On 13th January, the child was reported to have episodes of chocking and dyspnoea and a decision was made to follow up gastrograffin study which involved giving an oral contrast and taking an x-ray, to check if there is an abnormal connection with oesophagus and trachea. On the 14th the plan was to follow up on the gastrograffin study.

On 16th January 2021 the gastrograffin study was done and there was no such abnormal connection.

19. It was his testimony that his next interaction with the Patient was on 19th January 2021, during another major ward round under Prof. Otsyula, Dr Ondigo, Dr Oloo, and Dr Ismael. At that point, the decision was to conduct a CT bronchoscopy(3D reconstruction) because she still experienced difficulty in breathing. On 20th January 2021, the report of bronchoscopy was received, and it revealed a ring-like lesion in the right proximal bronchi, and a decision was made to undertake elective bronchoscopy with possible thoracotomy.

20. On 22nd January 2021, the Patient was taken to theatre. During bronchoscopy, two deciduous teeth came off, one was recovered and but the other was not. Intraoperatively, rigid bronchoscopy was done by Dr Ondigo as the main surgeon, but it was not possible to retrieve the foreign body and therefore necessitating a change to thoracotomy. A right thoracotomy was done during which he participated as the assistant surgeon. The main surgeon was Dr Ondigo, and the anaesthetist was Dr Nshom.

21. On cross-examination by Prof. Kiama, Counsel for the Complainant, he clarified that he first met the Deceased on 11th January 2021. The plan of management was to do bronchoscopy and gastrograffin, but his name doesn't appear on the records. In reference to the operation notes of 9th

January 2021, findings of which were confirmed, he stated that it is not indicated whether the foreign body was removed. They found a mucus plug which was removed.

22. It was his testimony that a review of the CT scan was done on 20th January and a decision for elective bronchoscopy with possible thoracotomy was made. He confirmed that the consent was for explorative bronchoscopy. He reiterated that the consent form indicates consenting for such further operations that may be found necessary intraoperatively. He stated that during the bronchoscopy, two upper incisors came out and one of the teeth was retrieved from the mouth and the other one could not be retrieved. The purpose of the thoracotomy was to completely check for the tooth that had not been retrieved which he opined because he was in surgery. He submitted that when they performed the thoracotomy, they palpated the lungs, felt a hard mass, and when they did the sharp dissection, they found a tooth.

23. On the issue of any family discussions, he confirmed that after the operation, he was called to explain the intra-operative findings which he clearly explained to the parents. He informed them that there was one tooth retrieved from the mouth and the other from the sharp dissection of the lung. He stated that when he gave them the explanation, it was not palatable to them, and it was one of the reasons for the unfair accusations. He stated that he could not make up a story of what they found in theatre.

24. About the post-mortem report dated 13th May 2021, he confirmed that it has the logo of the Hospital and that the pathologist was Dr David Chumba. Further, Dr Chumba concluded that the cause of death was asphyxia due to aspirated food-a foreign object in the right bronchus with multiple abscesses, and samples for histology were taken. He stated that he could not change the pathology report and that he noted the findings as indicated. On his opinion of the foreign body found at post-mortem, he stated that according to Hill's criteria on causality, there are several factors that need to be considered. One of them is timelines, events preceding an outcome. From the post-mortem, it is indicated that the child died due to asphyxia due to aspirated food. In terms of Hill's criteria, he could not directly link surgery and aspiration. He opined that the Deceased received standard care available at the hospital.

25. On cross-examination by Committee, about the episodes of difficulty in breathing, he stated that they did not have any associated or aggravating factors. The justification for the gastrograffin test was based on the child's presentation. The child was also reported to be drooling and based on the history of choking on a foreign body which was not retrieved in the first bronchoscopy. He confirmed that a tooth did not fit the description of a ring-enhancing lesion, but the thick mucus plug would appear like it. He confirmed they anticipated finding a foreign body. He also confirmed that the tooth which they removed was what the Patient had aspirated in theatre. He stated that the finding of a tooth did not mark the end of their

search. After sharp dissection, they palpated both sides of the lung and inflated the lungs, and they expanded well and there were no areas of collapse. He submitted that there was no step that they missed in trying to retrieve the foreign body. On the bronchoscope used, he submitted that they used a rigid bronchoscope.

26. On the question of when the CT scan was done and whether there was possibly another report before they went to theatre? He stated that the scan was done before they went to theatre. On whether the right bronchotomy was opened following the CT scan, he stated that a bronchotomy was not done and that they did rigid bronchoscopy. That the CT scan images don't correlate with the report.

27. Further cross-examination by the Committee, he indicated that the operation notes were written by him immediately after the operation. He confirmed that he was the assistant surgeon. He confirmed that his operation notes failed to indicate the issue of the missing teeth that came off during intubation which he mentioned in his statement. He further confirmed that he missed indicating the issue of the missing teeth in his operation notes. On when the teeth were lost, he stated that the teeth were lost during bronchoscopy which was being undertaken by Dr Ondigo. He explained that teeth can be lost during bronchoscopy(rigid) during either the initial introduction or during the manipulation of the bronchoscope. He confirmed that the operation notes do not make mention of where the foreign body was. He confirmed that he was called by the attending nurse

to explain to the relatives. He clarified that he first spoke to the Patient's mother and grandmother who told him to wait and appraise the father too, which he did. He stated that the rude Dr Wanyonyi whom the Complainant described was not him. He stated that he was not in any way rude and that his interactions with people are always cordial.

28. **Dr Stephen Ondigo,** the 4th Respondent was the next person before the Committee. He adopted his signed statement dated 30th July 2021 as his evidence in chief. He stated that he is a cardiothoracic surgeon working at MTRH. He has an MMed degree in Surgery and a Fellowship in Cardiothoracic surgery and had been doing cardiothoracic work for the last 11 years together with Prof. Otsyula. He stated that the Patient was admitted on 9th January 2021 with a history of choking on a flower seed. Had drooling of saliva, vomiting, and mild cough. At the time of admission, the symptoms had improved. An impression of foreign body oesophagus with a differential diagnosis of foreign body bronchus was made and the cardiothoracic team was consulted. He submitted that he first saw the patient on 11th January 2021 during a major ward round with Prof. Otsyula and Dr Oloo. The child was stable, but they requested for gastrograffin study to assess if the child could be having an oesophageal foreign body or tracheo-oesophageal fistula (TOF).

29. On cross-examination by Prof. Kiama, Dr Ondigo confirmed that he was involved in the management of the patient while she was in the ward. He clarified that he is the one who indicated to the mother that they would

perform the bronchotomy with the possibility of thoracotomy but that the consent was signed by Dr Ismael.

30. On cross-examination by the Committee, he clarified that intraoperatively, they still looked for the foreign body by palpating the lung. They looked for the seed intraoperatively, but they did not locate it. They did a CT Bronchogram to give an indication and better level of accuracy at 67% of where the foreign body might have been. After they could not retrieve the seed, they had to monitor the patient and then subsequently repeat the CT scan. On why they did a bronchogram the first time and a normal CT scan the 2nd time, he stated that he was not involved in the decision to conduct the normal CT scan the second time in February but that the bronchogram is ideally more accurate. He stated that they advised the parents to go back to the hospital in case of any incidences. Further, at the time of her demise, the child was not in their custody.

31. On the post-mortem finding of a seed. He stated that he could not explain the same. He confirmed that they did an audit of the case. It was his evidence that at the time of discharge, the Patient was stable. When she was readmitted to the medical ward, a CT scan found pneumonia.

32. On further cross-examination by the Committee, Dr Ondigo stated that at the two-week follow-up after discharge from the surgical ward, the Patient did not present with any symptoms.

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33. On the CT scan findings, he stated that he was informed by radiology that they saw a ring-like structure that was radiolucent in the right main bronchus. During the thoracotomy, they opened the right main bronchus as per the said CT scan. He confirmed that at Post-mortem the foreign body was found in the right bronchus. He submitted that literature postulates that 30% of foreign bodies can be ejected even without surgery.

34. Dr Ondigo confirmed that he was the team leader in the 2nd operation. On the contents of the operation notes, he confirmed that there was no mention of the teeth dislodgement. He stated that the teeth dislodged during bronchoscopy. He confirmed that during the procedure he did not remove the bronchoscope. He also confirmed that one tooth was found in the oral cavity, but he did not find the other tooth and he did not see the tooth while pushing in the bronchoscope. He stated that at the time they did not have tubes for lung isolation. He admitted that there was a possibility of having pushed the tooth with the bronchoscope or ET tube. He further stated that on using forceps he did not find any foreign body and on palpation, they did not feel any foreign body.

35. On whether a meeting was held at the hospital, he confirmed that the family meeting took about 10 hours because of arguments on whether the foreign body was removed or not.

36. On re-examination, he stated that when doing a major ward round and they would have explained to the parent what needs to be done, consent can be taken by any other doctor and not necessarily the consultant. On

the standard for removal of a foreign body, he stated thoracotomy is standard to be performed once an expected foreign body was not retrieved through bronchoscopy. On the findings at post-mortem, he stated that food particles were found in the airway and that is what the child had aspirated. Further, the foreign body was not the immediate cause of death.

37. **Prof. Barasa Otsyula Khwa,** the 3rd Respondent was the next person before the Committee. He adopted his statement dated of 29th July 2021 as his evidence in chief. It was his evidence that he saw the Patient three times. On all occasions, it was during the major ward round. He stated that on 11th January 2021, it was reported that the child had developed drooling of saliva, vomiting, and mild cough after choking on a flower seed on 9th January 2021. At bronchoscopy that evening, a mucus plug was found. The plug was suctioned out. At the review on 11th January, the child was reported to have had episodes of cough since the bronchoscopy. During the major ward round, he requested for a virtual bronchoscopy and gastrograffin swallow. On 18th January 2021, the child had no complaint. The gastrograffin swallow had been done and it was normal. They decided to wait for the virtual bronchoscopy.

38. It was his further statement that the virtual bronchoscopy done on 19th January 2021 was reported to show a "*right ring-like foreign body in the right main bronchus*". The child had a repeat bronchoscopy and right thoracotomy on 22nd January 2021. An incisor tooth was found and removed. On 25th January 2021, the chest tube, which was in place, was not

bubbling or draining and they decided to remove the tube and continue with physiotherapy.

39. Prof. Otsyula stated that he did not see the child again. He was not aware that the child had been admitted to the paediatric ward and he did not see the second CT scan. He learned of the demise of the child sometime in May 2021 after the family complained.

40. On cross-examination by Prof. Kiama, he stated that the doctors who operated stated that they found a tooth and no other foreign body was retrieved. He confirmed that the circumstances of the two teeth were brought to his attention and that they came out during bronchoscopy. On his opinion on the foreign body being found on the post-mortem, he stated that he did not dispute the finding at the post-mortem however, due diligence was done, and the child was well managed by the department.

41. On cross-examination by the Committee, he stated that when the Patient was readmitted, she should have been sent to the cardiothoracic surgical unit and they would have assessed her differently.

42. On re-examination, he stated that the cause of death as per post-mortem was not in doubt, the immediate cause of death was asphyxia due to aspirated food particles.

43. **Dr Ernest Nshom**, the 1st Respondent was the next person before the Committee. He stated that he qualified as a medical practitioner in 2013, and presently is a Resident in Anaesthesia and Critical Care at MTRH. He adopted his statement dated 29th July 2021 as his evidence in chief. It was his evidence that he was part of the management of the Deceased as part of the anaesthesia team in both procedures. He stated that on 9th January 2021 the main anaesthesia provider was a Clinical Officer anaesthetist who was leading the team but there was an anaesthesiologist on call.

44. During the 2nd procedure, the team leader was an anaesthesiologist assisted by a Clinical Officer anaesthetist and he was assisting. In response to the complaint against him for instructing the team, he stated that he was not in a position to instruct the team considering his role. Regarding the accusation of interaction with the mother after the procedure, he stated that he met the Complainant before the procedure and later at the entrance to the children's hospital when she enquired about what transpired intra-operatively (in an informal setup), he informed her of what he saw. He told her that they retrieved one tooth from thoracotomy.

45. On cross-examination by Prof. Kiama, he confirmed that at the theatre receiving area on 9th January 2021, the Complainant showed him the sample of the seed that the Deceased had indicated had swallowed. Further, after theatre, he denied that he told her that the seed she showed him was not what they found. Dr Nshom clarified that he only informed the Complainant of two teeth and denied telling her about three teeth in the

bandages. He stated that the lead anaesthesiologist was Dr Kimani Mbugua. He confirmed that he was present in both procedures. He also confirmed that his name was missing from the operation notes because the surgeon only indicate qualified practitioners. He stated that the role he played was that of a student assisting the lead anaesthesiologists.

46. **Dr Phillip Kirwa, ("Dr Kirwa")** the Senior Director, Clinical Services at MTRH, was the next person before the Committee. He adopted the executive case summary dated 30th July 2021 as his evidence in chief.

47. On cross-examination by Counsel for the Complainant, he confirmed that the Complainant expressed that the child was not managed well. He stated that they held a meeting with the family and the mother was very emotional. He stated that they offered the Complainant counselling because she was distressed and for emotional support. He confirmed that Dr Chumba works at MTRH, and his qualifications are known and acknowledged.

48. The last person to appear before the Committee was Dr Wilson Aruasa, **("Dr Aruasa")** the Chief Executive Officer of MTRH. Dr Aruasa submitted on behalf of the hospital. he adopted his statement of 4th October 2022 as his evidence in chief. It was his testimony that when the complaint was filed, he forwarded all the documents requested to the Council. He submitted that the hospital has invested heavily in the cardio-thoracic surgical unit; where they have an adult and paediatric ward, three well-trained surgeons and

equipment. They have several COSESCA trainees who get good training. That they hold clinical and mortality audits to improve the quality of care. In terms of the filing system, they have a robust system currently having an electronic system acting parallel to their existing manual system. They also started to migrate to fully electronic health records. Every patient has one file only which is easily retrievable. The same file used in the surgical ward would equally be used in the medical ward.

49. It was his testimony that they held a meeting with the family from 10 am to 4 pm, to go through the steps of management through all admissions. The meeting was partly chaired by Dr Kirwa and then by himself. In the meeting, there was some progress and a lot of back and forth. He stated that the Patient was taken to the funeral home on the day of the demise therefore they did not perform resuscitation. The food particles seen at post-mortem indicate that the cause of death was asphyxia due to aspirated food particles. It was his submission that the hospital provided the best care to the child. It was his further submission that while the case was lawfully before the Council, it was continually prosecuted on social media.

50. On cross-examination, he confirmed that Dr Wanyonyi was issued with a warning letter and the family was informed.

C. ISSUES FOR DETERMINATION

51. Upon careful evaluation and lengthy deliberation of the matter, the Committee notes that the substantive issue for determination are as hereunder: -

(i) Whether the Respondents owed the patient a duty of care and what is the expected standard of care;

(ii) Whether the 5th Respondent can be held liable for the acts or omissions of its servants/agents; and

(iii) Whether the 1st- 4th Respondents and 5th Respondent through its servants/agents were negligent in the treatment and management of the Patient.

D. FINDINGS

52. The Committee carefully considered the complaint as lodged before the Council, the statements and documents submitted by the parties herein to enable it to determine the matter fairly and judiciously. On careful evaluation and lengthy deliberation of the matter, the Committee notes that the complaint hinges on the treatment and management of the Deceased at the 5th Respondent Hospital.

53. The first issue for determination is whether the Respondents owed the patient a duty of care, and what is the expected standard. The Committee notes that duty of care is a legal obligation imposed on individuals or persons, requiring adherence to a standard of care while performing any acts that could foreseeably harm others. This means that hospitals and practitioners

shall be held to a particular standard when it comes to treating and managing patients who will fall under their care.

54. In the case of **Richard Njoki Wahome (suing as the administrator of the Estate of Wahome Mutahi (deceased) –vs- Attorney General & 2 others (2015) eKLR,** where the Court relied on the case of **Jimmy Paul Semenye -vs- Aga Khan Hospital & 2 others (2006) eKLR,** it was stated that;

> ***"There exists a duty of care between the patient and the doctor, hospital or health provider".***

55. On the expected standard, it can be stated that the standard will not be of an ordinary man but shall be a standard of the peers. Thus, a reasonable man can is substituted with "reasonable professional". **McNair J** in **Bolam vs Friern Hospital Management (1957) 2 All E.R,** explained the law on the test of professional negligence as;

> ***"but where you get a situation which involves the use of some special skill or competence, then the test whether there has been negligence or not is not the test if a man on the Chapman omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill at the risk of being found negligent.... It is sufficient is he exercises the ordinary skill of an ordinary competent man exercising that particular art."***

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The Committee considered the case of **Nevill and Another -vs- Cooper and Another (1958) EA 594** it was held that;

> ***"if he professes an art, he must be reasonably skilled at it. He must also be careful but the standard of care which the law requires is not an insurance against accidental slips. It is such a degree of care as a normally skilful member of the profession may reasonably be expected to exercise in the actual circumstances that may present themselves for urgent attention...."***

It is judicious to emphasize that the standard of care in medicine is that which is already laid out in established international, regional, and country standards and guidelines, books, and peer-reviewed scientific journals.

56. In **Herman Nyangala Tsuma vs- The Nairobi Hospital and 2 others**, Odunga J stated that;

> ***"it is accepted in the medical profession that there is no objective test for determining the negligence of a doctor. Whereas doctors are supposed to operate within certain known parameters of the diagnosis the profession is not straight-jacketed to the extent that all doctors must respond in exactly the same way when confronted with a set of circumstances. As long as the doctor does not go outside the well-known medical procedures, it is accepted that there may be variation in approaches to particular cases".***

Consequently, in determining whether the duty has been discharged by not only a doctor but by a health care professional, regard must be given to whether the professional observed or followed universally accepted standards, guidelines, and protocols.

57. Having established that indeed a duty of care was owed to the Patient, and the expected standard of care, the question then becomes whether the 5th Respondent can be held liable for the acts or omissions of its servants/agents. The courts have pronounced themselves in this regard. The Committee considered **Hellen Kiramana –vs- PCEA Kikuyu Hospital Nairobi HCCC No. 54 of 2013**, where the Court quoted and relied on the case of **M (A Minor) vs- Amulega & Another (2001) KLR 420**, where it was held that;

> ***"Authorities who own a hospital are in law under the safe-same duty as the humblest of doctors. Whenever they accept a patient for treatment, they must use reasonable care and skill to cure him of his ailment. The hospital authorities cannot of course do it by themselves. They must do it by the staff whom they employ and if the staff is negligent in giving the treatment, they are just as liable for the negligence as is anyone else who employs others to do duties for him...it is established that those conducting a hospital are under a direct duty of care to those admitted as patients at the hospital. They are liable for the negligent acts of the member of staff, which constitutes a breach of that duty of care owed by him to the patient thus there has been acceptance from the courts that hospital***

authorities are in fact liable for the breach of duty by members of its staff. It is trite law that a medical practitioner owes a duty of care to his patients to take all due care, caution, and diligence in the treatment."

58. In the instant case, the Committee guided by the above precedents holds that a hospital is responsible for all those in whose charge the patient is placed, and the Respondent can be held liable for the acts of its servants/agents.

59. The Committee considered the final issue for determination, whether the 1st-4th Respondents and 5th Respondent through its servants/agents were negligent in the treatment and management of the Patient. Black's Law Dictionary 9th Edition defines negligence as;

"a failure to exercise the standard of care that a reasonably prudent person would have exercised in a similar situation: Any conduct that falls below the legal standard established to protect others against unreasonable risk of harm, except for conduct that is intentionally, wantonly, or willfully disregardful of other rights. The term denotes culpable carelessness".

60. The Court in the case of **Hellen Kiramana –vs- PCEA Kikuyu Hospital Nairobi HCCC No. 54 of 2013**, quoted the case of **Dr Laxman Balkrishna Joshi V. Trimbark Babu God Bole and another; AIR 1969 SC 128 and A.S Mittal V state of U.P; AIR 1989 SC 1570**, where it was held that when a doctor is consulted by a patient, the doctor owes to his patient certain duties which are (a) duty

of care in deciding whether to undertake the case(b) duty of care in deciding what treatment to give, and (c) duty of care in the administration of that treatment. A breach of any of the above duties may give a cause of action for negligence and a patient may on that basis recover damages from his doctor. In this case, the Supreme Court of India observed, inter alia, that negligence has many manifestations.

61. When a patient generally approaches a doctor or a hospital, his or her expectations are twofold; that the doctor and the hospital will provide medical treatment with all the knowledge and skill at their command, and secondly, that they will not do anything to harm the patient in any manner either because of their negligence, carelessness, or reckless attitude of their staff.

62. The Committee considered the treatment and management of the Deceased and notes that the Late Anita Jepkorir six years of age presented at MTRH on 9th January 2021 with a history of having aspirated a seed. Upon evaluation, Dr Oloo a Thoracic and Cardiovascular surgeon was consulted. He reviewed the child and on finding her relatively stable, discharged her with advice to return in case of any problems. She returned later in the evening of the same day with complaints of difficulty in breathing. A decision was made to perform a bronchoscopy, although they entertained the possibility of the seed being in the oesophagus. The Patient was prepared and taken to theatre. During bronchoscopy, a mucus plug was

found and suctioned out. This was at the time considered to be the cause of the obstructive symptoms.

63. The child was returned to the ward where she continued to develop paroxysmal episodes of breathing difficulties. Based on this and upon review in the major ward round, a decision was made to conduct a CT Bronchogram, it demonstrated a ring-like foreign body in the proximal right main bronchus. On the strength of this finding, the Patient was scheduled for a repeat bronchoscopy.

64. The Committee notes that there is no evidence that consent was sought for thoracotomy, however, this finding notwithstanding, it was in the best interest of the Patient to perfume the thoracotomy where bronchoscopy is unsuccessful. The Committee finds that two incisor teeth were dislodged at the second bronchoscopy. One was retrieved from the oral cavity, and the other could not be accounted for. Having failed to locate the second tooth, Dr Ondigo introduced the bronchoscopy, and he visualized the foreign body. He, however, did not give details of the same. At that point, a decision was made to perform a right-sided thoracotomy and through it and after palpation of the lung for the foreign body, they removed a tooth through sharp dissection. Their effort to locate the foreign body by palpation was futile and they, therefore, closed the chest and sent the Patient back to the ward. Notably, during cross-examination by the Committee, Dr Wanyonyi stated that they closed the lung with Vicryl® suture. In the ward, the Patient

improved and was discharged to be followed up in the surgical outpatient clinic.

65. The Committee finds that at the second bronchoscopy, the misplaced incisor tooth was a red herring, and Dr Ondigo should have revisited the CT scan results before the incisor tooth dislodged. It is not possible to remove, an incisor tooth lost at bronchoscopy a few minutes earlier and claim it is the foreign body seen on the CT scan taken much earlier.

66. The Committee notes that after discharge the Patient was seen at both MTRH and Mediheal during which there was continued evidence of a retained foreign body and was finally admitted to the MTRH paediatrics ward with a pneumonic process. The Committee finds that there is no evidence that during this admission, the cardiothoracic team was consulted or involved in the management of the Patient. The Committee opines that had the cardiothoracic team been consulted, with her history and symptoms of a retained foreign body in the airway, the course of management would have changed, including consideration of a repeat CT bronchogram rather than a plain CT scan of the chest that only picked a pneumonic process and missed the seed that was eventually found at post-mortem examination. This further highlights the failures of internal consultation within the hospital given such a complicated case that needed close follow-up and lack of proper documentation on instructions given to the patient both within clinical continuation notes and on the discharge summary. If such instructions were clear on the discharge

summary, a copy of the same usually in the patient's file, the caregivers in the paediatric ward would have come across the information and consulted the thoracic surgical unit.

67. The Committee also finds that the failure to remove the foreign body "*black seed*", led to the accumulation of fluid distally. Sepsis set in leading to pneumonia and followed by septicaemia leading to the pus in the other organs found at post-mortem. The foreign body in question was missed at the first bronchoscopy as well as at the second bronchoscopy/thoracotomy. There was clinical evidence indicating the presence of a foreign body. Further, at thoracotomy, the clinical evidence was not interrogated critically. This error led to the removal of a tooth rather than both the tooth and the foreign body.

68. The Committee also considered the submissions made by the Complainant and the Respondents on the post-operative briefings in particular after the second procedure. The Committee notes that from the evidence, the briefings were done by Dr Nshom and Dr Wanyonyi, who were not the lead surgeon nor anaesthesiologist. It is good medical practice that the surgeon should conduct the post-operative briefing of either the patient or the guardian. Consequently, Dr Ondigo as the lead surgeon at the bronchoscopy and thoracotomy should have briefed the Patient's guardians of the findings intraoperatively, including the circumstances under which the teeth were dislodged and the management thereafter.

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69. The Committee also considered the complaint made against Dr Wanyonyi on his conduct towards the Complainant. The Committee notes that from the submissions made by Dr Aruasa, Dr Wanyonyi was issued with a written warning letter, which action the Committee finds sufficient.

E. DETERMINATION

70. Given the above findings, the Committee holds that the complaint lodged by the complainant against the 4th and 5th Respondents has merit. The Committee presented its findings, as set out herein above, and its recommendations to the Kenya Medical Practitioners and Dentists Council in its meeting held in December 2022 wherein the decision of the Committee was upheld. Consequently, the Committee hereby issues the following orders;

(i) The complaint of negligence made against Dr Ernest Nshom, Dr Alfred Wanyonyi and Prof. Barasa Otsyula Khwa be and is hereby dismissed.

(ii) Dr Stephen Ondigo and MTRH be and are hereby directed to mediate with the Estate of the Late Anita Jepkorir jointly and severally with a view of making restitution and thereafter inform the Council within Ninety (90) days from the date hereof.

(iii) Dr Stephen Ondigo be and is hereby directed to pay a fine of Kenya shillings Two Hundred Thousand (KSh. 200,00/-) within fourteen (14) days from the date hereof.

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(iv) Moi Teaching and Referral Hospital be and is hereby directed to pay a fine of Kenya Shillings Three Hundred and Fifty Thousand Shillings (KSh. 350,000/-) within fourteen days (14) from the date hereof.

(v) In the event of non-compliance with orders (ii), (iii) and (iv) above, the Council shall be at liberty to issue any such further orders as it deems fit.

Dated at Nairobi this 5th day of MAY, 2023

KENYA MEDICAL PRACTITIONERS AND DENTISTS COUNCIL
05 MAY 2023
P O Box 44839, NAIROBI

DR. TIMOTHY THEURI
CHAIR
DISCIPLINARY AND ETHICS COMMITTEE

TARIGO KIPTOO & COMPANY ADVOCATES

COMMISSIONERS FOR OATHS, & NOTARY PUBLIC

TARIGO KIPTOO
L.LB (HONS) MOI UNI.
PDG- DIP -IN- LAW K.S.L

HUGHES BUILDING, 2ND FLOOR,
UGANDA ROAD,
P.O BOX 10335-30100,
ELDORET.
CELL NO. 0729347354/0791928048
EMAIL: Tarigoadvocates@gmail.com

Our Ref: TK/MK/013/23 Your Ref: DATE: 2ND JUNE, 2023

THE CHIEF EXECUTIVE OFFICER,
MOI TEACHING AND REFERRAL HOSPITAL,
P.O BOX 3-30100,
ELDORET.
EMAIL: ceo@mtrh.go.ke

DR. STEPHEN ONDIGO,
P.O BOX 3-30100,
ELDORET.
EMAIL: stephenondigo@yahoo.com
TEL NO: 0722472319

Dear Sirs,

RE: KMPDC DC NO. 43 OF 2021
MERCY KIPRONO -VS- DR. ERNEST NSHOM & 4 OTHERS

The above matter refers,

We have been instructed by Mercy Kiprono now referred to as our client to address you as we shall do hereunder as follows;-

That our client has instituted medical negligence proceedings against the following;

1. Dr. Ernest Nshom
2. Dr. Alfred Wandeba Wanyonyi
3. Prof. Barasa Otsyula Khwa
4. Dr. Stephen Ondigo
5. Moi Teaching & Referral Hospital

The matter proceeding to full hearing and subsequently the Kenya Medical Practitioners & Dentist Council rendered its Ruling on 5th May, 2023. Dr. Stephen Ondigo and the Hospital were found to be guilty as charged and the Council proceeded to issue several ultimatums which must be complied with forthwith, and failure to do so the council is at liberty to issue any further orders that is deemed fit.

TARIGO DANIEL KIPTOO ADVOCATE

32

It is in this regards that we are writing to inform you about our client's position regarding the Ruling delivered by KMPDC on 5th May, 2023 as follows;-

a) The Advocates on record for the Complaint in this matter going forward is;-

M/S TARIGO KIPTOO & CO.
ADVOCATES,
HUGHES BUILDING, 2ND FLOOR, RM 31,
ALONG UGANDA RD, OPPOSITE NATIONAL LIBRARY,
P.O BOX 10335-30100,
ELDORET.
Email: Tarigoadvocates@gmail.com
Tel No: 0729347354/0791928048

NB:// All communication must be channeled through the said firm, at all times.

b) We are ready to comply with order no. (II) of the Ruling delivered by the Council on 5th May, 2023

c) The mediation can only happen in a neutral ground that shall be agreed upon by parties.

d) The parties can agree on a neutral mediator if need be.

We are looking forward to hear from you within the **next 7 (Seven) days**, in regards to the issues raised herein above, failure to do so, shall be treated as lack of interest in complying with the Ruling of the Council, and we shall explore other available avenues, and ensure our client and her family get the justice she deserves.

Yours Sincerely,

TARIGO DANIEL KIPTOO
ADVOCATE
P.O Box 10335-30100, ELDORET

M/S TARIGO KIPTOO & CO. ADVOCATES

Cc.

1. Client,
   Mercy Kiprono,
   P.O Box 9266-30100,
   ELDORET.

2. The Chair/CEO,
   Disciplinary & Ethics Committee,
   Kenya Medical Practitioners & Dentist Council,
   P.O Box 44839-00100,
   NAIROBI.
   Email: ceo@kmpdc.go.ke info@kenyamedicalboard.org

Nairobi Centre for International Arbitration

DIS/MED/02/23

26th July 2023

Dr. Wilson K. Aruasa, MBS, EBS
Chief Executive Officer
Moi Teaching and Referral Hospital
Nandi Road, Uasin Gishu County
P.O Box 3-30100
ELDORET

RE: REQUEST FOR MEDIATION
DISPUTE BETWEEN THE ESTATE OF THE LATE ANITA JEPKORIR, DR. STEPHEN ONDIGO AND MOI TEACHING AND REFERRAL HOSPITAL

We make reference to your request for appointment of a Mediator in the above captioned dispute vide the email of 24th July 2023.

We note the contents of the Ruling dated 5th May 2023 in DC Case No. 43 of 2021 in which the Committee directed Dr. Stephen Ondigo and MTRH to mediate with the estate of the Late Anita Jepkorir and inform the Council within Ninety (90) days from the date thereof. We also note that we received the Request when part of the period provided in the Ruling has passed.

To enable us process your request expeditiously, we request that you obtain the other party's written consent to the Centre being the appointing body and to the adoption of the NCIA's Mediation Rules (2015) (Revised 2022) as the rules of procedure. The Rules are available on our website www.ncia.or.ke

We also request that you remit a non-refundable Registration Fee of Kshs 5,000 which is payable at the time of filing the Request. Our Bank Details are as follows:

Bank Name:	Kenya Commercial Bank
Account name:	Nairobi Centre for International Arbitration
Branch name:	KICC Branch,
Swift Code:	KCBLKENX
Account No (KES):	1229086544

Thereafter, we will proceed with the appointment of a Mediator to mediate between the Parties as directed by the Committee. In the meantime and awaiting the payment we are proceeding to identify a suitable mediator for the dispute.

L. Muiruri Ngugi
REGISTRAR/CEO

Nairobi Centre for International Arbitration

Copy to: Mr. Josphat Mutuma Kirima
Principal Legal Officer
Moi Teaching & Referral Hospital
ELDORET

Mr. Daniel Tarigo
Advocate, Family of the late Anita Jepkorir

o, Wilson, CEO, me, legal, Philip, josphatkirima, Chief, registra, Joy, wamaithak93, Stephen, Director, Senior, awrence, victoria.kigen

afternoon Mr Kirima,
a also noted your concerns.You are very much aware that I wasn't aware of what was going concerning NCIA since id my previous lawyer decided to copy all parties and lock me out .I confirmed that after making a call to NCIA an epeatedly begged Mr Tarigo to forward all the emails.I realized that I was the only one who had not been copied.?

ile choosing mediator,who is suppose to do it?is it you,it is MTRH,is it me or both of us?
en you were choosing or whoever choose the mediator, did you consider me in terms of distance, finance and arency?
are very much aware that it's you who has made us to be here.
s I lost Annita.Why all this circles.?to frustrate justice or what?
ed justice is denied justice.

on Aruasa 16 Aug 2023, 13:45

phat, mercy, info, CEO, me, legal, Philip, josphatkirima, Chief, registra, Joy, wamaithak93, Stephen, Director, r, Lawrence, victoria.kigen

a,

e this. It seems your active e-mail is not copied.

on't we use one e-mail trail/thread for all these?

om my iPhone

16 Aug 2023, at 1:39 PM, mercy jepchirchir <chirimercy80@gmail.com> wrote:

hat Mutuma Kirima <josphatkirima@mtrh.go.ke> 16 Aug 2023, 18:36

son, mercy, josphat, info, CEO, legal, Philip, josphatkirima, Chief, registra, Joy, wamaithak93, Stephen, Director, r, Lawrence, victoria.kigen

vening C.E.O.
g forward I am not going to respond to Mercy in any other forum except the mediation email thread. I have informe he said email where Joy, the in charge of case management at NCIA, Gladys the mediator, Mercy herself and her te Catherine Akweyu are copied. Let us raise all her issues through the mediator henceforth.
all due respect to Mercy I answered all those questions in your above email over the phone. I don't see any need to them here again.
re interested in mediation let us mediate. If you are not interested, that is still fine. Why should you keep shifting liscussions from one forum to another, if you are ready to mediate? It is high time this discussion shifted to the future remain stuck in the past. If you are not comfortable with anything you can address it during the first meeting. It is be virtual so you can do it from your own house. There is no distance involved. But remember the charges are d on time spent in mediation. The more time spent the more the pay. Finally both parties will pay the mediation cost

s.
nat Mutuma Kirima,
f Dispute Settlement Services,
Public & Commissioner for Oaths,
ocate of High Court of Kenya,
al Legal Officer,
ncipal Clinical Officer Anaesthetist,
Teaching & Referral Hospital,
TH BUILDING RM 202/214.

i ry 16 Aug 2023, 18:36
stem

ssage blocked Your message to registra@ncia.or.ke has been blocked. See technical details below for more
nation. The response from the remote server was:

on Aruasa 16 Aug 2023, 18:43

mercy, josphat, info, CEO, legal, Philip, josphatkirima, Chief, registra, Joy, GLADYS, Stephen, Director, r, Lawrence, Victoria, me

it's OK Kirima. The mediation process must move forward to a conclusion ASAP.

LAIMER: All the information contained in this email message is strictly confidential and may be legally ged. Such information is intended exclusively for the use of the designated recipient(s). Any disclosure, ng or distribution of all or part of the information contained herein or other use of or the taking of any in reliance upon this information by third parties is prohibited and may be unlawful. If you have received mail message in error please delete it immediately and notify the hospital through email at nager@mtrh.go.ke

hat Mutuma Kirima <josphatkirima@mtrh.go.ke> 16 Aug 2023, 19:40

josphat, Wilson, mercy, info, CEO, legal, Philip, josphatkirima, Chief, registra, Joy, GLADYS, Stephen, Director, r, Lawrence, Victoria

nk you C.E.O

Delivery Subsystem <mailer-daemon@googlemail.com> 16 Aug 2023, 19:40

me

87

[redacted]

:sation opened. 5 messages. All messages read.

› to content
Moi Teaching and Referral Hospital Mail with screen readers

›f ?,186

ubject)

:rnal

jepchirchir 16 Aug 2023, 23:22

...o, legal, CEO, Philip, Wilson, me, josphatkirima, CEOs, Admin, Joy

CEO.
› telling your advocate to call me and my family. Be informed 90 days are over.
ave chosen mediator go a head.

38

16 Aug 2023, 23:32

e needs to call you for anything else other than mediation. And if you want the mediation to collapse so that the heads to the High Court, that's fi

..son Aruasa 16 Aug 2023, 23:34

cy, info, legal, CEO, Philip, me, josphatkirima, CEOs, Admin, Joy, josphat

one needs to call you for anything else other than mediation. And if you want the mediation to collapse so that the heads to the High Court, that's fine. In fact, and I'm sure of this,everyone fears talking with you as you intimidate eaten all who ever deal with you. Anyone who attempted to help you rued the day they did so, you're just so icult to deal with!

can't send anyone to talk with you and get threatened in the process. We only were interested in the mediation s which you have so demonstrated you're not interested at all.

n't fear you and you can not threaten me or MTRH. Learn that tonight.

I may just ask you, why are you jamming our e-mail inboxes with new e-mails all over the place? This habit has g p forthwith.

om my iPhone

phat Mutuma kirima 17 Aug 2023, 12:37

cy, Wilson, Philip, me, josphatkirima@gmail.com

following everything keenly but silently sir.
can say is that, the earlier Mercy starts listening to advice (including that of her advocates) etter. Unfortunately that may happen too late. I notice she is not willing to respond on the ition thread, neither is she willing to disclose the name of her advocate. You told her if she ncomfortable with the mediator appointed by NCIA by consent of both parties earlier on, she ropose another one from the NCIA pool of mediators. She didn't respond to that. On venue osts (despite the fact that she took the issue to KMPDC in Nairobi (near Forces memorial tal) further that NCIA (that is in Cooperative House) next to Eldoret Matatu stage in Nairob rmed that the initial meetings will be virtual and she can attend them from her own house nimal cost. Again she conveniently forgot that. She keeps saying we have not been given time by KMPDC yet she is not ready to appear before the mediator where parties can agre for extension. MTRH cannot ask for extension alone. She seems to erroneously believe an imaginary calamity will befall MTRH since the said 90 days have lapsed. I advised her to at Section 20(9) of the Medical Practitioners and Dentist Act. If she read it, she would know f mediation fails we are heading to the high Court. If everything else fails that is the final uination. But it is her decision to make not ours.

rds

89

Iessage blocked

our message to **registra@ncia.or.ke** has been blocked. See technical details below for more information.

2,186

o subject)

al

y jepchirchir 17 Aug 2023, 09:24

, legal, CEO, Director, Senior, Wilson, Philip, Stephen, wamaithak93, victoria.kigen, Joy, Josphat, josphatkirima, , Admin

CEO

structed Mr Kirima to call us for meditation yet the time for the same was over. KMPDC had not added more time

ot feared by any body.Those are your own thinking and words.My be you fear the Truth.You are fearing the TRUT That is why you have tried all kinds of intimidations to sabotage the justice of ANITA.You sent Dr Ondigo to the perform Kallenjin traditional apologies.....sent him again to my home in Eldoret with a Memorandum of anding from advocate Orina .... you sent people to my family to warn me not to go for hearing..... You sent a, Eunice Muriithi kmpdc to intimidate me .I repeat no body fear me it's you who fears the TRUTH. ave been warning me over high court.If you know you clean why worry a bout high court? Why do we have high t who has said I am going to high court.

n Aruasa 17 Aug 2023, 09:51

cy, info, legal, CEO, Director, Senior, Philip, Stephen, wamaithak93, victoria.kigen, Joy, Josphat, josphatkirima, dmin

ot engage you anymore. You can continue saying we sent so and so to you or anywhere else. Lies and paranoia

..t from my iPhone

17 Aug 2023, at 9:24 AM, mercy jepchirchir <chirimercy80@gmail.com> wrote:

son Aruasa 17 Aug 2023, 10:00

[redacted]

...ercy, info, legal, CEO, Director, Senior, Philip, Stephen, wamaithak93, victoria.kigen, Joy, Josphat, josphatkirima, ...dmin

e you get things mixed up; I never for once saw or treated your late daughter Anita. Our staff who treated her did est and went as per the Standards of Care required as we explained to you and KMPDC. That remains the factual ...tion. Stop bringing your misplaced anger and personalizing things here. Until I came across you during our 8-hour ...g you keep referring to(which was prolonged by the way because you're just too difficult to deal with), I never ...you and would be more than happy if I never ever interacted with you. You definitely need to reflect, help yourself ...e calm and reasonable first. From there, it will be easy to reason with you and clear with either the mediation process ...chever other process you elect to go through.

...o is your advocate again so that we deal directly with her or him instead of you? Who else from your family can we ...vith in this process?

...a said MTRH has appointed a mediator? If you have a problem with that, help us by appointing one yourself.

...om my iPhone

...7 Aug 2023, at 9:51 AM, Wilson Aruasa <aruasaw@gmail.com> wrote:

...'ll not engage you anymore. You can continue saying we sent so and so to you or anywhere else. Lies and paranoia ...d 100 times do not become true. You're the biggest enemy of yourself.

[redacted]

...lson Aruasa 17 Aug 2023, 10:10

...cy, info, legal, CEO, Director, Senior, Philip, Stephen, GLADYS, Victoria, Joy, Josphat, josphatkirima, me, Admi

...ay, what is this "Truth" you assume either MTRH or I fear by the way? Let that "Truth" come out in any fair and ...ve process, there is nothing for anyone to fear.

... just someone uses to bullying and subduing others into submission, it would seem. And having your way your ...ere you can't and won't bully anyone, not MTRH, not I or anyone else.

[redacted]

r of Dispute Settlement Services,
ary Public & Commissioner for Oaths,
ocate of the High Court of Kenya,
ipal Legal Officer,
r Principal Clinical Officer Anesthetist,
Teaching and Referral Hospital
. BOX 3 code 30100
nya
graduate Diploma Kenya Sch of Law Nrb,
helor of Laws Moi University.
Anaesthesia,
Clinical medicine & Surgery

son Aruasa 17 Aug 2023, 13:26

phat, mercy, Philip, me, josphatkirima@gmail.com

a,

y well stated.

set the record straight on all her lies and paranoia. I'm aware she is copied here. She needs to help herself by izing she is the only problem to herself. Shadow-boxing and sideshows will not help her. Let her tell us who is her ate, who else in her family is assisting her so that we can progress this matter of mediation as required of both . She can also tell us if she has since appointed or selected another mediator.

s, intimidation and outright lies will NOT work. She keeps saying I have sent I don't know who to who, which is o not true at all. Even then, I wonder if she is supposed to mediate all alone in a vacuum, without the other party RH, without her lawyer and without her family members!

lson K. Aruasa, (***MBS***), (***EBS***), MBChB(MU) ;MMed-ObsGyn(UoN) ;MBA(USIU);
ef Executive Officer, Moi Teaching and Referral Hospital & Consultant Obstetrician/ Gynaecologist.
t, Kenya.

An ISO 9001:2015 Certified Hospital

MOI TEACHING AND REFERRAL HOSPITAL

Telephone: (+254)-0532033471/2/3/4
Fax: 0532061749
Email: ceo@mtrh.go.ke/ceosoffice@mtrh.go.ke

NANDI ROAD
P.O. BOX 3-30100
ELDORET, KENYA

Ref: ELD/MTRH/ADMIN/1/15/VOL.111/2018

5th September, 2023

Eunice Muriithi
Assistant Director Disciplinary & Ethics
Kenya Medical Practitioners & Dentists Council
KMPDC Complex – Woodlands Rd off
Lenana Rd, Hurlingham
P.O. Box 44839 – 00100
NAIROBI
Email e.muriithi@kmpdc.go.ke, info@kmpdc.go.ke

Dear Eunice,

MTRH MEDIATION PROGRESS REPORT ON DC CASE NO. 43 OF 2021 MERCY J KIPRONO V MTRH

Moi Teaching and Referral Hospital (MTRH) submits mediation progress report on DC Case No. 43 of 2021 Mercy Kiprono v MTRH.

1. Following your ruling on 5th May, 2023 MTRH promptly got in touch with Mercy Kiprono's advocate on record Professor Kiama Wangai, in compliance with the order to mediate on restitution (quantum of damages).
2. The two parties agreed that quantum of damages will be ascertained from Case Law. They were to decide on the mode of mediation. That is whether between Mr. Josphat Kirima, the MTRH advocate and Mercy's advocate directly or through a mediator.
3. MTRH has a Professional Indemnity cover for its doctors. Therefore, following this agreement it started the process of seeking indemnity from insurer on 29th May, 2023. A formal notification of claim was sent to the insurer on 7th June, 2023 and acknowledged.
4. On 2nd June, 2023 an advocate named Tarigo Kiptoo wrote to MTRH claiming to represent Mercy in place of Professor Kiama Wangai.

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5. Between 9th and 23rd June 2023, the insurer contacted Mercy notifying her of case referral by MTRH to them for mediation on quantum of damages (restitution). She was requested to propose quantum but the process stalled since she didn't cooperate.
6. On 3rd July, 2023 Mr. Kirima called Mercy but she did not answer his call. He called her husband Isaac Kandie. Isaac asked Kirima why MTRH had sent insurers to them. He was explained that it was to restitute them on behalf of MTRH and Dr. Ondigo. That Dr. Ondigo in legal language is an MTRH agent hence one and same thing. That MTRH as corporate entity is not able to do anything except through its directors and employees like Dr. Ondigo. Mr. Kirima sought to know the expected quantum. Isaac informed him that their advocate would get in touch with him.
7. On 6th July, 2023 Mercy wrote to MTRH's advocate and informed him that Mr. Tarigo Kiptoo was her advocate. There were numerous email correspondences in May, June, and August 2023 to no avail. This forced MTRH insurers to revert the mediation back to MTRH since dealing with Mercy bore no fruits at all. Up to now for all intents and purposes it is clear MTRH is dealing with Mercy directly and on its own. The advocates she has hired so far have deserted her, attempts to have MTRH insurers and other Government entities like Nairobi Centre for International Arbitration (NCIA) to intervene have proven futile.
8. On 24 July, 2023 MTRH requested mediation done under the guidance of NCIA since it is statutory body tasked with mediation. This was due to poor progress of mediation process and the fact that 90 days granted for mediation were almost over. NCIA accepted to mediate and on 25th July, 2023 M/s Tarigo Kiptoo advocates supported the mediation under NCIA.
9. On 28th July, 2023 MTRH paid requisite registration fee to NCIA and sought the matter to be expedited.
10. On 1st August, 2023 several things happened. NCIA appointed a mediator, Mercy Kiprono acknowledged the appointment and M/s Akweyu and Co Advocates came on record for Mercy Kiprono in the place of M/s Tarigo Kiptoo & Co Advocates. She indicated that she would proceed with mediation and agreed to be bound by the NCIA mediation rules. She further proposed a quantum of damages amounting to Kenya Shillings Sixty-One Million, One Hundred and Sixty Thousand (Kshs 61,160,000/=). NCIA acknowledged her appointment.
11. On 4th August, 2023 MTRH agreed to appointment of the mediator and sought M/s Akweyu's concurrence to jump start mediation process. It further responded to her proposal thus "it was not the appropriate time to address it since a mediator had already been appointed". Hence it (quantum) was major issue for mediation under the mediator. That both parties had agreed to be bound by NCIA rules i.e. to mediate through a mediator appointed by NCIA. Sought her concurrence to request Kenya Medical Practitioners & Dentists Council (KMPDC) to extend the mediation period by consent of parties since we had started making progress. It requested her to sign the mediation agreement and other documents sent by NCIA earlier on for filing and signing by both parties. MTRH had already filled and signed the necessary parts.
12. On 5th August, 2023 Mercy Kiprono abandoned her advocate M/s Akweyu and personally sent a report to KMPDC.
13. On 6th August, 2023 MTRH advocate wrote to Mercy seeking her concurrence for extension of the mediation period. She never responded.
14. On 8th August, 2023 NCIA set a virtual preliminary mediation conference date on 15th August, 2023. MTRH confirmed its availability but Mercy did not.
15. On 9th August, 2023 she wrote an email titled "What I would request KMPDC to consider". That is (a) mediation is a delaying tactic. (b) There was no need to extend the mediation process since the first month was wasted. This left MTRH in a loss. Who wasted the first month. Was it not her by withdrawing instructions from Professor Kiama Wangai forcing the mediation process to restart from scratch?

09/09/2023

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16. On 15th August, 2023 NCIA called off the virtual Preliminary Mediation conference due to "lack of confirmation of availability from the claimant's (Mercy) side".
17. Despite all these things MTRH was hoping mediator would salvage the situation. That is why it sought NCIA's advice on whether the mediator could write a report of "no settlement due to non-attendance by the claimant (Mercy Kiprono)". The mediator sought for more time to try to get her on bound. Since MTRH has been and remains fully committed to the mediation process, Mercy has thwarted all attempts to mediate.
18. On 15th August, 2023 Mercy indicated via email that she is not against mediation and that she never replaced M/s Akweyu as an advocate.
19. On 16th August, 2023 Mercy wrote an email blaming MTRH for choosing the mediator and mediation venue. She was informed that she could change anything/everything that she was not agreeable to during the preliminary mediation conference if she agreed to it. That it would be at minimal cost since she could do it from her sitting room. She never responded.

From the prevailing facts MTRH is constrained to make this preliminary report as it awaits the mediator's directions.

Further it is clear to everybody that Mercy is a very difficult person to mediate with. Just like it was witnessed earlier before the hearing of her case and ruling dated 5th May, 2023, she has continued to malign and bully everybody who attempts to address this issue. Nobody has been spared including all three advocates she has hired in the last three months, KMPDC itself, NCIA, MTRH's Chief Executive Officer (CEO) and other Hospital Management Team members including all the doctors that interacted with her, MTRH advocate, etc. All her statements (which are always malicious) are in writing (electronic communications and most of them are copied to KMPDC, NCIA, their officers and even the NCIA appointed mediator) and will be availed at an opportune time (I have printed and attached a few of them here for ease of reference. Suffice it to say there are many more available).

Finally, it is our considered opinion that she can benefit from the mediator's input before the matter is escalated to the High Court of Kenya.

The purpose of this letter is to urge you grant mediation process a further forty-five (45) more days with effect from date of your communication NOT from 5th August, 2023 (the 90 days earlier granted).

We understand an Eldoret-based Non-Governmental Organization (NGO) is currently trying to assist her. It (the NGO) needs time to resolve this issue.

Kindly consider this preliminary report as you plan to make further orders.

Yours

MOI TEACHING AND REFERRAL HOSPITAL
C E O
APPROVED
05 SEP 2023
SIGN.....
P. O. Box 3-30100, ELDORET

05/09/2023

DR. WILSON K. ARUASA, *MBS, EBS*
CHIEF EXECUTIVE OFFICER

3.THAT the first 90 days as granted for meditation did include weekend and public holidays.It also had a timeline of 90 days after which the report was done.

4 .THAT the 45 more days granted for meditation did exclude the weekend and public holidays making it extend more time.It also noted that this has no time lapse and that report be submitted after meditation process.....

5. THAT meditation through virtual means is null and void.I may not be a partisan of it as it doesn't not show any Goodwill on whole process.

6 THAT these issues be addressed in a manner of goodwill in order to put this matter to closure.

In conclusion, Justice delayed is justice denied.

Regards
Mercy.

PRELIMINARY CONFERENCE - DIS/MED/02/23

External
Inbox

J

Joy Maina <Joy.Maina@ncia.or.ke> 13 Sept 2023, 11:35

to Gladys, chirimercy80@gmail.com, me

Dear Ms. Wamaitha,

The KMPDC has extended the period for Mediation in this dispute for 45 days as per the attached letter dated 11th September 2023.

Kindly provide us with dates that you are available for a preliminary conference for the parties consideration at the earliest to commence this Mediation process.

Kind Regards,

Joy Maina
Manager, Case Management

Dear Ms. Joy Maina,

Thank you for your email and the notification that the Board has extended the period by 45 days.

I write to inform you that I am available on either 25.09.23 or 26.09.23 for the pre- trial conference. I will appreciate notification of the convenient date to the Parties.

Yours Faithfully.

Gladys Wamaitha

Sent from Mail for Windows

From: Joy Maina
Sent: Wednesday, 13 September 2023 11:36
To: Gladys Wamaitha
Cc: chirimercy80@gmail.com; josphatkirima@mtrh.go.ke
Subject: PRELIMINARY CONFERENCE - DIS/MED/02/23

Dear Ms. Wamaitha,

Josphat Mutuma Kirima <josphatkirima@mtrh.go.ke> 14 Sept 2023, 10:54

to Joy, Gladys, chirimercy80@gmail.com, bcc: Wilson, bcc: Chief

Please consider the environment before printing this email.

Nairobi Centre for International Arbitration
Haile Selassie Avenue, Co-operative Bank House, 8th Floor
P.O. Box 548-00200 Nairobi | Mobile: +254720879674
Email: Joy.Maina@ncia.or.ke | Web: www.ncia.or.ke

G

Gladys Wamaitha <gladys@scmafrica.com> 13 Sept 2023, 21:27

to Joy, chirimercy80@gmail.com, me

Dear Ms. Joy Maina,

Thank you for your email and the notification that the Board has extended the period by 45 days.

I write to inform you that I am available on either 25.09.23 or 26.09.23 for the pre- trial conference. I will appreciate notification of the convenient date to the Parties.

Yours Faithfully.

Gladys Wamaitha

Sent from Mail for Windows

J

Joy Maina <Joy.Maina@ncia.or.ke> 14 Sept 2023, 09:08

to Gladys, chirimercy80@gmail.com, me

Dear Josphat and Mercy,

The Mediator, Ms. Wamaitha, is available for a preliminary conference on either 25th September 2023 or 26th September 2023.

Kindly let us know which of the two dates is available to you. This meeting will be held virtually.

Kind Regards,

Joy Maina
Manager, Case Management

Please consider the environment before printing this email.

Nairobi Centre for International Arbitration
Haile Selassie Avenue, Co-operative Bank House, 8th Floor
P.O. Box 548-00200 Nairobi | Mobile: +254720879674
Email: Joy.Maina@ncia.or.ke | Web: www.ncia.or.ke

From: Gladys Wamaitha <gladys@scmafrica.com>
Sent: Wednesday, September 13, 2023 9:27 PM
To: Joy Maina <Joy.Maina@ncia.or.ke>
Cc: chirimercy80@gmail.com <chirimercy80@gmail.com>; josphatkirima@mtrh.go.ke <josphatkirima@mtrh.go.ke>
Subject: RE: PRELIMINARY CONFERENCE - DIS/MED/02/23

Good morning, Joy.

I am available on both dates. Just choose any.

Regards.

Josphat Mutuma Kirima,
Head of Dispute Settlement Services,
Notary Public & Commissioner for Oaths,
Advocate of High Court of Kenya,
Principal Legal Officer,
Snr Principal Clinical Officer Anaesthetist,
Moi Teaching & Referral Hospital,
AMPATH BUILDING RM 202/214.

2 attachments • Scanned by Gmail

J

Joy Maina <Joy.Maina@ncia.or.ke> 14 Sept 2023, 17:31

to me, Gladys, chirimercy80@gmail.com

This is well noted Josphat.

Kind Regards,

Joy Maina
Manager, Case Management

Fwd: Discontentment on mediation process

External
Inbox

C

CEOs Office <directorsofficemtrh@gmail.com> 18 Sept 2023, 08:35

to me, Josphat, Chief, Wilson

Dear Kirima,

Forwarded is an -email from Mercy Jepchirchir on Discontentment on mediation process.

> ➢ follow up with MPDC. That we have no issue with all points raised, but mediation be done physically in neutral grounds, Nakuru, Nairobi or Kisumu cities.

Please acknowledge receipt.

Kind regards.

Dr. Wilson K. Aruasa, *MBS, EBS*
Chief Executive Officer

-- Forwarded message ---------
From: **mercy jepchirchir** <chirimercy80@gmail.com>
Date: Sat, 16 Sept 2023 at 12:10
Subject: Discontentment on mediation process
To: Eunice Muriithi <e.muriithi@kmpdc.go.ke>, Chief Executive <ceo@mtrh.go.ke>, CEOs Office <directorsofficemtrh@gmail.com>
Cc: CEO KMPDC <ceo@kmpdc.go.ke>, legal Department <legal@kmpdc.go.ke>

Good morning,
I accepted the request made by MTRH that we inform KMPDC to consider extending the mediation period by 45 more days in good faith/will, however I want to let your office be informed of the discontent on my part for the following reasons:

1 .THAT the council ignored the choice of mediator as requested by claimant.

2.THAT the request to meditate in Eldoret through physical means has been ignored.

PRELIMINARY CONFERENCE - DIS/MED/02/23

External
Inbox

Josphat Mutuma Kirima <josphatkirima@mtrh.go.ke> 9 Oct 2023, 14:56

to **Wilson, Chief**, Joy, Gladys, chirimercy80@gmail.com

Good afternoon, Madam Joy.
We were invited to a preliminary meeting on 25th or 26th September. I indicated my availability, but Mercy (copied this email) never commented. The 45 days (extension period) are almost over.
Has the mediator been able to reach out to Mercy? Can she give out a certificate of no settlement?
Kindly advice.

Regards.
Josphat Mutuma Kirima,
Head of Dispute Settlement Services,
Notary Public & Commissioner for Oaths,
Advocate of High Court of Kenya,
Principal Legal Officer,
Snr Principal Clinical Officer Anaesthetist,
Moi Teaching & Referral Hospital,
AMPATH BUILDING RM 202/214.

One attachment • Scanned by Gmail

Joy Maina <Joy.Maina@ncia.or.ke> 9 Oct 2023, 15:30

to me, Gladys, chirimercy80@gmail.com, Wilson, Chief

Good Afternoon Mr. Mutuma,

We are yet to receive any feedback from Mercy.

One attachment • Scanned by Gmail

Joy Maina <Joy.Maina@ncia.or.ke> 11 Oct 2023, 16:04

to me, Gladys, chirimercy80@gmail.com, Wilson, Chief

NCIA is inviting you to a scheduled Zoom meeting.

Topic: PRELIMINARY MEETING
Time: Oct 16, 2023 15:00 Nairobi

Join Zoom Meeting
https://us06web.zoom.us/j/88131195855?pwd=k4nivLxTyYQ1V1qlgX8ve5bHag9ML5.1

Meeting ID: 881 3119 5855
Passcode: 146027

One tap mobile
+15074734847,,88131195855#,,,,*146027# US
+15642172000,,88131195855#,,,,*146027# US

Dial by your location
- +1 507 473 4847 US
- +1 564 217 2000 US
- +1 646 931 3860 US
- +1 669 444 9171 US
- +1 669 900 6833 US (San Jose)
- +1 689 278 1000 US
- +1 719 359 4580 US
- +1 929 205 6099 US (New York)
- +1 253 205 0468 US
- +1 253 215 8782 US (Tacoma)
- +1 301 715 8592 US (Washington DC)
- +1 305 224 1968 US
- +1 309 205 3325 US
- +1 312 626 6799 US (Chicago)

However, noting that the 45 days extension given by the Council is almost over, we shall make a final attempt to commence the Mediation before time lapses. I will be sharing a Notice for a Preliminary Meeting shortly once I consult the Mediator on her availability.

Kind Regards,

Joy Maina
Manager, Case Management

Please consider the environment before printing this email.

Nairobi Centre for International Arbitration
Haile Selassie Avenue, Co-operative Bank House, 8th Floor
P.O. Box 548-00200 Nairobi | Mobile: +254720879674
Email: Joy.Maina@ncia.or.ke | Web: www.ncia.or.ke

From: Josphat Mutuma Kirima <josphatkirima@mtrh.go.ke>
Sent: Monday, October 9, 2023 2:56 PM
To: Joy Maina <Joy.Maina@ncia.or.ke>
Cc: Gladys Wamaitha <gladys@scmafrica.com>; chirimercy80@gmail.com <chirimercy80@gmail.com>; Wilson Aruasa <aruasaw@gmail.com>; Chief Executive <ceo@mtrh.go.ke>

Josphat Mutuma Kirima <josphatkirima@mtrh.go.ke> 9 Oct 2023, 16:15

to Joy, Gladys, chirimercy80@gmail.com, Wilson, Chief

Thank you so much Madam Maina.
We look forward to your further advice.

Regards.
Josphat Mutuma Kirima,
Head of Dispute Settlement Services,
Notary Public & Commissioner for Oaths,
Advocate of High Court of Kenya,
Principal Legal Officer,
Snr Principal Clinical Officer Anaesthetist,
Moi Teaching & Referral Hospital,
AMPATH BUILDING RM 202/214.

- +1 346 248 7799 US (Houston)
- +1 360 209 5623 US
- +1 386 347 5053 US

Meeting ID: 881 3119 5855
Passcode: 146027

Find your local number: https://us06web.zoom.us/u/kd53n8XCFj

Join by Skype for Business
https://us06web.zoom.us/skype/88131195855

Kind Regards,

Joy Maina
Manager, Case Management

Please consider the environment before printing this email.

Nairobi Centre for International Arbitration
Haile Selassie Avenue, Co-operative Bank House, 8th Floor
P.O. Box 548-00200 Nairobi | Mobile: +254720879674
Email: Joy.Maina@ncia.or.ke | Web: www.ncia.or.ke

From: Josphat Mutuma Kirima <josphatkirima@mtrh.go.ke>
Sent: Monday, October 9, 2023 4:15 PM

Josphat Mutuma Kirima <josphatkirima@mtrh.go.ke> 11 Oct 2023, 16:21

to Joy, Gladys, chirimercy80@gmail.com, Wilson, Chief

Good afternoon Madam Joy.
I will be available.

Will Mercy be available? She sent me a blank email today at 12:56 PM copied to KMPDC C.E.O & Legal Department & C.E.O MTRH in an email thread titled "dissatisfaction with mediation process". I do not know what she wanted to say. Maybe she can elaborate here.

Regards.
Josphat Mutuma Kirima,
Head of Dispute Settlement Services,
Notary Public & Commissioner for Oaths,
Advocate of High Court of Kenya,
Principal Legal Officer,
Snr Principal Clinical Officer Anaesthetist,
Moi Teaching & Referral Hospital,
AMPATH BUILDING RM 202/214.

One attachment • Scanned by Gmail

Josphat Mutuma Kirima <josphatkirima@mtrh.go.ke> 16 Oct 2023, 16:44

to **Director**, Wilson, Chief

C.E.O.
Good afternoon Sir.
This meeting took place today before M/S Wamaitha the mediator. Madam Joy Maina was present for NCIA. I was present for MTRH. There was no appearance for Mercy.
It was agreed that the mediator will wrote a report of no settlement to KMPDC and copy MTRH. She will be clear that mediation failed due to non attendance of the complainant Mercy Jepchirchir Kiprono. That MTRH paid and was always available for the mediation and that she reached out to Mercy who insisted that she will mediate directly with MTRH. She promised to deliver the report before Friday the 20th October 2023.

In my opinion this marks the end of the mediation process and the beginning of the litigation process.

Regards.
Josphat Mutuma Kirima,
Head of Dispute Settlement Services,
Notary Public & Commissioner for Oaths,
Advocate of High Court of Kenya,
Principal Legal Officer,
Snr Principal Clinical Officer Anaesthetist,
Moi Teaching & Referral Hospital,
AMPATH BUILDING RM 202/214.

Wilson Aruasa <aruasaw@gmail.com> 16 Oct 2023, 16:53

to **Chief, Director**, me

Thanks for the update Kirima.

No need for litigation unless Mercy goes for it herself. Even then, that will end with Court Annexed Mediation process.

Dr. Wilson K. Aruasa, (***MBS***), (***EBS***), MBChB(MU) ;MMed-ObsGyn(UoN) ;MBA(USIU);
Chief Executive Officer, Moi Teaching and Referral Hospital & Consultant Obstetrician/ Gynaecologist.
Eldoret, Kenya.

Josphat Mutuma Kirima <josphatkirima@mtrh.go.ke> 16 Oct 2023, 17:18

to Wilson, Chief, Director

C.E.O.
That is true sir. MTRH can not take any further steps other than to confirm the mediators report to KMPDC. It is Mercy to decide what to do with her case from there onwards. MTRH can not take it to court since it is not the complainant.

Regards.
Josphat Mutuma Kirima,
Head of Dispute Settlement Services,
Notary Public & Commissioner for Oaths,
Advocate of High Court of Kenya,
Principal Legal Officer,
Snr Principal Clinical Officer Anaesthetist,
Moi Teaching & Referral Hospital,
AMPATH BUILDING RM 202/214.

An ISO 9001:2015 Certified Hospital

MOI TEACHING AND REFERRAL HOSPITAL

Email: ceo@mtrh.go.ke
Telephone: 053 2033471/2/3
Fax: 053 2061749
ceo@mtrh.go.ke/directorsofficemtrh@gmail.com

NANDI ROAD
P.O. BOX 3-30100
ELDORET, KENYAEmail:

Ref: ELD/MTRH /ADMIN/1/VOL.11/2007

14th December 2023

Eunice Muriithi
Assistant Director Disciplinary & Ethics
Kenya Medical Practitioners & Dentists Council
P.O. Box 44839 - 00100
NAIROBI

Email e.muriithi@kmpdc.go.ke; info@kmpdc.go.ke

Dear Ms Muriithi

MTRH MEDIATION PROGRESS REPORT ON DC CASE NO. 43 OF 2021 MERCY J. KIPRONO Vs MTRH

Moi Teaching and referral Hospital (MTRH) refers to your letter reference number KMPDC/DEC/1268/43/2021/40 dated 11/09/2023. We greatly appreciate your extension of the mediation period for 45 days with effect from 11th September 2023.

All efforts to progress the mediation did not bear any fruits because Mercy J. Kiprono refused to participate in any way. There is enough evidence to demonstrate all that was done. All the communications are in writing (electronic communications and most of them are copied to Kenya Medical Practitioner's Dentist Council (KMPDC), Nairobi Centre for International Arbitration (NCIA) their officers and even the (NCIA) appointed mediator). Attached please find the various email correspondences.

It is our considered opinion that the mediation has irretrievably collapsed. This issue cannot be resolved by mediation or any other Alternative Dispute Resolution (ADR).

Kindly consider this report as you plan to make further orders.

Yours Sincerely

for DR. WILSON K. ARUASA, *MBS, EBS*
CHIEF EXCUTIVE OFFICER

14 DEC 2023

108

Annex 4:

Report from the Kenya Medical Dentists and Practitioners Council (KMPDC)

KENYA MEDICAL PRACTITIONERS AND DENTISTS COUNCIL

REPORT TO THE SENATE STANDING COMMITTEE ON HEALTH

ON

PETITION REGARDING THE ALLEGED MEDICAL NEGLIGENCE AND STAFF INCOMPETENCY LEADING TO THE DEATH OF MS. ANNITA JEPKORIR AT MOI TEACHING AND REFERRAL HOSPITAL

JULY, 2024

Kenya Medical Practitioners and Dentists Council
KMPDC House
Woodlands Rd, Off Lenana Rd
P.O. Box 44839 - 00100
Nairobi, Kenya
Tel: 0727666444/0111052222
E-Mail: info@kmpdc.go.ke
Website: www.kmpdc.go.ke

The Kenya Medical Practitioners and Dentists Council, hereinafter referred to as **"the Council"** or **"KMPDC"**, is a statutory body corporate established under Section 3 of the Medical Practitioners and Dentists Act Chapter 253 of the Laws of Kenya. The Council's mandate is to regulate the training and practice of medicine, dentistry, and community oral health within the Republic of Kenya. The Council is also entrusted with regulating all health institutions in the country.

The Council received a letter dated 17 July 2024 under Reference No. SEN/DSEC/SCH/331/2024, from the Clerk of Senate, informing KMPDC that the Committee is considering a petition on the alleged medical negligence and staff incompetency leading to the death of Ms Annita Jepkorir at Moi Teaching and Referral Hospital.

The Clerk of the Senate further requested that the Council submit comprehensive written responses to the issues raised in the Petition on or before Friday, August 2nd, **2024.**

The Council would like to state as follows:

1. On 12th July 2021, Ms Mercy J Kiprono and Mr Isaak Kandie submitted a complaint against Dr Stephen Mondego, Prof Barasa Otsyula, Dr Alfred Wanyonyi, Dr Ernest Nshom and Moi Teaching and Referral Hospital (MTRH) alleging medical negligence, patient mismanagement, intimidation and no follow-up on the second admission. The complaint related to the treatment and management of their daughter Annita Jepkorir, who choked on a seed and was admitted to the Hospital in January and February 2021, also treated as an outpatient before her demise on 10th May 2021. A post-mortem was done after the death of Annita and found a seed in the right bronchi. The complaint was processed and assigned **DC CASE NO 43 OF 2021.**
2. Through a letter dated 21st July 2021, the Respondents were requested to submit their respective responses to the complaint together with relevant documents. By a letter

dated 30th July 2021, Dr Wilson Aruasa, the then Chief Executive Officer of the Hospital, submitted to the Council a statement by Dr Philip Kirwa dated 30th July 2021, a statement by Prof. Barasa Khwa-Otsyula dated 29th July 2021, a statement by Dr Alfred Wanyonyi dated 29th July 2021, a statement by Dr Stephen Ondigo dated 30th July 2021, a statement by Dr Mark Oloo dated 30th July 2021, a statement by Dr Ismail Mohamed dated 29th July 2021, a statement by Dr Nshom Ernest dated 29th July 2021, a statement by Dr Ouma Victor, a copy of the Autopsy report by Dr David Chumba dated 26th May 2021, two (2) CT Scan CDs and a certified and paginated copy of the patient's file.

3. On 26th April 2022, the Disciplinary and Ethics Committee deliberated on the complaint and recommended that it be scheduled for a hearing. This was communicated to all the parties through a letter dated 10th May 2022. A notice for mention and directions was issued on 7th September 2022, inviting the parties to appear for mentions on 20th September 2022. The matter was mentioned on 20th September 2022, wherein directions for the hearing were issued, with the hearing being confirmed to take place on Wednesday, 12th October 2022. The Disciplinary and Ethics Committee hearing of the case took place on 12 October 2022, and all the parties were present.

4. The committee's decision was issued on 5th May 2023. The Committee, having heard all the parties and interrogated the evidence presented before it, found that the complaint against Dr Stephen Ondigo and Moi Teaching and Referral Hospital had merit. The Committee directed that Dr Stephen Ondigo and MTRH mediate with the Estate of the late Annita Jepkorir jointly and severally with a view to making restitution and thereafter inform the Council within 90 days. The Committee also directed Dr Ondigo and MTRH to each pay a fine of KSh. 200,000/= and 350,000/= respectively. ***(Copy of ruling attached as MK Annex 1)***

5. After the ruling was issued, the MTRH and the Complainant started discussing how to

ensure that the mediation took place within the given timelines. Dr Wilson Aruasa, through a letter dated 5th September 2023, informed the Council that after receipt of the ruling, the hospital promptly got in touch with Mercy's Kiprono's advocate on record, Prof Kiama Wangai, to mediate on restitution. The parties agreed that the quantum of damages would be ascertained from case law. They were also to decide on the mode of mediation. Following the agreement, MTRH sent a formal notification to its insurer on 7th June 2023. On 2nd June 2023, an advocate named Tarigo Kiprono wrote to MTRH, claiming to represent Mercy Kiprono in the place of Prof Kiama Wangai. Dr Aruasa stated that between 9th and 23 June 2023, the insurer contacted Mercy, notifying her that the case had been referred for mediation on the quantum of damages. Due to poor of progress on the mediation, the hospital requested that the mediation be done under the guidance of the Nairobi Center for International Arbitration (NCIA), a statutory body established under the Nairobi Centre for International Arbitration Act No. 26 of 2013. NCIA agreed to mediate, and on 25th July 2023, Tarigo Kiprono advocates supported the mediation under NCIA. On 28th July 2023, MTRH paid the requisite fees to NCIA. In August 2023, NCIA appointed a mediator; however, the mediation did not proceed. (***A copy of the letter is attached as MK Annex 2)***.

6. Dr Aruasa requested the Council grant the mediation process a further forty-five to (45) days. This request was granted and communicated through a letter dated 11th September 2023.

7. Through a letter dated 14th December 2023, Dr Aruasa informed the Council that efforts to progress the mediation had not yielded any result, as Mercy J Kiprono had refused to participate in any way. He submitted that it was their opinion that the mediation had irretrievably collapsed, and the issue could not be resolved through mediation or any other Alternative Dispute Resolution. ***(A copy of the letter is attached as MK Annex 3)***

From the above summary, the Council would like to highlight the following;

(i) As the Council does not have the legal authority to award damages to complainants when it finds that the case had merit and either the doctor (s) or hospital is culpable, it instead directs that the parties mediate. This is because CAP 253 allows the Disciplinary and Ethics Committee to not only promote mediation and arbitration between the parties but also record and adopt mediation agreements or compromises between the parties. This method serves to conclude a matter without the parties proceeding to court for damages. The Council also recognises the importance of Alternative Dispute Resolution (ADR) in speedy resolution of any dispute.

(ii) The Council does not interfere or influence the choice of mediator. The parties are at liberty to choose the person or persons to act as their mediator.

(iii) Where the parties are unable to conclusively use Alternative Dispute Resolution to resolve the matter (i.e damages), they are at liberty to seek compensation from the High Court of Kenya. They may also use the KMPDC's judgement to support their claim for damages before the High Court.

This report is signed as hereunder:

Date: 2/8/24.

DR. DAVID G. KARIUKI
CHIEF EXECUTIVE OFFICER/REGISTRAR
KENYA MEDICAL PRACTITIONERS AND DENTISTS COUNCIL

MK ANNEX 1

COPY OF RULING IN

DC CASE NO. 43 OF 2021

REPUBLIC OF KENYA

THE KENYA MEDICAL PRACTITIONERS AND DENTISTS COUNCIL

INQUIRY BY THE

DISCIPLINARY AND ETHICS COMMITTEE

(PURSUANT TO THE PROVISIONS OF THE MEDICAL PRACTITIONERS AND DENTISTS

ACT, CHAPTER 253 LAWS OF KENYA

DC CASE NO 43 OF 2021

MERCY JEPCHIRCHIR KIPRONO ON BEHALF OF

ANNITA JEPKORIR CHIRCHIR (DECEASED).....COMPLAINANT

AND

DR. ERNEST NSHOM.....1ST RESPONDENT

DR. ALFRED WANDEBA WANYONYI .....2ND RESPONDENT

PROF. BARASA OTSYULA KHWA.....3RD RESPONDENT

DR. STEPHEN ONDIGO.....4TH RESPONDENT

MOI TEACHING & REFERRAL HOSPITAL.....5TH RESPONDENT

RULING

A. INTRODUCTION

1. The Complaint leading to this inquiry was lodged before the Kenya Medical Practitioners and Dentists Council, hereinafter referred to as **"the Council"**, by **Mercy J. Kiprono** on behalf of The Late Annita Jepkorir, hereinafter referred to as **"the Complainant"** against **Dr Ernest Nshom** hereinafter referred to as **"Dr Nshom"** or **"1st Respondent"**, **Dr Alfred Wandeba Wanyonyi**, hereinafter referred to as **"Dr Wanyonyi"** or **"the 2nd Respondent"**,

Prof. Barasa Otsyula Khwa hereinafter referred to as **"Prof. Otsyula"** or **"the 3rd Respondent"**, **Dr Stephen Ondigo** hereinafter referred to as **"Dr Ondigo"** or **"the 4th Respondent"** and **Moi Teaching & Referral Hospital** hereinafter referred to as **"the Hospital"** or **"MTRH"** or **"the 5th Respondent"**

2. The Complainant submitted to the Council a signed Application for Lodging Complaint dated 28th June 2021. She attached thereto a statement that gave the chronology of events leading to the complaint, a copy of an autopsy report drawn by Dr David Chumba dated 13th May 2021, a copy of a CT scan Chest Bronchogram report from the Respondent Institution dated 19th January 2021, a copy of CT scan report dated 11th February 2021, a copy of a discharge summary dated 10th January 2021, a copy of a discharge summary from the Respondent Institution dated 14th February 2021, a colour picture of a black seed placed on a white paper and yellow glove, picture of a hospital attendance card issued on 9th January 2021, and several pictures of the Deceased while in Hospital.

3. The Council served the Respondents with a copy of the complaint through a letter dated 21st July 2021 and requested for a comprehensive report addressing the allegations raised by the Complainant, certified, and paginated copy of the patient's file, statements from the medical personnel who managed the patient and any other documents that would assist in the investigations.

4. In response thereto, the 5th Respondent through a letter by the Chief Executive Officer dated 30th July 2021, submitted to the Council an executive summary drawn by Dr Philip Kirwa, Senior Director, Clinical Services dated 30th July 2021, a statement by Prof. Otsyula dated 29th July 2021, a statement by Dr Wandeba dated 29th July 2021, a statement by Dr Ondigo dated 30th July 2021, a statement by Dr Mark Oloo dated 30th July 2021, a statement by Dr Ismail Mohamed dated 29th July 2021, a statement Dr Nshom dated 29th July 2021, a statement by Dr Victor Ouma, a copy of the autopsy report by Dr David Chumba dated 26th May 2021, and a copy of the patient's file.

5. The genesis of the complaint herein arises from the treatment and management of Annita Jepkorir Chirchir, hereinafter referred to as **"the Patient"** or **"the Deceased"** by the 1st to 4th Respondents and the 5th Respondent Institution. The Complainant in the Application for lodging a Complaint at Section E indicated the brief nature of the complaint as;

> "***Medical negligence, patient's mismanagement, intimidation, and no follow up on second admission***".

In the statement accompanying the application for lodging a complaint, on page 6, the Complainant enumerated the particulars of negligence as;

(i) Failing to note the presence of a seed in the patient's airway;

(ii) Failing to conduct a proper bronchoscopy procedure;

(iii) Failing to properly interpret the results of the bronchoscopy;

(iv) Misdiagnosis of the patient's condition;

(v) *Leaving a foreign object in the patient's airway/lung;*

(vi) *Conducting the wrong procedure when the patient was in theatre;*

(vii) *Extracting the patient's teeth when the same was not due for extraction;*

(viii) *Misinforming that the patient had swallowed a tooth when such was not the case;*

(ix) *Misdiagnosing the patient with pneumonia when she was brought back for further check;*

(x) *Failing to exercise proper skill and care required of the doctor; and*

(xi) *Failing to reveal the truth to the patient's parents.*

B. INQUIRY BY THE COMMITTEE

6. The Council referred the complaint to the Disciplinary and Ethics Committee, hereinafter referred to as **"the Committee"**, as **DC Case Number 43 of 2021**. Section 4A (1) (b) provides that the mandate of the Committee shall include:

(i) *Conducting inquiries into complaints submitted to it;*

(ii) *Regulating professional conduct;*

(iii) *Ensuring fitness to practice and operate;*

(iv) *Promoting mediation and arbitration between the parties; and*

(v) *At its own liberty, recording and adopting mediation agreements or compromise between parties, on the terms agreed.*

Section 20 of the Act further provides in subsection (1) that; "*Any person who is dissatisfied with the professional serviced offered or alleges a breach of standards by a registered or licensed person under this Act, may lodge a complaint in the prescribed manner to the Council*".

7. The Committee being cognisant of its mandate as provided in Section 4 A (1) (b) of the Act, considered the application for lodging a complaint and the documents submitted by the Complainant, documents submitted by the Respondent, the patient's files and all the documents before it and found that they were insufficient to make a determination. Consequently, the Committee recommended that the matter proceeds for hearing. The Council served the parties with a notice for mentions dated 7th September 2022. On 20th September 2022, mentions for directions were held at the Council offices wherein in the absence of the Respondents, the hearing was confirmed for 12th October 2022.

8. On 12th October 2022, the Committee held its sitting at the Kenya Medical Practitioners and Dentists Council offices, at Nairobi where the Complainant appeared in person, and was presented by learned Counsel Prof. Kiama Wangai. The Respondents were also present and were represented by Learned Counsel Mr Josphat Mutuma Kurima.

9. **Ms Mercy Jepchirchir Kiprono, ("Ms Mercy")** the Complainant was the first to testify before the Committee. She was led in her evidence by learned counsel Prof. Kiama Wangai. She stated that she is the mother to the Late Annita She adopted her signed statement as evidence in chief.

10. It was her evidence that she took her daughter to the hospital for treatment. She was six years old at the time she took her to MTRH as she had difficulty in breathing. She said that she had been choked by a sunflower seed that she could identify. She stated that they were referred to MTRH from Mediheal. They first went to Mediheal, but she began recovering and was discharged. However, within a short period before they left Mediheal, she experienced distress and they rushed her to MTRH.

11. She stated that they were advised to go to MTRH for Bronchoscopy. This was on 9th January 2021. At the Hospital, she was referred for surgery and booked for theatre the same night. At the theatre, she was received by Dr Ernest Nshom who informed her that they wanted to perform the procedure to check. When they left the theatre, she was informed that they did not see anything, and they remained admitted to the hospital. They stayed in the hospital until 19th January 2021 when a CT scan was done which revealed a ring-shaped foreign body in the right bronchus. Surgery was recommended and she was taken to theatre on 22nd January 2021. After the surgery, Dr Nshom informed them that they had found a tooth in the bronchus. Annita had already lost her lower incisor teeth. However, when she was brought back from theatre, she had two missing

upper incisor teeth. Dr Nshom informed her that they had removed the two upper incisor teeth after finding a tooth in the lungs. He also informed her that the white bandage had the tooth, that was removed from the right bronchus, while the blue bandage had the two teeth they assisted to remove since they were loose.

12. It was her evidence that while on the ward, she removed the bandage and found two teeth, one in the white and another in the blue bandage. She stated that Dr Nshom told her that they performed a thoracotomy because the bronchoscopy failed. The Deceased had a chest tube on the side where they had made an incision. She stated that she had consented for bronchoscopy and not the thoracotomy. On the ward, when they queried about the missing teeth, and after speaking to Dr Nshom, Dr Wanyonyi called her and her husband and directed them to a room at the nurses' station. He wanted to address the issue she had raised regarding the 3rd missing tooth which he claimed they removed in theatre. She claimed he was rude in addressing them and they apologized. She also claimed that he told them not to complain as their child was well. At the time the child was coughing like there was still a blockage.

13. Ms Mercy testified that they were advised to do another x-ray to check the status of the tube that had been inserted. Prof. Otsyula came to the ward, and she heard him telling the students that teeth were extracted, and one was removed from the lung. He also advised that they would be

discharged because the wound had dried. On 28th January, they were discharged on medication and advised to go for dressing of the wound. On 8th February, the Deceased began vomiting with a fever, so they returned to MTRH. On arrival, they were informed that her oxygen was low, she was nebulized and admitted to the ward. A CT scan was performed, and the diagnosis was pneumonia post-thoracotomy procedure was made. She was treated and they were discharged on 15th February.

14. On 6th March 2021, they took her back to the hospital for cough, vomiting, and fever. They also went back to MTRH on 16th April 2021 when she was treated at outpatient. On 22nd April, they went back to MTRH for a check-up, and they were given medicine at outpatient. On 10th May 2021, while playing, she coughed for a long and fainted. They rushed her to MTRH, and she was pronounced dead on arrival. On 13th May 2021, an autopsy was done by Dr David Chumba, and they found a seed in the right bronchus.

15. She testified that her complaint was that it was evident that the seed was the issue from the Deceased's description and the scan which revealed the same and yet they removed teeth. When they tried to get an explanation, they only met with students. They did not get an explanation from Dr Ondigo, Prof. Otsyula, or Dr Oloo.

16. On cross-examination by counsel for MTRH Mr Kurima, she confirmed that she consented to the procedures done on the 9th and 22nd of January 2021. She confirmed that she noticed the fresh upper tooth gaps after the

theatre. She also confirmed that there was a meeting held between MTRH and the family. She stated that she was not going to MTRH for any counselling.

17. **Dr Alfred Wandeba Wanyonyi**, the 1st Respondent, was the next person to testify before the Committee. He stated that he was registered in 2001, was currently undertaking a Fellowship in General Surgery (COSECSA) and was in his second year of residency. During the said case he was undertaking his rotation in the cardiothoracic surgery department. He adopted his statement dated 29th July 2021 as his evidence in chief.

18. Dr Wanyonyi testified that he first met Anita on 11th January 2021 during a major ward round. On a review, she had been admitted on 9th January 2021 to the cardiothoracic surgical unit with a cough and vomiting following a history of having inhaled a seed and choking on the same. She had undergone a bronchoscopy on the day of admission. During the ward round, a decision was made to conduct a gastrograffin study and virtual bronchoscopy to assess the child because she was drooling saliva to rule out an oesophageal fistula that might have occurred. Under the guidance of Dr Oloo, Dr Ismael(MO), and Dr Kibos (Resident in general surgery). On 13th January, the child was reported to have episodes of chocking and dyspnoea and a decision was made to follow up gastrograffin study which involved giving an oral contrast and taking an x-ray, to check if there is an abnormal connection with oesophagus and trachea. On the 14th the plan was to follow up on the gastrograffin study.

On 16th January 2021 the gastrograffin study was done and there was no such abnormal connection.

19. It was his testimony that his next interaction with the Patient was on 19th January 2021, during another major ward round under Prof. Otsyula, Dr Ondigo, Dr Oloo, and Dr Ismael. At that point, the decision was to conduct a CT bronchoscopy(3D reconstruction) because she still experienced difficulty in breathing. On 20th January 2021, the report of bronchoscopy was received, and it revealed a ring-like lesion in the right proximal bronchi, and a decision was made to undertake elective bronchoscopy with possible thoracotomy.

20. On 22nd January 2021, the Patient was taken to theatre. During bronchoscopy, two deciduous teeth came off, one was recovered and but the other was not. Intraoperatively, rigid bronchoscopy was done by Dr Ondigo as the main surgeon, but it was not possible to retrieve the foreign body and therefore necessitating a change to thoracotomy. A right thoracotomy was done during which he participated as the assistant surgeon. The main surgeon was Dr Ondigo, and the anaesthetist was Dr Nshom.

21. On cross-examination by Prof. Kiama, Counsel for the Complainant, he clarified that he first met the Deceased on 11th January 2021. The plan of management was to do bronchoscopy and gastrograffin, but his name doesn't appear on the records. In reference to the operation notes of 9th

January 2021, findings of which were confirmed, he stated that it is not indicated whether the foreign body was removed. They found a mucus plug which was removed.

22. It was his testimony that a review of the CT scan was done on 20th January and a decision for elective bronchoscopy with possible thoracotomy was made. He confirmed that the consent was for explorative bronchoscopy. He reiterated that the consent form indicates consenting for such further operations that may be found necessary intraoperatively. He stated that during the bronchoscopy, two upper incisors came out and one of the teeth was retrieved from the mouth and the other one could not be retrieved. The purpose of the thoracotomy was to completely check for the tooth that had not been retrieved which he opined because he was in surgery. He submitted that when they performed the thoracotomy, they palpated the lungs, felt a hard mass, and when they did the sharp dissection, they found a tooth.

23. On the issue of any family discussions, he confirmed that after the operation, he was called to explain the intra-operative findings which he clearly explained to the parents. He informed them that there was one tooth retrieved from the mouth and the other from the sharp dissection of the lung. He stated that when he gave them the explanation, it was not palatable to them, and it was one of the reasons for the unfair accusations. He stated that he could not make up a story of what they found in theatre.

24. About the post-mortem report dated 13th May 2021, he confirmed that it has the logo of the Hospital and that the pathologist was Dr David Chumba. Further, Dr Chumba concluded that the cause of death was asphyxia due to aspirated food-a foreign object in the right bronchus with multiple abscesses, and samples for histology were taken. He stated that he could not change the pathology report and that he noted the findings as indicated. On his opinion of the foreign body found at post-mortem, he stated that according to Hill's criteria on causality, there are several factors that need to be considered. One of them is timelines, events preceding an outcome. From the post-mortem, it is indicated that the child died due to asphyxia due to aspirated food. In terms of Hill's criteria, he could not directly link surgery and aspiration. He opined that the Deceased received standard care available at the hospital.

25. On cross-examination by Committee, about the episodes of difficulty in breathing, he stated that they did not have any associated or aggravating factors. The justification for the gastrograffin test was based on the child's presentation. The child was also reported to be drooling and based on the history of choking on a foreign body which was not retrieved in the first bronchoscopy. He confirmed that a tooth did not fit the description of a ring-enhancing lesion, but the thick mucus plug would appear like it. He confirmed they anticipated finding a foreign body. He also confirmed that the tooth which they removed was what the Patient had aspirated in theatre. He stated that the finding of a tooth did not mark the end of their

search. After sharp dissection, they palpated both sides of the lung and inflated the lungs, and they expanded well and there were no areas of collapse. He submitted that there was no step that they missed in trying to retrieve the foreign body. On the bronchoscope used, he submitted that they used a rigid bronchoscope.

26. On the question of when the CT scan was done and whether there was possibly another report before they went to theatre? He stated that the scan was done before they went to theatre. On whether the right bronchotomy was opened following the CT scan, he stated that a bronchotomy was not done and that they did rigid bronchoscopy. That the CT scan images don't correlate with the report.

27. Further cross-examination by the Committee, he indicated that the operation notes were written by him immediately after the operation. He confirmed that he was the assistant surgeon. He confirmed that his operation notes failed to indicate the issue of the missing teeth that came off during intubation which he mentioned in his statement. He further confirmed that he missed indicating the issue of the missing teeth in his operation notes. On when the teeth were lost, he stated that the teeth were lost during bronchoscopy which was being undertaken by Dr Ondigo. He explained that teeth can be lost during bronchoscopy(rigid) during either the initial introduction or during the manipulation of the bronchoscope. He confirmed that the operation notes do not make mention of where the foreign body was. He confirmed that he was called by the attending nurse

to explain to the relatives. He clarified that he first spoke to the Patient's mother and grandmother who told him to wait and appraise the father too, which he did. He stated that the rude Dr Wanyonyi whom the Complainant described was not him. He stated that he was not in any way rude and that his interactions with people are always cordial.

28. **Dr Stephen Ondigo,** the 4th Respondent was the next person before the Committee. He adopted his signed statement dated 30th July 2021 as his evidence in chief. He stated that he is a cardiothoracic surgeon working at MTRH. He has an MMed degree in Surgery and a Fellowship in Cardiothoracic surgery and had been doing cardiothoracic work for the last 11 years together with Prof. Otsyula. He stated that the Patient was admitted on 9th January 2021 with a history of choking on a flower seed. Had drooling of saliva, vomiting, and mild cough. At the time of admission, the symptoms had improved. An impression of foreign body oesophagus with a differential diagnosis of foreign body bronchus was made and the cardiothoracic team was consulted. He submitted that he first saw the patient on 11th January 2021 during a major ward round with Prof. Otsyula and Dr Oloo. The child was stable, but they requested for gastrograffin study to assess if the child could be having an oesophageal foreign body or tracheo-oesophageal fistula (TOF).

29. On cross-examination by Prof. Kiama, Dr Ondigo confirmed that he was involved in the management of the patient while she was in the ward. He clarified that he is the one who indicated to the mother that they would

perform the bronchotomy with the possibility of thoracotomy but that the consent was signed by Dr Ismael.

30. On cross-examination by the Committee, he clarified that intraoperatively, they still looked for the foreign body by palpating the lung. They looked for the seed intraoperatively, but they did not locate it. They did a CT Bronchogram to give an indication and better level of accuracy at 67% of where the foreign body might have been. After they could not retrieve the seed, they had to monitor the patient and then subsequently repeat the CT scan. On why they did a bronchogram the first time and a normal CT scan the 2nd time, he stated that he was not involved in the decision to conduct the normal CT scan the second time in February but that the bronchogram is ideally more accurate. He stated that they advised the parents to go back to the hospital in case of any incidences. Further, at the time of her demise, the child was not in their custody.

31. On the post-mortem finding of a seed. He stated that he could not explain the same. He confirmed that they did an audit of the case. It was his evidence that at the time of discharge, the Patient was stable. When she was readmitted to the medical ward, a CT scan found pneumonia.

32. On further cross-examination by the Committee, Dr Ondigo stated that at the two-week follow-up after discharge from the surgical ward, the Patient did not present with any symptoms.

33. On the CT scan findings, he stated that he was informed by radiology that they saw a ring-like structure that was radiolucent in the right main bronchus. During the thoracotomy, they opened the right main bronchus as per the said CT scan. He confirmed that at Post-mortem the foreign body was found in the right bronchus. He submitted that literature postulates that 30% of foreign bodies can be ejected even without surgery.

34. Dr Ondigo confirmed that he was the team leader in the 2nd operation. On the contents of the operation notes, he confirmed that there was no mention of the teeth dislodgement. He stated that the teeth dislodged during bronchoscopy. He confirmed that during the procedure he did not remove the bronchoscope. He also confirmed that one tooth was found in the oral cavity, but he did not find the other tooth and he did not see the tooth while pushing in the bronchoscope. He stated that at the time they did not have tubes for lung isolation. He admitted that there was a possibility of having pushed the tooth with the bronchoscope or ET tube. He further stated that on using forceps he did not find any foreign body and on palpation, they did not feel any foreign body.

35. On whether a meeting was held at the hospital, he confirmed that the family meeting took about 10 hours because of arguments on whether the foreign body was removed or not.

36. On re-examination, he stated that when doing a major ward round and they would have explained to the parent what needs to be done, consent can be taken by any other doctor and not necessarily the consultant. On

the standard for removal of a foreign body, he stated thoracotomy is standard to be performed once an expected foreign body was not retrieved through bronchoscopy. On the findings at post-mortem, he stated that food particles were found in the airway and that is what the child had aspirated. Further, the foreign body was not the immediate cause of death.

37. **Prof. Barasa Otsyula Khwa,** the 3rd Respondent was the next person before the Committee. He adopted his statement dated of 29th July 2021 as his evidence in chief. It was his evidence that he saw the Patient three times. On all occasions, it was during the major ward round. He stated that on 11th January 2021, it was reported that the child had developed drooling of saliva, vomiting, and mild cough after choking on a flower seed on 9th January 2021. At bronchoscopy that evening, a mucus plug was found. The plug was suctioned out. At the review on 11th January, the child was reported to have had episodes of cough since the bronchoscopy. During the major ward round, he requested for a virtual bronchoscopy and gastrograffin swallow. On 18th January 2021, the child had no complaint. The gastrograffin swallow had been done and it was normal. They decided to wait for the virtual bronchoscopy.

38. It was his further statement that the virtual bronchoscopy done on 19th January 2021 was reported to show a "*right ring-like foreign body in the right main bronchus*". The child had a repeat bronchoscopy and right thoracotomy on 22nd January 2021. An incisor tooth was found and removed. On 25th January 2021, the chest tube, which was in place, was not

bubbling or draining and they decided to remove the tube and continue with physiotherapy.

39. Prof. Otsyula stated that he did not see the child again. He was not aware that the child had been admitted to the paediatric ward and he did not see the second CT scan. He learned of the demise of the child sometime in May 2021 after the family complained.

40. On cross-examination by Prof. Kiama, he stated that the doctors who operated stated that they found a tooth and no other foreign body was retrieved. He confirmed that the circumstances of the two teeth were brought to his attention and that they came out during bronchoscopy. On his opinion on the foreign body being found on the post-mortem, he stated that he did not dispute the finding at the post-mortem however, due diligence was done, and the child was well managed by the department.

41. On cross-examination by the Committee, he stated that when the Patient was readmitted, she should have been sent to the cardiothoracic surgical unit and they would have assessed her differently.

42. On re-examination, he stated that the cause of death as per post-mortem was not in doubt, the immediate cause of death was asphyxia due to aspirated food particles.

43. **Dr Ernest Nshom**, the 1st Respondent was the next person before the Committee. He stated that he qualified as a medical practitioner in 2013, and presently is a Resident in Anaesthesia and Critical Care at MTRH. He adopted his statement dated 29th July 2021 as his evidence in chief. It was his evidence that he was part of the management of the Deceased as part of the anaesthesia team in both procedures. He stated that on 9th January 2021 the main anaesthesia provider was a Clinical Officer anaesthetist who was leading the team but there was an anaesthesiologist on call.

44. During the 2nd procedure, the team leader was an anaesthesiologist assisted by a Clinical Officer anaesthetist and he was assisting. In response to the complaint against him for instructing the team, he stated that he was not in a position to instruct the team considering his role. Regarding the accusation of interaction with the mother after the procedure, he stated that he met the Complainant before the procedure and later at the entrance to the children's hospital when she enquired about what transpired intra-operatively (in an informal setup), he informed her of what he saw. He told her that they retrieved one tooth from thoracotomy.

45. On cross-examination by Prof. Kiama, he confirmed that at the theatre receiving area on 9th January 2021, the Complainant showed him the sample of the seed that the Deceased had indicated had swallowed. Further, after theatre, he denied that he told her that the seed she showed him was not what they found. Dr Nshom clarified that he only informed the Complainant of two teeth and denied telling her about three teeth in the

bandages. He stated that the lead anaesthesiologist was Dr Kimani Mbugua. He confirmed that he was present in both procedures. He also confirmed that his name was missing from the operation notes because the surgeon only indicate qualified practitioners. He stated that the role he played was that of a student assisting the lead anaesthesiologists.

46. **Dr Phillip Kirwa, ("Dr Kirwa")** the Senior Director, Clinical Services at MTRH, was the next person before the Committee. He adopted the executive case summary dated 30th July 2021 as his evidence in chief.

47. On cross-examination by Counsel for the Complainant, he confirmed that the Complainant expressed that the child was not managed well. He stated that they held a meeting with the family and the mother was very emotional. He stated that they offered the Complainant counselling because she was distressed and for emotional support. He confirmed that Dr Chumba works at MTRH, and his qualifications are known and acknowledged.

48. The last person to appear before the Committee was Dr Wilson Aruasa, **("Dr Aruasa")** the Chief Executive Officer of MTRH. Dr Aruasa submitted on behalf of the hospital. he adopted his statement of 4th October 2022 as his evidence in chief. It was his testimony that when the complaint was filed, he forwarded all the documents requested to the Council. He submitted that the hospital has invested heavily in the cardio-thoracic surgical unit; where they have an adult and paediatric ward, three well-trained surgeons and

equipment. They have several COSESCA trainees who get good training. That they hold clinical and mortality audits to improve the quality of care. In terms of the filing system, they have a robust system currently having an electronic system acting parallel to their existing manual system. They also started to migrate to fully electronic health records. Every patient has one file only which is easily retrievable. The same file used in the surgical ward would equally be used in the medical ward.

49. It was his testimony that they held a meeting with the family from 10 am to 4 pm, to go through the steps of management through all admissions. The meeting was partly chaired by Dr Kirwa and then by himself. In the meeting, there was some progress and a lot of back and forth. He stated that the Patient was taken to the funeral home on the day of the demise therefore they did not perform resuscitation. The food particles seen at post-mortem indicate that the cause of death was asphyxia due to aspirated food particles. It was his submission that the hospital provided the best care to the child. It was his further submission that while the case was lawfully before the Council, it was continually prosecuted on social media.

50. On cross-examination, he confirmed that Dr Wanyonyi was issued with a warning letter and the family was informed.

C. ISSUES FOR DETERMINATION

51. Upon careful evaluation and lengthy deliberation of the matter, the Committee notes that the substantive issue for determination are as hereunder: -

(i) Whether the Respondents owed the patient a duty of care and what is the expected standard of care;

(ii) Whether the 5th Respondent can be held liable for the acts or omissions of its servants/agents; and

(iii) Whether the 1st- 4th Respondents and 5th Respondent through its servants/agents were negligent in the treatment and management of the Patient.

D. FINDINGS

52. The Committee carefully considered the complaint as lodged before the Council, the statements and documents submitted by the parties herein to enable it to determine the matter fairly and judiciously. On careful evaluation and lengthy deliberation of the matter, the Committee notes that the complaint hinges on the treatment and management of the Deceased at the 5th Respondent Hospital.

53. The first issue for determination is whether the Respondents owed the patient a duty of care, and what is the expected standard. The Committee notes that duty of care is a legal obligation imposed on individuals or persons, requiring adherence to a standard of care while performing any acts that could foreseeably harm others. This means that hospitals and practitioners

shall be held to a particular standard when it comes to treating and managing patients who will fall under their care.

54. In the case of **Richard Njoki Wahome (suing as the administrator of the Estate of Wahome Mutahi (deceased) –vs- Attorney General & 2 others (2015) eKLR,** where the Court relied on the case of **Jimmy Paul Semenye -vs- Aga Khan Hospital & 2 others (2006) eKLR,** it was stated that;

> ***"There exists a duty of care between the patient and the doctor, hospital or health provider".***

55. On the expected standard, it can be stated that the standard will not be of an ordinary man but shall be a standard of the peers. Thus, a reasonable man can is substituted with "reasonable professional". **McNair J** in **Bolam vs Friern Hospital Management (1957) 2 All E.R**, explained the law on the test of professional negligence as;

> ***"but where you get a situation which involves the use of some special skill or competence, then the test whether there has been negligence or not is not the test if a man on the Chapman omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill at the risk of being found negligent.... It is sufficient is he exercises the ordinary skill of an ordinary competent man exercising that particular art."***

The Committee considered the case of **Nevill and Another -vs- Cooper and Another (1958) EA 594** it was held that;

> ***"if he professes an art, he must be reasonably skilled at it. He must also be careful but the standard of care which the law requires is not an insurance against accidental slips. It is such a degree of care as a normally skilful member of the profession may reasonably be expected to exercise in the actual circumstances that may present themselves for urgent attention...."***

It is judicious to emphasize that the standard of care in medicine is that which is already laid out in established international, regional, and country standards and guidelines, books, and peer-reviewed scientific journals.

56. In **Herman Nyangala Tsuma vs- The Nairobi Hospital and 2 others**, Odunga J stated that;

> ***"it is accepted in the medical profession that there is no objective test for determining the negligence of a doctor. Whereas doctors are supposed to operate within certain known parameters of the diagnosis the profession is not straight-jacketed to the extent that all doctors must respond in exactly the same way when confronted with a set of circumstances. As long as the doctor does not go outside the well-known medical procedures, it is accepted that there may be variation in approaches to particular cases".***

Consequently, in determining whether the duty has been discharged by not only a doctor but by a health care professional, regard must be given to whether the professional observed or followed universally accepted standards, guidelines, and protocols.

57. Having established that indeed a duty of care was owed to the Patient, and the expected standard of care, the question then becomes whether the 5th Respondent can be held liable for the acts or omissions of its servants/agents. The courts have pronounced themselves in this regard. The Committee considered **Hellen Kiramana –vs- PCEA Kikuyu Hospital Nairobi HCCC No. 54 of 2013**, where the Court quoted and relied on the case of **M (A Minor) vs- Amulega & Another (2001) KLR 420**, where it was held that;

> ***"Authorities who own a hospital are in law under the safe-same duty as the humblest of doctors. Whenever they accept a patient for treatment, they must use reasonable care and skill to cure him of his ailment. The hospital authorities cannot of course do it by themselves. They must do it by the staff whom they employ and if the staff is negligent in giving the treatment, they are just as liable for the negligence as is anyone else who employs others to do duties for him...it is established that those conducting a hospital are under a direct duty of care to those admitted as patients at the hospital. They are liable for the negligent acts of the member of staff, which constitutes a breach of that duty of care owed by him to the patient thus there has been acceptance from the courts that hospital***

authorities are in fact liable for the breach of duty by members of its staff. It is trite law that a medical practitioner owes a duty of care to his patients to take all due care, caution, and diligence in the treatment."

58. In the instant case, the Committee guided by the above precedents holds that a hospital is responsible for all those in whose charge the patient is placed, and the Respondent can be held liable for the acts of its servants/agents.

59. The Committee considered the final issue for determination, whether the 1st-4th Respondents and 5th Respondent through its servants/agents were negligent in the treatment and management of the Patient. Black's Law Dictionary 9th Edition defines negligence as;

"a failure to exercise the standard of care that a reasonably prudent person would have exercised in a similar situation: Any conduct that falls below the legal standard established to protect others against unreasonable risk of harm, except for conduct that is intentionally, wantonly, or willfully disregardful of other rights. The term denotes culpable carelessness".

60. The Court in the case of **Hellen Kiramana –vs- PCEA Kikuyu Hospital Nairobi HCCC No. 54 of 2013**, quoted the case of **Dr Laxman Balkrishna Joshi V. Trimbark Babu God Bole and another; AIR 1969 SC 128 and A.S Mittal V state of U.P; AIR 1989 SC 1570**, where it was held that when a doctor is consulted by a patient, the doctor owes to his patient certain duties which are (a) duty

of care in deciding whether to undertake the case(b) duty of care in deciding what treatment to give, and (c) duty of care in the administration of that treatment. A breach of any of the above duties may give a cause of action for negligence and a patient may on that basis recover damages from his doctor. In this case, the Supreme Court of India observed, inter alia, that negligence has many manifestations.

61. When a patient generally approaches a doctor or a hospital, his or her expectations are twofold; that the doctor and the hospital will provide medical treatment with all the knowledge and skill at their command, and secondly, that they will not do anything to harm the patient in any manner either because of their negligence, carelessness, or reckless attitude of their staff.

62. The Committee considered the treatment and management of the Deceased and notes that the Late Anita Jepkorir six years of age presented at MTRH on 9th January 2021 with a history of having aspirated a seed. Upon evaluation, Dr Oloo a Thoracic and Cardiovascular surgeon was consulted. He reviewed the child and on finding her relatively stable, discharged her with advice to return in case of any problems. She returned later in the evening of the same day with complaints of difficulty in breathing. A decision was made to perform a bronchoscopy, although they entertained the possibility of the seed being in the oesophagus. The Patient was prepared and taken to theatre. During bronchoscopy, a mucus plug was

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found and suctioned out. This was at the time considered to be the cause of the obstructive symptoms.

63. The child was returned to the ward where she continued to develop paroxysmal episodes of breathing difficulties. Based on this and upon review in the major ward round, a decision was made to conduct a CT Bronchogram, it demonstrated a ring-like foreign body in the proximal right main bronchus. On the strength of this finding, the Patient was scheduled for a repeat bronchoscopy.

64. The Committee notes that there is no evidence that consent was sought for thoracotomy, however, this finding notwithstanding, it was in the best interest of the Patient to perfume the thoracotomy where bronchoscopy is unsuccessful. The Committee finds that two incisor teeth were dislodged at the second bronchoscopy. One was retrieved from the oral cavity, and the other could not be accounted for. Having failed to locate the second tooth, Dr Ondigo introduced the bronchoscopy, and he visualized the foreign body. He, however, did not give details of the same. At that point, a decision was made to perform a right-sided thoracotomy and through it and after palpation of the lung for the foreign body, they removed a tooth through sharp dissection. Their effort to locate the foreign body by palpation was futile and they, therefore, closed the chest and sent the Patient back to the ward. Notably, during cross-examination by the Committee, Dr Wanyonyi stated that they closed the lung with Vicryl® suture. In the ward, the Patient

improved and was discharged to be followed up in the surgical outpatient clinic.

65. The Committee finds that at the second bronchoscopy, the misplaced incisor tooth was a red herring, and Dr Ondigo should have revisited the CT scan results before the incisor tooth dislodged. It is not possible to remove, an incisor tooth lost at bronchoscopy a few minutes earlier and claim it is the foreign body seen on the CT scan taken much earlier.

66. The Committee notes that after discharge the Patient was seen at both MTRH and Mediheal during which there was continued evidence of a retained foreign body and was finally admitted to the MTRH paediatrics ward with a pneumonic process. The Committee finds that there is no evidence that during this admission, the cardiothoracic team was consulted or involved in the management of the Patient. The Committee opines that had the cardiothoracic team been consulted, with her history and symptoms of a retained foreign body in the airway, the course of management would have changed, including consideration of a repeat CT bronchogram rather than a plain CT scan of the chest that only picked a pneumonic process and missed the seed that was eventually found at post-mortem examination. This further highlights the failures of internal consultation within the hospital given such a complicated case that needed close follow-up and lack of proper documentation on instructions given to the patient both within clinical continuation notes and on the discharge summary. If such instructions were clear on the discharge

summary, a copy of the same usually in the patient's file, the caregivers in the paediatric ward would have come across the information and consulted the thoracic surgical unit.

67. The Committee also finds that the failure to remove the foreign body "*black seed*", led to the accumulation of fluid distally. Sepsis set in leading to pneumonia and followed by septicaemia leading to the pus in the other organs found at post-mortem. The foreign body in question was missed at the first bronchoscopy as well as at the second bronchoscopy/thoracotomy. There was clinical evidence indicating the presence of a foreign body. Further, at thoracotomy, the clinical evidence was not interrogated critically. This error led to the removal of a tooth rather than both the tooth and the foreign body.

68. The Committee also considered the submissions made by the Complainant and the Respondents on the post-operative briefings in particular after the second procedure. The Committee notes that from the evidence, the briefings were done by Dr Nshom and Dr Wanyonyi, who were not the lead surgeon nor anaesthesiologist. It is good medical practice that the surgeon should conduct the post-operative briefing of either the patient or the guardian. Consequently, Dr Ondigo as the lead surgeon at the bronchoscopy and thoracotomy should have briefed the Patient's guardians of the findings intraoperatively, including the circumstances under which the teeth were dislodged and the management thereafter.

69. The Committee also considered the complaint made against Dr Wanyonyi on his conduct towards the Complainant. The Committee notes that from the submissions made by Dr Aruasa, Dr Wanyonyi was issued with a written warning letter, which action the Committee finds sufficient.

E. DETERMINATION

70. Given the above findings, the Committee holds that the complaint lodged by the complainant against the 4th and 5th Respondents has merit. The Committee presented its findings, as set out herein above, and its recommendations to the Kenya Medical Practitioners and Dentists Council in its meeting held in December 2022 wherein the decision of the Committee was upheld. Consequently, the Committee hereby issues the following orders;

(i) The complaint of negligence made against Dr Ernest Nshom, Dr Alfred Wanyonyi and Prof. Barasa Otsyula Khwa be and is hereby dismissed.

(ii) Dr Stephen Ondigo and MTRH be and are hereby directed to mediate with the Estate of the Late Anita Jepkorir jointly and severally with a view of making restitution and thereafter inform the Council within Ninety (90) days from the date hereof.

(iii) Dr Stephen Ondigo be and is hereby directed to pay a fine of Kenya shillings Two Hundred Thousand (KSh. 200,00/-) within fourteen (14) days from the date hereof.

(iv) Moi Teaching and Referral Hospital be and is hereby directed to pay a fine of Kenya Shillings Three Hundred and Fifty Thousand Shillings (KSh. 350,000/-) within fourteen days (14) from the date hereof.

(v) In the event of non-compliance with orders (ii), (iii) and (iv) above, the Council shall be at liberty to issue any such further orders as it deems fit.

Dated at Nairobi this 5th day of MAY, 2023

KENYA MEDICAL PRACTITIONERS AND DENTISTS COUNCIL
05 MAY 2023
P O Box 44839, NAIROBI

DR. TIMOTHY THEURI
CHAIR
DISCIPLINARY AND ETHICS COMMITTEE

MK ANNEX 2

COPY OF LETTER FROM MTRH DATED 5TH SEPTEMBER, 2023 WITH ATTACHED E-MAILS

An ISO 9001:2015 Certified Hospital

MOI TEACHING AND REFERRAL HOSPITAL

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Email: ceo@mtrh.go.ke/ceosoffice@mtrh.go.ke

NANDI ROAD
P.O. BOX 3-30100
ELDORET, KENYA

Ref: ELD/MTRH/ADMIN/1/15/VOL.111/2018

5th September, 2023

KMPDC/DEC. 1283/43/2021

Eunice Muriithi
Assistant Director Disciplinary & Ethics
Kenya Medical Practitioners & Dentists Council
KMPDC Complex – Woodlands Rd off
Lenana Rd, Hurlingham
P.O. Box 44839 – 00100
NAIROBI
Email e.muriithi@kmpdc.go.ke, info@kmpdc.go.ke

Dear Eunice,

MTRH MEDIATION PROGRESS REPORT ON DC CASE NO. 43 OF 2021 MERCY J KIPRONO V MTRH

Moi Teaching and Referral Hospital (MTRH) submits mediation progress report on DC Case No. 43 of 2021 Mercy Kiprono v MTRH.

1. Following your ruling on 5th May, 2023 MTRH promptly got in touch with Mercy Kiprono's advocate on record Professor Kiama Wangai, in compliance with the order to mediate on restitution (quantum of damages).
2. The two parties agreed that quantum of damages will be ascertained from Case Law. They were to decide on the mode of mediation. That is whether between Mr. Josphat Kirima, the MTRH advocate and Mercy's advocate directly or through a mediator.
3. MTRH has a Professional Indemnity cover for its doctors. Therefore, following this agreement it started the process of seeking indemnity from insurer on 29th May, 2023. A formal notification of claim was sent to the insurer on 7th June, 2023 and acknowledged.
4. On 2nd June, 2023 an advocate named Tarigo Kiptoo wrote to MTRH claiming to represent Mercy in place of Professor Kiama Wangai.

07/09/2023

5. Between 9th and 23rd June 2023, the insurer contacted Mercy notifying her of case referral by MTRH to them for mediation on quantum of damages (restitution). She was requested to propose quantum but the process stalled since she didn't cooperate.
6. On 3rd July, 2023 Mr. Kirima called Mercy but she did not answer his call. He called her husband Isaac Kandie. Isaac asked Kirima why MTRH had sent insurers to them. He was explained that it was to restitute them on behalf of MTRH and Dr. Ondigo. That Dr. Ondigo in legal language is an MTRH agent hence one and same thing. That MTRH as corporate entity is not able to do anything except through its directors and employees like Dr. Ondigo. Mr. Kirima sought to know the expected quantum. Isaac informed him that their advocate would get in touch with him.
7. On 6th July, 2023 Mercy wrote to MTRH's advocate and informed him that Mr. Tarigo Kiptoo was her advocate. There were numerous email correspondences in May, June, and August 2023 to no avail. This forced MTRH insurers to revert the mediation back to MTRH since dealing with Mercy bore no fruits at all. Up to now for all intents and purposes it is clear MTRH is dealing with Mercy directly and on its own. The advocates she has hired so far have deserted her, attempts to have MTRH insurers and other Government entities like Nairobi Centre for International Arbitration (NCIA) to intervene have proven futile.
8. On 24 July, 2023 MTRH requested mediation done under the guidance of NCIA since it is statutory body tasked with mediation. This was due to poor progress of mediation process and the fact that 90 days granted for mediation were almost over. NCIA accepted to mediate and on 25th July, 2023 M/s Tarigo Kiptoo advocates supported the mediation under NCIA.
9. On 28th July, 2023 MTRH paid requisite registration fee to NCIA and sought the matter to be expedited.
10. On 1st August, 2023 several things happened. NCIA appointed a mediator, Mercy Kiprono acknowledged the appointment and M/s Akweyu and Co Advocates came on record for Mercy Kiprono in the place of M/s Tarigo Kiptoo & Co Advocates. She indicated that she would proceed with mediation and agreed to be bound by the NCIA mediation rules. She further proposed a quantum of damages amounting to Kenya Shillings Sixty-One Million, One Hundred and Sixty Thousand (Kshs 61,160,000/=). NCIA acknowledged her appointment.
11. On 4th August, 2023 MTRH agreed to appointment of the mediator and sought M/s Akweyu's concurrence to jump start mediation process. It further responded to her proposal thus "it was not the appropriate time to address it since a mediator had already been appointed". Hence it (quantum) was major issue for mediation under the mediator. That both parties had agreed to be bound by NCIA rules i.e. to mediate through a mediator appointed by NCIA. Sought her concurrence to request Kenya Medical Practitioners & Dentists Council (KMPDC) to extend the mediation period by consent of parties since we had started making progress. It requested her to sign the mediation agreement and other documents sent by NCIA earlier on for filing and signing by both parties. MTRH had already filled and signed the necessary parts.
12. On 5th August, 2023 Mercy Kiprono abandoned her advocate M/s Akweyu and personally sent a report to KMPDC.
13. On 6th August, 2023 MTRH advocate wrote to Mercy seeking her concurrence for extension of the mediation period. She never responded.
14. On 8th August, 2023 NCIA set a virtual preliminary mediation conference date on 15th August, 2023. MTRH confirmed its availability but Mercy did not.
15. On 9th August, 2023 she wrote an email titled "What I would request KMPDC to consider". That is (a) mediation is a delaying tactic. (b) There was no need to extend the mediation process since the first month was wasted. This left MTRH in a loss. Who wasted the first month. Was it not her by withdrawing instructions from Professor Kiama Wangai forcing the mediation process to restart from scratch?

09/09/2023

16. On 15th August, 2023 NCIA called off the virtual Preliminary Mediation conference due to "lack of confirmation of availability from the claimant's (Mercy) side".
17. Despite all these things MTRH was hoping mediator would salvage the situation. That is why it sought NCIA's advice on whether the mediator could write a report of "no settlement due to non-attendance by the claimant (Mercy Kiprono)". The mediator sought for more time to try to get her on bound. Since MTRH has been and remains fully committed to the mediation process, Mercy has thwarted all attempts to mediate.
18. On 15th August, 2023 Mercy indicated via email that she is not against mediation and that she never replaced M/s Akweyu as an advocate.
19. On 16th August, 2023 Mercy wrote an email blaming MTRH for choosing the mediator and mediation venue. She was informed that she could change anything/everything that she was not agreeable to during the preliminary mediation conference if she agreed to it. That it would be at minimal cost since she could do it from her sitting room. She never responded.

From the prevailing facts MTRH is constrained to make this preliminary report as it awaits the mediator's directions.

Further it is clear to everybody that Mercy is a very difficult person to mediate with. Just like it was witnessed earlier before the hearing of her case and ruling dated 5th May, 2023, she has continued to malign and bully everybody who attempts to address this issue. Nobody has been spared including all three advocates she has hired in the last three months, KMPDC itself, NCIA, MTRH's Chief Executive Officer (CEO) and other Hospital Management Team members including all the doctors that interacted with her, MTRH advocate, etc. All her statements (which are always malicious) are in writing (electronic communications and most of them are copied to KMPDC, NCIA, their officers and even the NCIA appointed mediator) and will be availed at an opportune time (I have printed and attached a few of them here for ease of reference. Suffice it to say there are many more available).

Finally, it is our considered opinion that she can benefit from the mediator's input before the matter is escalated to the High Court of Kenya.

The purpose of this letter is to urge you grant mediation process a further forty-five (45) more days with effect from date of your communication NOT from 5th August, 2023 (the 90 days earlier granted).

We understand an Eldoret-based Non-Governmental Organization (NGO) is currently trying to assist her. It (the NGO) needs time to resolve this issue.

Kindly consider this preliminary report as you plan to make further orders.

Yours

MOI TEACHING AND REFERRAL HOSPITAL
CEO
APPROVED
05 SEP 2023
SIGN.....
P. O. Box 3-30100, ELDORET

05/09/2023

DR. WILSON K. ARUASA, *MBS, EBS*
CHIEF EXECUTIVE OFFICER

Mediation after 90 days that were given by KMPDC.

External
Inbox

m

mercy jepchirchir 16 Aug 2023, 13:39

to info, Wilson, CEO, me, legal, Philip, josphatkirima, Chief, registra, Joy, wamaithak93, Stephen, Director, Senior, Lawrence, victoria.kigen

Good afternoon Mr Kirima,
I have also noted your concerns.You are very much aware that I wasn't aware of what was going concerning NCIA since you and my previous lawyer decided to copy all parties and lock me out .I confirmed that after making a call to NCIA and later repeatedly begged Mr Tarigo to forward all the emails.I realized that I was the only one who had not been copied.?
Ok.

(1) while choosing mediator,who is suppose to do it?is it you,it is MTRH,is it me or both of us?
(2) when you were choosing or whoever choose the mediator, did you consider me in terms of distance, finance and transparency?
You are very much aware that it's you who has made us to be here.
Yes I lost Annita.Why all this circles.?to frustrate justice or what?
Delayed justice is denied justice.

W

Wilson Aruasa 16 Aug 2023, 13:45

to **josphat**, mercy, info, CEO, me, legal, Philip, josphatkirima, Chief, registra, Joy, wamaithak93, Stephen, Director, Senior, Lawrence, victoria.kigen

Kirima,

Handle this. It seems your active e-mail is not copied.

Why don't we use one e-mail trail/thread for all these?

Sent from my iPhone

> On 16 Aug 2023, at 1:39 PM, mercy jepchirchir <chirimercy80@gmail.com> wrote:
>
>

Josphat Mutuma Kirima <josphatkirima@mtrh.go.ke> 16 Aug 2023, 18:36

to Wilson, mercy, josphat, info, CEO, legal, Philip, josphatkirima, Chief, registra, Joy, wamaithak93, Stephen, Director, Senior, Lawrence, victoria.kigen

Good evening C.E.O.
Going forward I am not going to respond to Mercy in any other forum except the mediation email thread. I have informed her in the said email where Joy, the in charge of case management at NCIA, Gladys the mediator, Mercy herself and her advocate Catherine Akweyu are copied. Let us raise all her issues through the mediator henceforth.
With all due respect to Mercy I answered all those questions in your above email over the phone. I don't see any need to discuss them here again.
If you are interested in mediation let us mediate. If you are not interested, that is still fine. Why should you keep shifting the discussions from one forum to another, if you are ready to mediate? It is high time this discussion shifted to the future and not remain stuck in the past. If you are not comfortable with anything you can address it during the first meeting. It is going to be virtual so you can do it from your own house. There is no distance involved. But remember the charges are based on time spent in mediation. The more time spent the more the pay. Finally both parties will pay the mediation cost equally.

Regards.
Josphat Mutuma Kirima.
Head of Dispute Settlement Services.
Notary Public & Commissioner for Oaths.
Advocate of High Court of Kenya.
Principal Legal Officer.
Snr Principal Clinical Officer Anaesthetist.
Moi Teaching & Referral Hospital.
AMPATH BUILDING RM 202/214.

Mail Delivery Subsystem 16 Aug 2023, 18:36

Message blocked Your message to registra@ncia.or.ke has been blocked. See technical details below for more information. The response from the remote server was:

Wilson Aruasa 16 Aug 2023, 18:43

to **mercy, josphat, info, CEO, legal, Philip, josphatkirima, Chief, registra, Joy, GLADYS,**

Stephen, Director, Senior, Lawrence, Victoria, me

That's OK Kirima. The mediation process must move forward to a conclusion ASAP.

Josphat Mutuma Kirima <josphatkirima@mtrh.go.ke> 16 Aug 2023, 19:40

to **josphat**, Wilson, mercy, info, CEO, legal, Philip, josphatkirima, Chief, registra, Joy, GLADYS, Stephen, Director, Senior, Lawrence, Victoria

Thank you C.E.O

Mail Delivery Subsystem <mailer-daemon@googlemail.com> 16 Aug 2023, 19:40

to me

Message blocked

Your message to **registra@ncia.or.ke** has been blocked. See technical details below for more information.

Conversation opened. 5 messages. All messages read.

Skip to content
Using Moi Teaching and Referral Hospital Mail with screen readers

59 of 2,186

(no subject)

External
Inbox

m

mercy jepchirchir 16 Aug 2023, 23:22

to info, legal, CEO, Philip, Wilson, me, josphatkirima, CEOs, Admin, Joy

MTRH CEO.
Stop telling your advocate to call me and my family. Be informed 90 days are over.
You have chosen mediator go a head.

W

Wilson Aruasa 16 Aug 2023, 23:32

No one needs to call you for anything else other than mediation. And if you want the mediation to collapse so that the matter heads to the High Court, that's fi

W

Wilson Aruasa 16 Aug 2023, 23:34

to mercy, info, legal, CEO, Philip, me, josphatkirima, CEOs, Admin, Joy, josphat

No one needs to call you for anything else other than mediation. And if you want the mediation to collapse so that the matter heads to the High Court, that's fine. In fact, and I'm sure of this,everyone fears talking with you as you intimidate and threaten all who ever deal with you. Anyone who attempted to help you rued the day they did so, you're just so difficult to deal with!

So we can't send anyone to talk with you and get threatened in the process. We only were interested in the mediation process which you have so demonstrated you're not interested at all.

We don't fear you and you can not threaten me or MTRH. Learn that tonight.

And if I may just ask you, why are you jamming our e-mail inboxes with new e-mails all over the place? This habit has got to stop forthwith.

Sent from my iPhone

josphat Mutuma kirima 17 Aug 2023, 12:37

to mercy, Wilson, Philip, me, josphatkirima@gmail.com

C.E.O.
I am following everything keenly but silently sir.
All I can say is that, the earlier Mercy starts listening to advice (including that of her advocates) the better. Unfortunately that may happen too late. I notice she is not willing to respond on the mediation thread, neither is she willing to disclose the name of her advocate. You told her if she is uncomfortable with the mediator appointed by NCIA by consent of both parties earlier on, she can propose another one from the NCIA pool of mediators. She didn't respond to that. On venue and costs (despite the fact that she took the issue to KMPDC in Nairobi (near Forces memorial hospital) further that NCIA (that is in Cooperative House) next to Eldoret Matatu stage in Nairobi) I informed that the initial meetings will be virtual and she can attend them from her own house at minimal cost. Again she conveniently forgot that. She keeps saying we have not been given more time by KMPDC yet she is not ready to appear before the mediator where parties can agree to ask for extension. MTRH cannot ask for extension alone. She seems to erroneously believe that an imaginary calamity will befall MTRH since the said 90 days have lapsed. I advised her to look at Section 20(9) of the Medical Practitioners and Dentist Act. If she read it, she would know that if mediation fails we are heading to the high Court. If everything else fails that is the final destination. But it is her decision to make not ours.

Regards
Josphat Mutuma Kirima,
Head of Dispute Settlement Services,

Notary Public & Commissioner for Oaths,
Advocate of the High Court of Kenya,
Principal Legal Officer,
Snr Principal Clinical Officer Anesthetist,
Moi Teaching and Referral Hospital
P.O.BOX 3 code 30100
Kenya
Post graduate Diploma Kenya Sch of Law Nrb,
Bachelor of Laws Moi University.
HND Anaesthesia,
Dip Clinical medicine & Surgery

W

Wilson Aruasa 17 Aug 2023, 13:26

to josphat, mercy, Philip, me, josphatkirima@gmail.com

Kirima,

Very well stated.

I have set the record straight on all her lies and paranoia. I'm aware she is copied here. She needs to help herself by realizing she is the only problem to herself. Shadow-boxing and sideshows will not help her. Let her tell us who is her advocate, who else in her family is assisting her so that we can progress this matter of mediation as required of both parties. She can also tell us if she has since appointed or selected another mediator.

Threats, intimidation and outright lies will NOT work. She keeps saying I have sent I don't know who to who, which is of course not true at all. Even then, I wonder if she is supposed to mediate all alone in a vacuum, without the other party MTRH, without her lawyer and without her family members!

Dr. Wilson K. Aruasa, (***MBS***), (***EBS***), MBChB(MU) ;MMed-ObsGyn(UoN) ;MBA(USIU);
Chief Executive Officer, Moi Teaching and Referral Hospital & Consultant Obstetrician/ Gynaecologist.
Eldoret, Kenya.

60 of 2,186

(no subject)

External
Inbox

m

mercy jepchirchir 17 Aug 2023, 09:24

to info, legal, CEO, Director, Senior, Wilson, Philip, Stephen, wamaithak93, victoria.kigen, Joy, Josphat, josphatkirima, me, Admin

MTRH CEO

You instructed Mr Kirima to call us for meditation yet the time for the same was over. KMPDC had not added more time.

I am not feared by any body.Those are your own thinking and words.My be you fear the Truth.You are fearing the TRUTH not me.That is why you have tried all kinds of intimidations to sabotage the justice of ANITA.You sent Dr Ondigo to the village perform Kallenjin traditional apologies.....sent him again to my home in Eldoret with a Memorandum of understanding from advocate Orina .... you sent people to my family to warn me not to go for hearing..... You sent Yumbya, Eunice Muriithi kmpdc to intimidate me .I repeat no body fear me it's you who fears the TRUTH.
You have been warning me over high court.If you know you clean why worry a bout high court? Why do we have high court. who has said I am going to high court.

W

Wilson Aruasa 17 Aug 2023, 09:51

to mercy, info, legal, CEO, Director, Senior, Philip, Stephen, wamaithak93, victoria.kigen, Joy, Josphat, josphatkirima, me, Admin

I will not engage you anymore. You can continue saying we sent so and so to you or anywhere else. Lies and paranoia repeated 100 times do not become true. You're the biggest enemy of

yourself.

Sent from my iPhone

> On 17 Aug 2023, at 9:24 AM, mercy jepchirchir <chirimercy80@gmail.com> wrote:
>
>

Wilson Aruasa 17 Aug 2023, 10:00

to mercy, info, legal, CEO, Director, Senior, Philip, Stephen, wamaithak93, victoria.kigen, Joy, Josphat, josphatkirima, me, Admin

May be you get things mixed up; I never for once saw or treated your late daughter Anita. Our staff who treated her did their best and went as per the Standards of Care required as we explained to you and KMPDC. That remains the factual position. Stop bringing your misplaced anger and personalizing things here. Until I came across you during our 8-hour meeting you keep referring to(which was prolonged by the way because you're just too difficult to deal with), I never knew you and would be more than happy if I never ever interacted with you. You definitely need to reflect, help yourself to be calm and reasonable first. From there, it will be easy to reason with you and clear with either the mediation process or whichever other process you elect to go through.

Who is your advocate again so that we deal directly with her or him instead of you? Who else from your family can we work with in this process?

You said MTRH has appointed a mediator? If you have a problem with that, help us by appointing one yourself.

Sent from my iPhone

> On 17 Aug 2023, at 9:51 AM, Wilson Aruasa <aruasaw@gmail.com> wrote:
>
> I will not engage you anymore. You can continue saying we sent so and so to you or anywhere else. Lies and paranoia repeated 100 times do not become true. You're the biggest enemy of yourself.

Wilson Aruasa 17 Aug 2023, 10:10

to mercy, info, legal, CEO, Director, Senior, Philip, Stephen, GLADYS, Victoria, Joy, Josphat, josphatkirima, me, Admin

And pray, what is this "Truth" you assume either MTRH or I fear by the way? Let that "Truth" come out in any fair and objective process, there is nothing for anyone to fear.

You're just someone uses to bullying and subduing others into submission, it would seem. And having your way your wish. Here you can't and won't bully anyone, not MTRH, not I or anyone else.

Chirimeray80@gmail.com.

MK ANNEX 3

COPY OF LETTER FROM MTRH DATED 14TH DECEMBER, 2023 WITH ATTACHED E-MAILS

Eldoret, Kenya.

Josphat Mutuma Kirima <josphatkirima@mtrh.go.ke>

16 Oct 2023, 17:18

to Wilson, Chief, Director

C.E.O.
That is true sir. MTRH can not take any further steps other than to confirm the mediators report to KMPDC. It is Mercy to decide what to do with her case from there onwards. MTRH can not take it to court since it is not the complainant.

Regards.
Josphat Mutuma Kirima,
Head of Dispute Settlement Services,
Notary Public & Commissioner for Oaths,
Advocate of High Court of Kenya,
Principal Legal Officer,
Snr Principal Clinical Officer Anaesthetist,
Moi Teaching & Referral Hospital,
AMPATH BUILDING RM 202/214.

C.E.O.
Good afternoon Sir.
This meeting took place today before M/S Wamaitha the mediator. Madam Joy Maina was present for NCIA. I was present for MTRH. There was no appearance for Mercy.
It was agreed that the mediator will wrote a report of no settlement to KMPDC and copy MTRH. She will be clear that mediation failed due to non attendance of the complainant Mercy Jepchirchir Kiprono. That MTRH paid and was always available for the mediation and that she reached out to Mercy who insisted that she will mediate directly with MTRH. She promised to deliver the report before Friday the 20th October 2023.

In my opinion this marks the end of the mediation process and the beginning of the litigation process.

Regards.
Josphat Mutuma Kirima,
Head of Dispute Settlement Services,
Notary Public & Commissioner for Oaths,
Advocate of High Court of Kenya,
Principal Legal Officer,
Snr Principal Clinical Officer Anaesthetist,
Moi Teaching & Referral Hospital,
AMPATH BUILDING RM 202/214.

W

Wilson Aruasa <aruasaw@gmail.com>
16 Oct 2023, 16:53

to **Chief**, **Director**, me

Thanks for the update Kirima.

No need for litigation unless Mercy goes for it herself. Even then, that will end with Court Annexed Mediation process.

Dr. Wilson K. Aruasa, (***MBS***), (***EBS***), MBChB(MU) ;MMed-ObsGyn(UoN) ;MBA(USIU);
Chief Executive Officer, Moi Teaching and Referral Hospital & Consultant Obstetrician/ Gynaecologist.

An ISO 9001:2015 Certified Hospital

MOI TEACHING AND REFERRAL HOSPITAL

Email: ceo@mtrh.go.ke
Telephone: 053 2033471/2/3
Fax: 053 2061749
ceo@mtrh.go.ke/directorsofficemtrh@gmail.com

NANDI ROAD
P.O. BOX 3-30100
ELDORET, KENYAEmail:

Ref: ELD/MTRH /ADMIN/1/VOL.11/2007

14th December 2023

Eunice Muriithi
Assistant Director Disciplinary & Ethics
Kenya Medical Practitioners & Dentists Council
P.O. Box 44839 - 00100
NAIROBI

Email e.muriithi@kmpdc.go.ke; info@kmpdc.go.ke

KENYA MEDICAL PRACTITIONERS AND DENTISTS COUNCIL
[illegible] 2023
DISCIPLINARY AND ETHICS DEPARTMENT
P.O. Box 44839 - 00100, NAIROBI

Dear Ms Muriithi

MTRH MEDIATION PROGRESS REPORT ON DC CASE NO. 43 OF 2021 MERCY J. KIPRONO Vs MTRH

Moi Teaching and referral Hospital (MTRH) refers to your letter reference number KMPDC/DEC/1268/43/2021/40 dated 11/09/2023. We greatly appreciate your extension of the mediation period for 45 days with effect from 11th September 2023.

All efforts to progress the mediation did not bear any fruits because Mercy J. Kiprono refused to participate in any way. There is enough evidence to demonstrate all that was done. All the communications are in writing (electronic communications and most of them are copied to Kenya Medical Practitioner's Dentist Council (KMPDC), Nairobi Centre for International Arbitration (NCIA) their officers and even the (NCIA) appointed mediator). Attached please find the various email correspondences.

It is our considered opinion that the mediation has irretrievably collapsed. This issue cannot be resolved by mediation or any other Alternative Dispute Resolution (ADR).

Kindly consider this report as you plan to make further orders.

Yours Sincerely

for DR. WILSON K. ARUASA, *MBS, EBS*
CHIEF EXCUTIVE OFFICER

CHIEF EXECUTIVE OFFICER
14 DEC 2023

CEOs Office <ceosoffice@mtrh.go.ke>

Re: DIRECTIONS-DC CASE NO. 43 OF 2021

josphat Mutuma kirima <josmukir@yahoo.com> 22 November 2023 at 10:18
Reply-To: josphat Mutuma kirima <josmukir@yahoo.com>
To: Chief Executive <ceo@mtrh.go.ke>, Wilson Aruasa <aruasaw@gmail.com>
Cc: CEOs Office <directorsofficemtrh@gmail.com>

Good morning C.E.O.

The 45 days extension of the mediation period lapsed on 1st November 2023. Both Mercy and the mediator went quiet. It is in interest of MTRH to file a report to KMPDC-DC informing them what transpired for them to issue further orders.

With your permission I can draft a report after the Legal & Corporate Affairs directorate meeting starting at 11.AM today for your consideration.

Regards
Josphat Mutuma Kirima,
Head of Dispute Settlement Services,
Notary Public & Commissioner for Oaths,
Advocate of the High Court of Kenya,
Principal Legal Officer,
Snr Principal Clinical Officer Anesthetist,
Moi Teaching and Referral Hospital
P.O.BOX 3 code 30100
Kenya
Post graduate Diploma Kenya Sch of Law Nrb,
Bachelor of Laws Moi University.
HND Anaesthesia,
Dip Clinical medicine & Surgery

[Quoted text hidden]

Fwd: Discontentment on mediation process

External
Inbox

CEOs Office <directorsofficemtrh@gmail.com>
18 Sept 2023, 08:35

to me, Josphat, Chief, Wilson

Dear Kirima,

Forwarded is an -email from Mercy Jepchirchir on Discontentment on mediation process.

- follow up with MPDC. That we have no issue with all points raised, but mediation be done physically in neutral grounds, Nakuru, Nairobi or Kisumu cities.

Please acknowledge receipt.

Kind regards.

Dr. Wilson K. Aruasa, *MBS, EBS*
Chief Executive Officer

-- Forwarded message ---------
From: **mercy jepchirchir** <chirimercy80@gmail.com>
Date: Sat, 16 Sept 2023 at 12:10
Subject: Discontentment on mediation process
To: Eunice Muriithi <e.muriithi@kmpdc.go.ke>, Chief Executive <ceo@mtrh.go.ke>, CEOs Office <directorsofficemtrh@gmail.com>
Cc: CEO KMPDC <ceo@kmpdc.go.ke>, legal Department <legal@kmpdc.go.ke>

Good morning,
I accepted the request made by MTRH that we inform KMPDC to consider extending the mediation period by 45 more days in good faith/will, however I want to let your office be informed of the discontent on my part for the following reasons:

1 .THAT the council ignored the choice of mediator as requested by claimant.

2.THAT the request to meditate in Eldoret through physical means has been ignored.

3.THAT the first 90 days as granted for meditation did include weekend and public holidays.It also had a timeline of 90 days after which the report was done.

4 .THAT the 45 more days granted for meditation did exclude the weekend and public holidays making it extend more time.It also noted that this has no time lapse and that report be submitted after meditation process.....

5. THAT meditation through virtual means is null and void.I may not be a partisan of it as it doesn't not show any Goodwill on whole process.

6 THAT these issues be addressed in a manner of goodwill in order to put this matter to closure.

In conclusion, Justice delayed is justice denied.

Regards
Mercy.

PRELIMINARY CONFERENCE - DIS/MED/02/23

External
Inbox

J

Joy Maina <Joy.Maina@ncia.or.ke>

13 Sept 2023, 11:35

to Gladys, chirimercy80@gmail.com, me

Dear Ms. Wamaitha,

The KMPDC has extended the period for Mediation in this dispute for 45 days as per the attached letter dated 11th September 2023.

Kindly provide us with dates that you are available for a preliminary conference for the parties consideration at the earliest to commence this Mediation process.

Kind Regards,

Joy Maina
Manager, Case Management

Please consider the environment before printing this email.

Nairobi Centre for International Arbitration
Haile Selassie Avenue, Co-operative Bank House, 8th Floor
P.O. Box 548-00200 Nairobi | Mobile: +254720879674
Email: Joy.Maina@ncia.or.ke | Web: www.ncia.or.ke

Gladys Wamaitha <gladys@scmafrica.com>
13 Sept 2023, 21:27

to Joy, chirimercy80@gmail.com, me

Dear Ms. Joy Maina,

Thank you for your email and the notification that the Board has extended the period by 45 days.

I write to inform you that I am available on either 25.09.23 or 26.09.23 for the pre- trial conference. I will appreciate notification of the convenient date to the Parties.

Yours Faithfully.

Gladys Wamaitha

Sent from Mail for Windows

Joy Maina <Joy.Maina@ncia.or.ke>

14 Sept 2023, 09:08

to Gladys, chirimercy80@gmail.com, me

Dear Josphat and Mercy,

The Mediator, Ms. Wamaitha, is available for a preliminary conference on either 25th September 2023 or 26th September 2023.

Kindly let us know which of the two dates is availabie to you. This meeting will be held virtually.

Kind Regards,

Joy Maina
Manager, Case Management

Please consider the environment before printing this email.

Nairobi Centre for International Arbitration
Haile Selassie Avenue, Co-operative Bank House, 8th Floor
P.O. Box 548-00200 Nairobi | Mobile: +254720879674
Email: Joy.Maina@ncia.or.ke | Web: www.ncia.or.ke

From: Gladys Wamaitha <gladys@scmafrica.com>
Sent: Wednesday, September 13, 2023 9:27 PM
To: Joy Maina <Joy.Maina@ncia.or.ke>
Cc: chirimercy80@gmail.com <chirimercy80@gmail.com>; josphatkirima@mtrh.go.ke <josphatkirima@mtrh.go.ke>
Subject: RE: PRELIMINARY CONFERENCE - DIS/MED/02/23

Dear Ms. Joy Maina,

Thank you for your email and the notification that the Board has extended the period by 45 days.

I write to inform you that I am available on either 25.09.23 or 26.09.23 for the pre- trial conference. I will appreciate notification of the convenient date to the Parties.

Yours Faithfully.

Gladys Wamaitha

Sent from Mail for Windows

From: Joy Maina
Sent: Wednesday, 13 September 2023 11:36
To: Gladys Wamaitha
Cc: chirimercy80@gmail.com; josphatkirima@mtrh.go.ke
Subject: PRELIMINARY CONFERENCE - DIS/MED/02/23

Dear Ms. Wamaitha,

Josphat Mutuma Kirima <josphatkirima@mtrh.go.ke>

14 Sept 2023, 10:54

to Joy, Gladys, chirimercy80@gmail.com, bcc: Wilson, bcc: Chief

Good morning, Joy.

I am available on both dates. Just choose any.

Regards.

Josphat Mutuma Kirima,
Head of Dispute Settlement Services,
Notary Public & Commissioner for Oaths,
Advocate of High Court of Kenya,
Principal Legal Officer,
Snr Principal Clinical Officer Anaesthetist,
Moi Teaching & Referral Hospital,
AMPATH BUILDING RM 202/214.

2 attachments • Scanned by Gmail

J

Joy Maina <Joy.Maina@ncia.or.ke>

14 Sept 2023, 17:31

to me, Gladys, chirimercy80@gmail.com

This is well noted Josphat.

Kind Regards,

Joy Maina
Manager, Case Management

PRELIMINARY CONFERENCE - DIS/MED/02/23

External
Inbox

Josphat Mutuma Kirima <josphatkirima@mtrh.go.ke>

9 Oct 2023, 14:56

to **Wilson**, **Chief**, Joy, Gladys, chirimercy80@gmail.com

Good afternoon, Madam Joy.
We were invited to a preliminary meeting on 25th or 26th September. I indicated my availability, but Mercy (copied this email) never commented. The 45 days (extension period) are almost over.
Has the mediator been able to reach out to Mercy? Can she give out a certificate of no settlement?
Kindly advice.

Regards.
Josphat Mutuma Kirima,
Head of Dispute Settlement Services,
Notary Public & Commissioner for Oaths,
Advocate of High Court of Kenya,
Principal Legal Officer,
Snr Principal Clinical Officer Anaesthetist,
Moi Teaching & Referral Hospital,
AMPATH BUILDING RM 202/214.

to Joy, Gladys, chirimercy80@gmail.com, Wilson, Chief

Thank you so much Madam Maina.
We look forward to your further advice.

Regards.
Josphat Mutuma Kirima,
Head of Dispute Settlement Services,
Notary Public & Commissioner for Oaths,
Advocate of High Court of Kenya,
Principal Legal Officer,
Snr Principal Clinical Officer Anaesthetist,
Moi Teaching & Referral Hospital,
AMPATH BUILDING RM 202/214.

One attachment • Scanned by Gmail

Joy Maina <Joy.Maina@ncia.or.ke>

11 Oct 2023, 16:04

to me, Gladys, chirimercy80@gmail.com, Wilson, Chief

NCIA is inviting you to a scheduled Zoom meeting.

Topic: PRELIMINARY MEETING
Time: Oct 16, 2023 15:00 Nairobi

Join Zoom Meeting
https://us06web.zoom.us/j/88131195855?pwd=k4nivLxTyYQ1V1qlgX8ve5bHag9ML5.1

Meeting ID: 881 3119 5855
Passcode: 146027

One tap mobile
+15074734847,,88131195855#,,,,*146027# US

+15642172000,,88131195855#,,,,*146027# US

Dial by your location
- +1 507 473 4847 US
- +1 564 217 2000 US
- +1 646 931 3860 US
- +1 669 444 9171 US
- +1 669 900 6833 US (San Jose)
- +1 689 278 1000 US
- +1 719 359 4580 US
- +1 929 205 6099 US (New York)
- +1 253 205 0468 US
- +1 253 215 8782 US (Tacoma)
- +1 301 715 8592 US (Washington DC)
- +1 305 224 1968 US
- +1 309 205 3325 US
- +1 312 626 6799 US (Chicago)
- +1 346 248 7799 US (Houston)
- +1 360 209 5623 US
- +1 386 347 5053 US

Meeting ID: 881 3119 5855
Passcode: 146027

Find your local number: https://us06web.zoom.us/u/kd53n8XCFj

Join by Skype for Business
https://us06web.zoom.us/skype/88131195855

Kind Regards,

Joy Maina
Manager, Case Management

Nairobi Centre for International Arbitration
Haile Selassie Avenue, Co-operative Bank House, 8th Floor

P.O. Box 548-00200 Nairobi | Mobile: +254720879674
Email: Joy.Maina@ncia.or.ke | Web: www.ncia.or.ke

From: Josphat Mutuma Kirima <josphatkirima@mtrh.go.ke>
Sent: Monday, October 9, 2023 4:15 PM

Josphat Mutuma Kirima <josphatkirima@mtrh.go.ke>

11 Oct 2023, 16:21

to Joy, Gladys, chirimercy80@gmail.com, Wilson, Chief

Good afternoon Madam Joy.
I will be available.
Will Mercy be available? She sent me a blank email today at 12:56 PM copied to KMPDC C.E.O & Legal Department & C.E.O MTRH in an email thread titled "dissatisfaction with mediation process". I do not know what she wanted to say. Maybe she can elaborate here.

Regards.
Josphat Mutuma Kirima,
Head of Dispute Settlement Services,
Notary Public & Commissioner for Oaths,
Advocate of High Court of Kenya,
Principal Legal Officer,
Snr Principal Clinical Officer Anaesthetist,
Moi Teaching & Referral Hospital,
AMPATH BUILDING RM 202/214.

One attachment • Scanned by Gmail

Josphat Mutuma Kirima <josphatkirima@mtrh.go.ke>

16 Oct 2023, 16:44

to **Director**, Wilson, Chief