(2) Hon. Speaker
You may approve for tabling
31/5/23

(1) COS
Recommended for approval for tabling
31/05/2023

APPROVED
31/5/23

THE REPUBLIC OF KENYA

THIRTEENTH PARLIAMENT

THE SENATE

THE STANDING COMMITTEE ON HEALTH

REPORT ON THE DEATH OF THE LATE EDWARD OTIENO ONYANGO AT MAMA LUCY KIBAKI HOSPITAL DUE TO ALLEGED MEDICAL NEGLIGENCE

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

Clerks Chambers,

Parliament Buildings,

NAIROBI

MAY, 2023

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

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PRELIMINARIES

A. Establishment and Mandate of the Standing Committee on Health

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

B. Membership of the Committee

The Committee is comprised of the following Members:

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

C. Functions of the Committee

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

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

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

3. Study and review all legislation referred to it;

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

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

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

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

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

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

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

D. Government Agencies and Departments

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

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

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

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

CHAIRPERSONS' FOREWORD

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

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

The Statement sought to establish the circumstances that led to the avoidable death of the late Edward Otieno Onyango who died at Mama Lucy Kibaki Hospital from injuries sustained in a road traffic accident on 12th September, 2022.

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

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

a. Issues for Determination

In conducting this inquiry, the Committee noted that the key issue for determination centered around whether the late Edward received timely emergency treatment and treatment at Mama Lucy Kibaki Hospital (MLKH) prior to his death.

b. Committee Findings

On 11th September, 2022, at 11.23 pm, the late Edward Otieno Onyango was brought into the Accident & Emergency (A&E) Department at Mama Lucy Kibaki Hospital by officers from Mowlem Police Station following a road traffic accident along Kangundo Road.

At the time of being received at the A&E, the late Edward was described as being in fair general condition, albeit pale and agitated. It was the evidence of Nairobi City County and Mama Lucy Kibaki Hospital that the late Edward refused treatment and

insisted on being referred to a different facility.

According to members of his family, following the accident, they arrived at the facility on 12th September, 2022, at approximately 12.30 am to find the late Edward bleeding on the floor of the A&E department at Mama Lucy Kibaki Hospital (MLKH) without any assistance.

As attempts were being made to transfer him into an ambulance in order to refer him to a different facility as per the family's request, the condition of the late Edward suddenly changed. Attempts to resuscitate him commenced immediately but failed. At 2.30 am, he was pronounced dead.

Following his death, there was general public outcry with allegations of delayed treatment and medical negligence being leveled against Mama Lucy Kibaki Hospital (MLKH)

c. Committee Observations

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

1. Contrary to the provisions of Article 46(1) of the Constitution, section 4 of the Health Act and the Kenya EMC policy, the late Edward was not properly triaged at the Accident & Emergency (A&E) department at MLKH; neither did MLKH institute prompt emergency trauma care for the late Edward, as required; and, that there was a delay of at least 2 hours before emergency interventions were instituted;

2. In relation to the above, the Committee further noted that emergency medical treatment for the patient seemingly commenced only after the arrival of his relatives;

3. The attitude of the nursing personnel that ought to have attended to the late Edward was callous, poor and dismissive. Despite having fallen, the late Edward laid in distress bleeding on the floor for at least two hours without any attempt by the staff at the A&E department to assist him. In fact, in the presence of his family, a cleaner came and cleaned his blood around him, leaving him where he was lying; and

4. There was no evidence to support submissions by Nairobi City County (NCCG) and MLKH that emergency treatment was not instituted owing to the fact that

the late Edward allegedly declined treatment as demonstrated by the following-

- As per standard procedures, the hospital ought to have obtained a signed declaration by the patient indicating that he had declined to receive treatment. It was, however, unable to provide such proof; and

- With a Glascow Coma Scale (GCS) of 14/15 the late Edward was confused, and could not have been considered clinically competent to make such a decision.

d. Committee Recommendations

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

1. Mama Lucy Kibaki Hospital be investigated by the relevant health regulatory bodies for culpability in the wrongful death of the late Edward Otieno Onyango owing to proof of medical negligence at the facility.

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

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

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

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

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

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

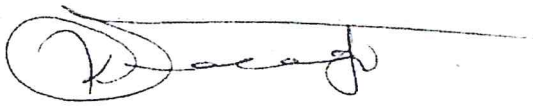
The Standing Committee on Health wishes to sincerely condole with the family and friends of the late Edward Otieno Onyango. The Committee also condoles and empathizes with the families and friends of the hundreds of Kenyans who lose their lives every day as a result of being unable to access emergency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

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

The Committee further wishes to thank the various stakeholders who came before the Committee and submitted their statements, including- the Governor, Nairobi City County, the management of Mama Lucy Kibaki Hospital, the Kenya Health Professionals Oversight Authority (KPOA), Kenya Medical Practitioners and Dentists Council (KMPDC), Nursing Council of Kenya (NCK), Kenya Clinical Officers Council (KCOC), Kenya Medical Association (KMA), National Nurses Association of Kenya (NNAK), Kenya Clinical Officers Association (KCOA), Kenya Medical Practitioners and Dentists Union (KMPDU), Kenya National Union of Nurses (KNUN), Kenya Union of Clinical Officers (KUCO), Emergency Medicine Kenya Foundation (EMKF), Bioethics Society of Kenya (BSK), the Law Society of Kenya (LSK) and Confraternity of Patients of Kenya (COFPAK).

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

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



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

Date: .....**31/3/2023**.....

SEN. JACKSON MANDAGO, EGH, M.P.,

CHAIRPERSON, STANDING COMMITTEE ON HEALTH

CHAPTER ONE

INTRODUCTION

A. Background

On 11th September, 2022, at 11.23 pm, the late Edward Otieno Onyango was brought into the Accident & Emergency (A&E) Department at Mama Lucy Kibaki Hospital by officers from Mowlem Police Station following a road traffic accident along Kangundo Road *(Annex 1b, c and d).*

At the time of being received at the A&E, the late Edward was described as being in fair general condition, albeit pale and agitated. According to the hospital, the late Edward refused treatment and insisted on being referred to a different facility *(Annex 1b, c and d).*

According to members of his family, following the accident, they arrived at the facility on 12th September, 2022, at approximately 12.30 am to find the late Edward bleeding on the floor of the A&E department at MLKH without any assistance *(Annex 2).*

As attempts were being made to transfer him into an ambulance in order to refer him to a different facility as per the family's request, the condition of the late Edward suddenly changed. Attempts to resuscitate him commenced immediately but failed. At 2.30 am, he was pronounced dead *(Annex 1b, c, d and 2).*

Following his death, there was general public outcry with allegations of delayed treatment and medical negligence being leveled against KNH.

B. Referral of the Statement by Sen. Hamida Kibwana regarding the circumstances that led to the death of the late Master Travis Maina at Kenyatta National Hospital

Pursuant to Standing order 53 (1) of the Senate Standing Orders, at the sitting of the Senate held on Wednesday, 26th October, 2022, Sen. Hamida Kibwana, MP, requested for a Statement regarding alleged medical negligence at Mama Lucy Kibaki Hospital. In the Statement, the Senator requested the Committee to -

1. Shed light on the circumstances that led to the avoidable deaths of Maureen Anyango a mother who died after bleeding profusely after delivering her twin babies and one Edward Otieno Onyango, who died at the same facility from injuries sustained in a road accident, stating the respective dates of their

admission, the time they were attended to, and the date and time of their respective deaths;

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

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

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

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

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

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

A copy of the Statement has been attached herein as Annex 11.

C. Brief on Mama Lucy Kibaki Hospital (MLKH)

Mama Lucy Kibaki Hospital is a high-volume Level 5 Hospital located in the populous Eastlands area in Nairobi City County According to a joint inspection report by relevant health regulatory bodies, it provides both primary and secondary level care, and is a 188 inpatient bed capacity hospital.

From evidence adduced before the Committee, the hospital lacks the capacity to provide quality and responsive emergency care as evidenced by: a high workload of up to 2,000 outpatients every day, of which 80 to 120 were emergencies; inadequate staff with a doctor to patient ratio of 1:8 at the A&E department, against the recommended doctor to patient ratio of 1.4; and, a nurse-to-patient ratio of 1:15 and 1:25 in the A&E and inpatient departments, compared to the recommended ratio of 1:6 and 1:4 respectively. The facility lacks adequate infrastructure including triaging space, outpatient consultation rooms, A&E facilities, and HDU/ICU; and, poor general patient flow, which is not commensurate with a level 5 facility.

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

Notably, despite serving as one of the largest County referral facilities in Nairobi, according to evidence adduced before the Committee, during the FY 2021/2022, aside from facility improvement funds (FIF) the hospital did not receive any additional funding from the NCCG.

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

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

D. Methodology

Pursuant to Standing Order 53 (3) (b) at its sitting held on 25th October, 2022, the Committee considered the Statement and resolved to invite various stakeholders in relation to the matters raised as follows-

a) Members of the family of the deceased patient;

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

c) Relevant regulatory bodies, including the-

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

e) Health Professional Associations, including-

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

f) Health worker unions-

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

g) Civil society organizations-

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

A schedule of the Committee meetings in relation to the same has been annexed to this report as *Annex 12*.

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

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

CHAPTER TWO

CONSTITUTIONAL, LEGAL AND REGULATORY CONSIDERATIONS

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

1. The Constitution of Kenya, 2010

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

(1) Every person has the right –

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. International treaties, conventions and agreements

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Nurses and Midwives Act (Cap 257)

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

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

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

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

7. The Kenya National Patients' Rights Charter, 2013

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

Every person, patient or client has a: -

1. *Right to access health care. Health care shall include promotive, preventive, curative, reproductive, rehabilitative and palliative care.*
2. *Right to receive emergency treatment in any health facility. In emergency situations, irrespective of the patient's ability to pay, treatment to stabilize the patient's condition shall be provided.*
3. *Right to the highest attainable quality of health care products and services. Every person has the right to the highest attainable quality of health care products and services.*
4. *Right to be treated with respect and dignity.*

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

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

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

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

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

CHAPTER THREE

COMMITTEE PROCEEDINGS

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

A schedule of the Committee's meetings in relation to the same has been annexed to this report as *Annex 12*.

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

1. Meeting with the Family of the Late Edward Otieno Onyango

The Committee met with the family of the late Edward Otieno Onyango during its sitting held on Tuesday, Ist November, 2022, in Committee Room 4, Main Parliament Buildings.

a. Submissions by Prof. Rogena, Aunt of the late Edward Otieno Onyango

Ms. Ruth Otieno Onyango, mother of the Late Edward Otieno Onyango, introduced herself to the Committee and requested that Prof. Emily Rogena, her sister and aunt to the Late Edward Otieno, to make submissions on her behalf.

The Committee, through Prof. Rogena, was then taken through the chronology of events that occurred leading up to the death of the Late Edward Otieno as summarized below-

i. On Sunday, 11th September, 2022, towards midnight, Prof. Rogena received a call from her sister, Mrs Ruth Otieno Onyango, informing her that the late Edward Otieno had been involved in a road accident, and had been taken to Mama Lucy Kibaki Hospital (MLKH);

ii. As reported, the late Edward had been taken to Mama Lucy Kibaki Hospital by police officers from Mowlem Police Post, between 10:30 and 11:00 pm on 11th September, 2022. He had been found along the road having been involved in an accident while riding as a passenger on a motorbike;

iii. According to the police report to the family, the late Edward had been unconscious when they picked him, but upon arrival at MLKH, he had regained

consciousness. He was then transferred to the Emergency Care Unit using a wheelchair, where with the help of the police, he called his mother for help. He then shared with his mother the contact details of a lady who had been taking care of an injured victim at the same unit;

iv. Professor Rogena stated that, accompanied by her husband, she then rushed to the hospital, arriving approximately 30 minutes later. They headed straight to the emergency unit where they located Edward at the Emergency Unit;

v. On arrival, Prof. Rogena and her husband found the late Edward lying on the cold tiled floor of the emergency unit, approximately two meters away from the nurse's desk. As per her account, he looked confused and appeared very pale. He complained of pain and stress;

vi. While speaking to him, Prof. Rogena stated that a cleaner came with a mop and mopped around him as he lay on the floor. At the time, there was no evidence that any intervention had been given to assist him;

vii. Recognising that the late Edward needed an intravenous (IV) line and blood, Prof. Rogena rushed into the stitching room where she found two young doctors stitching stable patients with fresh open wounds. One of the doctors happened to be a former student of hers, and on recognising her, immediately offered to help;

viii. Back at the reception, the doctor tried to trace Edward's documents and found them at the bottom of a heap. At this time, Edward's blood pressure was unrecordable, and his Glascow Coma Scale was 14/15. Together with Prof. Rogena and others present, she then fixed an IV line. As per the family's testimony, all this time, the nurses did not come to their aid, and just stood at their desk watching;

ix. Shortly after, a St. John's Ambulance came to transfer the late Edward to Kenyatta University Teaching, Referral & Research Hospital (KUTTRH) where a referral had been organized. However, as he was being put into the ambulance, his eyes rolled back and he gasped. They attempted to start resuscitation but it was not to be as the ambulance equipment was unable to deliver the oxygen that he needed;

x. As per her testimony, Prof. Rogena then ran back to the Emergency Care Unit at MLKH and asked the nurses to assist her with a resuscitation tray. However, there was none. Neither could she prevail upon them to give her adrenaline, nor any other emergency equipment that she required to save his life (e.g. a mouthpiece or laryngoscope).

xi. The late Edward was certified dead at around 2.00 am on 12th September, 2022, and his body was transferred to the funeral home at KUTTRH; and

xii. A post mortem examination by Dr. Oduor revealed blood loss of up to 1.5 liters in the soft tissues, and a skull fracture.

b. Submissions by Mrs. Ruth Atieno Onyango, Mother of the late Edward Otieno

In her submissions, Mrs. Ruth Atieno, the mother of the late Edward, thanked the Committee for inviting her to make her submissions.

She informed the Committee that on the fateful night, at around a quarter to 11.00 pm, she received a call from a strange number. The caller, presumably a policeman, told her that he had been given her number by her late son, Edward Onyango. He informed her that her son had had an accident involving a lorry, and that he had been taken to MLKH. He then reportedly asked her to hurry to his aid since no one would touch him unless a relative got there.

She informed the policeman that she was far away in Kisumu, but that she would try to get help. She called her sister, Prof. Rogena, following which she immediately called the late Edward. He picked up the phone, and on asking him where he was, he informed her that he did not know where he was, or how he had gotten there.

She then stated that she called his wife, and mobilized her relatives to go to his aid.

At this point of her testimony, the witness became overwhelmed and was unable to continue.

A copy of the written submissions by the family of the late Edward have been attached herein as Annex 2.

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

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

In their submissions, NCCG indicated that the Accident and Emergency Department at MLKH had a capacity of 11 beds against a daily workload of approximately 80 - 120 patients. It was manned by a total of 31 staff, including 21 nurses and 10 doctors, who worked in shifts.

NCCG submitted that on the material day, that is 11th September, 2022, the department had handled a total of 119 patients, with the night shift accounting for 41 patients, including 9 assault cases, 24 road traffic accidents, 4 referral cases, and 4 pediatric cases.

With regards to the late Edward, NCCG submitted that on 11th September, 2022, at 11.23 pm, the late Edward Otieno was brought to the A&E Department by officers from Mowlem following a road traffic accident along Kangundo Road. He stated that the late Edward was received and triaged.

On being examined the late Edward was found to be in a fair general condition, not pale but agitated. He exhibited normal heart sounds and had heart rate of 123 beats per minute.

On examination of his chest, he was found to have equal bilateral chest expansion and clear breath sounds.

An abdominal examination revealed frictional burns on his right lumbar area extending to his gluteal region.

Neurologically, the late Edward had a Glasgow Coma Scale (GCS) of 14/15. His pupils were equal and bilaterally reactive to light. He had no lateralizing signs, and had one laceration on the frontal region of his head which was not actively bleeding.

As per the submission made by the doctor who attended to him, upon concluding his examination, a trauma series was requested for the patient as follows: cervical spine, chest, lumbar-sacral, skull and pelvic x-rays, an abdominal FAST and a head CT Scan. However, the Committee was informed that despite requesting for them, the tests were not done as the patient had insisted that he wanted to be referred to another facility.

Further to this, the Committee heard that the hospital lacked CT scan services, and that conducting the test would have necessitated referring the patient to another facility.

Pain relieving medication was then administered to the patient, (Tramadol 100mg stat) but he reportedly insisted on being referred out. At 1.00 am, the late Edward's wife arrived at the facility, and she likewise reportedly informed the staff that they wished to be referred to another facility for management.

At 1.23 am, more relatives arrived and they reportedly also asked for the patient to be transferred to Kenyatta University Referral and Teaching Hospital (KUTRRH). The late

Edward was then started on IV fluids and pain medication as he waited for a St. John's Ambulance to arrive for his transfer.

At 1.30, the St. John's ambulance arrived and preparations to transfer Edward were made. A referral letter to KUTRRH was prepared, and at approximately 2.00 am, he was wheeled to the ambulance. While in the ambulance, his condition changed and he started gasping. Immediately cardiopulmonary resuscitation was initiated and continued up to 2.30 am. Having observed no evidence of cardiac or respiratory activity, Dr. Kevin pronounced the late Edward dead at 2.30 a.m. The family then requested to take the body to a facility of their choice and he was ferried in the same ambulance.

The County further submitted that, following his death:

a) An advisory meeting was held.

b) The hospital committed to ensuring that the staff undertook refresher courses for basic life support, advanced cardiac life support, advanced life support and pediatrics advanced life support.

c) Standard operating procedures were re-emphasized.

d) Statements were obtained from all the staff that had been involved in his care.

e) A memo was dispatched to the A&E department highlighting the importance of proper triaging, vital sign examination, proper documentation, patient centered care and escalation of matters /issues when need arises.

f) On 2nd November 10, 2022 a special hospital management board meeting was held to discuss the matter.

The County further noted that the Kenya Medical Practitioners and Dentist Council was investigating the matter and that they were awaiting its response and recommendations.

A copy of the written submissions by NCCG have been attached herein as Annex1.

3. Visit to Mama Lucy Kibaki Hospital

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

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

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

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

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

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

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

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

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

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

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

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

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

With regards to the operationalisation of the hospital ICU, the CEO stated that a task force had been appointed to oversee the project and that more than 80 % of the structure was complete. However, at the time of the visit, the hospital was referring patients to KNH and KUTRRH for critical care. She however noted that KUTRRH required patients to make an initial deposit before admission. Most of the referral cases were for ICU and CT scans.

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

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

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

4. Meeting with Relevant Health Regulatory Bodies

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

Submissions by the Kenya Health Professionals Oversight Authority (KHPOA)

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

In the statement, Dr. Kioko stated that on 11th September 2022 at around 11:20 pm, the late Edward, then a 41- year-old male, was brought to the MLKH A&E by police officers from the Mowlem Police Station with a history of having been involved in a road traffic accident as he was heading home on a motorcycle. The officers said that the patient had been found lying by the roadside after the accident.

The triage nurse noted that although the patient was fully awake, and that he seemed agitated. In addition, he reportedly did not remain still to permit for measurement of blood pressure and insertion of the intravenous line. He was advised to call his relatives.

At 11.40 pm, he was reviewed by a medical doctor. Examination findings were as follows: the patient was sick-looking, confused and aggressive with pallor++; chest and abdomen were normal. The head and neck noted mild lacerations in the frontal region with no active bleeding. Glasgow Coma Scale was 14/15 with no lateralizing signs. Pupils were bilaterally equal and reactive to light. He was further noted to have antalgic gait, with friction burns noted on the lumbar and gluteal regions.

A plan to insert an IV-line was made, but failed as the patient reportedly became agitated and aggressive.

The doctor further requested a full hemogram, blood group cross-matching, IV fluids (normal saline alternating with Ringer's lactate), a trauma series (x-ray of pelvis, chest and spine), a head CT scan and head elevation. Additional notes however stated that no bed was available.

The patient then received IM Tramadol at 12:40 am. At 1:00 am, the patient's wife arrived and requested for a referral to KUTRRH.

At 1:23 am, more relatives arrived, and with their help, the medical officer managed to fix an IV line and to start IV fluids. IM Diclofenac 75mg was administered. The medical officer then wrote the referral notes and gave it to the relatives, who had already secured an ambulance and informed KUTRRH.

At around 2:00 am, the patient was wheeled into the ambulance and started having difficulty in breathing. The doctor started cardiopulmonary resuscitation (CPR), which continued until 2:30 am. Upon reassessment of the patient, no cardiac or respiratory activity was found, and the pupils were found to be fixed and dilated. At 2:30 am on 12th September 2022, the patient was confirmed dead. The family was permitted to move the body to a facility of their choice using the same ambulance.

In his statement, Dr. Kioko noted that it was not clear how the late Edward, a road traffic accident victim, reportedly confused and with a degree of pallor (suggesting possible blood loss) with a possible head injury, had been moved from the A&E Department into the ambulance.

He further noted that it was unclear from the patient's notes whether the trauma series had been done as requested. He further observed generally, the hospital had delayed to institute prompt emergency trauma care to the patient by nearly 2 hours.

A copy of the written submissions by KHPOA and other health regulators have been attached herein as Annex3.

5. Meeting with Health Professional Associations and Health Worker Unions

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

a. Submissions by the Kenya Medical Association (KMA)

Led by its President, Dr. Simon Kigondu, KMA submitted that the case of the late Edward was a reflection of what was happening in the public health care system. He observed that the late Edward had been brought to Mama Lucy Hospital by the National Police Service following a road traffic accident. He was resuscitated at the A&E department for about two hours after arrival on the way to a referral.

Having collected views and reports from members of KMA working at the institution, he submitted the following observations:

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

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

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

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

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

6) There is a need to look into the coordination of health regulatory bodies to provide for patient-centeredness. He noted that the current regulatory framework was disjointed with various cadres having different levels of accountability.

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

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

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

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

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

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

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

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

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

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

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

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

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

He concluded his submissions by calling for the establishment of a Health Service Commission. Noting that the Health Sector Medium Term Plan of the Vision 2030 recognized the need to de-link the Ministries of Health (Medical Services, Public Health and Sanitation) from service delivery through the establishment of a Health Service Commission, he noted that this would make the MoH focus on formulation of policies, standards, guidelines, and regulation of delivery of health services, and help generate data for the management of HRH. He further stated that the establishment of the HSC would not take away the roles of County Public Service Boards, but rather, serve to strengthen devolution.

He concluded his remarks by recommending the following documentation: the Musyimi Taskforce Report, the Final Baseline and Workload Indicator Assessment Report

(April, 2013), the Late Ken Walibora Senate Health Committee Report, Legal Notice No. 269 on the Kenya Medical Practitioners and Dentists Act, the Medical Practitioners and Dentists (Medical Institution) Rules, the National Emergency Medical Care Treatment Guidelines, the PCC Alex Madaga Ruling and the Health Service Commission Bills of 2012 and 2018.

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

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

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

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

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

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

He further noted that the National government had since 2018, refused to implement provisions section 18 of the Health Act of 2017, which defined the structure at the Ministry headquarters. He therefore called for the Committee to act to ensure that the structure of the ministry is streamlined and that takes into account the various directorates that have been suggested in the Act.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

He concluded his submissions by calling for the establishment of a Health Service Commission. Noting that the Health Sector Medium Term Plan of the Vision 2030 recognized the need to de-link the Ministries of Health (Medical Services, Public Health and Sanitation) from service delivery through the establishment of a Health Service Commission, he noted that this would make the MoH focus on formulation of policies, standards, guidelines, and regulation of delivery of health services, and help generate data for the management of HRH. He further stated that the establishment of the HSC would not take away the roles of County Public Service Boards, but rather, serve to strengthen devolution.

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

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

d. Submissions by the Kenya Union of Clinical Officers (KUCO)

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

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

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

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

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

He further stated that having examined the cases of alleged medical negligence, KUCO had noted with great concern the following issues:

a) Understaffing across the health facilities in Kenya

b) Severe shortages of essential cadres

c) Persistent inability to attract and retain health workers

d) Poor and uneven remuneration among cadres

e) Poor working conditions

f) Inadequate or lack of essentials tools and medical and non-medical supplies

g) Inadequate and inequitable distribution of staff, and

h) Diminishing productivity among the health workforce, etc.

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

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

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

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

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

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

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

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

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

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

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

Based on the foregoing, he made the following recommendations:

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

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

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

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

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

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

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

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

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

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

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

l) Streamline coordination of referral services at all levels.

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

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

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

6. Meeting with Civil Society Organizations

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

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

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

The Ministry of Health adopted the World Health Organization (WHO) Emergency Care System Framework for essential emergency care functions during the development

of the Kenya Emergency Medical Care (EMC) Policy 2020-2030. According to the EMC Policy, emergency medical treatment is defined as the necessary immediate health care that must be administered to prevent death or worsening of a medical situation as defined in the Health Act (2017).

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

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

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

Lack of guidelines or regulations for prehospital healthcare providers: He noted that Emergency Medical Technicians who are trained and certified pre hospital healthcare providers are currently not recognized or licensed by the government. While nurses occasionally accompanied patients in ambulances, they lacked formal training in prehospital emergency medical care and were thus ill-equipped for the job.

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

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

With regards to the case of the late Edward, he noted that he had been taken to the A&E Department at MLKH by the police close to 11 pm following a road traffic accident on September 11th, 2022.

Based on available reports, he noted that the late Edward did not receive any emergency medical treatment. He lay on the hospital floor until his aunt (a doctor) arrived. The healthcare providers then began to assist him, as one of them knew the aunt.

He stated that a decision was made to transfer him to KUTRRH. While being loaded into the ambulance, he started gasping. Resuscitation was attempted but the ambulance equipment did not work, and the hospital emergency unit reportedly did not have any resuscitation equipment. Eddy was certified dead at around 2 am on September 12th, 2022.

He observed that in the case of the late Edward at MLKH, there was clearly no triage system in place, and it was unclear if the staff had refused to provide emergency medical care or lacked the required knowledge and skills to provide this care.

Based on the foregoing, he made the following recommendations:

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

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

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

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

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

f) Emergency Medical Care Financing – A precise mechanism for financing emergency medical care for the public must be well defined. This should include access to prehospital emergency medical care (ambulance services), care in the emergency department and immediate inpatient care for any emergency cases that cannot afford to pay.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

c) Provide guidelines and legislative measures to quality healthcare;

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

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

f) Promote quality healthcare through sustainable multi sector partnership;

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

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

In so far as the treatment that the late Edward received, he identified the following gaps:

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

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

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

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

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

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

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

Based on the foregoing, COFPAK recommended the following:

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

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

c) To reduce the huge gap in accountability, COFPAK recommended the establishment of tribunals to try cases of alleged medical negligence.This would ensure that whenever a matter was filed, the complainant was provided with

findings just like in the penal code hearing before a judge. This information would go along to help victims convict perpetrators;

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

e) Establishment of a proper referral system;

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

g) Decongestion of referral hospitals;

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

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

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

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

CHAPTER FIVE

COMMITTEE OBSERVATIONS

A. In respect of the late Edward Otieno Onyango

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

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

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

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

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

6. The World Health Organization (WHO) Emergency Care System Framework captures essential emergency care functions at the scene of injury or illness, during transport, and through to the emergency unit and early inpatient care.

7. The Kenya Emergency Medical Care (EMC) Policy 2020-2030 defines emergency medical treatment as the necessary immediate health care that must be administered to prevent death or worsening of a medical situation as defined in the Health Act (2017).

8. With regards to whether the late Edward Otieno Onyango received emergency medical treatment in accordance with Article 46(1) of the Constitution, section 4 of the Health Act and the Kenya EMC policy, the Committee observed-

    a) That on 11th September, 2022, at 11.23 pm, the late Edward Otieno was brought to the A&E Department by officers from Mowlem Police Station following a road traffic accident along Kangundo Road.

    b) On arrival at the A&E at MLKH, the late Edward was noted to be in fair general condition, albeit pale and agitated, with a GCS of 14/15.

    c) Prof. Rogena, a health professional, and maternal aunt of the late Edward, arrived at the A&E department at approximately 12:30 am to find the late Edward in distress on the floor at the A&E. He was bleeding and had been left unattended.

    d) By 12.30 am, despite having been at the A&E for at least one hour, an IV line was yet to be fixed for the late Edward.

    e) Prof. Rogena sought assistance from nurses who were standing at the Nurses' Desk but was ignored. She then located two doctors in the stitching room, and mobilized their assistance in aid of the late Edward. an IV line was finally fixed.

    f) As per the hospital's account, on being received at the facility, a trauma series consisting of cervical spine, chest, lumbar-sacral, skull and pelvic x-rays, an abdominal FAST and a head CT Scan was requested for the late Edward. However, the relevant health regulatory bodies did not find evidence to suggest that any attempt was made to conduct the tests.

    g) It was the evidence of the hospital that the trauma series had not been done owing to the fact that the late Edward allegedly declined treatment. The Committee nonetheless observed that:

        i) As per standard procedures, the hospital ought to have obtained a signed declaration by the patient indicating that he had declined to receive treatment. It was, however, unable to provide such proof; and

        ii) With a GCS of 14/15 the late Edward was confused, and could not

have been considered clinically competent to make such a decision.

h) On 12th September, 2022, at 2.00 am, the condition of the late Edward suddenly changed as he was being transferred to an ambulance. Efforts to resuscitate him immediately commenced. However, the ambulance lacked the necessary oxygen equipment.

i) Attempts by Prof. Rogena to obtain a resuscitation tray and other emergency equipment from the A&E reportedly failed after her requests for assistance to the nurses on call were allegedly ignored.

j) At 2:30 am, 12th September 2022, the patient was confirmed dead.

Based on the foregoing, the Committee observed that the late Edward was not properly triaged: MLKH did not institute prompt emergency trauma care for the late Edward, as required, and that there was a delay of at least 2 hours

9. In relation to the above, the Committee further noted that emergency medical treatment for the patient seemingly commenced only after the arrival of his relatives; and

10. The attitude of the nursing personnel that ought to have attended to the late Edward was callous, poor and dismissive. Despite having fallen, the late Edward lay in distress bleeding on the floor for at least two hours without any attempt by the staff at the A&E department to assist him. In fact, in the presence of his family, a cleaner came and cleaned his blood around him, leaving him where he lay.

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

11. The Committee noted that as per submissions made by the relevant health regulators, the A&E department lacked the capacity to provide quality and responsive emergency care as evidenced by the following-

a) High workload with records indicating that the hospital served up to 2,000 outpatients every day, of which 80 to 120 were emergencies;

b) Inadequate staff to handle its considerable workload with a doctor to patient ratio of 1:8 at the A&E department, against the recommended doctor to patient ratio of 1.4. Further, the nurse-to-patient ratio was 1:15

and 1:25 in the A&E and inpatient departments, compared to the recommended ratio of 1:6 and 1:4 respectively;

c) MLKH lacked adequate infrastructure (triaging space, outpatient consultation rooms, A&E facilities, and HDU/ICU); and

d) The general patient flow was not commensurate with a level 5 facility.

12. The Committee observed that in their submissions, NCCG indicated that the A&E at MLKH had a bed capacity of 11 beds against a daily workload of approximately 80 - 120 patients, and that it was manned by a total of 31 staff, including 21 nurses and 10 doctors, who worked in shifts.

13. On the material day, that is 11th September, 2022, the department had handled a total of 119 patients, with the night shift accounting for 41 patients, including 9 assault cases, 24 road traffic accidents, 4 referral cases, and 4 pediatric cases.

14. The above factors notwithstanding, on the night that the late Edward was received at the hospital, nursing personnel were available, but unresponsive. And there did not appear to be a triage system in place as evidenced by the fact that the two available doctors were in the stitching room, attending to the injuries of relatively stable patients, while the late Edward lay on the floor dying.

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

16. Despite being classified as a level 5 hospital, MLKH did not meet the standard or criteria for such a classification.

17. In addition, the Committee observed that in the FY 2021/2022, the hospital received a total approved budget of Kshs. 241,438,541.00 against a budget requirement of Kshs. 535,444,355.20, translating to a budget deficit of approx. -54.91%.

18. Notably, despite serving as one of the largest County referral facilities in Nairobi, according to evidence adduced before the Committee, during the FY 2021/2022,

aside from facility improvement funds (FIF) the hospital did not receive any additional funding from the NCCG.

C. In respect to the provision of Emergency Care

19. The Committee observed that as per submissions made by the various health regulatory bodies, and the Emergency Medicine Foundation- Kenya, the A&E department at MLKH was not up to standard, did not have a well-defined triage system, and did not provide immediate access to a functioning theater for surgical emergencies. This had hindered its ability to provide quality emergency medical care and treatment.

20. Noting that the staff at the A&E had failed to properly triage the late Edward Otieno, the Committee observed that there was a need for personnel at the hospital to undergo training in basic principles of triage, emergency medical care (basic life support, advanced life support, advanced cardiac life support and advanced trauma life support).

21. In addition, the Committee noting that emergency medical care training was not part of undergraduate training, the Committee observed that it was necessary to provide pre-service training in emergency care for all cadres of health workers.

D. In respect to access to ambulance / emergency referral services

22. With respect to the late Edward, the Committee observed that the private ambulance that was to transfer him to a referral facility lacked basic oxygen equipment. As such, when his condition suddenly changed as they were transferring him to the ambulance, the ambulance personnel were unable to resuscitate him.

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

24. In order to improve access to ambulance services, the Committee observed that there was a need to establish a Single Short Code Public Ambulance Access

Number in Kenya that was easily accessible to members of the public in cases of emergencies.

25. Further, the Committee observed that the private sector had exploited gaps in emergency referral services to provide expensive ambulance services that were inaccessible to the majority of Kenyans. As such, the Committee noted that there was a need for counties to invest in quality and functional ambulance services that were affordable and responsive to emergencies to all members of the public.

E. Upholding of Professional Standards of Care

26. The Committee observed that it was a primary role and responsibility for professional health associations to help define and set standards for their professional fields, and to promote high standards and quality of care. However, the Committee observed that the health professional bodies that appeared largely failed to address any of the pertinent issues surrounding the case at hand. While they provided valuable information regarding the broader structural issues affecting the case, little effort was made to uphold any professional accountability and/or responsibility on the part of the health workers with regards to the case.

F. Regulatory Failures in the health sector

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

G. In respect to the management of professional misconduct

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

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

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

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

32. Further, the Committee noted that whereas the disciplinary committees mainly focused on disciplining the medical practitioner, complainants had to seek redress from the courts. In relation to the above, the Committee noted that attempts had been made through the Health Laws Amendments Act of 2019 to introduce the requirement for medical practitioners in Kenya to take a professional indemnity cover annually, and for health institutions to insure against professional liability associated with its employees. However, the Amendment Act was declared unconstitutional by a high court ruling. As such, there remained a *lacuna* with dealing with the compensation of victims.

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

CHAPTER SIX

COMMITTEE RECOMMENDATIONS

Based on the foregoing, the Committee made the following recommendations-

1. Mama Lucy Kibaki Hospital be investigated by the relevant health regulatory bodies for culpability in the wrongful death of the late Edward Otieno Onyango owing to proof of medical negligence at the facility;

2. The professional conduct of the nurse(s) on duty who were responsible for managing the late Edward from the time he was received at the A&E, to the point he was transferred to the ambulance, be investigated by the Nursing Council of Kenya, and held accountable for mismanagement;

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

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

5. Harmonization of the disciplinary mechanisms among the health professionals with a view towards improving indemnity and strengthening accountability;

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

7. The Cabinet Secretary of Health, in accordance with section 112(i) of the Health Act, enact regulations for emergency medical services and emergency medical treatment;

8. The Cabinet Secretary of Health, and the Nursing Council of Kenya to review the Codes of Conduct of Nurses, with a view towards bringing them in line with

the provisions of the Constitution of Kenya, the Health Act 2017, and other relevant laws;

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

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

11. A Single Short Code Public Ambulance Access Number be established in Kenya for purposes of ensuring easy access to members of the public in case of emergencies;

12. The role and mandate of the Government check unit be expanded to include checking both public and private ambulances for compliance with the KEBS ambulance standards in the short-term;

13. The Ministry of Health, in collaboration with the Council of Governors, take measures to provide for the measurable and progressive realization of the MoH Norms and Standards across the different levels of care within a four-and-a-half-year period;

14. Nairobi City County Government take urgent action to address the personnel, infrastructural and health financing needs of MLKH, including, but not limited to:

    a) the completion of the ICU;

    b) establishing of a trauma center at the facility;

    c) expansion of the hospital's theater and bed capacity;

    d) development and implementation of standard operating procedures (SOPs) and guidelines for triage and emergency care; and

    e) urgent training and capacity-building of all staff deployed to the A&E in basic life support, advanced life support, advanced cardiac life support and advanced trauma life support.

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

In light of the above, the Committee determined that -

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

2. This report be dispatched to the Health Professionals Oversight Authority. the Kenya Medical Practitioners and Dentists Council, the Nursing Council of Kenya and any other relevant regulatory body for the purposes of investigating the professional conduct of the health workers identified above, and recommending appropriate action **within 1 month** upon receipt of this report.