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(2) Hon. Speaker
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31/5/23

APPROVED
31/5/23

THIRTEENTH PARLIAMENT

THE SENATE

THE STANDING COMMITTEE ON HEALTH

REPORT ON THE CIRCUMSTANCES THAT LED TO THE DEATH OF THE LATE MASTER TRAVIS MAINA AT KENYATTA NATIONAL HOSPITAL.

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

Clerks Chambers,
Parliament Buildings,
NAIROBI

MAY 2023

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List of Abbreviations

BSK	-	**Bioethics Society of Kenya**
COFPAK	-	**Confraternity of Patients of Kenya**
INR	-	**International Normalized Ratio**
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**
PT	-	**Prothrombin Time Test**
PTT	-	**Partial Thromboplastin Time Test**

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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(4), 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 / EXECUTIVE SUMMARY

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 Thursday, 13th October, 2022, Sen. Hamida Kibwana, MP, requested for a Statement from the Committee on the circumstances that led to the death of the late Master Travis Maina at Kenyatta National Hospital (KNH) on Monday, 10th October, 2022, aged two and a half years, after suffering from a medical emergency arising from a *fork jembe* getting lodged in his head.

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

The meetings were aimed at investigating the circumstances surrounding the death of the late Master Travis Maina, 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 issues for determination centered around the following-

1. The pre-hospital factors that hindered access to the timely referral and transfer of the late Master Travis Maina to the nearest county referral hospital where treatment and management could commence;

2. The treatment and management of the deceased at Thika Level 5 Hospital from the time he was received to the time he was referred to Kenyatta National Hospital;

3. The treatment and management of the deceased at Kenyatta National Hospital (KNH) from the time he was received at the Accident and Emergency/Casualty Department, to the time he was taken to theater; and

4. Whether there was a delay in commencing the treatment and management of the deceased owing to the inability of the parent/guardian to pay a deposit of Kshs. 20,000.00.

b. Committee Findings

As per an investigative report by the Directorate of Criminal Investigations (DCI), the late Baby Travis Maina sustained penetrating head injuries on 10th October, 2022, at approximately 12.00 pm, having been accidentally struck on the left side of his head with a fork *jembe* by his elder brother.

Owing to lack of access to health and/or emergency referral services, the late Master Travis was first attended to in a formal health set-up at Ndula Medical Center, a private facility, on 10th October, 2022, at 2:00 pm, approximately two hours after he had sustained his injuries.

Following basic first aid treatment at the facility, the late Master Travis was transported by private means to Thika Level 5 Hospital (TL5H) where he arrived at 3:15 pm, more than three hours since he had first sustained his injuries.

At Thika Level 5 Hospital, the late Master Travis was initiated on emergency treatment consisting of anticonvulsants, analgesia and medication to reduce brain edema. Owing to the lack of requisite pediatric neurosurgical capacity at the hospital, a decision to refer the deceased to Kenyatta National Hospital (KNH) was reached at 4.25 pm after X-ray and CT scan results showed penetrating injury to the left side of his brain. The late Travis was then transferred to an ambulance for departure to KNH by 5:13 pm.

Regarding the treatment and care that the late Master Travis Maina received at KNH, the Committee established that he arrived at the Accident and Emergency Department (A&E) at 6:03 pm, and was handed-over by 6:49 pm. He was immediately admitted to Resuscitation Room A (RRA) at the A&E, where he was reviewed by a Resident Neurosurgeon at 6.55 pm. Treatment consisting of IV fluids, antibiotics, pain medication and anticonvulsants was initiated.

However, a decision to transfer the patient to theater was deferred to 7:30 am the next day (that is, 11th October, 2023) ostensibly owing to a deranged clotting time and low hemoglobin (Hb levels). A further five hours were lost from the time the patient was deemed stable for surgery (7:30 am) to the time the patient was transferred to the theater and the procedure commenced (12:30 pm).

The late Master Travis succumbed in the theater at 2:55 pm on 11th October, 2022. A post-mortem performed by the Government Pathologist on 18th October, 2022, established the cause of death as fatal raised intracranial pressure secondary to penetrating brain injury caused by a fork *jembe.*

c. Committee Observations

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

1. Owing to lack of access to health and/or emergency referral services, there was a delay of at least three hours from the time the late Master Travis sustained his injuries, to the time he was transferred to Thika Level 5 Hospital (TL5H) for specialized services;

2. The late Travis received appropriate treatment at TL5H, and was referred to KNH in a timely manner;

3. There was an avoidable delay of at least twelve and a half hours from the time that the late Master Travis was admitted in KNH (6.55 pm on 10th October, 2022), to the point a decision was reached to take him to the theater (i.e. approx. 7:30 am on 11th October, 2022) as evidenced by the following:

    a) KNH attributed the delay in making the decision to take the late Master Travis to theater on the need to stabilize his hemoglobin level (Hb), and clotting time (International Normalised Ratio) (INR). However, the Committee found that, as per a report by KMPDC, the decision to transfer the patient to theater at 7.30 am, was made on the basis of a bedside clinical test known as bleeding time, and not the laboratory-based INR as had been suggested.

    b) According to the report by KMPDC, it had been the evidence of Prof. Walter Mwanda, the Consultant Hematologist, that even with a high International Normalised Ratio (INR), emergency patients could still be taken to the theater, with blood transfusion being carried out intraoperatively, provided that an ICU bed was made available.

4. The Committee noted that there was a further avoidable delay of at least five hours from the point that the decision to take the late Master Travis to the theater

was made (i.e. 7:30 am) to the point he was finally transferred to the theater (i.e. 12:30 pm) as evidenced by the following-

a) KNH attributed the delay to an ongoing pediatric neurosurgery emergency in its pediatric neurosurgical theater (theater 2).

b) Contrary to submissions by KNH that theater 2 was the only theater suitable for the procedure, as per the report by KMPDC, at least two other theaters were suitable and available for emergency procedures i.e. theater 12 and theater 9. However, at the time that the late Master Travis was being kept waiting for theater 2, there was an elective list running in theater 9.

In relation to the above, the Committee observed that during the approximately 18 hours it took to transfer the late Master Travis to theater, his condition progressively deteriorated, and he suffered significant pain and discomfort.

5. As per the post-mortem results, the cause of death in the late Master Travis was fatally raised intracranial pressure secondary to penetrating brain injury caused by a fork *jembe*. As per the report by KMPDC, it was recognised that the patient's intracranial pressure started rising from the point of sustaining the injury. However, despite raised intracranial pressure being a well recognised neurological emergency, it took KNH at least 18 hours to transfer the late Master Travis to theater.

6. The Committee did not find evidence to support the claim the late Master Travis was denied treatment on first presenting at KNH owing to the inability of his mother to raise Kshs. 20,500.00. However, it was noted that it was possible that the demand for the payment of the Kshs. 20,500.00 had been made by a rogue person or staff, and that this demand was outside the official hospital policy.

d. Committee Recommendations

Based on the foregoing, amongst others, the Committee recommended that Kenyatta National Hospital be investigated by the relevant health regulatory bodies for culpability in the wrongful death of the late Master Travis Maina owing to proof of medical negligence at the facility.

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.

Mr. Speaker Sir,

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

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

Indeed 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 Master Travis Maina. 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.

ACKNOWLEGMENT

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, Kiambu County, Kiambu County Government officials, the management of Kenyatta National Hospital and Thika Level Five 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 pursuant to Standing Order No. 223(6) of the Senate Standing Orders.

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

Date: .....02/05/2023.....

SEN. JACKSON MANDAGO, EGH, M.P.

CHAIRPERSON, STANDING COMMITTEE ON HEALTH

CHAPTER ONE

INTRODUCTION

A. Background

According to an investigative report by the Directorate of Criminal Investigations (DCI), on 10th October, 2022, at approximately 12.00 noon, the late Master Travis Maina, aged two and a half years, joined his brothers aged eight and six respectively, in weeding their family *shamba* (*Annex 1b*).

As they were weeding, the late Master Travis reportedly got tired and laid down on the ground to rest without the knowledge of his brothers (*Annex 1*). As per the DCI report, his eldest brother who was weeding, accidentally struck him on the head with the fork *jembe* that he was using, injuring him on the left side of his head. Present at the scene were five children: Travis, his two elder siblings, and two other children (*Annex 1*).

As per the DCI report, the children immediately raised an alarm, and caught the attention of an uncle of the late Travis. As he approached the scene, he found the late Master Travis with the fork *jembe* stuck in his head. He attempted to remove the *jembe*, but abandoned the attempt when he realized that the jembe had gone in too deep (*Annex 1b*).

It is then reported that he picked up the late Master Travis and rushed him to a nearby murram road where he stopped a *boda boda* and transported him to Ndula Dispensary. Unfortunately, as it was a public holiday, he found the dispensary closed. He then proceeded to a nearby private health facility known as Ndula Medical Center where he was met by Mr. Cyrus Wambugu Maina, a nurse (*Annex 1b*).

At Ndula Medical Center, the nurse, that is, Mr. Cyrus Wambugu Maina, removed the handle of the *jembe*, and volunteered to transport the child to Thika Level 5 Hospital (TL5H) (*Annex 1b, 2 and 4*) .

They arrived at TL5H at approximately 3:15 am and were immediately attended to. An urgent CT scan was ordered, and the late Master Travis was started on emergency treatment consisting of phenytoin, an anticonvulsant, mannitol to reduce brain edema and pain medication. At this point, the patient was in fair general condition, his vital signs were stable and he was fully conscious albeit irritable *(Annex 2)*.

When the CT scan results came out, they showed 4.25 cm deep intraparenchymal left parietal lobe injury (that is, a penetrating injury to the left side of the brain) *(Annex 2)*. Owing to lack of requisite pediatric neurosurgical capacity at the hospital, a decision to refer the late Master Travis was reached at approximately 4:25 pm. By 5:13 pm, the late Master Travis had been transferred to an ambulance ready for departure to Kenyatta National Hospital (KNH)*(Annex 4)* .

The ambulance arrived at KNH at 6:03 pm, and the process of handing over the patient was concluded by 6.49 pm *(Annex 2)*. At KNH, the late Master Travis was reviewed by a Neurosurgery Resident at 6.55 pm. Blood samples were taken and treatment commenced with IV fluids, antibiotics, analgesics and anticonvulsants *(Annex 3)* .

According to the submissions received by the Committee, he was next reviewed by a Neurosurgeon at 9.15 pm (*Annex 3*). On review, the laboratory results revealed low hemoglobin levels, and a problem with his clotting time *(Annex 3)*. As per submissions made by KNH, owing to the risk of excessive bleeding posed by the deranged clotting time, a decision was made to defer surgery until the low hemoglobin and clotting time had been corrected *(Annex 3)*. Thereafter, the late Master Travis was reviewed intermittently through the night.

At 7.30 am on 11th October, 2022, the late Master Travis was reviewed by a consultant surgeon and found fit for theater based on his bleeding time *(Annex 3)*. However, it was not until 12.30 pm that a theater was allegedly found available *(Annex 3)*. According to the mothers' account, by this time, the child's condition had deteriorated significantly as he was reportedly prostrating himself, breathing with difficulty and had become unresponsive to verbal stimulation.

In theater the procedure of removing the *jembe* was carried out successfully *(Annex 3)*. However, according to the hospital's account, during the procedure, the patient suffered shock, convulsions and multiple episodes of cardiac arrest. Resuscitation was done but the patient succumbed in the theater at 2:55 pm on 11th October, 2022 *(Annex 3)*.

A post-mortem performed by the Government Pathologist on 18th October, 2022, revealed the cause of death as raised intracranial pressure secondary to penetrating brain injury caused by a fork *jembe (Annex 3)*.

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

that the delays in treatment were occasioned by the inability of his mother to pay a deposit sum of the Kshs. 20,500.00 for the commencement of treatment.

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

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

Pursuant to this provision, at the sitting of the Senate held on Thursday, 13th October, 2022, Sen. Hamida Kibwana, MP, requested for a statement from the Committee regarding the circumstances that led to the death of Master Travis Maina at Kenyatta National Hospital. In the statement, the Senator requested the Committee to-

1. Shed light on the circumstances that led to the death of Master Travis Maina aged two and a half years who had a medical emergency of a fork *jembe* lodged in his head, at the Kenyatta National Hospital on Monday, 10th October, 2022;
2. Give reasons for the inordinate delay in attending to the boy, noting the time difference between which the patient arrived at the hospital and the time when the patient was seen, considering the urgent and critical nature of the care he needed;
3. Undertake an investigation into the conduct of the hospital in dealing with the patient and propose disciplinary actions on the medical officers found culpable; and
4. Undertake a visit to the hospital to ascertain the state of health care provision.

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

A copy of the statement has been attached to this report as Annex 13.

C. Brief on Hospitals Where the Late Master Travis Maina was attended

1. Thika Level 5 Hospital (TL5H)

Thika Level 5 Hospital is a secondary referral hospital located in Thika Town, Kiambu County. According to the provisions of Fourth Schedule of the Health Act of 2017, as a county referral hospital, TL5H is mandated to-

a) provide specialized services;

b) train cadres of health workers who function at the primary care level (paramedical staff);
c) serve as an internship center for all staff, up to medical officers; and,
d) serve as a research center that provides research services for issues of county importance.

A key question to the Committee during the course of its investigation, was whether TL5H rendered services commensurate with a level 5 hospital in the case of the late Master Travis as prescribed above.

2. Kenyatta National Hospital (KNH)

According to a Joint Inspection Report by relevant health regulatory bodies, Kenyatta National Hospital (KNH) is a national public hospital mandated to provide specialized medical care, facilitate training and research and participate in policy formulation. The hospital has been delivering its mandate since its establishment in 1901 as the former King George Hospital.

The Hospital-

a) Has a bed capacity of 1800 with an occupancy rate of 100%, over 6,000 staff (425 medical doctors), 50 inpatient wards, 22 outpatient clinics, 24 theaters (16 specialized) and an Accident & Emergency department;

b) Provides surgical, medicinal, diagnostic, pharmaceutical, nursing, and specialized outpatient services. On average, the hospital attends to an annual average of 700,000 inpatients and 600,000 outpatients;

c) Has six theaters at A&E of which two are for trauma cases (one for orthopedics and the other for surgical cases). However, the theaters at the A&E lack anesthetic equipment to handle pediatric cases who then have to be attended to at the main theater;

d) The remaining four theaters at the A&E are for day care patients. However, due to lack of human resources and equipment, they have not been completely operationalized for optimal use.

e) In addition, according to a report by the Kenya Medical Practitioners and Dentists Council (KMPDC), KNH has 26 theaters all of which are available for emergency cases. According to the report, the hospital had at least three theaters where neurosurgical procedures could be performed i.e. theater 2, theater 9 and

theater 12 *(see Annex 5b).*

f) Further, according to Kenya Health Professionals Oversight Authority (KHPOA), patient flow through the accident and emergency (A&E) is clearly outlined, with an elaborate A&E process map displayed on the wall. All emergency patients are seen in the resuscitation room and managed as needed.

g) There are two (2) resuscitation rooms, one medical and one surgical both with a capacity to ventilate 12 patients.

D. Methodology

In conducting this inquiry, the Committee noted that with regards to the treatment and care that the late Master Travis received, the issues for determination centered around the following-

1. The pre-hospital factors that may have hindered access to the timely referral and transfer of the late Master Travis Maina to the nearest county referral hospital where treatment and management could commence;

2. The treatment and management of the deceased at Thika Level 5 Hospital from the time he was received, to the time he was referred to Kenyatta National Hospital;

3. The treatment and management of the deceased at Kenyatta National Hospital (KNH) from the time he was received at the Accident and Emergency/Casualty Department, to the time he was taken to theater; and

4. Whether there was a delay in commencing the treatment and management of the deceased owing to the inability of the parent/guardian to pay a deposit of Kshs. 20,000.00.

Accordingly, pursuant to standing order 53 (3) which provides that a *Committee may invite the Senator who requested the Statement, relevant Cabinet Secretary or any other person during deliberations on the Statement and may prepare and Table a report on the matter*, at its sitting held on Thursday, 27th October, 2022, the Committee resolved to invite various stakeholders and request for written submissions, in relation to the matters raised as follows:

a) Members of the family of the deceased patient;

b) The Governor, Kiambu County, and the management of Thika Level 5 Hospital;

c) The management of Kenyatta National Hospital;

d) Relevant regulatory bodies, including the:

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

e) Health Professional Associations, including:

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

f) Health worker unions

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

g) Civil society organizations.

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

A schedule of the Committee's meetings in relation to the same has been annexed to this report as *Annex 14*.

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 clarifying 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. Copies of the minutes of the Committee proceedings have been annexed to this report under *Annex 1a*.

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

CHAPTER TWO

CONSTITUTIONAL, LEGAL AND REGULATORY CONSIDERATIONS

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

1. The Constitution of Kenya, 2010

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

(1) Every person has the right –

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. International Treaties, Conventions and Agreements

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

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

Further to this, paragraph 11 of General Comment No 14 on the right to the highest attainable standard of health (Twenty-second session, 2000), the right to health envisaged under Article 12(1) of the International Covenant on Economic, Social and Cultural Rights captures, inter alia, access to "timely and appropriate health care." There is also a requirement placed on the Party States to make available "functioning public

health and health-care facilities, goods and services", which will include, among others, "hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries."

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

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

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

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

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

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

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

Section 20(1) and (2) of the Kenya Medical Practitioners and Dentists Act provides that any person may lodge a complaint directly to the Council if dissatisfied with

professional services received from a medical practitioner. The Council, or through a committee, may inquire into the complaint of professional misconduct, malpractice or any breach of standards.

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

The Kenya Medical Practitioners and Dentists Act, as read together with the Medical Practitioners and Dentists (Disciplinary Proceedings) (Procedure) Rules refers to conduct warranting disciplinary proceedings. Rule 2 and section 19A, of the Act provides that such conduct 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.

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 FOUR

COMMITTEE PROCEEDINGS

In considering the Statement, between Tuesday, 27th October, 2022, and Wednesday, 7th December, 2022, the Committee held meetings with the family of the Late Master Travis Maina, The Governor, Kiambu County, Kiambu County Government officials, the management of Kenyatta National Hospital and Thika Level Five 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, and minutes of the Committee's proceedings have been annexed to this report as *Annex 14* and *Annex 1a* respectively.

This chapter provides a summary of the submissions presented before the Committee by the various stakeholders.

1. Meeting with the Family of the Late Master Travis Maina

The Committee met with the family of the late Master Travis Maina during its sitting held on Monday, 31st November, 2022, in Committee Room 5, Main Parliament Buildings.

a. Submissions by Ms. Jane Muthoni, Aunt to the late Master Travis Maina

Ms. Judy Muthoni, mother of the Late Master Travis Maina, appeared before the Committee, accompanied by her sister Ms. Jane Muthoni, who then made submissions on her behalf.

In her submissions, Ms. Jane Muthoni informed the Committee that on Monday 10th October, 2022, the late Master Travis while playing with his siblings at their home in Kiambu, was involved in an accident that resulted in a *jembe* getting lodged in his skull.

He was then rushed to a nearby unnamed chemist where first aid was provided, and the handle removed. The late Master Travis was then referred to Thika Level Five Hospital (TL5H) for further treatment.

He arrived at TL5H at approximately 4.00 pm whereupon IV fluids were administered, and a CT scan done. She informed the Committee that the results of the CT scan were

sent to Kenyatta National Hospital (KNH) whereupon a decision to refer to the late Master Travis was made.

The referral was organized, and the late Master Travis was then transferred from Thika Level Five Hospital by ambulance, eventually arriving at KNH at around 6.30 pm.

It was the evidence of Ms. Jane Muthoni that upon their arrival at KNH, she was requested to fill admission forms, and pay an admission fee of Kshs. 1,250 and was thereafter directed to a 'Room 4' within the Hospital.

At Room 4, she indicated that she found a male health personnel, who, without looking up to see who he was speaking to, or why she was there, reportedly dismissively instructed her to pay Kshs. 20,500 before the late Master Travis could be admitted.

She reportedly pleaded with the male health personnel to admit the child as they did not have the required Kshs. 20,500.00, and had in fact been forced to borrow the initial admission fee of Kshs. 1,250. However, the male health personnel reportedly turned her away.

She then went back to the reception where the late Master Travis and his mother were waiting, and explained to her sister, mother to the late Travis, that the doctor had declined to admit them without the required Kshs. 20,500. Following this, she went back to the reception where she was again sent back to 'Room 4' to plead her case.

She informed the Committee that upon being referred back to 'Room 4', she reportedly showed the doctor a picture that she had taken, showing the condition of late Master Travis. He then reportedly agreed to have the child admitted, but on condition that the Kshs. 20,500 would be paid as soon as they were able to raise it.

Ms. Jane Muthoni further indicated that they were not further attended to until 10.00 pm when a doctor attended to the late Travis, and uncovered the bandages around the child's head before taking pictures. He explained to them that it was for purposes of further consultation. He then fixed a line and started IV fluids but provided no further relief for the child.

In her submissions, she indicated that, all this while, the late Master Travis was in distress and repeatedly asked his mother for water. However, they were unable to give him any water because the doctor had reportedly requested them not to give the child anything as he needed to be on an empty stomach before proceeding to the theater.

They, that is the late Travis, his mother and Ms. Lucy, were then reportedly left to wait at the Casualty where they stayed through the night.

Up to this time, the late Master Travis had reportedly not been admitted to a ward, or given a bed. The mother stayed up all night, seated on a plastic chair at the Casualty as she held him. At some point in the night, he developed high fevers and was undressed.

In addition to his fevers, the late Master Travis was hungry and thirsty, having not eaten anything since the accident, and constantly asked his mother for water. However, they had been advised against giving him any water or food as he was scheduled for an operation.

At several intervals during the night, doctors came to draw blood samples from the late Travis. The doctors informed them that his blood was not clotting. They also pinched him severally to confirm if he was responsive to which he repeatedly cried.

The doctor who had taken the pictures then reportedly returned at 6.00 a.m. the following day. He drew more blood samples and administered IV fluids.

He returned at 8.00 a.m. and informed them that the late Master Travis was to be taken to the theater immediately for an operation. However, the promised operation was postponed severally, reportedly due to other emergency cases.

To note, all this time, they had held the baby in their hands through the night, and through that morning, while seated on the plastic chair, and with the fork *jembe* still lodged in his head. He had neither been allocated a ward or a bed.

The late Master Travis was eventually taken to the theater at 1.00 p.m. By this time, he had already started stiffening up, was looking critically ill and was barely responsive.

Upon the late Master Travis being transferred to theater, they, that is, the mother and his aunt, were advised to check back after two hours. However, after two hours, they were reportedly advised to return after another two hours.

At around 4.00 pm before the two hours were over, they were called to the theater and informed that the late Master Travis had passed on during the operation.

In concluding her submissions, the mother, Ms. Judy Muthoni, testified that she believed that her son had died because they were unable to raise the Kshs. 20,500 to pay for the operation in time.

Noting that her son had remained conscious for most of the period that they had sat waiting, and that he had repeatedly asked for food and water, she stated that had he received timely treatment, he may have stayed alive.

She further stated that the hospital should have treated him first before asking for money since it was an emergency case.

She further noted that of all three health facilities where she presented with her son, that is, the private chemist, Thika Level 5 Hospital, and KNH, the treatment that they received at KNH was by far the worst.

b. Submissions by Ms. Evelyn Ogendo, Kenya Psychologists and Counselors Association (KCPA)

The Committee heard from Ms. Evelyne Ogendo, a member of the Kenya Psychologists and Counselors Association (KCPA), which had been providing psychosocial support to the family on a *pro bono* basis.

In her submissions, Ms. Ogendo thanked the Committee for giving the family a chance to give their side of their story. She noted that many Kenyans were suffering but lacked the opportunity to be heard.

She further stated that there were multiple layers of conflict in the case of the late Master Travis Maina, but that the medics who attended to the late Master Travis seemed insensitive to the issues that were facing the family. For instance, she noted that the mother was asked unnecessary questions such as where her husband was, even though they were irrelevant to the matter in that immediate context.

She further noted that mental wellness being key to the wellbeing of every person, there was a need for the Ministry of Health to put the right policies in place to ensure that health personnel are sensitized on the psychosocial and mental challenges that patients and families face.

2. Meeting with the Governor, Kiambu County, and Kiambu County Officials

The Committee met with officials of Kiambu County Referral Hospital led by the Governor, Hon. Paul Wamatangi, at its sitting held on 7th December, 2022.

a. Submissions by Gov. Paul Wamatangi, Governor, Kiambu County

In his remarks, Gov. Paul Wamatangi stated that he recognised the need to upgrade and scale up services at Thika Level 5 Hospital (TL5H). He committed to act to ensure that the necessary upgrades would be effected within the period of one year to make it a fully functional Level 5 Hospital.

He noted that whereas Gatundu Level 5 Hospital was equipped to the standard of a Level 5 facility, it was yet to be operationalised. As such, there was a need to distribute the equipment at the facility to where it may better serve the residents of Kiambu.

Noting that the county was constrained to deliver health services due to lack of resources, he requested for the Senate's intervention in ensuring that the National Government through the Ministry of Health took up the burden of paying for post-graduate training, and interns. In this regard, he noted that Kiambu County was disproportionately affected as it had 95 doctors away on postgraduate training, and over 1500 interns on its payroll.

b. Statement by Mr. Cyrus Wambugu Maina

The Committee, through Mr. Cyrus Wambugu Maina, heard that the late Master Travis Maina first presented to him with the *fork jembe* lodged in his head on 10th October, 2022, at approximately 1400 hrs. At the time, he was running errands in Ndula sub-location at Ngoliba Ward.

He quickly took the baby to his private clinic where he applied an anti-rust agent on the nails that were holding the handle of the fork jembe in place in order to make them loose. He then proceeded to remove the nails with a pair of pliers before safely removing the handle with the help of local community members.

He fastened the fork on Travis' head using a crepe bandage and strapping to prevent it from moving.

He then used his own private means to transport the baby to TL5H. He was accompanied by his mother, and a cousin to the mother by the name Mr. Hussein.

They arrived at TL5H at approximately 1500 hrs and headed straight for the Casualty Department where they were met by Dr. Mustafa, a MO Intern. An x-ray was immediately ordered at no cost to the patient.

When the results of the X-Ray were out, Dr. Mustafa consulted Dr. Musonye. She was in the theater conducting a procedure. She ordered an urgent CT scan of the head. After the radiologist reported on the CT scan, Dr. Musonye consulted Dr. Wanjiru Karimi, the third on call, and Dr. Phillip Mulingwa, the head of the Surgery Department and a decision to transfer the child to KNH was arrived at. Pre-referral treatment was administered at the Casualty Department.

The nurse-covering then organized for an ambulance, and the baby was transferred to KNH in the company of his mother and aunt. At the time, the child was in fair general condition.

c. Statement by Sr. Monica Gichu, Nursing Officer, Thika Level 5 Hospital

In her statement, Sr. Monica Gichu stated that the late Master Travis presented at TL5H on 10th October, 2022, at 3:15 pm, in the company of a nurse from Gachororo Health Center (see above) and his mother. A CT scan and X-Ray were promptly done.

An emergency team was summoned, and treatment commenced. At the time, Travis was in a stable general condition and his vital signs were normal.

At 4:49 pm, following consultations with the surgeon on call, a decision to refer the patient to KNH was made.

By 5:00 pm, the late Master Travis had been handed over to the ambulance crew.

d. Statement by Sr. Mercy Alice Wachuka, Senior Registered Nurse, Thika Level 5

In her statement, Sr. Mercy Alice Wachuka stated that the late Master Travis Maina first presented at TL5H on 10th October, 2022, at 3:15 pm. He was directed to the office of the covering nurse by 3:20 pm for purposes of waiving an X-Ray and CT-scan. This was done immediately and the investigations done.

The management of the patient continued at Casualty until a decision to refer the baby to KNH was arrived at. Having reached the decision to refer the baby, E-Plus ambulance services were notified by 4.15 pm, and by 5.00 pm, the patient had been on boarded. However, no nurse from TL5H accompanied the patient.

e. Statement by Dr. Joseph Njoroge, Radiologist, Thika Level 5 Hospital

In his statement, Dr. Njoroge indicated that the late Master Travis was brought from Casualty where he was being attended to after sustaining penetrating head injuries from a fork jembe.

A CT scan of the head was done on 10th October, 2022, at 3:30 pm, by the radiographer on call. A report of the CT scan was prepared by 3:40 pm and it indicated two prongs of a fork jembe penetrating the left parietal lobe at 4.25cm and 1.58 cm deep into the brain tissue respectively.

There was no bleeding in the brain, the brain and ventricular structures appeared normal. No other abnormal signs were found. The baby was in fair general condition.

f. Statement by Dr. Lilian Musonye, COSECSA Surgical Resident, Thika Level 5 Hospital

In her statement, Dr. Musonye informed the Committee that having been informed about the case of the late Master Travis Maina, she reviewed his x-ray whilst in theater at 3:15 pm. She then recommended an urgent head CT scan which was done and promptly reported.

Following examination and history, the late Master Travis was started on emergency treatment consisting of phenytoin, an anticonvulsant, mannitol to reduce brain edema and pain medication. At this point, the patient was in fair general condition, vital signs were stable and he was fully conscious albeit irritable. Upon consulting with the head of department, a decision to refer the patient to KNH for further neurosurgical intervention was made.

g. Statement by Dr. Wanjiru Karimi, Consultant Surgeon, Thika Level 5 Hospital

In her statement, Dr. Karimi submitted that she was consulted as the third on-call. On examination, the late Master Travis was stable. He was started on mannitol phenytoin and pain medication while at Casualty. A skull x-ray and CT scan were done which showed a 4.25 cm intraparenchymal left parietal lobe penetrative injury.

Owing to the fact that TL5H lacks a pediatric neurosurgeon, a pediatric anaesthesiologist and a pediatric ICU, she recommended a referral to KNH for urgent neurosurgical intervention.

h. Statement by E-Plus Services Ltd

In her statement, the Chief Operations Manager, E-Plus Service stated that the Ruiru E-Plus team comprising Mr. Daniel Onega, an ambulance operator, and Mr. Michael Chirchir, an Advanced Emergency Medical Technician, received a call from the Kiambu Emergency Operation Center at 1700 hrs on 10th October, 2022.

The late Master Travis presented with sharp penetrating head injury to the head with mild to moderate brain injury. He was alert, not on oxygen support and his vitals were within normal range. Management for traumatic brain injury had been initiated at TL5H.

The E-Plus team left Tl5H at 1713hrs, and headed for KNH. Enroute, the late Master Travis was put on a continuous infusion of Phenytoin. They arrived at KNH at 6:03 pm. At the triage, the ambulance team did not find any nurse as they were responding to another patient in Resuscitation Room A.

Altogether, it took the ambulance crew 20 minutes to have him admitted, and a file opened. It took another 20 minutes before the nurse at KNH, Mr. Onesmus Momanyi. accepted to receive the child at Resuscitation Room A. Thus, the handing over process concluded at 6.49 pm.

Asked for further clarification, Mr. Michael Chirchir, the A-EMT who accompanied the late Master Travis informed the Committee that prior to his admission, the relatives were asked to pay Kshs. 1250 at the admission desk. He further stated that the mother was asked to remain seated at Casualty since the *jembe* was heavy on the head of the late Travis. He further clarified that the patient was accompanied by himself and a driver. There was no nurse on board.

i. Statement by the Chief Officer of Health

In his remarks, the Chief Officer of Health noted that despite attempts by the County Government to upgrade the services at Tl5H, they were faced by severe resource constraints. He further noted that despite there being little variance in the services offered at a Level 6 Hospital *vis a vis* that of a Level 5, the former received budget support from the National Government in the billions while Level 5 hospitals were forced to compete with facilities at Levels 1 to 4 for resources.

A copy of the written submissions by Kiambu County has been attached hereto as Annex 4.

3. Visit to Kenyatta National Hospital

The Committee met with the management of Kenyatta National Hospital (KNH) led by the Chair of the Board, Mr. George Ooko, and the Chief Executive Officer, Dr. Evanson Kamuri, at its sitting held on Tuesday, 6th December, 2022, at the KNH Boardroom.

a. Submissions by Dr. Evanson Kamuri, CEO, KNH

Dr. Kamuri commenced his submissions by passing his sincere condolences and a vote of sympathy to the family and friends of the late master Travis Maina on behalf of the hospital. He then proceeded to give a chronological report of event form admission and demise of master Travis as summarized below-

That on 10th October, 2022, the hospital received a call from TL5H at around 5.30 pm regarding the referral of a baby with penetrating head injury.

At approximately 6.00 pm, the patient arrived at KNH in a Red Cross ambulance accompanied by two EMTs, the patient's mother and the auntie. They give a history of the patient having sustained the head injury from a fork *jembe* inflicted by the brother while playing. They had referral notes and a CT scan results.

Upon being received at KNH they were taken to triage, vitals taken and were subsequently transferred to Resuscitation Room 4 for close observation.

Treatment was commenced with IV fluids, antibiotics, analgesics and anti-consultants being administered.

The mother proceeded for credit assessment from the hospital's health worker for admission as she could not pay for the services. He was then reviewed by the medical team and Dr. Jabu, a neurosurgeon. It was recommended that tests be done, and hemoglobin and urea electrolytes tests were conducted.

At the time, the patient was conscious and alert with the fork *jembe* lodged in his head: one fork was in the left parietal region, and the other in the midline of the vertex. The handle of the *jembe* was missing. He was pale with vital signs of 140 beats per minute, a respiratory rate of 30, temperatures of 36.7 degree Celsius and an oxygen saturation of 96%.

At 9.15 pm Dr. Jabu from the neurosurgical department reviewed the patient at the Casualty and reported to the senior neurosurgeon who recommended surgery as soon as the lab results were ready.

At 9.45 am, it was noted that the late Master Travis blood was not coagulating well, and that he had a low hemoglobin level of 9.5 g/dl. A decision was made to correct the coagulation in order to prevent patient bleeding on the operating table.

Senior Consultant Prof. Mwanda, a hematologist Consultant was consulted and he reviewed the patient. He started the patient on packed cells and transfusion of fresh frozen plasma. The hemoglobin went up and transfusion continued gradually till 6.00 am morning.

The late Master Travis was then reviewed by the head of Neurosurgery at 8.30 am. The baby was prepared for theater, but could not proceed immediately as other operations were already ongoing. Extra blood for surgery was requested and the theater team assembled.

At 12.30 pm, the patient was taken to the theater and the surgical team proceeded with the operation. They successfully removed the *jembe*. The patient however developed complications requiring cardiopulmonary resuscitation on the operation table but succumbed.

With regards to the treatment that the patient had received prior to being taken to the theater, Dr. Kamuri clarified that the patient was admitted in Resuscitation Room A which had similar functionality with an ICU, and which had beds just like any ward. He further iterated that the room had monitors, nurses and doctors.

Further, he stated that allegations that the patient was not seen on time were not correct, and that this could be proven by available CCTV footage.

In addition, he cast doubt on how long the patient had stayed with the *jembe* lodged on his head. He noted that upon operation, the information given did not tally with what was observed due to the development of advanced sepsis. He further stated that the amount of pus produced could not have developed within the time period that the family had claimed the accident had occurred.

He further explained that prior to the operation, several investigations were to be carried out by the hospital. Among the investigations was coagulation and Hb level tests. The hemoglobin levels for Master Travis were below normal and his blood had issues

coagulating. It would have therefore been a big risk to take the patient to the theater without correcting the two factors.

He further stated that the hospital had consulted Prof. Mwanda who was a senior Hematologist. It is he who had advised that the blood transfusion be administered slowly over a period of at least six hours since the patient was a child. According to the professor, rushing the transfusion would have led to drowning the patient's lungs due to age. Furthermore, a second test had to be carried out after the correction to check on the blood clotting capacity.

The CEO further clarified that at 8.30 am, the patient's HB levels and clotting level were found to be safe to proceed to the theater. However, the patient went to the theater at 12.00 pm. He attributed this to the fact that by that time they were ready, there was already an emergency in the theater of a small boy with fluid accumulation in the brain who was unstable. Being the only Pediatric Neurosurgery theater, they had to wait for the operation to end before proceeding with that of baby Travis.

He further stated that in emergency cases, patients were not typically asked to pay for services. He noted that around 85% of the emergency patients wound up not paying their medical bills.

Furthermore, he noted that there was no procedure that charged an amount of Kshs. 20,500.00. He stated that billing and payments were normally done on discharge, or when a patient died in the course of receiving treatment.

He further clarified that indeed Mama Travis had had to sit on a plastic chair and hold the baby in an upright position through the night. In his explanation, he noted that due to the position of the *jembe* on the baby's head, he could not be laid on a bed as it would have aggravated his injuries. The only time the baby could be put in a sleeping position was upon intubation and sedation under general anesthesia. However, the child being stable could not be intubated or sedated.

Dr. Kamuri also stated that the hospital had interviewed every staffer who had handled baby Travis, from the nurse at the triage, the health workers and the operating team. They had subsequently submitted a report to the Kenya Medical Practitioners and Dentists Council who had initiated their own investigation into the matter.

He further stated that the hospital had appeared before the Council who had initiated an investigation into the matter. He stated that KPMDC had interviewed all those who had

attended baby Travis, and had also interrogated his medical records and would release their report for any disciplinary action.

He further stated that the Council had recommended areas for improvement by the hospital even as they continued with their investigations

Among the areas identified for improvement was the hospital's consent form. He noted that the consent form had since been improved. The improved form would provide better information and give clear communication to the patient and next of kins on what was being done to the patient and the possible outcomes.

He further noted that the hospital had improved on its communication policy to include escalation between clinicians, patients and relatives.

b. Remarks by Mr. George Ooko, Chair of Board, KNH

In his submissions, Mr. Ooko, Chair of the Board, KNH, stated that there was a need to build capacity in county hospitals to handle specialized treatments and operations in order to decongest KNH.

He informed the committee that programmes to send specialists and surgeons to such hospitals would save time and save many lives especially in emergency cases.

He further informed the Committee that there were more Specialists exiting the service, than were being trained. Accordingly, he called for the extension of the retirement age of Specialists. For example, he noted that the University of Washington retired their doctors at the age of 70 years.

He further stated how programmes like telemedicine were now enabling doctors to monitor patients from as far as the North Eastern region, and other rural areas. He requested the members to engage county governments to create a conducive environment that would facilitate such facilities to thrive.

In conclusion, Mr. Ooko iterated that there was a need to establish the circumstances that led to Master Travis ending up with the *jembe* lodged in his head. He alleged that in the initial distress after being informed that Master Travis had died, the mother shouted that the father of Master Travis had accidentally injured the baby with the *jembe* while aiming it at her in a domestic fight. He noted that for a *jembe* to lodge that deep in the skull, certain force was needed that the brother could not possess.

The Committee's visit to KNH ended with a tour of the hospital led by the Chairperson, Mr. George Ooko, and the CEO, Dr. Kamuri. During the tour, amongst other, the Committee was shown the general outlay of the KNH Casualty, including Resuscitation Room A where the late Master Travis was attended to.

A copy of the written submissions by KNH have been attached hereto as Annex 3.

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.

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

In his submission, Dr. Jackson Kioko, CEO, KHPOA, stated that his submissions were the result of a Joint Report with other regulatory bodies including 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.

He then proceeded to give a chronological report of events that led to the death of the late Master Travis as summarized below:

The late Master Travis was received in Thika Level Five Hospital on 10th October 2022 at 3.25pm as a referral form Gachororo health center with the *jembe* lodged in his head. A head x-ray and CT scan were done, and the patient was started on treatment (phenytoin, IV mannitol and paracetamol).

Owing to the lack of specialized pediatric neurosurgical services, a decision was made to refer him to KNH.

At 4.30 pm Master Travis was handed over to the ambulance team and received at KNH (accident and emergency) at 6.15 pm. After triage he was admitted to a resuscitation room with similar functionality to an ICU.

The patient was reviewed by a resident neurosurgeon at 6.55 p.m. At the time, he was conscious and pale. Blood samples were taken and treatment commenced with IV fluids, antibiotics, analgesics and anticonvulsants.

A credit assessment was conducted at 7.07 pm to determine ability to pay as the mother did not have money or medical insurance. The credit assessment allowed for patient's admission and management.

At 9.15 pm the patient was reviewed by a neurosurgeon and laboratory tests were ordered.

At 9.45 pm, the laboratory results revealed a low hemoglobin and a problem with the clotting system which would put the patient at a risk of excessive bleeding during surgery and required correction before the procedure.

At 11.30 pm, a senior consultant was consulted and recommended transfusion with packed red cells and fresh frozen plasma to correct the problem.

On 11th October, 2022 at 3.00am blood and blood products were ready for collection in the lab and 4.00 am transfusion commenced.

At 7.30 am the patient was reviewed by a consultant surgeon, and bleeding and clotting time was found acceptable.

At 8.30 am the theater list was dropped at the main theater where another operation was going on.

At 12.30 pm, the theater was available and procedure began with the *jembe* successfully being removed. Operation notes indicated that the patient suffered shock and convulsions and multiple episodes of cardiac arrest. Resuscitation was done but the patient succumbed in the theater at 2.55 pm on 11th october, 2022.

With regards to what appeared to be an inordinate delay in attending to the boy at KNH, Dr Kioko noted that it took 4-5 hours from the time of request for blood and blood products up to the time commencing transfusion. He attributed this delay to longer processes of preparing blood products. He further noted that it took eleven hours to stabilize the patient owing to his low Hb, and deranged blood clotting time. Additionally, he noted that it took another four hours of waiting before commencing the operation due to another ongoing emergency procedure.

He further provided a summary of the findings of a joint inspection of the hospital that was undertaken on 15th November, 2022 as provided below-

i. KNH was mandated to provide specialized medical care, facilitate training and research and participate in policy formulation.
ii. KNH was a national referral hospital with all specialized services with a bed occupancy of 100 %, over 6000 staff, 50 inpatient wards, 22 outpatient clinics,24 theaters (16 specialized) and accident and emergency department.
iii. KNH offered surgical, medical, diagnostic, pharmaceutical, nursing services and specialized clinics.
iv. Patient flow through the A&E was clearly outlined with an elaborate A&E process map displayed on the wall.
v. The A&E had two triage desks (one for ambulatory patients, and the other for emergency patients) both manned by nurses and medical officers. There was a patient coding system in place.
vi. There were two resuscitation rooms, one medical and one surgical with the capacity to ventilate 12 patients in emergency cases.
vii. There were 6 theaters at A&E of which two are for trauma cases (one for orthopedic and the other for surgical cases). The A&E theaters however lacked anesthetic equipment to handle pediatric cases who then have to be attended to in the main theater.
viii. The other four theaters were for day cases. He noted that they have not been fully operationalized for optimum use due to inadequate human resource and equipment
ix. There was a coordination office at A&E for handling referral cases
x. The hospital had an established laboratory at the A&E with the capacity to prepare blood and blood products.
xi. There was a social worker's office situated at the A&E and operates 24 hours for evaluation of capacity to pay.

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

A copy of the written submissions by KHPOA have been attached hereto as Annex 2.

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

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

He stated that the attention of the Council was drawn to the public outcry arising from various social media posts, and news aired on various television channels on 11th October, 2022, where allegations of delayed treatment and negligence were leveled against KNH.

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

Vide a letter dated 1st November, 2022, the Council had directed KNH to submit:

a) Medical reports/statements by the medical personnel who managed the patient;
b) Statements from the KNH Marketing & Communication Department;
c) A copy of the post-mortem report stamped 18th October, 2022; and
d) A certified copy of the patient's file (IP No. 2222603).

Further, the Council, through a letter dated 13th October, 2022, wrote to TL5H and requested the hospital to submit:

a) A comprehensive report detailing the treatment and management that the late Master Travis had received at the facility; and
b) Any other relevant document(s) or information that would assist the Council in its investigations.

In response thereto, TL5H had submitted a medical report by Dr. Robert Muchena, Medical Superintendent, dated 1st November, 2022, and a copy of the patient file serialized TL5H 19091.

He stated that on receipt of the documents from TL5H and KNH, the Council referred the matter for investigation to its Disciplinary and Ethics Committee, established under section 4A(1)(b) of the Act, and whose mandate included:

a) Conducting inquiries into complaints submitted to it;
b) Regulating professional conduct;
c) Ensuring fitness to practice and operate;

d) *Promoting mediation and arbitration between the parties; and*
e) *At its own liberty, recording and adopting mediation agreements or compromise between parties, on the terms agreed.*

He further confirmed on 8th November, 2022, the Council's Disciplinary and Ethics Committee had commenced its hearings in relation to the case.

A copy of the written submissions by KMPDC have been attached hereto as Annex 5a. Further, a subsequent Report of KMPDC to the Senate Standing Committee on Health in the matter of the death of Travis Maina at Kenyatta National Hospital and in the matter of the death of the late Maureen Anyango due to alleged negligence at Mama Lucy Kibaki Hospital has been attached hereto as Annex 5b.

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 21ST 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 Master Travis was a reflection of what was happening in the public health care system. Having collected views and reports from members of KMA working at the institution, he submitted the following observations:

1) There was a need to use this unfortunate health outcome to strengthen the current health systems;
2) There was a need to come up with measures to mitigate the strain that came with the loss of any Kenyan through disease or accident.
3) There was a need to protect medical professionals, medical institutions and indeed any person working towards the medical care of patients from negative publicity occasioned by a weak health system, or a lapse in the health system. This protection included protection from adverse media.
4) There was a need to allow bodies that are charged by law to deal with medical issues to do so without undue interference. He further noted that it was time that audits in healthcare adopted the aviation industry audit model whose implementations were immediate.
5) There was a need for the government to support the work of health workers through adequate funds allocation.

6) There is a need to look into the coordination of health regulatory bodies to provide for patient-centeredness. He noted that the current regulatory framework was disjointed with various cadres having different levels of accountability.
7) He further noted that adverse medical outcomes needed to be approached from a Health Systems Strengthening point of view as per the WHO framework.

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

He further noted that the initial hearings in the Senate ought not to have been made public, but that the eventual recommendations should have been publicized widely and implemented. This was in order to 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 hereto as Annex 6.

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

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

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

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

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

He further noted that the National government had since 2018, refused to implement provisions section 18 of the Health Act of 2017, which defined the structure at the Ministry headquarters. He therefore called for the Committee to act to ensure that the structure of the ministry is streamlined and that 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 our hospitals – 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, the "regulatory body must take up the matter and propose a remedy to correct the gap - including imposing suctions deemed necessary and in accordance with the provisions of their various acts".

He called for the establishment of a Health Service Commission in order to address the 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 hereto as Annex 7.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

He further noted that it was important to improve documentation of the patient's journey so as not to be subjective. He called for the installation of CCTV cameras in health facilities in order to avoid 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 hereto as Annex 8.

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 seven (7) guaranteed every person the right to emergency medical treatment which includes pre-hospital care, stabilization, and referral.

In the case of the late Baby Travis, he noted that it took 4-5 hours from the time of request for blood and blood products up to the time of commencing transfusion. This delay was attributed to the long process of preparing blood products.

Further, the time taken to stabilize the patient before commencing the surgery took 11 hours (that is, from 9:15 pm-7:30 am).

A credit assessment that was conducted by the social worker to determine the ability to pay was done at 7.07 pm (The mother did not have enough money nor any insurance coverage). It was therefore the opinion of KUCO that the waiver process may have played a role in delaying the commencement of definitive management.

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

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

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

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

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

He further noted that health facilities must have an appropriate physical environment, including functional, reliable and safe water, energy, sanitation, hand hygiene, and waste

disposal facilities, and that hospital spaces need to be designed, organized and maintained to allow for privacy and facilitate the provision of quality services.

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 Master Travis Maina was regrettable, 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.

A copy of the written submissions by KUCO have been attached hereto as Annex 9.

e) Submissions by the Kenya National Union of Nurses (KNUN)

In their submission, the Kenya National Union of Nurses (KNUN) welcomed the invitation by the Committee to participate in the deliberations concerning alleged medical negligence at health facilities.

With regards to the case of the late Master Travis, the union representatives submitted that it had been appropriate to have Mama Travis sit on the plastic chair and hold the

baby in an upright position through the night due to the position of the *jembe* on the baby's head, and the concomitant risk of aggravating the baby's injuries.

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 KNUN have been attached hereto as Annex 10.

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

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

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

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

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

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

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

With regards to the late Baby Travis, he submitted that from the initial presentation at Thika Level 5, specific emergency resuscitative measures needed to have been instituted. These include immediate intubation, ventilation, resuscitation and monitoring.

Further, he should have been transferred to KNH in an appropriately equipped ambulance with trained pre-hospital personnel and close monitoring as needed.

On arrival at KNH, the above measures could have been provided in the emergency department if they had not already been instituted. Subsequently, he should have been admitted to the Intensive Care Unit for continuity of care and close monitoring while awaiting surgery.

Further to the above, he noted that in an ideal situation, noting that Master Travis Maina had been injured at home, from the first instance, the relatives ought to have been able to call an ambulance immediately.

He further observed that having the fork *jembe* lodged in the baby's head was a delicate situation as unnecessary handling would easily have lodged this further in the head or dislodged it, leading to significant, even fatal, bleeding.

The ambulance personnel on arrival would have immediately stabilized the fork *jembe* and even called the Fire Department through the Dispatch Centre to come and cut off the handle safely. They would then have instituted standardized emergency trauma protocols, including bleeding control and pain relief. Based on the available information, intubation and ventilation would not have been immediately necessary in the field.

After the initial evaluation and stabilization, they would have conveyed this information to the Dispatch Centre who would then have contacted the most appropriate nearby hospital with a Pediatric Neurosurgeon, Theatre, Blood Transfusion Services, and an Intensive Care Unit (ICU) capable of handling Paediatrics so they could prepare accordingly.

On arrival at the hospital emergency department, immediate resuscitative measures would have been instituted, including immediate intubation, ventilation, resuscitation, and monitoring. The baby would have subsequently had the necessary imaging and been admitted to the Intensive Care Unit (ICU) for close monitoring and continued care as the Pediatric Neurosurgeon prepared to take Master Travis to the theater when appropriate.

He further noted that the above interventions were time-sensitive and could have been potentially lifesaving based on the extent of the initial injuries.

Based on the foregoing, he made the following recommendations:

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

was a need to institute the necessary regulatory mechanisms to ensure that the guidelines and standards were adhered to.

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

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

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

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

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

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

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

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

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

She noted that there was a need to establish Hospital Ethics Boards as a means to improve health services. According to the professor, only two hospitals in the country had established Ethics Committees i.e. Aga Khan and KNH. She noted that despite several engagements with the Ministry of Health, the ministry was yet to make it a requirement for hospitals to set up the 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. Ogolla noted that COFPAK was a nonprofit organization that was established in recognition of the need to have a structured means of representing, promoting, advancing and safeguarding the interests of patients in the healthcare ecosystem.

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

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

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

c) Provide guidelines and legislative measures to quality healthcare;

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

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

f) Promote quality healthcare through sustainable multi sector partnership;

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

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

In so far as the treatment that the late Master Travis 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 hereto as Annex 12.

CHAPTER FIVE

COMMITTEE OBSERVATIONS

The Committee made the following observations:

A. In respect of the late Master Travis Maina

1. Article 43(2) of the Constitution and Section 7(1) of the Health Act, 2017 guarantee every person the right to emergency medical treatment.

2. 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.

3. 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.

4. 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.

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

6. Regarding the circumstances under which the late Master Travis Maina sustained his injuries, the Committee observed that according to an investigative report by the Directorate of Criminal Investigations (DCI) (*Annex 1b):*

    a) On 10th October, 2022, at around 12.00 noon, the late Master Travis Maina, then aged two and a half years, joined his brothers, aged eight and six respectively, in weeding their family *shamba*;

    b) As the brothers were weeding, the late Master Travis reportedly got tired and laid on the ground to rest without the knowledge of his brothers. He was shortly, accidentally, struck on the left side of his head by his elder brother (aged six years) with a fork *jembe*, and sustained penetrating head injuries;

    c) Present at the scene were five children: Travis, his two elder siblings, and two other children. In addition, an adult male identified as the children's uncle, who was the first person to respond, confirmed that there was no other person present at the scene save for the children;

    d) The first respondent, a Mr. Hussein, uncle to the late Travis, responded to the screams of the children and discovered the late Master Travis with the *jembe* lodged in the left side of his head: He reportedly tried to remove the *jembe*, but abandoned the attempt when he realized that the *jembe* had gone in too deep.

    e) Upon discovering the late Master Travis where he lay with the fork *jembe in situ*, and having tried, and then abandoned efforts to remove the *jembe*,

the said uncle physically picked him up and rushed him to the nearest nearby murram road where he boarded a *boda boda*. He then transported him to Ndula Dispensary. Unfortunately, the public dispensary was closed owing to it being a public holiday. He then proceeded to take the child to a nearby private facility known as Ndula Medical Center;

f) The Committee observed that, as per the DCI report, during the time it took to transfer the late Master Travis to Ndula Medical Centre, he was at high risk of having his injuries aggravated as demonstrated by the following:

   i) The initial layman's attempt by his uncle to remove the *jembe*, while well-intentioned, and aimed at assisting the child, may have aggravated his injuries;

   ii) During the time it took the uncle to physically carry the late Master Travis to the murram road; and then hail a *boda boda*; and then arrive at Ndula Dispensary only to find it closed; and, then turn back to go to Ndula Medical Center, the fork *jembe* with its handle was stuck in the head of the late Master Travis. Given that it would have been difficult to maintain his head in a secure position with such a heavy implement under these circumstances, the Committee observed that his injuries may have been further aggravated during this period.

In light of the above, the Committee noted that whereas it had been the evidence of Kenyatta National Hospital (KNH) that the injuries sustained by the late Master Travis may have been inflicted by his estranged father:

a) Available evidence produced by the criminal investigations did not place the father within the vicinity of the scene;

b) As per the DCI report, it was common practice for the brothers to weed their *shamba*, suggesting that, despite their seemingly tender age, the children were physically adapted to hard physical labor (*Annex 1b*);

c) As per the report of the KMPDC to the Senate, the allegation by KNH was made on the basis of unsubstantiated second-hand information received by Dr. Brenda Lasoi, an Anaesthesia Resident, from a Mr.

Kamau, an anesthetist student in training, who alleged that the mother of the deceased had informed him about it. *(Paragraphs 57 & 58, Annex 5b).*

7. The Committee observed that prior to his arrival at Thika Level 5 Hospital (TL5H), owing to lack of access to health and/or emergency referral services, there was an important delay of at least three hours from the time the late Master Travis sustained his injuries, to the time he was transferred to TL5H for specialized services as demonstrated by the following:

    a) The late Master Travis sustained his injuries on 10th October, 2022, at approximately 12.00 noon. However, in order to reach a primary health facility in the locality, he first had to be physically carried for an undefined distance to reach an access road *(murram),* and then be transported to the nearest primary facility using a *boda boda*;

    b) As per the DCI report, and as per submissions made by Kiambu County, the late Master Travis was first attended to in a formal health set-up at Ndula Medical Center on 10th October, 2022, at 2:00 pm, approximately two hours after he had sustained his injuries;

    c) Following basic first aid treatment at the facility, the late Master Travis was transported by private means to Thika Level 5 Hospital (TL5H) where he arrived at 3:15 pm, more than three hours since he had first sustained his injuries.

8. Regarding the treatment and management that the late Master Travis received at TL5H, the Committee observed that:

    a) The late Master Travis arrived at TL5H at approximately 3:15 pm, more than three hours since he had first sustained his injuries.

    b) On arrival, he was reported to be in fair general condition, his vital signs were stable and he was fully conscious albeit irritable.

    c) An X-ray and CT scan were ordered urgently, and the late Master Travis was started on emergency treatment consisting of phenytoin, an anticonvulsant, mannitol to reduce brain edema and pain medication.

    d) Upon establishing from the CT scan results that the late Master Travis had sustained a 4.25 cm deep intraparenchymal left parietal lobe injury (that is, a penetrating injury to the left side of his brain), in view of the fact that

TL5H did not have a Pediatric Neurosurgeon, a decision was reached to refer the late Master Travis to KNH at approximately 4:25 pm.

e) By 5:13 pm, the late Master Travis had been transferred to an ambulance ready for departure to Kenyatta National Hospital (KNH).

Based on the foregoing, the Committee observed that the late Master Travis had received appropriate management at TL5H, and that he was referred to KNH in a timely manner.

9. Regarding the treatment and management that the late Master Travis received at KNH, the Committee noted that:

a) The ambulance from TL5H arrived at KNH at 6:03 pm, and the process of handing over the patient was concluded by 6.49 pm;

b) The late Master Travis was immediately admitted to Resuscitation Room A (RRA) at the A&E. Notably, RRA had the same functionality as a HDU/ICU, and allowed for continuous monitoring of the patient;

c) By 6:55 pm, the late Master Travis had been reviewed by a Neurosurgery Resident. Blood samples were taken for a full hemogram, urea/electrolytes and creatinine (u/e/c), a coagulation profile (International Normalised Ratio (INR), Prothrombin Time (PT) and Partial Thromboplastin Time Test (PTT) and blood grouping and cross match. Treatment was also initiated with IV fluids, antibiotics, analgesics and anticonvulsants. At the time, the late Master Travis was reportedly conscious and alert, but pale;

d) At 9.15 pm, the late Master Travis was reviewed by a Neurosurgeon, and a decision to wait for the laboratory results ahead of surgery was made;

e) At 9.45 pm, the laboratory results were availed, and revealed that the late Master Travis had low hemoglobin levels, and a delayed clotting time with an INR of 2.85, a PTT of 33.4 and a PTI of 40%, all of which suggested a high risk of bleeding *(Annex 5b)*;

f) Owing to his low hemoglobin, and prolonged clotting time, at approximately 11:30 pm, the late Master Travis was reviewed by a Consultant Hematologist. The Hematologist recommended that he receive a blood transfusion and blood products.

g) At 3.00 am, blood and blood products were reportedly ready for collection, but it was not until 4.00 am that transfusion commenced;

h) At 7:30 am, the late Master Travis was reviewed by a Consultant Neurosurgeon, and a decision was made to transfer him to theater based on an acceptable *bleeding time* (*Paragraph 22, Annex 5b*);

i) The mother was informed about the late Master Travis being cleared for theater at approximately 8.00 am. However, ostensibly owing to a concurrent pediatric emergency case, the late Master Travis was eventually transferred to theater at 12.30 pm *(Annexes 2,3 and 5b)*;

j) By the time the late Master Travis was being received in theater, he was convulsing and had elevated blood pressures *(Paragraph 51, Annex 5b)*. During the course of the procedure to remove the fork *jembe*, he suffered shock, convulsions and multiple episodes of cardiac arrest. Resuscitation was done, but he succumbed in the theater at 2:55 pm on 11th october, 2022 *(Annexes 2,3 and 5b)*;

k) A post-mortem performed by the Government Pathologist on 18th October, 2022, revealed the cause of death as raised intracranial pressure secondary to penetrating brain injury caused by a fork *jembe (Annexes 2,3 and 5b)* .

10. With regards to whether the treatment and management that the late Master Travis received at KNH was *timely*, the Committee observed that there were avoidable delays as demonstrated by the following:

a) There were inordinate delays in obtaining laboratory test results: As per reports by KHPOA and KMPDC, various laboratory tests (i.e. full hemogram, urea/electrolytes and creatinine (u/e/c), International Normalised Ratio (INR, also known as clotting time) and blood grouping and cross match) were ordered at 6.55 pm. However, despite being an emergency case, the results were only availed at 9.45 pm, almost three hours later;

b) As per submissions made by the KHPOA, it took 4-5 hours from the time of request for blood and blood products up to the time commencing transfusion. This delay was attributed to the long process of preparing the blood products.

c) There was a delay of at least 12 and a half hours from the time that the late Master Travis was admitted in KNH (6.55 pm on 10th October, 2022), to the point a decision was reached to take him to the theater (i.e. approx. 7:30 am on 11th October, 2022).

d) The delay in making the decision to take the late Master Travis to theater was attributed to the need to stabilize his hemoglobin level, and clotting time. However, the Committee found that, as per the report by KMPDC, the decision to transfer the patient to theater at 7.30 am, was made on the basis of a bedside clinical test known as bleeding time *(paragraph 22, Annex 5b),* and not the laboratory-based coagulation profile as had been suggested.

e) In addition, the Committee noted that according to the KMPDC report, it had been the evidence of Prof. Walter Mwanda, the Consultant Hematologist, that even with high INRs, emergency patients could still be taken to the theatre, with blood transfusion being carried out intraoperatively, provided that an ICU bed was made available *(Paragraph 31, Annex 5b).*

f) The Committee noted that there was a further delay of at least five hours from the point that the decision to take the late Master Travis to the theater was made (i.e. 7:30 am) to the point he was finally transferred to the theater (i.e. 12:30 pm).

g) KNH attributed this delay to there being an ongoing pediatric emergency in the pediatric neurosurgical theater (theater 2). However, the Committee established that contrary to submissions by KNH that theater 2 was the only theater suitable for the procedure, as per the KMPDC report, at least two other theaters were suitable and available for emergency procedures i.e. theater 12 (*Paragraph 42, Annex 5b*) and theater 9 (*Paragraph 76, Annex 5b*). However, at the time that the late Master Travis was being kept waiting for theater 2, there was an elective list running in theater 9 (*Paragraph 76, Annex 5b*); and

h) As per the post-mortem results, the cause of death in the late Master Travis was fatally raised intracranial pressure secondary to penetrating brain injury caused by a fork *jembe*. As per the report by KMPDC, it was recognised that the patient's intracranial pressure started rising from the

point of sustaining the penetrating head injury (*Paragraph 40, Annex 5b*). However, despite raised intracranial pressure being a well recognised neurological emergency, it took KNH at least 18 hours to transfer the late Master Travis to theater.

In light of the above, the Committee noted that there was a need for KNH to review/audit its systems with a view towards identifying where the lapses may have occurred, and why; and taking steps to ensure that they did not occur again.

11. The Committee observed that owing to the various delays experienced as described above, the condition of the late Master Travis progressively deteriorated: From being conscious and alert when he first presented at the hospital (6.15 pm on 19th October, 2022) to being barely responsive by the time he was being transferred to the theater (12.30 pm on 11th October, 2022). As described by the mother, by 11.00 am on 11th October, 2022, he had begun prostrating himself, was breathing with difficulty and was no longer responding to verbal stimulation.

12. The deterioration in his condition as reported by his mother was corroborated by the fact that while the late Master Travis was reported to have been conscious and alert at intermittent times from the point of his admission, by the time he was being intubated for surgery, he was convulsing, and had elevated blood pressure. Notably, as per the report by KMPDC, at the time of his admission, the late Master Travis had no prior history of loss of consciousness or convulsions *(Annex 5b).*

13. The Committee further observed that, during the approximately 18 hours it took to transfer the late Master Travis to the theater for his procedure, he suffered significant pain and discomfort: For example, according to the mother's account, he developed high fevers during the night and had to be undressed. In addition, he was hungry and thirsty, having not eaten or drunk anything since the accident, and constantly asked his mother for water. However, as he was scheduled for theater, the mother was unable to offer him anything.

    Further to this, he had suffered discomfort from having to stay seated up on his mother's lap throughout the night, and into the following morning with the fork *jembe* still lodged in his head. In view of his tender age (two and a half years), and the extreme and traumatic nature of his injuries, the Committee observed that urgent measures ought to have been taken to alleviate his suffering.

14. In addition to the above, the Committee noted that owing to an alleged lack of sensitivity and poor communication by the various staff who attended to him, the mother of the late Master Travis perceived their entire experience at KNH as unjust and negligent: For example, the mother seemingly did not understand why the late Master Travis had not been offered a bed, or why it had been necessary for her to stay seated up in a plastic chair and maintain him in an upright position. As explained by KNH, this had been necessitated by the need to avoid aggravating his injuries. However, she perceived it as a lack of care owing to her inability to pay for the services.

15. Nonetheless, noting that it was the evidence of KNH and of the various medical personnel that attended to the late Master Travis that consent was sought from the mother, and that the details of the case were adequately explained to her (*Annex 5b*), the Committee noted that in high-risk cases such as that of the late Master Travis, there was a need for KNH to institute more robust mechanisms for documenting and improving its consent processes.

16. Further, the Committee took note that while the mother had alleged that the late Master Travis was denied treatment on first presenting at KNH by the attending nurse owing to her inability to raise Kshs. 20,500.00, there was no evidence adduced to support the claim. However, it was noted that it was possible that the demand for the payment of the Kshs. 20,500.00 had been made by a rogue person or staff, and that this demand was outside the official hospital policy.

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

17. With respect to the late Baby Travis, the Committee observed that in an ideal situation, having been found severely injured at home, from the first instance, the first respondent ought to have been able to call an ambulance immediately. However, owing to the lack of emergency referral services, the first respondent resorted to using whatever means were available to him at the time e.g. physically carrying the late Master Travis to an access road, and subsequently using a *boda boda* to transport him to the nearest health facility with the fork *jembe* and its handle still attached to his head.

18. In the process, the Committee observed that despite the best intentions of the first respondents, the manner in which the late Master Travis was transferred to the first health facility had left him exposed to several risks, and may have further aggravated his injuries.

19. The Committee further noted that this was not a unique situation, as according to submissions made by the Emergency Medicine Kenya Foundation (EMKF), many cases needing emergency medical care do not even make it to the hospital, with many dying within the community or on their way to the hospital while using public or private means.

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

21. Further, noting that the private sector had exploited gaps in emergency referral services to provide expensive ambulance services that were inaccessible to the majority of Kenyans, 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 at the grassroots .

22. The Committee further 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.

23. The Committee further observed that there was a need for precise mechanisms for financing emergency medical care for the public, including: access to pre-hospital emergency medical care (ambulance services); care in the emergency department; and, immediate inpatient care for any emergency cases that patients cannot afford to pay.

C. In respect of Thika Level 5 Hospital

24. The Committee observed that as a fully functional Level 5 Hospital, TL5H ought to have been able to provide definitive treatment to the late Master Travis. However, owing to the lack of a Pediatric Neurosurgeon, and the lack of pediatric neurosurgical facilities, the hospital had been compelled to refer the patient to KNH.

25. Nevertheless, the Committee observed that the late Master Travis received timely and appropriate care while at the facility.

26. The Committee noted that during his submissions to the Committee, the Governor, Kiambu County, had made a commitment to upgrade and scale-up services at the facility to the standard and level of a level 5 hospital within the period of one year.

27. The Committee further took note that, according to the submissions made by the Governor, Kiambu County was constrained to deliver health services due to lack of adequate resources. Noting that a key constraint had arisen from the fact that the County was shouldering the burden of paying for 95 doctors on post-graduate training, and over 1500 interns, the Committee observed that there was a need for the National Government to take over the burden of post-graduate training as per Schedule Four of the Constitution.

D. In respect of Kenyatta University Teaching, Referral and Research Hospital (KUTRRH)

28. The Committee observed that owing to its proximity to TL5H, KUTRRH ought to have been the referral hospital of choice by TL5H. However, as per the KMPDC report, a key reason that the decision was made to refer the late Master Travis to KNH despite the increased distance, was that KUTRRH typically demanded the payment of a deposit (*Paragraphs 69 and 77(ii), Annex 5b*).

29. With regard to the above, the Committee noted that by prioritizing monetary security over the admission of a patient and provision of emergency care, the KUTRRH was in violation of Article 43 of the Constitution, sections 7(3) and 91 of the Health Act and the Kenya National Patients' Rights Charter, and therefore should be held sanctioned for failure to provide access to emergency care treatment.

E. In respect of Upholding of Professional Standards of Care

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

F. In respect of Regulatory Failures in the health sector

31. 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

32. 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.

33. 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.

34. 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.

35. 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.

36. 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.

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

H. In respect of Patient Communication and Informed Consent

38. Further, the Committee noted that, as per submissions made by the Kenya Psychologists and Counselors Association, there were multiple layers of conflict in the case of the late Master Travis Maina. However, it was the evidence of the Association that the medics who attended to the late Master Travis had appeared insensitive to the issues that were facing the family, and had asked the mother unnecessary questions (e.g. where her husband was), even though they were irrelevant in the immediate context of the emergency.

39. Noting that mental wellness is key to the wellbeing of every person, the Committee observed that there was a need for the Ministry of Health to put the right policies in place to ensure that health personnel are sensitized on the psychosocial and mental challenges that patients and families face.

CHAPTER SIX

COMMITTEE RECOMMENDATIONS

Based on the foregoing, the Committee recommends that-

1. Kenyatta National Hospital (KNH) be investigated by the relevant health regulatory bodies for culpability in the wrongful death of the late Master Travis Maina owing to proof of medical negligence at the facility;

2. KNH to review/audit its emergency care systems with a view towards identifying where the lapses may have occurred, and why; and taking steps to ensure that they did not occur again;

3. KNH to institute more robust mechanisms for documenting and improving its patient communication and consent processes, particularly in high risk cases such as that of the late Master Travis Maina;

4. The Chief Executive Officer and the Board of KUTRRH be held liable for prioritizing monetary security over the admission of patients and the provision of emergency care, in contravention of Article 43(2) of the Constitution which guarantees every person the right to emergency medical treatment; section 7(3) of the Health Act which provides for emergency treatment; and, section 91 (b) of the Health Act provides that private institutions and private health workers shall "*...provide emergency services in their field of expertise as required or requested either by individuals, population groups or institutions, without regard to the prospect or otherwise of direct financial reimbursement.*".

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

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

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

8. Measures are 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.

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

10. 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;

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

In light of the above, the Committee further recommends that the Senate resolves that-

1. This report be dispatched to the Ministry of Health, the Kenya Bureau of Standards and the National Police Service for purposes of implementing the recommendations contained herein within **three (3) months** of receipt of this report.

2. This report be dispatched to the Health Professionals Oversight Authority, the Kenya Medical Practitioners and Dentists Council and any other relevant regulatory body for the purposes of investigating the culpability of Kenyatta National Hospital in the wrongful death of the late Master Travis Maina, and recommending appropriate action **within 1 month** of receipt of this report.

3. This report be dispatched to Kenyatta National Hospital (KNH) for purposes of implementing the recommendations contained herein **within 1 month** of receipt of this report.

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