REPUBLIC OF KENYA

THE MEDICAL PRACTITIONERS AND DENTISTS BOARD

INQUIRY BY THE

PROFESSIONAL CONDUCT COMMITTEE

(PURSUANT TO THE PROVISIONS OF THE MEDICAL PRACTITIONERS AND DENTISTS ACT, CHAPTER 253 OF THE LAWS OF KENYA AND THE RULES MADE THEREUNDER)

IN

PROFESSIONAL CONDUCT COMMITTEE CARE NO 2 OF 2016

BETWEEN

JESCA MORAA
ON BEHALF OF THE LATE ALEX MADAGA MATINI.....COMPLAINANT

AND

KENYATTA NATIONAL HOSPITAL.....1ST RESPONDENT
COPTIC HOSPITAL.....2ND RESPONDENT

RULING

A. NATURE OF THE COMPLAINT

1. The Complaints leading to this inquiry was initiated and lodged at the Medical Practitioners and Dentists Board, herein after referred to as "***the Board***", through the Cabinet Secretary of Health vide a letter dated 8th October, 2015, the family of Alex Madaga Matini and also taken up by the Board from wide media coverage. At all material times there were wide media reports circulating in the local dailies alleging that the Alex Madaga Matini, herein after referred to as "**the deceased**" or "**the patient**", had been involved in a road accident and he died due to delay in accessing Intensive Care Unit or High Dependence Unit services in various Hospitals. The Media reports further alleged that the several Hospitals, including Nairobi Women's Hospital, Ladnan Hospital and Coptic Hospital, refused to admit the patient

prior to payment of a deposit of Kenya Shillings Two Hundred Thousand (Kshs. 200,000.00). Further, the reports alleged that Kenyatta National Hospital delayed in admitting the patient.

2. The Board wrote to the Hospitals mentioned in the local dailies and obtained the requisite documents relating to the patient and upon review of the documents received it referred the complaint to the Preliminary Inquiry Committee herein after referred to as "**the PIC**", for an inquiry as PIC Case No 40 of 2015 as provided for by the Medical Practitioners and Dentists Act, Chapter 253 Laws of Kenya and Rule 4 (1) (a) of the Medical Practitioners and Dentists (Disciplinary Proceeding) (Procedure) Rules. The PIC conducted an inquiry into the complaint in its sitting of 16th October, 2015 wherein all the parties involved submitted documents in relation to the matter and also gave their written and oral evidence. After considering the evidence presented before it, the PIC made the following findings;

(a) PCEA Kikuyu Hospital

(i) The Hospital undertook the required measures and steps after the patient was brought to their facility by good Samaritans as a result of a road traffic accident. The documents further confirm that the Hospital examined the patient within its facility and took steps to manage him under the circumstances of the case prior to taking steps and referring him to another facility.

(ii) The Kikuyu Hospital should have ensured the availability of a qualified clinician to accompany the patient in the ambulance as he was critically ill at the material time.

(b) Nairobi Women's' Hospital

(i) The doctor and nurse on duty at the facility on the material date reviewed the patient upon arrival. Thereafter they called other facilities as they did not have an ICU bed and then made referral.

(c) Ladnan Hospital

(i) The paramedics opted to take the patient to Ladnan Hospital. The ICU beds at the facility were occupied at the material time hence necessitating referral of the patient.

(d) Kenyatta National Hospital

(i) The patient was taken to KNH in an ambulance while in critical condition and was later taken back to the referring facility. The same patient was returned the following day and there is no evidence that the issue was escalated to higher Authorities in an effort to seek intervention or assistance. KNH, being a National Referral Hospital, should have made an effort to escalate the issue to other Authorities, including the Ministry of Health.

(ii) There is no evidence to show that the Hospital undertook all requisite steps to refer the patient to another facility that could have helped under the circumstances of the case.

(iii) That the Hospital allowed a critically ill patient to be returned to the referring Hospital for oxygen instead to taking appropriate steps to intervene more so under the circumstances of the case.

(e) Coptic Hospital

(i) A critically ill patient arrived at the said Hospital in an ambulance but he was not examined by a clinician nor admitted. Further; there was no documentation to show steps or any examination or otherwise that may have been done by its nurse or staff at the material time.

(ii) The staff working at the facility at the material time failed to follow the Hospital's ICU admission policy, as explained by the Medical Director, in respect to the patient herein.

3. In view of the above findings, the PIC held that there was no evidence to warrant any further inquiry against Nairobi Women's and Ladnan Hospital, and the complaints against the two hospitals were dismissed. However, PCEA Kikuyu Hospital was admonished for referring a patient in an ambulance without ensuring that there was a qualified clinician.

4. The PIC further held that the complaint against Kenyatta National Hospital and Coptic Hospital had merit and recommended that the Board should prefer and serve appropriate notices of inquiry and/or charges upon the Hospitals and the matter be referred to the Professional Conduct Committee (the "**PCC**") for further inquiry.

5. In view of the aforestated recommendations by the Preliminary Inquiry Committee, the Board constituted the Professional Conduct Committee as provided by Rule 4A of the Medical Practitioners and Dentists (Disciplinary

Proceedings) (Procedure) Amendment Rules and it consisted of the following members;

(i) Dr. Bernard Muia - Chairman
(ii) Dr. John Tole;
(iii) Col (Dr.) George Kiguta;
(iv) Dr. Jane Kabutu;
(v) Ms. Alice Mwongera;
(vi) Mr. Daniel M. Yumbya, and
(vii) Mr. Peter Munge.

B. INQUIRY BY THE PROFESSIONAL CONDUCT COMMITTEE

6. On 17th October, 2016, the PCC held its sitting at the commencement of its inquiry at the offices of Medical Practitioners and Dentists Board located within Nairobi County. The Complainant was represented by Learned Counsel, Ms. Tabitha Saoyo, the 1st Respondent was presented by Learned Counsel, Ms. Evelyn Gicheru, whereas the 2nd Respondent was represented by Learned Counsel, Mr. Makori. At the commencement of the inquiry, the charges preferred against the Respondents were read out to them and in response thereto they all denied the charges and allegations therein.

7. Ms. Tabitha Saoyo, the Counsel for the complainant, commenced her presentation with her opening remarks before the Committee wherein she highlighted allegations of failures by the Respondents. She further stated that the complainant's case against Kenyatta National Hospital ("***KNH***") was that they did not respond adequately to the emergency.

8. In reference to Coptic Hospital, she submitted that the Hospital did not have a nurse to attend to the patient when he was taken there by an ambulance

and they did not make any effort to admit the patient even when they had the bed capacity. It was her further submission that Coptic's Referral mechanism clearly indicates that their priority is for any patient ought to first pay a deposit of Kshs. 200,000 before being admitted. It was her contention that the actions by Coptic Hospital were in violation of Article 43 of the Constitution of Kenya and the provisions of the National Patient's Right Charter (2013) that was prepared by the Ministry of Health. She submitted that the Charter provided that no person ought to be denied emergency medical treatment and money should not be a barrier to provide emergency medical treatment. It was their submission that the Committee should find the two hospitals culpable and subsequently give appropriate remedies.

9. **Ms. Jesca Moraa** (Mrs. Madaga) was the first witness before the Committee. She was led in her evidence by Learned Counsel, Tabitha Saoyo. She adopted her written statement dated 11th October, 2016 and stated that she was the wife of the deceased, the Late Alex Madaga (Deceased) and they were living at Mount View Estate near Kangemi.

10. It was her evidence that immediately after the accident the deceased was treated at the PCEA Kikuyu Hospital and they were then referred to Nairobi Women's Hospital ("NWH"). On arriving at the said Hospital they were informed that there was no ICU bed available. Thereafter; they proceeded to KNH where they were informed that there was no ICU bed. At that point it was noted that the oxygen in the ambulance was running out and a decision was made for the patient to be taken back to PCEA Kikuyu. On the

way, they passed by Coptic Hospital. She stated that on arrival at the Hospital, a nurse came to the ambulance door but he did not attend to the patient.

11. It was the evidence of Mrs. Madaga that the nurse and a security guard at Coptic Hospital informed them that they had entered the compound illegally as it was against the rules of the Hospital and that Alex would not be admitted without the payment of the required deposit of Kshs. 200,000.00. She stated that she requested to use her NHIF card but the request was denied. They left Coptic Hospital and went back to Kikuyu Hospital as the oxygen was running out. Upon return at Kikuyu Hospital, they were told that arrangements had been made and they needed a CT scan before the patient could be admitted at Nazareth Hospital. However; once Nazareth Hospital got the results from the scan they stated that they could not handle the case. It was her statement they then went to Ladnan Hospital on their way to KNH but the said facility could not admit the patient as it had no ICU bed available at the time. At that point they had no option but to go back to Kenyatta National Hospital where they stayed from morning until the patient was admitted at around 5.00 pm.

12. On cross examination by Ms. Gicheru, the Learned Counsel for the 1st Respondent, she stated that at KNH they were informed by a nurse and a doctor that there was no space in ICU because all the beds were occupied. She also stated that no nurse attended to the patient while they were at the Hospital and it was only after staying for a long time that they decided to go back to Kikuyu Hospital.

13. It was the evidence of Mrs. Madaga that at NWH the patient was examined and they were the advised to go to KNH. She confirmed that at KNH they were informed that there was no ICU bed and the nurse offered to give them oxygen but it could not fit.

14. On cross examination from Mr. Makori, the Learned Counsel for the 2nd Respondent, it was her evidence that a nurse at Kikuyu Hospital told them that they had called NWH which had indicated that they would admit the patient. She also confirmed that they did not have a doctor or nurse from Kikuyu Hospital but were accompanied in the ambulance by a paramedic called Brian.

15. On further cross examination, she stated that after they were told that KNH had no ICU beds, they decided to go back to Kikuyu Hospital because the oxygen was running out and they need to get a better equipped ambulance. She confirmed that it was on their way to Kikuyu Hospital that they decided to go to Coptic Hospital.

16. On re-examination she confirmed that they went to KHN twice. On the first visit a nurse came to check on the patient and they requested for oxygen. She stated that they decided to leave KNH because they could not get the required assistance. She testified that when they left KNH they were not given a referral note nor accompanied by a nurse. It was her evidence that at Coptic a nurse and a receptionist checked on the patient through the ambulance window but did not physically examine him and that though

they confirmed the availability of an ICU bed they would not admit the patient without the deposit of Kshs. 200,000.00

17. **Mr. Brian Ochieng Odhiambo** ("Brian") was the next witness and he adopted his statement dated 15th October, 2015. It was his evidence that when they took the patient to NWH and were informed that there was no space. They were then advised to proceed to KNH. It was his evidence at KNH the nurse informed them that there were no ICU beds and oxygen ports at the Out Patients Department. The nurse at KNH came to the ambulance and checked on the patient but did not physically examine him. He stated that during this period the patient was in the ambulance being bagged through the bag by the driver.

18. He testified that he went to request for oxygen but the cylinders were not compatible. It was at this point they decided to go back to Kikuyu. On the way, they opted to enter Coptic Hospital where they were received by a nurse, who assessed the patient while in the ambulance and the nurse stated that the patient needed ICU and that he would be taken there directly after they had processed his admission. The nurse directed them to the admission desk where the receptionist informed them that they had to pay a deposit of Kshs. 200,000.00. It was his evidence that when they realized that they would not get any assistance at Coptic they decided to go back to Kikuyu Hospital so as to change the ambulance.

19. It was the evidence of Brian that while at Kikuyu Hospital, the staff at the facility called Nazareth Hospital and they indicated that there was a bed

available but they would need to have the patient's CT scan so as to determine whether they could manage him. They then went to German center where a CT scan was done and the report was given to Nazareth Hospital by telephone and after receiving the report they stated that they could not manage the patient and we were advised to go back to KNH. On their to KHN they went through Ladnan Hospital where they were informed that there was no ICU bed. They went to KNH where the patient stayed inside the ambulance until he was admitted at around 5.00 pm. It was his evidence that at KNH the patient was attended to while he was in the ambulance up to the time a bed became available at its ICU.

20. On cross examination by Counsel for the 2nd Respondent, he stated that he holds a License from Kenya Council of Emergency Medical Technicians. He stated that on arrival at Kikuyu Hospital, they were informed that a call had been made to NWH at the Adams Arcade Branch for ICU care. He confirmed that at Kikuyu Hospital, he received the patient who was already intubated. He testified that in referral systems, the referring facility has to notify the receiving facility which will in turn prepare to receive the patient by having a bed ready. He further testified on arrival at a Hospital upon referral, the patient has to be accompanied by a nurse from the referring facility but in this case they were not accompanied by a nurse.

21. It was his evidence that at KNH a nurse came to the ambulance and checked on the patient and then informed them that there was no ICU bed. He confirmed that he was taken round the hospital casualty with a relative of the patient's relative to verify that there was no available bed. It was his

further evidence that the driver was left in the ambulance bagging the patient when the nurse informed them that the oxygen was not compatible with what was at the Hospital.

22. On cross examination by Counsel for 2nd Respondent, he stated that he is neither a nurse nor a doctor. He confirmed that Swift Care Medics is a private organization and they had two ambulances at the time. He stated that while at KNH he consulted the nurse when the oxygen was running out. However, he confirmed that during the time they were taking the patient to NWH, KNH and Coptic Hospitals he did advise Mrs. Madaga on the options. He also confirmed that they entered Coptic Hospital on their way back to Kikuyu Hospital.

23. On re-examination he stated that when they arrived at KNH the first day, there was no effort made to refer the patient to another Hospital. On the 2nd day they arrived at around 10.00 am and the patient was admitted at about 5.30 pm. It was his evidence that at Coptic the patient did not receive any assistance at all. He stated that the nurse saw the patient and then informed them that he needed ICU care and immediately referred them to the admission desk to pay the deposit. At the admission desk they were given a sheet which had the ICU charges.

24. On cross examination by the Committee members, it was his evidence that it was not proper to transfer the patient in an ambulance that did not have a ventilator. He stated that he called his boss to request for an ambulance that was fully equipped but it was not available. He confirmed that they

were given medical records by Kikuyu Hospital which they gave to the nurses at KNH. It was his evidence that at the material time he still had no experience as an EMT.

25. **Dr. Ben Githae** was the next witness who testified on behalf of KNH and he stated that he was the acting Deputy Director, Clinical Services, at the said Hospital. It was his evidence that the events which transpired on 5th and 6th October, 2015 at KNH had been expounded in the statements given by Dr. Monda who served as the Deputy Director Clinical Services, Dr. Opere, the Head of ICU, and Dr. Maingi. It was his evidence that on 5th October, 2015 Kikuyu Hospital called KNH and they were informed that there was no ICU bed. However the patient was brought to KNH and was not admitted because there was no bed.

26. He further stated that though the patient was not admitted at KNH, the floor cover nurse tried to call other Hospitals to inquire whether they had an ICU bed available. It was his evidence that due to the Hospital's workload at Accident and Emergency Unit, they could not provide a nurse to accompany the patient when they left KNH the first time. The patient was later admitted when a bed became available after they moved another patient from the ICU to the ward. He stated that the patient became a KNH patient when upon admission on 6th October, 2015. It was his evidence that as a matter of practice when a patient is referred to another facility he remains the patient of the referring facility until he is received by the receiving facility.

27. It was his testimony that on 5th October, 2015 KNH did not have an obligation to provide a nurse or equip the ambulance with a ventilator because at the material time he was not a KNH patient.

28. On cross examination by Counsel for the Complainant, he reiterated that on 5th October, KNH did not have the capacity to refer to the patient to another Hospital which had an ICU bed. He did testify that their nurses made efforts to contact other Hospitals to seek availability of an ICU bed. It was his evidence that there is a National Referral Policy which clearly stipulates the pathways of referral.

29. He stated that as a National Hospital and following the matter, the Director of Medical Services put out a circular stating that all critically ill patients should be accompanied by a nurse or a doctor trained in ACLS and no patient should be sent to KNH when the referring Hospital has been informed on whether the availability of a bed. It was his further evidence that they have not had any meetings with Private Hospitals on referrals. On cross examination by the Counsel for Coptic Hospital, he stated that the patient's relatives and the ambulance crew were not asked to leave the hospital but they left on their own.

30. On cross examination by members of the Committee, he confirmed that the case was first highlighted by the local media. He stated that the WHO guidelines recommend that there should be 1 ICU bed per 1,000 people however, the country's capacity is still low and the Hospitals currently with ICU capacity cannot cope. It was his testimony that since then, KNH had

increased its ICU capacity by five beds but it still could not cope with the numbers.

31. On further cross examination by members of the Committee, it was his evidence that on the material day, the hospital did not have a transport ventilator which would have taken the patient for the CT scan, however, he was clinically assessed and it was noted that he had a GCS of 3T/15 which was confirmed by the neurologist at ICU. It was his opinion that parties involved could have communicated better to the relatives on the state of the patient.

32. **Dr. Simon Monda** was the next witness who testified that he works at KNH. He testified that on the material day he was in the office of Deputy Director, Clinical Services when he was informed by the in charge A & E Unit that there was a patient in an ambulance who ICU needed care. He then went to the ambulance and spoke to the relatives of the patient and in his evidence they appeared as though they did not believe that the Hospital had no ICU bed. He then showed them the 5 beds in A & E and the 21 in beds the ICU and all were occupied. As they were walking out of the ICU he was informed by one of the ICU doctors that they had reviewed the patients admitted therein and they could get a bed on moving one of the patients. Arrangements were made and the patient was then admitted.

33. On cross examination by Counsel for the complainant, he stated that it is not a policy to refer a patient who was still in an ambulance. He clarified that a patient who has been brought in without having passed through any

other facility would be admitted and thereafter KNH would make efforts to attend to the patient.

34. On further cross examination he stated that had it was have been risky to remove a patient from an ambulance which had a ventilator. He further stated that patients are often referred to KNH from other hospitals mostly due to financial grounds.

35. **Dr. Mark Gachie** an anesthesiologist with the University of Nairobi, College of Health Sciences, was the next witness and he testified that he was also working at Kenyatta National Hospital. It was his evidence that the patient was admitted at KNH on 6th October, 2015 and he had a GCS of 2T/15 which is the most profound form of coma. The patient was reviewed by the neurological team and it was decided that he would be managed conservatively. By the 8th October, 2015 he was still very comatose with GCS of 2T/15 with low blood pressure, fixed and dilated pupils which is an indication of brain stem death. Tests to confirm brain stem death were done and they indicated that he was brain dead. On 9thOctober, 2015 the brain stem tests were repeated and they also confirmed that he was brain dead. The patient passed on after he had a second arrest on 9th October, 2015. He stated that a patient with the prognosis which the patient herein presented with could not be managed outside an ICU set up.

36. On cross examination by counsel for the complainant, he confirmed that he came into contact with the patient after he was admitted to the ICU.

37. On cross examination by the Committee members, he stated that from admission the patient's prognosis was very poor. It was his evidence that the patient was at the deepest point of coma, his pupils were none reactive and he had no brain stem reflexes. It was his opinion that referring facility should have informed the relatives on the prognosis of the patient before the referral.

38. **Dr. S. R. Sakr** was the next witness who appeared on behalf of Coptic Hospital and he was led in his evidence by Learned Counsel, Mr. Makori. He stated that he is the Medical Director at Coptic Hospital and he adopted his written statements. It was his evidence that the deceased was not referred to Coptic Hospital. He denied allegations that their guards chased the ambulance and the relatives. He further stated that the doctor on call was not informed of the incidence. It was his testimony that the ambulance decided to pass by Coptic on their way to Kikuyu Hospital. He stated that when the ambulance went into the Hospital the nurse and the technologist went to ambulance to check on the patient. They saw the referral note which indicated that the patient had been referred for a CT scan and ICU care after which they informed the relatives that the patient would be taken directly to the ICU as the relatives were processing the admission.

39. It was his evidence that after the relatives and the technologist at the Hospital held a discussion the ambulance drove away. He testified that Coptic Hospital admits numerous patients without the deposit after the family or the patient makes a commitment to pay. He stated that he was

not made aware of the patient and only got to know about the issue on the local dailies.

40. On cross examination by the Learned Counsel for the Complainant, he stated that most of the critical patients are taken directly to the emergency unit where the doors are always open or to the ICU. He confirmed that on the material date the Hospital had an ICU bed available. It was his evidence that the nurse informed the complainant and the paramedic to go process the admission so that the patient could be taken directly to the ICU. He stated that the hospital had no record of the events which took place on the morning of 6th October, 2015 when the patient was brought to the Hospital. Dr. Sakr admitted that the lack of documentation was noted after the incident appeared in the media. The matter was taken up by management and the hospital implemented the reporting of incidences through it incidence book.

41. On cross examination the Learned Counsel from KNH, Dr. Sakr confirmed that the patient was brought to Coptic Hospital without any referral. It was his evidence that documents shows that the patient was referred from PCEA Kikuyu Hospital to the Nairobi Women's Hospital.

42. On cross examination by members of the Committee he stated that the relatives were aware that they needed ICU admission and not emergency care. He confirmed that the nurse read the referral note from PCEA Kikuyu Hospital and stated that the Hospital has a policy for receiving patients who cannot meet the full cost of the treatment. He stated that in most instances

the patient's next of kin or the patient would discuss with administration on payment after treatment is given. He also stated that the relatives of the patient did not make any effort to discuss the issue of the deposit with the Hospital's management.

43. It was the evidence of Dr. Sakr that the patient was not a referral for emergency care since emergency treatment had already been provided at the PCEA Kikuyu Hospital. It was his opinion that the ICU care and emergency care are different and what the patient need was ICU care for which he did not need to be taken to the emergency room.

44. He further confirmed that after the incident was highlighted by the local media, he held a meeting with the staff who were present on the material day. He stated that following the incident they developed an incident book or record which helps to capture any incident which occurs at the Hospital. He further stated that right from PCEA Kikuyu Hospital the patient had a GCS of 3T/15 which indicates that the patient was already brain dead. He further stated that they had no prior communication from any Hospital on the patient.

45. **Mr. Samuel Nyarango** ("*Mr. Nyarango*") was the next witness who stated that he is a KRCHN currently working at the Coptic Hospital at the Emergency and Accident Department. He adopted his written statement as filed before the Board. It was his evidence that on the material day, they received an ambulance attendant with a referral note from PCEA Kikuyu Hospital. The referral note indicated that the patient needed to be admitted

at the ICU. He stated that the attendant informed him that they had gone to KNH but there was no ICU bed. He then made a call to the ICU Department and confirmed that a bed was available. Thereafter he told the EMT and the patient's relative to go to the admission desk to process his admission.

46. He testified that after he directed the EMT to the admission desk, he went to the ambulance where he found the patient on a stretcher intubated with intravenous fluids being manually bagged. He stated that he was later informed that the ambulance had left but he did not know what transpired at the admission desk.

47. On cross examination by the Learned Counsel for the complainant he stated that he assessed the patient while in the ambulance and noted that his SPO2 was reading 70 to 85% and he was being bagged. He confirmed that although he assessed the patient, he did not record anything because the patient had not yet been admitted. He stated that for any patient who is brought in by good Samaritans, a temporary outpatient file is opened. He further stated that all patients who are attended to at Coptic Hospital need to go through admission so as to open the patient's file. It was his evidence that in the case of the patient herein all emergencies had already been taken care off.

48. It was the evidence of Mr. Nyarango that had Brian introduced himself and informed them that he was still a student he would have received further help. He further stated that the patient should have been referred with a

nurse or a doctor. He confirmed that he went to the ambulance and made a preliminary assessment and noted that the patient's SPO2 was at around 77 to 85% which indicated that the patient was in respiratory distress and needed to be assisted in breathing through a ventilator.

49. The witness further stated that the hospital's emergency room did not have a ventilator which could have been used to stabilize the patient. He stated that in his assessment the patient needed a ventilator which was not available at the Emergency Room. He also confirmed that the patient was intubated and was being bagged.

50. **Mr. Walter Matete**, ("*Mr. Matete*") was the next witness who appeared on behalf of Coptic Hospital. He adopted his statement as filed before the Board and testified that on the material date he was a receptionist at the Hospital. It was his evidence that on the material day, two gentlemen and two ladies came to the reception and asked on the chargers for ICU admission. He gave them the charges sheet together with the admission form and left them discussing amongst themselves as he was attending other clients. He stated that when he came back he found that they had already left.

51. It was the evidence of Mr. Matete that at the material time he had worked at Coptic Hospital for more than eight months and during that period he had seen several patients being admitted without paying the deposit. He stated that in such cases, the relatives or the patients would make a

commitment stating how they would facilitate payment after admission and after the commitment they would be admitted.

52. On cross examination by the Learned Counsel for the complainant he stated that he gave them the sheet containing the charges by the Hospital and heard them discussing amongst themselves on the rates. He confirmed that all admissions at Coptic Hospital have to go through the admission process.

C. SUBMISSIONS

53. The Learned Counsel for the Complainant filed submissions before the Committee and further highlighted on the same. It was her submissions that the matter before the Committee was about the failure, refusal and denial of emergency medical treatment to the Late Alex Madaga Matini by the 1st and 2nd Respondents. She submitted that Article 43 (1) (a) of the Constitution of Kenya guarantees that every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care. Relatedly, Article 43 (2) provides that a person shall not be denied emergency medical treatment. In defining what constitutes an emergency and in support of this submission, the counsel relied on the ***Kenya Health Policy, 2014-2030*** which defines an emergency as follows;

> ***"Health threats that are of sudden onset in nature, are beyond the capacity of the individual/community to manage, and are life threatening or will lead to irreversible damage to the health of the individual/community if not addressed."***

54. Further, the Kenya Health Policy describes emergency treatment as follows;

> ***"Healthcare services necessary to prevent and manage the damaging health effects due to an emergency situation. It involves services across all aspects of healthcare services.***

The counsel submitted that the policy also provides that ***"emergency health services shall be part of the referral services and shall be provided by the nearest health facility, regardless of ownership".***

55. The Counsel also submitted that the ***Kenya National Patients' Rights Charter, 2013*** *provides* that every person has a right to receive emergency treatment in any health facility, irrespective of the patient's ability to pay. Further, ***The Code of Professional Conduct and Discipline, 2nd Edition, 2012*** requires every practitioner to respect all aspects of human life and that practitioners involved in private practice and private health institutions may not withhold treatment in emergency cases on the basis of a lack of fees or funds.

56. In respect to Kenyatta National Hospital, it was submitted that the hospital failed, refused or neglected to make efforts to transfer the patient as required by the Kenya Health Policy or take such necessary steps to provide emergency care. Further, the said failure in turn caused delay in the treatment of the patient causing unnecessary suffering to the patient, and was part of the chain of events which ultimately contributed to the patient's death. The counsel submitted that the said failure also subjected the patient's family to mental anguish, emotional distress, pain and suffering.

57. The complainant's counsel further submitted that the actions and inactions by Kenyatta National Hospital violated the constitutional right of the late Alex Madaga Matini. It was further submitted that the Kenyatta National Hospital's lack of appreciation of the need to put in place proper, functional, timely and effective referral measures violates not only the constitutionally rights as enshrined in the Constitution but also violates the laid down procedures as stipulated in the ***Kenya Health Sector Referral Implementation Guidelines, 2014***.

58. In reference to Coptic Hospital, it was the complainant's submission that, the hospital failed and neglected to give emergency care to the patient in breach of Article 43(2) of the Constitution. It was submitted that the Hospital had the capacity at the particular time to provide the care to the patient. Further, it was also submitted that the hospital acted in violation of the Kenya National Patient's Right Charter, 2013, by demanding for a cash deposit before they could admit the patient.

59. The 1st Respondent in response to the first Charge submitted through its Learned Counsel that prior to arriving at KNH, the patient had already received emergency treatment at PCEA Kikuyu Hospital. The emergency care that the patient needed at that material time was intubation, oxygenation, ventilation and IV mannitol all of which had been done by the PCEA Kikuyu Hospital and as such she submitted that KNH did not deny the patient emergency treatment. It was their further submission that the patient was already brain dead after the accident and this was confirmed by the

referral form from PCEA Kikuyu Hospital which noted the state of the patient as having a Glasgow Coma Scale (GCS) of 3T/15.

60. The 1st Respondent also submitted that the complainant was informed on time that there was no ICU bed at KNH so as to enable her seek alternative medical care. The Hospital also made efforts to secure the admission in alternative Hospitals without successful.

61. In reference to the second charge, the Learned Counsel submitted that KNH did not send the patient to the referring hospital. They reiterated that the complainant was fully aware that it did not have an ICU bed available at the time and the decision to return the patient to referring hospital was made by the complainant and the Emergency Medical Technician (EMT) without informing the Hospital.

62. On the third charge, KNH submitted that the charge was vague and it did not disclose what inappropriate systems of work it maintained and how that contributed to the delay in treatment of the patient. The 1st Respondent averred that the right to health is intrinsically connected with the right to life. However, the Constitution of Kenya recognizes the right to health can only be achieved progressively and its realization is subject to availability of resources. The counsel referred to Article 21 (2) of the Constitution which provides that;

> ***"The State shall take legislative, policy and other measures including setting of standards, to achieve the progressive realization of the rights guaranteed under Article 43".***

63. The Learned counsel further referred to **Article 20(5)** of the Constitution which provides that;

> ***"in applying any right under Article 43, it the State claims that it does not have the resources to implement the right, a court, tribunal or other authority shall be guided by the following principles;***
>
> ***... (c) the court, tribunal or other authority may not interfere with a decision by a State Organ concerning the allocation of available resources, solely on the basis that it would have reached a different conclusion".***

64. The 1st Respondent also submitted that it has 36 ICU beds as opposed to the recommended standards by the World Health Organization of at least 63 ICU beds at a ratio of one bed to forty patients. It avers that intensive care requires, inter alia, enormous labour and specially trained human resources with specific expertise, and that the cost of a single equipped ICU bed is about Kshs. 8,000,000/=. The 1st Respondent further submitted that it had written to the Government, through the Ministry of Health, on the status of its intensive care unit and the issue is being addressed. It was the 1st Respondent's further submission that the fact that the complainant was not able to access an ICU bed for the patient did not mean that it had violated the patient's rights as provided under Article 43(2) of the Constitution.

65. The 1st Respondent urged the Committee to be guided by the judgement in the High Court Case ***LN & 21 others -vs.- Ministry Of Health and 2 others (2015) eKLR*** and further urged the Committee to dismiss the complaint against the Hospital.

66. The 2nd Respondent, Coptic Hospital, submitted written submission signed by its Learned Counsel. They urged the Committee to note that, the patient was placed in an ambulance at PCEA kikuyu Hospital and he was not accompanied by a doctor or a nurse. The ambulance which is operated by a private organization had at the time an unqualified person acting as the EMT. They further submitted that the Complainant's witness, Brian Ochieng, confirmed that at the material time he was still a novice and had not handled such a matter before. Further, he also confirmed that he had worked continuously for a period of two days.

67. The 2nd Respondent submitted that the complainant and the paramedic, both unqualified persons, were making the decisions in regard to the patient, without guidance of a qualified profession. As an example, it was submitted that they made the decision to leave KNH without informing anyone.

68. The 2nd Respondent concurred with the position of the 1st Respondent that the emergency care needed for the patient at the material time was intubation, oxygenation, ventilation and IV mannitol which had been given at the PCEA Kikuyu Hospital. It was the 2nd Respondent's further submission that, it did not deny the patient the right of emergency treatment as alleged by the complainant. They submitted that the patient needed ICU admission and this was a process which should have been done properly with no delay through good communication, opening the file and taking responsibility for the bills which is not necessarily paying cash deposit.

69. The 2nd Respondent further submitted that the complainant's evidence had mutated with time. They submitted that there were conflicting facts in the complainant's written statement, her oral evidence before the Preliminary Inquiry Committee and the oral evidence before the Professional Conduct Committee. In closing, the 2nd Respondent submitted that its only weakness was that its staff did not document the incident at the material time but they urged the Committee to consider the circumstances at the time. The Learned Counsel submitted that the said gap had been recognized and measures put in place to correct it. The 2nd Respondent also urged the Committee to be guided by the judgement in high Court case of ***LN & 21 others -vs.- Ministry of Health and 2 others (2015) eKLR.***

D. FINDINGS

70. The Committee carefully perused copies of the available records of the patient's file from the Kenyatta National Hospital, the statements and statutory declarations presented by the parties herein and all other documents before it and also considered the evidence tendered before it by the witnesses to enable it consider the complaint fairly and judiciously. It also reviewed and considered the documents relating to the proceedings previously before the Preliminary Inquiry Committee of the Board and the evidence of all the witnesses who appeared before it and submissions made by Learned Counsels.

71. Upon careful evaluation and lengthy deliberations of the above, the Committee makes the following findings as relates to each of the Respondents, to wit;

A. KENYATTA NATIONAL HOSPITAL

72. The Committee notes that the first charge in the Notice of Inquiry against Kenyatta National Hospital states, inter alia, that

> *"THAT you, Kenyatta National Hospital ... received a patient, Alex Madaga Matini, (now Deceased) at your Hospital but* ***failed to transfer the patient or take the necessary steps to provide emergency care and management*** *of the patient under the circumstances of the case and the condition of the patient thus delaying treatment and care of the said patient".*

73. In view of the above, the Committee notes that the first charge against Kenyatta National Hospital relates to failure to transfer the patient or take necessary steps to provide emergency care and management.

74. The Committee considered and adopted the definition of emergency treatment as is contained in The Kenya Health Policy which describes it as;

> ***"Healthcare services necessary to prevent and manage the damaging health effects due to an emergency situation. It involves services across all aspects of healthcare services.***

75. The policy also defines an "***emergency***" as;

> ***"Health threats that are of sudden onset in nature, are beyond the capacity of the individual/community to manage, and are life***

threatening or will lead to irreversible damage to the health of the individual/community if not addressed."

76. The Committee also considered and adopted the definition of emergency medical condition ("EMC") from the case before the South African Constitutional Court in ***Thiagraj Soobramoney –vs- the Ministry of Health (Kwanzulu- Natal) (1998) (1) SA 765 (CC), 1997 (12) BCLR 1696 (CC)*** wherein the Constitutional Court defined an emergency medical condition as;

"...a dramatic, sudden situation or event which is of passing nature in terms of time that can be cured through medical treatment..."

77. The Committee also considered and adopted the definition of emergency medical condition by ***The Emergency Medical Treatment and Labor Act (EMTALA) (1986)*** which defines EMC;

"a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the individual's health ... in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of bodily organs."

78. From the aforegoing definitions of emergency medical condition and emergency treatment as quoted above, the Committee holds that reasonable inference can be drawn that an emergency would entail imminent death or serious and irreparable damage to the patient's health and emergency medical treatment therefore refers to remedial treatment that is necessary and available be given immediately to avert that harm.

Further the Committee holds that emergency care and emergency treatment are one and the same thing.

79. The Committee having considered the above finds that the Late Alex Madaga was involved in a road traffic accident on 5th October, 2015 and thereafter taken to PCEA Kikuyu Hospital by a Good Samaritan. At the PCEA Kikuyu Hospital the patient was reviewed and managed before being referred for ICU Care. In this case, the Respondents have submitted that emergency care needed for the patient at the material time included intubation, oxygenation, ventilation and IV mannitol had been done at the PCEA Kikuyu Hospital. The Respondents also submitted that in the context of this case, ICU care cannot be classified as part of emergency treatment. The Committee also notes that it's not dispute that the deceased's condition was grave.

80. The Committee having considered the facts before it finds that Kenyatta National Hospital informed the referring facility that it did not have an available ICU bed on the material date. However, the patient was referred to the said Hospital and an emergency care nurse assessed the patient while in the ambulance and informed the complainant and the EMT that the Hospital did not have an available bed. The Committee notes that the transfer of a patient from one facility to another can only be done through the facility where the patient in being treated. On the 6th of October 2015 Dr. Monda, who was a consultant at the Hospital and the then Deputy Director-Clinical Services, was informed of the case and he immediately went to review the position. Dr. Monda confirmed that he saw the patient,

who was then in the ambulance, and confirmed that he was better off in the ambulance under the circumstance of the case than being removed as there was no ICU bed at the time. The Hospital then made arrangements to move another patient to the ward on the advice of the concerned doctors and thereafter moved the patient herein to its ICU. The Committee thus finds that under the circumstances of the present case Kenyatta National Hospital did take appropriate action in view of the condition of the patient and the prevailing circumstances. Having made the above finding and considered the circumstances of the case the Committee holds that Charge 1 as framed in the Notice of Inquiry against Kenyatta National Hospital cannot be sustained and it thus fails.

81. In respect to Charges 2 and 3 in the Notice of Inquiry against Kenyatta National Hospital, the Committee considered the facts as set out above and finds that KNH, despite being a referral Hospital, did not have an ICU bed available at the time. It is noteworthy that when the patient was brought to the Hospital the second time on 6th October, 2015, KNH undertook appropriate steps to assess the patient's conditions and notify a senior practitioner. The Committee also notes from the evidence before it that the medical personnel at KNH assessed the patient several times while he was still in the ambulance until he was eventually admitted in its ICU. In view of the above, the Committee finds that charges 2 and 3 against Kenyatta National Hospital cannot be sustained and hence the said charges do fail.

82. The above notwithstanding, the Committee finds that under the circumstances of the case and the condition of the patient at the material

time, the Hospital should have taken steps to ensure that the patient was assessed by one of their consultants or qualified professional and the prognosis of the patient appropriately communicated to the relatives or other relevant authorities.

83. In view of the above, the Committee hereby reprimands Kenyatta National Hospital for failing to ensure that the patient was appropriately assessed by a consultant and his prognosis explained to the relatives.

B. COPTIC HOSPITAL

84. The Committee notes that the first charge in the Notice of Inquiry against Coptic Hospital states, inter alia, that

> *"THAT on or about 5th October 2015 you, Coptic Hospital, ... received a patient, Alex Madaga Matini, (now deceased) at your facility but **failed to give emergency treatment** to the said patient or undertake the care and management expected of you as a Hospital and/or medical facility, notwithstanding the condition of the patient at the material time, **in breach of the provisions of Article 43(2) of the Constitution.***

85. In view of the above, the Committee finds that the first charge against Coptic Hospital relates to failure to give emergency treatment in breach of the provisions of Article 43(2) of the Constitution.

86. The Committee has taken into account the fact that emergency treatment is not defined in the Constitution but having adopted the definitions of

emergency care and emergency medical treatment as described above finds that charges against the 2nd Respondent on alleged failure to give emergency treatment to the patient herein cannot be sustained. In view of the above, the Committee finds that charge 1 as framed against Coptic Hospital cannot be sustained and it's thus dismissed.

87. The second charge in the Notice of Inquiry against Coptic Hospital states, inter alia, that

> *"... received a patient, Alex Madaga Matini, (now deceased) at your facility but **failed to give emergency treatment** to the said patient or undertake the care and management expected of you as a Hospital and/or medical facility, despite the condition of the patient at the material time, **in breach of the provisions of Chapter 1 of the Patient's Charter and Chapter IV and V of the Code of Professional Conduct and Discipline".***

88. The definition of emergency and emergency treatment has already been addressed in the previous paragraphs. Chapter 1 of the **Patients' Rights Charter** at paragraph 2 provides for the right to receive emergency treatment in any health facility and states, inter alia, that;

> ***"In emergency situations, irrespective of the patients' ability to pay, treatment to stabilize the patient's condition shall be provided".***

89. The said Charter provides that treatment to stabilize a patient's condition shall be provided. From the foregoing and the definition of what entails emergency treatment, the Committee finds that 2nd Respondent did not fail

to give the patient emergency treatment as the patient had already been stabilized by the referring facility and what was required was ICU care. However, the ambulance team and the relative drove out of the Hospital with the patient without informing the staff present then or seeking guidance on the issue of admission or the deposit. In view of the above, the Committee finds that Charge 2 as framed against Coptic Hospital cannot be sustained and is thus dismissed.

90. The above notwithstanding, the Committee notes that the requirement of paying a deposit before the patient was admitted to the Intensive Care Unit played a role in the decision making by the complainant that led to the ambulance leaving the facility without informing the staff therein. The 2nd Respondent's submission indicated that they would have admitted the patient even without payment of the deposit but there was no request made by the complainant.

91. However, a review of the documents before the Committee shows that the staff on duty did not make efforts to relay the said information to the Complainant. In this regard the Committee directs the Hospital to train its staff on customer care and also put up clear policies in that regard to enable them communicate appropriately with patients and their relatives.

92. As regards, Charge 3 in the Notice of Inquiry, the Committee notes that Dr. Sakr admitted before the Committee that at the material time the Hospital had ICU Admission and Referral Protocol System but in the present case the

staff did not follow the said protocol. The protocol provides under clause (D), inter alia, that;

> ***"In case that the patient was seen at any other hospital before Coptic, we request for a detailed referral from this hospital, as provided by the relatives before bringing the patient on or at least a phone call from the other hospital ICU or ER doctor .... also to prepare the patient's family financially to be ready "***

93. The Hospital's witness admitted while on cross examination that the staff on duty on the material date did not follow the protocol on admission and as the patient was not assessed by a doctor and the relatives were not guided appropriately on the issue of the required deposit.

94. In view of the above the Committee finds that the medical personnel present at the Coptic Hospital on the material date failed to follow the Hospital's ICU Admission and Referral Protocol System when the patient was brought in by an ambulance.

95. The Committee notes that although the nurse stationed at the emergency room assessed the patient in the ambulance and noted that his SPO2 was at 70 to 85 %, which actually indicated that his respiration was compromised; no action was taken to further stabilize the patient as the ICU admission was being sorted out. Further, there is no evidence of any records taken or efforts to notify any of the practitioners therein at the time. In view of the above the Committee holds that charge 3 against Coptic Hospital has been proved satisfactorily.

E. ORDERS

96. In view of the above findings and having consulted and obtained approval from the Medical Practitioners and Dentists Board makes the following orders;

(i) The Chairman of the Medical Practitioners and Dentists Board is directed to reprimand the Coptic Hospital for the failure by its staff at the material time to assess the patient appropriately and failure to communicate appropriately to the patient's relatives on the issue of payment of the deposit.

(ii) Coptic Hospital is directed to put in place structures for continuous training of its staff on customer care and also put up clear policies in that regard to enable its staff communicate appropriately with patients and their relatives.

97. The Committee has carefully and in the interest of the general public considered the fact that private Hospitals are expected under the Constitution of the Republic of Kenya and the Law to offer emergency treatment to patients but there are no guidelines on payment for such services in the event affected patients are unable to pay. In that regard the Committee directs that the Medical Practitioners and Dentists Board to take immediate steps to liaise with the Ministry of Heath to facilitate the creation of guidelines for payment of emergency treatment.

98. In view of the above, the Committee further directs the Medical Practitioners and Dentists Board to liaise with the Ministry of Health to put in place and disseminate policies and guidelines for referral of emergency cases.

99. The Committee do also directs that the Medical Practitioners and Dentists Board to liaise with the Ministry of Health, the Council of Governors and other key stakeholders to develop and implement regulations and guidelines for registration, Licensing and operation of ambulance services within a period of 90 days from the date hereof.

Dated in Nairobi this 21st day of December, 2016

DR. BERNARD MUIA
CHAIR
PROFESSIONAL CONDUCT COMMITTEE