THE REPUBLIC OF UGANDA

IN THE MATTER OF MEDICAL AND DENTAL PRACTITIONERS ACT

AND

IN THE MATTER OF AN INQUIRY INTO ALLEGED MEDICAL NEGLIGENCE AND MISCONDUCT BY MEDICAL PERSONNEL OF BUGIRI GENERAL HOSPITAL IN TREATING NALUBANGA MONICA LEADING TO HER DEATH

FINDINGS AND RESOLUTIONS OF THE COUNCIL

Background

Uganda Medical and Dental Practitioners Council received a letter dated 29th July 2022 from Dr. Okware Joseph, the Director Health Services-Governance and Regulation in which Bugiri district alleged negligence by the Medical personnel of Bugiri General Hospital that led to the death of a mother, Nalubanga Monica, who had been admitted at the said health facility and needed emergency obstetric care services.

The complaint was served by Uganda Medical and Dental Practitioners Council on the Medical Superintendent of Bugiri General Hospital on 30th March 2023, seeking the hospital's response.

Responses together with the original Copy of the patient's file attached were received by the Council on 3rd April 2023.

On 1st March 2024, the Ethics and Disciplinary Committee of the Council conducted a preliminary hearing of the matter, and upon perusing the complaint and the responses thereto, resolved that the complaint be subjected to a full inquiry by the Council.

Accordingly, an inquiry was conducted on the 8th day of May 2024 where upon Council received oral testimonies from witnesses as follows:

Nansubuga Rose (sister to the deceased)

Nansubuga, 42 years of age, a resident of Kilelema and a sister to the deceased testified that Monica's labor started at around 5:00am at Kilelema, and they hired a boda-boda to take her to Bugiri General Hospital where they reached at around 7:00 am. She then went to buy kavera (polythene sheet) and a basin.

She stated that when she returned from buying the items, she found two (2) ladies (nurses) on duty (one of whom she was able to identify as Cissy during the inquiry), who asked why she had bought a basin.

It was her evidence that the said ladies, gave her a list of items to buy to prepare for the operation, and these included; 7 bottles of water (normal saline), gloves, polythene and catheter. When she came back, she was told to put the patient on the trolley to the theater and told her to keep standing watching the patient which she did up to between 11am, and 12pm. During all that time, no treatment was rendered to the patient except intravenous normal saline and was not taken to the theatre.

At midday, the nurse told her that they were going to refer them to Jinja and asked for thirty thousand (30,000) shillings to pay for fuel for the ambulance to Iganga hospital. She did not have the money and she started to call relatives asking them to raise the money. The patient died at 2pm without any help from doctors because she didn't see any doctor ever coming to attend to her. The Anaesthetic Officer was not available for all the time they were in the Hospital.

She testified that the patient asked if she could be helped because she felt that she was dying and the nurse told her that **"even if she died, she was not going to be the first one to die".** The patient died at around 2pm and by 5pm she was already taken to the mortuary. The nurses asked her for the phone number of the deceased's other relatives, but she declined to give them any contact after all they had not helped in treating or saving the patient's life. The deceased in-law came with a car and took the body for burial.

She testified that the deceased had three other children of which the first one was delivered by Cesarean Section and the subsequent two were delivered normally. She said that the deceased attended Antenatal Care at Bulage Health Centre and when asked if they had gone to a Traditional Birth Attendant (TBA) before coming to the hospital, she answered that they never went to the TBA as alleged.

She further testified that the **hospital officials did not help them at all** to save her sister who died leaving very young children and she was not happy with all that happened and asked the Council to intervene so that they can get justice as a family.

Mr. Isabirye George (husband)

Isabirye a resident of Kilelema, a farmer and a husband to the deceased testified that when Monica started feeling labor pains at around 4am, he called the boda-boda rider to take them to the hospital but he said that it was risky to move at that time and told them to get ready by 5am. He came at 5am and the husband requested Ruth (Rose-sister to the deceased) to go with the patient as he stayed behind looking for money for hospital bills.

He testified that Ruth (Rose) called him in the morning telling him to come quickly as the patient was going to be referred to Jinja because she was very sick. He rushed to the Hospital and the patient died soon after he had arrived.

He testified that after the death of Monica, he was in shock and almost became unconscious. Ruth started calling people at home telling them that the patient had died. They contacted their area Member of Parliament for an ambulance to transport the body. He told them to wait for the feedback within about 40 minutes. As they were still waiting, a relative came with a car and transported them home for the burial. That was when he lost control of himself and broke down.

Atyang Cissy Rebecca (Enrolled midwife).

Cissy 33 years old, an enrolled midwife who qualified from Arua School of Nursing in 2012 and has been working at Bugiri Hospital since 2018 to date, testified that on 9th July 2022, she was on night duty with Aanyu Angella, another midwife.

She told Council that on 10th July 2022, they received a mother at 8:50am being escorted by her sister, she was visibly in pain and **her condition was alarming**. She asked the attendant where they were coming from, and she answered that they were coming from home. She used disposable gloves to check on the patient and asked the attendant to buy more items to be used in the theatre as they were out of stock at the hospital.

It was her testimony that she asked the patient who said that she had been previously operated twice in 2017 and 2018 respectively while giving birth. She further asked the patient whether she attended antenatal, and she said no.

She examined the patient, who exhibited guarding of her abdomen and had a previous scar; took vital signs and recorded them. The patient's sister came back with a pair of surgical gloves, a catheter, and a cannula.

She stated that she tried to pass the catheter, but did not succeed in passing it. At around 9:30am Dr. Nabongo Joshua who was **on covering duty** came, examined the patient and wrote notes in her file. She testified that she called the theater nurse to prepare for operation, but the theatre nurse told her the Anaesthetic Officer was not around.

She testified that she called the hospital Medical Supervisor, Dr. Oundo Abanga, and informed him that Anaesthetic Officer was not around and there was a mother who was in critical condition that needed an emergency operation. She went back to the mother and replaced the normal saline that had run off. She went to attend to another mother who was in labor, and she assisted her to deliver. The Medical Superintendent called back and said the Anaesthetic Officer was not around and was trying to get another Anaesthetic Officer from another Health Centre.

At that moment, the midwife for the next duty Doreen Namulondo came in and she handed over to her. Shortly after she had reached home (at around **10:20am**), Doreen called and told her that the mother had passed on. She said that she was called back to the hospital because a representative from the LCV Chairperson of Bugiri district had come and wanted to talk to her concerning the death of Monica.

Anena Ketty Atube (In Charge Labour/ CS Unit)

Anena testified that she is a Nursing officer, a holder of Bachelors degree in Nursing from Clarke University obtained in 2017 and did internship at Mulago Hospital in 2018, had a Diploma in Midwifery from Mengo Hospital in 2011, certificate in midwifery in 2002 from Kamuli school of nursing and midwifery. Got employed at Bugiri Hospital as enrolled midwife in 2005.

It was her evidence that on 10th/7/2022, she got a call from Cissy between 9.30am and 10am while in church, that there was a mother who needed to be operated on because her condition was critical. She rushed there and found the patient on bed and Dr. Nabongo was on the ward.

She testified that the Anaethestic Officer was off and had gone to Kampala for his child's Visiting Day. She called Jackline Waffu, the Principal Nursing Officer, who said that she was trying to talk to the Obstetrician and Gynecologist Dr. Nakendo Abubakar, his phone was ringing, but he was not picking up.

She opted to call Muyodi, Anaesthetic officer at Nankoma Health Center IV, who said that she was also not at the Centre and she was far away. She called the Iganga Hospital administration who said that they were ready to receive the patient.

She told the Medical Superintendent about the referral, and he said there was no fuel for the ambulance so she had to wait or look for any other solution. As she was thinking of what to do next, the nurse on the ward called her at 11am saying that the mother had died.

She testified that at around 2pm, Personal Assistant to the LCV Chairperson called her saying that she had been sent to meet her about the death of Monica. During the meeting, the deceased's sister declined to say much and declined to share contacts of the deceased's other relatives. After some days, they were called by LC5 and senior district staff, who asked them to come along with the file of the patient. While there, they explained to the officials what had happened.

During the inquiry, she admitted that the Hospital staff did not do maternal audit as it is required, no postmortem was done and she suspected that the mother died due to rapture of the uterus.

Atim Jackline Waffu (Principal Nursing Officer)

Atim testified that she is 50 years of age a holder of Bachelors of Science in Nursing from Clarke International University obtained in 2020, a Diploma in Nursing from St. Mary's Nursing School Lacor obtained in 2006, Diploma in midwifery from Nsambya School of Nursery and Midwifery in 2001, Certificate in nursing from St Mary's School of Nursing and Midwifery, Kalongo obtained in 1996.

She testified that she was off duty and had gone to the village when she got a call around 10am that there was a mother who was in emergency condition that needed a Caesarean Section. She called the Gynecologist Dr Nakendo, his phone was ringing, but he was not picking the call. She tried to call the Anaesthetic Officer but his phone was off. Shortly after Dr. Nakendo called back and she told him that she was calling him about the mother who needed emergency Caesarian Section; **he said okay**. Shortly after, she received a message that the mother had died. She came back to the hospital on Monday. She said that she never talked to the deceased's relatives because they left on Sunday before she came back.

Okumu Paul (Anaesthetic Officer)

Okumu testified that holds a certificate in nursing from international school of Health Science Jinja in 2006, Diploma in nursing from Jinja school of Nursing and Midwifery in 2012, Higher diploma in anesthesia from Gulu College of Health Science in 2016. He dropped out of training in diploma in dispensing from Paramedical school, Mulago in 2010.

It was his evidence that he was off duty on 10th July 2022 and he had left Bugiri to go and check on his sick child at school in Kampala. He received a call from the Medical Superintendent asking him where he was. He told him that he was not around as he had gone to visit his child at school. At around 4pm, he received another call from the Medical Superintendent informing him that he is a liar, and had killed someone yet he didn't know or see the patient who had died. He went back to Bugiri, on the morning of 11th July 2022 reported on duty and did his operations that day and night.

He testified that on 12th July 2022, he received summons from the district requiring him to attend a meeting on 14th July; he attended and gave his explanation and was allowed to go back to the hospital and attend to an emergency.

He further testified that he was then only Anaesthetic Officer at the hospital. That he makes his own duty roster and sends it to all departments and Medical Superintendent (MS). He said that he had discussed with the MS and the Administrator that wherever he is not around then the patients be referred to the nearest Health facility.

Dr Kenneth Muwanguzi (Doctor on duty)

Kenneth testified that he is 34 year old and a holder of Bachelors of Medicine and Bachelors of Surgery from Kampala International University obtained in 2017, did internship at Jinja Regional Referral Hospital, Post Graduate diploma in hospital and Health Care Management in 2022 from the Uganda Management Institute and has been working at Bugiri hospital since 2020 to date.

It was his evidence that he was the Medical Officer duty/ call with Dr. Nabongo Dr Nabongo had formally requested for an extended stay after the internship and the Administrator approved his request.

He had gone for morning service at church when Dr. Nabongo notified him about the mother who required emergency Cesarean Section. The Anaesthetic Officer

was not around, and they could not do much without him. They made a decision to refer the patient to another health facility. By the time he returned to the facility, the patient had passed on.

Dr. Muwanguzi admitted during the inquiry that there was no death certificate which was given to the relatives of the deceased and postmortem was also not done. He further said that he did not call Dr. Nakendo the Obstetrician and Gynecologist.

On further questioning about the suitability of Dr. Nabongo as a covering doctor for himself, he responded defending his decision to the effect that he "delegated to someone of equal qualification and competence like himself". He did not appear to acknowledge the short comings and consequences of his decisions to delegate duty to a post-intern doctor who was not in formal deployment with Bugiri hospital.

Dr. Nakendo Abubakar

Nakendo testified that he was 44 year old and holds a Bachelor of Medicine and Bachelor of Surgery degree obtained from Makerere University in 2004, Masters of Medicine in Obstetrics and Gynaecology from Makerere University in 2020 and a post graduate diploma in Hospital and healthcare management from UMI in 2024, started working at Bugiri in 2005 as a Medical Officer and later promoted to Senior Medical Officer in 2008.

It was his evidence that he was not actively involved in the said case and got **scanty information about the said patient**. He said that he got calls from doctors and the Medical Superintendent. He was preparing to go and see the mother but after a short while he was called and informed that the patient had died. He admitted that he is a head of Department, and he is fully responsible for maternal issues. He said that the Medical Officer called him telling him about the death of a mother, and he advised the ward In Charge to do the notification. However, maternal death audit was not done.

He said that he was very sorry for what happened and the team has learnt a lot since that incident, a lot has since improved. He requested Council to give them the opportunity to make things right.

Dr Abang Oundo John (Medical Superintendent)

Abang testified that he is 55 years of age and a holder of Bachelor of Medicine and Bachelor of Surgery from Makerere University in 1997, Masters of Science

in Reproductive Health UK in 2022, Masters of Science in Hospital Management from Nkozi University in 2013, has worked in Bugiri since 1999 and became a Medical Superintendent from 2013 to 2022 when he was interdicted.

It was his evidence that on 10th July 2022, he got a call from Cissy at 10.52am telling him they had a patient who was not in good shape. Then in 23 minutes, he received another call from Doreen that the patient had died. He said that he made several calls within that short period whereby he had arranged to evacuate the mother to Iganga Hospital, though he didn't succeed with that.

He testified that when he went to the hospital, he couldn't talk to the deceased's relatives as he was being intimidated and searched for with guns; he was on the run fearing for his life.

He was later interdicted for 6 months and by the time he came back, he found that he had been replaced with a new Medical Superintendent in the office. He testified that he thinks the mother died of a ruptured uterus and chances were high she would have died.

It was his evidence that the issue of fuel was a challenge at that time because the financial year had just ended and they did not have any money and were waiting for release from the ministry of finance. He said that the issue of supplies is above the hospital Administration and District leadership yet they are serving a large population from surrounding districts.

He admitted that his approval of Dr. Nabongo to work at the Hospital was illegal. He also admitted that there were key gaps at that time which included

1. Delay in the community by the patient
2. Human resource (no Anaesthetic Officer at the time the mother was admitted)
3. Finance (money delays as there was no money for fuel)
4. There was lack of teamwork

Mutanda Emmanuel (former Hospital Administrator)

Mutanda testified that he is 40 years old and a degree holder in Bachelor of Social Work and Social Administration from Kampala University 2019, Post Graduate Diploma in Administration and Management from Team University in 2021, worked at Bugiri Local Government as Town agent in 2010 and was employed as the Hospital Administrator in 2022.

It was his evidence that on 10th July 2022 he had travelled to the village for burial and received a call past midday from the Principal Nursing Officer requesting for the ambulance to take the patient to another facility because Dr. Muwanguzi who was supposed to be on duty was not at the Hospital and the Anaesthetist had travelled to Kampala for his child's visiting day. He added that Dr. **Muwanguzi is always away and has a habit of hiring other private doctors to** work for him.

He called the driver of the ambulance (Mr. Ojambo James), and he responded immediately. A midwife then called him saying there was no fuel for the ambulance to take the patient to Iganga Hospital. He asked her to go to the patient's attendant and talk to her to buy fuel worth 30,000 Uganda shillings which the Hospital was going to reimburse after getting the money. After some time, the ambulance driver called him and told him that the patient had died.

Davidson Kasajja Mulumba (LC V Chairperson)

Kasajja 40 years old and holds a Bachelor degree in Business Administration from Makerere University obtained in 2016, and the LCV Chairperson of Bugiri District Local Government since 19th May 2021 to date testified that he got information from his personal assistant that they had lost a mother in the hospital. He said that his leadership considers health as a priority.

It was his testimony that the hospital had poor hygiene and sanitation, the issue of extortion of money from poor patients, and poor management of the hospital. He testified that 18 executive committee meetings were held concerning the status of the Hospital. He pledged to share the copies of the said minutes of the meetings with the Medical Council.

He testified that he got communication from his personal assistant at around 1 pm that a mother had just passed on. He asked his personal assistant to convene a meeting at the hospital. He there after called the hospital staff for a meeting at the district.

It was his evidence that the information and defense that the Hospital staff provided to the district was not convincing and the patient's original file they submitted to the Council was doctored and different from the one that was presented to the District Executive meeting. That the patient died much later than the Hospital staff allege.

He testified that he visited the family of the deceased to extend his condolence and got information from them. He said the Medical Superintendent (Dr Oundo) put agents at the hospital gates to send patients to his private clinics instead of obtaining treatment from the Hospital.

He said that he has introduced medical camps to bring back people to the Hospital since 2022 and the population has started appreciating government works. The district came up with the policy of fueling the ambulance to cater for referrals.

He said that believes in promoting justice, and requested that the family gets justice and the culprits are punished.

Mr. Kisule Martin Mabanda (former CAO)

Mabanda testified that he is 60 years old, degree holder in Bachelor of Arts in Geography from Makerere University, Post Graduate in Public Administration from Islamic University in Uganda and Masters in Public Administration from Islamic University in Uganda and was CAO at Bugiri for 6 months until retirement.

He testified that by time he was transferred to Bugiri District, the Hospital was a mess. He used to call Dr. Oundo to his office for meetings. The major problem was absenteeism of staff. He testified that the LCV Chairperson was correct when he told Council members that the file which the Hospital officials submitted to the Council was doctored and different from what they submitted at the district.

He testified that they got information that Dr. Muwanguzi was absent and Okumu was not in Kampala as alleged. That it was on that basis that he took action to interdict them.

It was his evidence that Dr. Nabongo was not there but they rather used him as a cover up to convince the Council Members that there was doctor on duty to cover the gap because there was no instrument deploying him. He said that the Medical Superintendent has a clinic near the Hospital and he would use the district ambulance to transport patients from his private clinic to the theatre and then back to his clinic after the operation.

He testified that there is a problem of Traditional Birth Attendants in Bugiri District and many mothers fail to go for antenatal care and opt for TBAs leading to increased maternal death.

Dr. Nankendo was also interdicted because he was absent when Deputy IGG came to the hospital. went to Nakendo's clinic and found their condoms and blood.

Mr. Wotti Ronald Wapakala

Wotti, 39-year-old male holds a Bachelor degree in SWASA (IUIU,2009), Law course for administrative officers obtained in 2016 from LDC, certificate in computer 2010, post-graduate diploma in Hospital and healthcare Management (UMI) 2024.

It was his evidence that he started to work in Bugiri hospital in March 2019 as a hospital administrator until September 2021 when he was interdicted on an allegation of theft of the hospital water pump. The matter was Investigated by the Health Monitoring Unit of State House. He was given a letter clearing him by HMU, took it to CAO and he was re-instated on a court order from Sept 2022. He had no further testimony to make before the Council on the case before it since he was away when the incident happened. He proposed recommendations to make the hospital better including improvement of communication and team work, recruitment of more staff, improve the work relationship among staff, reduce political interference with the hospital administration.

Mukasa Joseph Maira (current Chief Administrative Officer)

Mukasa male 58 years and a graduate of BA political science and admin from Makerere University obtained in 1982, Certificate in administration law from Law Development Center 1989, PGD PA MUK 1995, masters, PA (MUST) 2001, UMI MBA (executive, ESAMI 2019). He has been working at Bugiri District as the CAO for one month.

He testified that the said incident happened before he was transferred to Bugiri but being the accounting officer for the district, he observed that the areas which need to be addressed included;

1. Dr Nankendo, appeared before rewards and sanctions committee and his interdiction was going to be to lifted.

2. There is a need to streamline administration in Bugiri Hospital because there are role conflicts among the staff (clinicians and administrators), including the question of leadership.
3. Need to regularize the posting of staff to the hospital and staff duty roster needs to be clearly defined by the MS rather than leaving it to individuals as was the case with the anaesthetist.
4. The issue of volunteering staff was abolished in public service as this often leads to extortion of money.
5. There is a problem with TBAs in Bugiri who are active and rampant leading to delay of mothers seeking care from qualified health workers in health facilities.
6. The hospital needs to have systems that work in addressing emergencies.
7. He decried the impunity and environment of fear among staff in the hospital.

   He promised to hold meetings with the hospital staff and other stakeholders.

Summary of the Case

The patient, Nalubanga Monica was a 42-year-old gravid mother at term (G4P3+0) with 1 previous Caesarian Section and 2 Vaginal births after CS and reported to have attended antenatal care at Bulage Health Centre III. She went into labour beginning at 4am to 5am of Sunday 10th July 2022 and was admitted at Bugiri Hospital having arrived at 7am, according to the relative. She is reported to have been reviewed by a doctor (Dr. Nabongo) a volunteer who was covering the doctor on duty (Dr. Muwanguzi). Dr. Nabongo reportedly reviewed her at 9.30am and noted the patient to be a 30-year-old female G3P2+0 at term with 2 previous scars with labor-like pains. He noted a fundal height of 38/40, fetal heart heard and regular, the cervical os was 10cm. The blood pressure was recorded as 100/86mmHg and pulse of 166 beats per minute. He made a diagnosis of a mother with 2 PS with obstructed labor. He recommended referral to Iganga hospital for lack of anaesthetic officer. However, the patient was not transferred because there was no fuel in the ambulance. She later died at 11.15am presumably due to ruptured uterus which unfortunately was not confirmed because a post-mortem was not done because it was not requested for. A maternal death audit was also not done.

ANALYSIS OF FACTS BY THE COUNCIL.

1. Pre-hospital events

The patient went into labour at 4am to 5am although there is an allegation that the patient had been to a traditional birth attendant at 1pm the previous day, had been forced to push and had taken herbs. The patient arrived at Bugiri hospital at 7am. Regardless of the facts in this patient, the Council notes the following:

a) The issue of TBAs is a wide-spread problem country-wide that continues to demand action by various stakeholders.
b) The managerial issues with this patient begin with her arrival at Bugiri hospital.

2. In-hospital events

The patient whose condition on arrival was described as "alarming" by enrolled midwife Cissy Atyang and "critical" by in charge Sr. Anena Kate Atube was attended almost entirely by nurses and midwives for the estimated 4 to 7 hours she spent in the hospital before she died.

The only anesthetist at the hospital (Mr. Okumu Paul) was off-station apparently without the knowledge of the hospital administration. His absence precipitated the attempts to have this patient transferred to another facility.

The midwives made frantic phone calls to various people including Dr. Muwanguzi Kenneth (the doctor on duty) Dr. Nakendo Abubakar (obstetrician), Dr. Oundo Abang (the MS), Mr. Mutanda Emmanuel (hospital administrator), Sr. Atim Jacke (PNO) and Mr. Okumu Paul (the anaesthetist).

The only doctor reported to have seen this patient was a recently qualified post-intern volunteer doctor with no formal employment by the hospital, who recommended referral. Although immediate transfer was not possible due to alleged lack of fuel in the ambulance, there is nothing to show attempts to save this patient's life in the interim by way of investigations and resuscitation.

The Medical Superintendent Dr. Oundo and the Head of department of obstetrics and gynaecology Dr. Nakendo failed to ensure that postmortem and maternal death audit were done.

There are multiple alterations in the clinical notes and inconsistencies in the timelines of the different events suggestive of attempts to falsify the records.

3. The hospital doctors

The doctor on duty, Dr. Muwanguzi Kenneth, was absent and he didn't come even after being called. Neither did he report to the hospital for the whole time the patient was in the hospital. He alleges that he delegated his duties to Dr. Nabongo. He did not contact the obstetrician.

The head of department and an obstetrician, Dr. Nakendo Abubakar, was called by midwives including the PNO but gave an inappropriate and unhelpful response saying "okay". He never came to the hospital that day.

The medical superintendent, Dr. Oundo Abang John, although he reported to have made some administrative calls in response, he did not show up at the hospital that day. He also did not contact the Obstetrician, Dr. Nakendo Abubakar.

4. Emergency preparedness and response plan

There was no fuel in the ambulance of a hospital that daily receives emergencies and is likely to refer outwards. This significantly contributed to failure to save this patient's life.

There was lack of essential supplies in the hospital including gloves, intravenous fluids, catheters.

There was no anaesthetist on duty to handle the emergency. The only anaesthetist available was absent from duty and there was no arrangement for another one to step-in.

There is no documented emergency response plan.

5. Postmortem events

a) A post mortem was not performed in this patient making it impossible to establish with certainty the pathology and underlying cause of death. Postmortem is important as a learning and diagnostic tool. It also helps to put to rest the cause of death in the family members' minds, and for medicolegal reasons.

b) The maternal death audit was not done in contravention to the ministry of health policy.
c) No death certificate was issued, another contravention to policy.

The above three issues tantamount to professional negligence.

6. Observations during Council Inquiry

In our interactions with the Bugiri hospital staff and the district authorities, its evident that the working environment in Bugiri hospital can be described as toxic as evidenced by the following:

bitterness, animosity, lack of respect for one another, lack of trust, impunity, fear, cliques, intrigue, unprofessionalism, extortion, misuse of hospital facilities and resources, poor communication and absenteeism. These vices have a negative effect on service provision and puts the safety of the patients at risk. It also discourages, demotivates, alienates health workers.

This environment is reflected by the fact that four officers were interdicted almost at the same time.

Council notes that the three Medical officers namely Dr. Oundo Abang John, Dr. Nakendo Abubakar and Dr. Muwanguzi Kenneth had already served six months interdiction over the same matter. The CAO indicated that he had already met the staff and laid strategies to improve the services in the hospital. We take note of the observations in coming up with the sanctions against the said officers.

Conclusion;

The Council received a letter from the Director health services governance and regulation in which he stated that: "the purpose of this letter is to request UMDPC to investigate the case involving the medical doctors in Bugiri hospital as described in this letter to its' logical conclusion" The Council investigated this case and found that the death of this mother brings to light the various contributing factors to maternal death that includes the 3Ds i.e., delay at home, delayed transportation, delay at the facility in decision making and interventions. The biggest contributors to this mother's death include:

a) The patient's presentation in critical condition
b) Individual health workers

c) Administrative lapses
d) Shortage of supplies

Recommendations

1. Medical Superintendent, Dr. Oundo Abang John as the over-all head of the facility is held responsible for administrative lapses that contributed to sub optimal management of the patient and subsequently her death. The failure to ensure that postmortem and maternal death audit were done tantamounts to professional negligence. Because of these and taking into account the period served in interdiction, Council hereby issues a letter of severe reprimand. Any repeat of such malpractice,will lead to more severe sanction which could include erasure from the register.
2. The doctor on duty Dr Muwanguzi Kenneth was absent from station. His absence meant that the patient on arrival had no assessment, diagnosis and management plan by a doctor. Even after being called, he never came nor contacted the consultant. He instead he abdicated his duties to a junior doctor. This therefore meant that this critically ill patient did not receive the right care. His actions tantamount to acts of professional negligence. Because of these and taking into account the period served in interdiction, Council hereby issues a letter of severe reprimand. Any repeat of such malpractice, will lead to more severe sanction which could include erasure from the register.
3. The Head of department and obstetrician and gynaecologist, Dr. Nakendo Abubakar was contacted on phone by the principal nursing officer but he did not show up thus denying the patient specialist opinion and intervention and failed in his supervisory role. This amounts to professional negligence. Because of these and taking into account the period served in interdiction, Council hereby issues a letter of severe reprimand. Any repeat of such malpractice, will lead to more severe sanction which could include erasure from the register.

4. Anaesthetist, Okumu Paul the only anaesthetist at the station was absent without notifying the authorities. His absence meant that the patient could not be operated at the facility. This necessitated the referral of the critically ill patient to another facility which unfortunately was not effected and she died un attended at the facility. It is recommended that

Okumu Paul be referred to Allied Health Professional Council for sanctions.

5. The hospital administrator Mutanda Emmanuel whose responsibility is to ensure the availability of medical supplies and fuel for the ambulance failed in his duties for this critically ill patient contributing to her death. The Council refers Mutanda Emmanuel to the CAO for appropriate action.

6. At institutional level, Bugiri hospital and Bugiri district administration have overtime developed an unfavorable working environment that has led to sub optimal service delivery. There is a need for an integrated administrative and professional overhaul, as an attempt to create a new service environment and culture. The Council refers the said matter to the CAO for appropriate action.

7. The Council applauds the role played in this case by the nursing team.

Signed on this 28th day of June 2024 by

1.	Assoc Prof. Joel Okullo Odom	Chairman
2.	Prof. Sarah Kiguli	Vice Chairperson
3.	Dr. Apollo O Epuwatt	Member
4.	Dr. Nsubuga Yosam	Member
5.	Dr. Kaducu Felix Ocaka	Member
6.	Dr. Okello Maxwell	Member
7.	Dr. Ayub Twaha	Member