**THE REPUBLIC OF UGANDA**

**IN THE MATTER OF AN INQUIRY INTO ALLEGED PROFESSIONAL MISCONDUCT AND OR MEDICAL NEGLIGENCE BY THE MEDICAL PERSONNEL OF TMR HOSPITAL IN THE TREATING AND MANAGING MS. FRANZISKA ATWII RESULTING IN THE DEATH OF HER NEW BORN BABY**

**1.ATWII ROBERT OBUA ACHUR**
**2. FRANZISKA ATWII :::::::::::::::::::::::::::::::: COMPLAINANTS**

**VERSUS**

**1. DR. SAMUEL HENRY KIZITO**

**2.DR. MAGALA JONATHAN**

**3. TMR HOSPITAL :::::::::::::::::::::::::::::::::::::::::: RESPONDENTS**

## FINDINGS AND RESOLUTIONS OF THE COUNCIL

### Complaint Summary

The complainants, Mr. Atwii Robert Obua Achur and Ms. Franziska Atwii, allege that their newborn baby died as a result of improper treatment and negligence by the respondent, Dr. Samuel Henry Kizito and Dr. Magala Jonathan, at TMR Hospital. Dr. Samuel Henry Kizito and Dr. Magala Jonathan are registered and licensed medical doctors under the Uganda Medical and Dental Practitioners Council (hereinafter referred to as "the Council"). They were the attending doctors for Ms. Franziska Atwii during her antenatal and admission.

## Background

The complaint was formally lodged on 3rd December 2024, citing professional and medical negligence by the Respondent which allegedly led to the death of their new born baby. Both Dr. Samuel Henry Kizito and Dr. Magala Jonathan denied the allegations, asserting that Ms. Franziska was properly managed throughout her labour and delivery.

## The Council's Mandate

Under Section 3 of the Medical and Dental Practitioners Act (CAP 300), the Council is empowered to supervise medical and dental practices, exercise disciplinary control over practitioners, and protect the public from substandard care. The Council conducts inquiries upon receiving complaints regarding medical professionals or facilities within its jurisdiction.

In line with this mandate, the Council convened an inquiry on 19th November 2025 to determine whether the Respondents were guilty of professional misconduct or dereliction of duty of care.

## Proceedings

The inquiry took place in the Council's Boardroom. Both parties attended the session to testify and be cross examined. The complainants were represented by Counsel Omara Andrew while the Respondent was represented by Counsel Simon Tendo Kabenge. The individuals that testified were:

1. Mr. Atwii Robert Obua Achur – 1st Complainant
2. Ms. Franziska Atwii – 2nd Complainant
3. Dr. Samuel Henry Kizito- 1st Respondent
4. Dr. Magala Jonathan – 2nd Respondent
5. Dr. Akena Winfred- The third Respondent's Clinical Director

**Complainants' Evidence**

**Ms. Franziska Atwii (2nd Complainant)**

Ms. Franziska Atwii, an adult female, a resident of New City Road, Namugongo, and the mother of the deceased newborn baby, testified that

On 6th April 2024, she started feeling unwell, experiencing dizziness, a constant headache, and blurred vision. The edema she had developed during the last six months of pregnancy worsened, and her feet became extremely swollen. These symptoms persisted throughout the night.

On 7th April 2024, she and her husband contacted their gynecologist, Dr. Magala Jonathan of TMR Hospital, who advised them to go to the hospital. Upon arrival at around 11:00 a.m., she was found to have high blood pressure and was admitted to a bed in the emergency section for observation.

Dr. Magala, who was not physically present at the hospital at the time, instructed Dr. Kizito H. Samuel to conduct several tests. She underwent laboratory and ultrasound examinations. The ultrasound report indicated that the baby weighed approximately 4 kilograms, was fully grown, had a normal heart rate, and appeared to be in good condition. The blood and urine tests were largely normal, except for a urinary tract infection (UTI). Pre-eclampsia was ruled out due to the absence of protein in the urine.

On the same day, while in Dr. Kizito's office, Dr. Magala Jonathan informed them via phone call that he would be traveling abroad and had handed over her care to Dr. Kizito H. Samuel, who had been fully briefed.

Dr. Kizito recommended induction of labor due to the baby's size and her high blood pressure. The complainants requested time to consider the recommendation and inquired about alternative options. During a phone call, Dr. Magala confirmed that they could wait, provided they continued monitoring her blood pressure. They then returned home, commenced treatment for the UTI, and continued monitoring her condition.

She stated that she was not made aware that her condition was critical despite the absence of protein in the urine. She was advised to remain active to encourage natural onset of labor; however, labor did not begin, her blood pressure was not controlled, and the blurred vision persisted.

On Monday, 8th April 2024, Ms. Franziska and her husband informed Dr. Kizito via phone call that they wished to proceed with induction of labor. They also re-shared their birth plan, which had previously been discussed with Dr. Magala.

On Tuesday, 9th April 2024, she was admitted, and a pelvic examination was conducted by a general doctor, who indicated that her pelvis was borderline but did not provide further explanation. Induction medication was initiated around midnight.

She was administered oral medication diluted in water every 2–3 hours. The effects were minimal, resulting in only mild contractions. Upon the first cervical examination, there was little to no dilation.

During a cervical examination, she experienced extreme pain and was informed that her cervix was inverted. When she inquired whether this would affect natural delivery, she was told it would not. Several fetal heart rate measurements were taken using a portable monitoring device. Although generally normal, the heart rate appeared to drop intermittently. Due to the pain experienced during prior examinations and the absence of significant contractions, she requested that one of the cervical examinations be skipped.

She was subsequently administered Pitocin intravenously to induce labor, which resulted in stronger contractions. Despite the intense pain and several hours of contractions, a subsequent cervical examination showed only 2 cm dilation. Due to the severity of the pain and the slow progress, she requested an epidural for pain management.

She reported that the labor pain was concentrated in the front of her abdomen rather than her back, making it difficult to relieve through

massage. She was informed of the risks and conditions associated with the epidural.

Dr. Thomas Atunyo informed her that continuous monitoring of both maternal and fetal heart rates would be conducted. However, the fetal heart rate fluctuated beyond acceptable limits. The doctor stated that as long as these fluctuations did not last longer than one minute, they were not considered serious.

Dr. Kizito later observed the fetal heart rate variations and stated that he had not encountered such a pattern before, suggesting that a Caesarean section be considered. She requested that another cervical examination be conducted before making a decision, as she felt that her water had broken. The examination, first conducted by a midwife, revealed full cervical dilation. Dr. Kizito confirmed that she was fully dilated. Upon inquiring whether natural delivery was still possible, she was advised that it was, and the option of a Caesarean section was not pursued further at that time.

She was then moved to the labor room for rupture of membranes, as suggested by the midwife, in the presence of Dr. Kizito. Attempts to connect her to a monitoring machine were unsuccessful due to malfunction. She was then instructed to begin pushing. After some time, the midwife indicated that she could see and feel the baby's head.

She pushed several times but became exhausted after nearly 24 hours of labor. The midwife suggested a 10-minute break and advised her to take Lucozade to regain strength. The doctor administered additional pain medication.

Before resuming pushing, attempts were made to monitor the baby's heart rate using a handheld device, but no heartbeat could be detected. At that point, the doctor requested her consent to perform an emergency Caesarean section.

The doctor proceeded with the operation and delivered the baby. She waited to hear the baby cry but heard nothing. The doctor then informed her and her husband that the baby had not survived.

**Atwii Robert Obua Achur (1ST Complainant).**

Atwii Robert, an adult male, a resident of New City Road, Namugongo, and the father of the deceased newborn baby, testified as follows:

He stated that throughout the antenatal period, everything progressed well, and they attended all required hospital visits and received the necessary care. However, the problem arose at the hospital due to the failure by the medical staff to inform them of the risks involved in his wife's labour.

He further stated that they had been assured by the doctor that both the mother and the baby would be continuously monitored; however, this did not occur. While in the labour room, as his wife attempted to push, a small handheld fetal heart monitoring device was only introduced later, after she had taken a break from pushing.

He noted that the machines in the labour room, as well as the one brought in later, were faulty and did not function properly. He emphasized that their birth plan allowed for a Caesarean section if deemed necessary by the doctor due to any arising risks. However, Dr. Kizito did not make that decision at the appropriate time, despite several opportunities, including when they initially arrived at the hospital with high blood pressure and blurred vision.

He also stated that a midwife identified as "Best" misled them by informing them that the baby was close to delivery.

He explained that prior to Dr. Kizito H. Samuel taking over their care, they had discussed the birth plan with Dr. Magala Jonathan during routine antenatal visits. Dr. Magala had informed them that his wife would be allowed one hour to push for a vaginal delivery, and if unsuccessful, a Caesarean section would be performed. This plan, however, was not followed.

He further stated that the delivery process was excessively prolonged and that Dr. Kizito was not consistently present during their time at the hospital. He believes that better decisions might have been made had the doctor been physically present to closely monitor the situation.

He stated that they remained in the hospital until they were discharged on Saturday, 13th April 2024. On Monday, 15th April 2024, they returned to the hospital due to his wife developing a fever. It was discovered that she had an infection, and she was administered intravenous (IV) treatment. They later requested to continue the IV treatment from home, as returning to the hospital frequently was difficult due to the pain from the Caesarean section.

He further stated that a friend, Barbra, who is a midwife, visited their home in Namugongo and administered the prescribed IV medication. His wife continued with oral medication and completed the course on 21st April 2024. He noted that Barbra later informed them that a woman aged 36 years would be at higher risk if a Caesarean section was not considered—information that had not been communicated to them prior to the incident.

On 23rd April 2024, they went to Nsambya Hospital for a CT scan and Doppler studies because the swelling in his wife's legs had not subsided, and she continued to experience difficulty breathing at night. They later returned to TMR Hospital due to a high fever of 39.6°C, where they were attended to by Dr. Shadia, who informed them that there had been a delay in performing the Caesarean section, which contributed to the death of their baby.

He also stated that during the entire induction and labour process, there were multiple changes of midwives attending to his wife. He believes that these frequent changes may have contributed to the negative outcome, possibly due to inadequate handovers and poor communication of critical information to Dr. Kizito H. Samuel, who was not present for most of the time from admission until the loss of the baby.

He further stated that prior to the administration of the epidural, the baby's heart rate was fluctuating, as observed by one of the midwives, identified as Joventa, who attributed this to the baby moving away from the cold gel during monitoring. He also noted that Dr. Kizito arrived much later after admission and the initiation of induction.

He expressed doubt as to whether Dr. Magala followed proper handover protocols when transferring care to Dr. Kizito H. Samuel, including whether their birth plan was adequately communicated to Dr. Kizito and the attending midwives.

He concluded by stating that it had taken them more than six years to conceive the baby due to various challenges, including unsuccessful IVF attempts, all of which had been disclosed to Dr. Magala Jonathan. He therefore believes that the doctors did not give adequate attention and care to his wife and their baby.

**Respondents' Evidence**

**Dr. Samuel Henry Kizito (Respondent)**

Dr. Samuel Henry Kizito testified that he is a medical practitioner with five (5) years' experience as an Obstetrician/Gynaecologist and is employed at TMR International Hospital in that capacity. He stated that he had interacted with Ms. Franziska on four occasions prior to her admission for delivery and that it is therefore not accurate to say that he only attended to her after taking over from Dr. Magala.

He stated that her antenatal care visits were conducted on 6th August 2023, 1st October 2023, and 1st December 2023, with a subsequent visit on 7th April 2024 when she presented at the Outpatient Department (OPD).

It was his evidence that Ms. Franziska was a 36-year-old primigravida with a history of primary infertility and failed attempts at assisted reproduction. He described her as knowledgeable and stated that her decisions, including her birth plan, were made from an informed perspective.

On 7th April 2024, Ms. Franziska presented to the OPD clinic at approximately 39 weeks of gestation, accompanied by her husband. She complained of headache and blurred vision of one day's duration. Her blood pressure was recorded at 135/92 mmHg. Laboratory investigations were conducted to rule out pre-eclampsia, and the results did not indicate any organ dysfunction. An obstetric ultrasound scan with fetal Doppler velocimetry was also performed.

Dr. Kizito stated that he consulted with Dr. Magala, her primary obstetrician/gynaecologist, via telephone regarding the findings and the appropriate course of action. Dr. Magala briefed him on the previously agreed birth plan, and a routine handover of care was conducted as Dr. Magala was traveling out of the country that day.

He advised the couple that delivery should be undertaken on the same day to avert potential complications, including progression to pre-eclampsia, eclampsia, or severe pregnancy-induced hypertension. He further stated that he held a comprehensive discussion with the couple regarding delivery options and recommended an elective Caesarean section, given her obstetric history. However, the couple declined and opted to adhere to their original birth plan.

He then recommended induction of labour on the same day, but the couple chose to return home to consider the recommendation while continuing to monitor her condition.

Two days later, Mr. Robert Atwii informed him that they would present for induction of labour on the evening of 9th April 2024 and re-shared their birth plan, which indicated a preference for vaginal delivery.

Ms. Franziska was admitted at approximately 23:00 hours on 9th April 2024 by the Medical Officer on duty, who conducted a preliminary assessment and consulted Dr. Kizito by phone. He recommended initiation of labour induction using oral misoprostol (25 mcg in solution every two hours, up to a maximum of eight doses).

The induction process commenced at 01:00 hours on 10th April 2024. He stated that Ms. Franziska was closely monitored overnight by a midwife providing one-on-one care and by the Medical Officer on duty, who remained in communication with him. There were no complaints overnight; her blood pressure readings were stable, the fetal heart rate was stable, and there were no significant contractions at that time.

Dr. Kizito reviewed Ms. Franziska at approximately 09:20 hours on 10th April 2024 after she had received five doses of misoprostol, and her condition was stable. The plan was to continue with induction.

He conducted another review at 13:20 hours after she had received seven doses. At that time, she reported increasing contractions; however, clinical assessment revealed only two contractions in ten minutes, each lasting 15–20 seconds. A vaginal examination showed that the cervix was soft, thick, posterior, and minimally dilated. The pelvis was deemed adequate, although there was a noted "tight perineum." A membrane sweep was performed, and the plan was to administer the final dose of misoprostol and, if necessary, augment labour with intravenous oxytocin.

At approximately 15:40 hours, he was informed that the fetal heart rate had dropped to between 108–119 beats per minute. At that point, all eight doses of misoprostol had been administered with minimal contractions. Intrauterine resuscitation measures, including intravenous fluids, were initiated.

He reviewed the patient at around 16:00 hours and discussed the implications of the fetal heart rate changes with the couple, advising delivery by Caesarean section. He addressed their concerns regarding surgical risks and future pregnancies; however, the couple declined and requested continuation of labour induction with close monitoring.

He informed them that a Caesarean section would be necessary if the concerning fetal heart rate patterns recurred. By 17:15 hours, the fetal heart rate had stabilized to 136–140 beats per minute. Contractions

remained minimal. The patient declined a vaginal examination, and a plan was made to augment labour with intravenous oxytocin.

Further reviews were conducted at 19:00 hours and 23:00 hours. The midwife and anaesthesia team had been briefed about earlier fetal heart rate concerns. The anaesthesia team also recommended Caesarean section over epidural anaesthesia due to the fluctuating fetal heart rate; however, the couple again declined.

Dr. Kizito stated that he held further discussions with the couple regarding the need to expedite delivery by Caesarean section to avoid potential risk to the baby. Despite explicit communication of these concerns, the couple remained opposed to the procedure and requested continued monitoring. He stated that, in respect of patient autonomy, the medical team proceeded with close monitoring within acceptable clinical limits.

He emphasized that Ms. Franziska was continuously monitored, with the midwife present throughout, and that the rest of the team, including himself and the anaesthetist, remained available to intervene if necessary. He therefore denied any allegation that the patient was not informed of the risks involved.

At approximately 02:10 hours, the fetal heart rate became undetectable on both CTG and handheld Doppler. He stated that the monitoring equipment was functional and had been used throughout. A decision was immediately made to proceed with an emergency Caesarean section, at which point the patient consented.

He noted that Ms. Franziska delayed in signing the consent form, and as she was conscious and of sound mind, consent could not be obtained solely from her husband.

Unfortunately, the baby was delivered as a fresh stillbirth. Despite attempts at neonatal resuscitation, the baby could not be revived. During

the Caesarean section, no placental abnormalities or cord accidents were identified, and the amniotic fluid was clear. This led to suspicion of a possible fetal cause, including a congenital anomaly. A postmortem examination was recommended to determine the exact cause of death; however, the complainants declined.

**Dr. Magala Jonathan (Respondent)**

Dr. Magala Jonathan, an adult, testified that he is a qualified Obstetrician and Gynaecologist with ten (10) years of experience and serves as a resident Obstetrician and Gynaecologist at TMR International Hospital.

He stated that Ms. Franziska Atwii first encountered him during her 5th antenatal care (ANC) visit on 10th November 2023, during his routine antenatal clinic at the hospital. Prior to this, she had attended four ANC visits with other obstetricians and Gynaecologists at TMR Hospital. Her clinical history indicated that she was a 36-year-old primigravida at approximately 17 weeks of amenorrhea (WOA), with a poor obstetric history and blood group A Rhesus D negative. The visit was noted to be of normal progress.

He further stated that Ms. Franziska Atwii had her second encounter with him during her 7th ANC visit on 29th December 2023, when she presented with an upper respiratory tract infection and vulvovaginal candidiasis. She was managed with oral antibiotics and vaginal pessaries.

Her third encounter with him was during the 9th ANC visit on Friday, 22nd January 2024, at approximately 28 weeks of amenorrhea. The antenatal progress was normal, and she received Anti-D immunoglobulin during that visit.

Her fourth encounter occurred during the 11th ANC visit on Friday, 11th March 2024, at approximately 35 weeks of amenorrhea. This was a routine visit during which he initiated discussion of the birth plan and educated both Mr. and Mrs. Atwii on the available delivery options. He recommended an elective Caesarean section in view of certain risk factors, including her poor obstetric history and advanced maternal age as a

primigravida. However, the couple declined the recommendation and expressed a preference for vaginal delivery.

During her 12th ANC visit on 25th March 2024, Ms. Franziska underwent a routine assessment, including an obstetric ultrasound scan. The findings were normal, with an estimated fetal weight of 3.8 kg, adequate amniotic fluid, and no evidence of a nuchal cord. A pelvic assessment was also conducted and found to be adequate for delivery.

He stated that during the same visit, he revisited the discussion on the birth plan, again highlighting that a Caesarean section remained a viable option in light of the previously discussed risk factors. However, the couple reaffirmed their preference for vaginal delivery.

On 5th April 2024, he experienced a family emergency that required him to travel abroad. He stated that he briefed his colleagues to continue managing his patients in his absence, which he described as standard hospital practice.

On 7th April 2024, while in transit, he received a call from Mr. Robert Atwii informing him that Ms. Franziska was unwell, experiencing headache and blurred vision at home. He advised them to proceed immediately to the hospital for urgent medical attention under the care of his colleague, Dr. Henry Kizito, who was the Obstetrician/Gynaecologist on duty at the time.

Approximately one hour later, he received a call from Dr. Kizito, who updated him on Ms. Franziska's condition and initial clinical findings. He instructed Dr. Kizito to take over her management, noting that Dr. Kizito had previously attended to her during ANC visits. They agreed on further investigations, including an obstetric ultrasound scan for biophysical profile (BPP), umbilical Doppler flow studies, and laboratory tests such as

complete blood count (CBC), liver function tests (LFTs), renal function tests (RFTs), and urine protein analysis.

He further stated that, while Ms. Franziska and her husband were in consultation with Dr. Kizito, he spoke with them by phone and informed them of his emergency travel and inability to continue with her care. He reassured them that Dr. Kizito, who had previously attended to her, would manage her case. He also informed them that he had briefed Dr. Kizito on her antenatal history and birth plan and advised that they share a copy of the birth plan with him.

Approximately two hours later, while still in transit, he received a call from Mr. Robert Atwii informing him that Dr. Kizito had recommended expedited delivery and had counselled them on initiating labour induction immediately. However, the couple expressed a preference to wait for spontaneous labour. He stated that, given his absence, he advised them to continue under the care of Dr. Kizito.

He concluded by stating that this was his last interaction with the complainants and that he was not involved in the subsequent events leading to the unfortunate outcome of a fresh stillbirth.

**Dr. Akena Winfred (For the 3rd Respondent).**

Dr. Akena Winifred testified that he is an adult, Obstetrics and Gynaecologist working full-time at TMR International Hospital since 2019 working as Head of Clinical Services and the Obstetrics and Gynaecology Department.

He testified that he received a letter from the Council regarding allegations raised by Ms. Franziska Atwii but denied any medical negligence on the part of the hospital or its staff.

He stated that documented evidence shows that TMR International Hospital provided a conducive environment for patient care, with adequate infrastructure and necessary equipment. The hospital has over 30 beds, with ongoing expansion, and provides a wide range of services, including two operating theatres dedicated to Obstetrics and Gynaecology.

He further stated that upon reviewing the sequence of events from the time Ms. Atwii began her antenatal visits, he found no evidence of negligence. In his view, all necessary steps were taken to support the patient and her husband throughout the process.

He emphasized that there was no equipment failure at the time of the incident and that all required machines were functional and available. He noted that the mobile Doppler was appropriately used to monitor the fetal heart rate. He added that, based on his professional experience, including prior work at TMR Hospital, he has encountered similar cases to that of Ms. Franziska but have been managed.

He stated that TMR International Hospital follows established guidelines in patient management and referrals, and that these guidelines were adhered to in this case. He maintained that there was no breach of the standard of care.

He described TMR International Hospital as a reputable facility with established systems for equipment maintenance. He noted that the hospital employs a resident engineer, who is responsible for routine equipment checks, and that nurses are required to verify equipment status daily. He stated that the hospital is well-equipped, including with labour monitoring equipment.

He further testified that the patient was counselled regarding the need for a Caesarean section, which she initially declined but later accepted, and that informed consent was obtained from her. He noted that there was some delay in obtaining consent due to discussions involving confidential patient information.

He stated that although congenital anomalies were considered as a possible cause of the outcome, there was no definitive evidence. He noted that the patient had elevated blood pressure, but it was not at a level considered clinically significant, and she was not a known hypertensive patient.

He further stated that there was initially an opportunity for vaginal delivery; however, when this failed, the option of Caesarean section was again recommended. He emphasized that the patient initially declined but later consented.

He concluded that the hospital could not determine the exact cause of the baby's death due to the absence of a postmortem examination. However, he stated that the hospital remains open to continuous improvement and would implement any recommendations made by the Council.

**Kaweesa Evalyn Best (Respondent Witness).**

Kaweesa Evalyn Best (RW3), a registered midwife, testified that she has worked at TMR Hospital, Nalya, for the past seven (7) years.

She stated that while on night duty, she received Ms. Franziska, who had been admitted for induction of labour. A pelvic examination had earlier been conducted by a general doctor, who indicated that the pelvis was borderline. Induction medication was initiated at around midnight.

On 9th April 2024, Ms. Franziska was administered oral medication diluted in water every 2–3 hours. The effects were minimal, resulting in mild contractions. During the initial cervical examination, there was little to no dilation.

She further stated that several fetal heart rate assessments were conducted using a portable monitoring device. Although the readings were generally normal, there were intermittent drops in the fetal heart rate.

Ms. Franziska was subsequently administered intravenous Pitocin to augment labour; however, the contractions remained inconsistent. A subsequent cervical examination revealed that she was only 2 cm dilated after several hours of contractions. Due to severe pain and slow progress, Ms. Franziska requested an epidural for pain management and was informed of the associated risks and conditions.

She testified that there was continuous monitoring of both the mother's and the baby's condition. However, the fetal heart rate fluctuated beyond acceptable limits. The doctor advised that such fluctuations would not be considered serious unless they persisted for more than one minute.

She further stated that Dr. Kizito later examined Ms. Franziska and confirmed that the cervix had fully dilated. Upon being asked whether she could proceed with vaginal delivery, Ms. Franziska agreed, and the option of a Caesarean section was not pursued at that point.

Ms. Franziska was then transferred to the labour room for rupture of membranes. In the labour room, attempts were made to connect her to a monitoring machine; however, the machine was not functioning. She was then instructed to begin pushing. After some time, Ms. Kaweesa indicated that she could see and feel the baby's head.

Ms. Franziska pushed several times but became exhausted after being in labour for nearly 24 hours. Ms. Kaweesa suggested a short break of approximately 10 minutes and advised her to take Lucozade to regain strength before resuming pushing. During this time, she experienced increased pain, and additional pain medication was administered by the doctor.

She stated that at approximately 02:10 hours, the fetal heart rate became undetectable on cardiotocography (CTG). A decision was immediately made to proceed with an emergency Caesarean section, at which point Ms. Franziska consented to the Caesarian section procedure.

Ms. Franziska, being conscious and of sound mind, signed the consent form herself, and there was no basis to obtain consent solely from her husband. She was then taken to theatre, and the procedure lasted approximately 15 minutes, after which the baby was delivered.

**Akello Margret (Respondent witness)**

Akello Margaret (RW4), an adult and registered Midwife testified that she has been working at TMR Hospital since 2023.

She stated that while on night duty, at approximately 11:00 p.m., Ms. Franziska was admitted to the hospital to commence the process of labour induction. Upon admission, a pelvic examination was conducted by a general doctor, who indicated that the pelvis was borderline, and induction medication was initiated.

The induction process commenced at 01:00 hours on 10th April 2024. She testified that Ms. Franziska was closely monitored throughout the night by a midwife providing one-on-one care and by the Medical Officer on duty, who remained in communication with Dr. Kizito. There were no complaints during the night; blood pressure readings remained normal, the fetal heart rate was stable, and no significant contractions were observed at that time.

She further stated that the doctor reviewed Ms. Franziska at approximately 09:20 hours after she had received five doses of oral misoprostol. The plan at that stage was to continue with the induction of labour.

A subsequent review was conducted at 13:20 hours, by which time she had received seven doses of oral misoprostol (25 mcg). She reported increasing contractions; however, clinical assessment revealed only two palpable contractions in ten minutes, each lasting 15–20 seconds. A vaginal examination indicated that the cervix was soft, thick, posterior, and minimally dilated. The pelvis was assessed as adequate, although a "tight perineum" was noted. A membrane sweep was performed, and the plan was to administer the final dose of misoprostol and later consider augmentation with intravenous oxytocin (10 IU in 500 ml normal saline) if contractions remained inadequate.

At approximately 15:40 hours, the doctor was informed that the fetal heart rate had dropped to between 108–119 beats per minute. At that point, all eight doses of misoprostol had been administered, but

contractions remained minimal. Intrauterine resuscitation was initiated using intravenous normal saline.

At around 16:00 hours, the doctor discussed with the couple the implications of the changes in fetal heart rate and counselled them on the need for delivery by Caesarean section. He addressed their concerns regarding possible complications and the impact on future pregnancies. However, the couple declined the option and requested that labour induction continue with close monitoring of the fetal heart rate.

She stated that the doctor informed the couple that a Caesarean section would be necessary if the concerning fetal heart rate patterns recurred. By 17:15 hours, the fetal heart rate had stabilized to between 136–140 beats per minute. At that time, Ms. Franziska was experiencing one palpable contraction in ten minutes lasting approximately 15 seconds. She declined a vaginal examination, and a plan was made to augment labour using intravenous oxytocin.

She further testified that the anaesthesia team also discussed with the couple the fluctuating fetal heart rate observed during their review and recommended delivery by Caesarean section instead of proceeding with epidural anaesthesia. The couple again declined.

The doctor continued to advise the couple on the need for delivery by Caesarean section to avoid potential risks to the baby due to the non-reassuring fetal heart rate pattern; however, the couple maintained their decision to decline the procedure.

Close monitoring of the fetal heart rate continued. At approximately 02:10 hours, the fetal heart rate became suddenly undetectable on both cardiotocography (CTG) and handheld Doppler. She stated that the monitoring equipment was functional and had been used throughout.

A decision was immediately made to proceed with an emergency Caesarean section. Ms. Franziska was requested to sign a consent form authorizing the procedure. Upon signing the consent, she was taken to theatre, where the operation was performed and the baby was delivered.

## ANALYSIS BY THE COUNCIL

Upon review of the complaint, responses, patient records, witness testimonies, and applicable medical standards, the Council identified the following issues for determination:

1. Whether the actions of personnel and/or TMR hospital constituted professional misconduct.
2. What appropriate sanctions and recommendations should be made.

### Resolution of issue Number 1

Section 33 cap 300 of the Medical and Dental Practitioners Act empowers the Council to hold an inquiry where it receives an allegation which, if proved, would constitute professional misconduct on the part of the registered practitioner under this Act.

In the birth plan, the couple was provided with information on the different modes of delivery namely vaginal or caesarian and they chose vaginal delivery. Elective caesarean delivery was recommended to them due to high-risk pregnancy with poor obstetric history, being a primigravida of advanced maternal age and with failed previous invitro fertilization. On admission, she had pre-eclampsia which necessitated delivery of the baby with the safest and quickest means possible which was delivery by caesarian section. However, it was documented that the patient and the husband withheld consent for this form of delivery despite repeated information and explanation for its indication. Induction of labour was done. Prolonged labour led to fetal distress. Consent by the mother to deliver by caesarian was delayed. At caesarian section, the outcome was a fresh still birth.

According to the American College of Obstetrics and Gynecology (ACOG) committee opinion no.664 of June 2016 on the refusal of medically

recommended treatment during pregnancy, an autonomous competent pregnant woman holds the fundamental right to refuse any medically recommended procedure including a caesarian section.

In a scenario where a patient of sound mind repeatedly declines recommended treatment proposed by the caring team, there are other alternatives to be considered including consultation of colleagues, multidisciplinary team management and referral/transfer of the patient to another facility. This was not done for this patient.

Furthermore, the Council noted the following gaps in the management of the patient at TMR hospital.

1. **Risk Communication**

The Respondents reportedly counselled the complainants regarding the risks of advanced maternal age, prolonged induction, and fetal heart rate fluctuations and the need for caesarian delivery. Although this was done, the couple repeatedly declined consent.

The Council finds that the mother's delay to consent for delivery by cesarean section significantly contributed to the poor fetal outcome.

2. **Timeliness of Intervention**

Multiple opportunities existed to escalate to caesarean section earlier, particularly after prolonged induction and recurrent fetal heart rate decelerations.

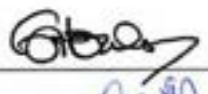
The Council finds that excessive reference to patient preference, without firm medical insistence, contributed to delayed intervention.

**Resolution of issue number 2.**

The Council hereby makes the following sanction and recommendation:

1) Dr. Samuel Henry Kizito is hereby given a written reprimand for failure to consult colleagues and/or refer/transfer the patient.

Signed on this 25th day of May 2026 by Council members hereunder:

| NUMBER | NAME | POSITION | SIGNATURE |
|---|---|---|---|
| 1. | Assoc. Prof. Joel Okullo | Chairperson |  |
| 2. | Dr. Ayub Twaha | Vice Chairperson |  |
| 3. | Prof. Joseph Ngonzi | Member |  |
| 4. | Dr. Okello Maxwell | Member |  |
| 5. | Dr. Owaraganise Asiphas | Member |  |
| 6. | Dr. Tumwine Daniel | Member |  |
| 7. | Dr. Muyanga Mark | Member |  |