THE REPUBLIC OF UGANDA

IN THE MATTER OF THE MEDICAL AND DENTAL PRACTITIONERS ACT
AND
IN THE MATTER OF AN INQUIRY INTO THE ALLEGED PROFESSIONAL NEGLIGENCE AND/OR INCOMPETENCE OF THE MEDICAL STAFF OF WOMEN'S HOSPITAL & FERTILITY CENTER IN THE TREATMENT & MANAGEMENT OF MS. JOANA NAMUTEBI WABWIRE THAT LED TO HER BRAIN DEATH AND EVENTUAL DEMISE.

DEREK JONATHAN WABWIRE
]::COMPLAINANT

VERSUS

WOMEN HOSPITAL INTERNATIONAL & FERTILITY CENTER
]::::::::::::::::::::::::RESPONDENT

FINDINGS & RESOLUTIONS OF THE COUNCIL

Introduction

The complainant Derek Jonathan Wabwire is the husband of the late Ms. Joana Namutebi Wabwire. Joanna is herein after referred to as the deceased. The Respondent is a medical facility registered and licensed by the Uganda Medical and Dental Practitioners Council (herein after referred to as the Council). Some of the medical staff, the subject of this inquiry are also registered and Licensed by the Council.

The Council's mandate as spelt out under **Section 3 of the Medical and Dental Practitioners Act**, (CAP 72) includes inter-alia: exercising general supervision of medical and dental practice at all levels; exercising disciplinary control over medical and dental practitioners; and to protect society from abuse of medical and dental care.

Among various ways of executing its mandate, the Council conducts inquiries when it receives complaints against medical practitioners and/or medical units under its ambit. This inquiry was pursuant to a complaint lodged by Derek Wabwire.

The Complaint

The Council received a written complaint dated 16/12/2021 from Derek Wabwire (Husband to the deceased) and a supplementary statement of complaint by Richard Wejuli Wabwire, (the father-in-law of the deceased) to the effect that the medical staff of the Respondent medical facility, "negligently and carelessly handled the insertion of the IUCD, resulting into neurogenic shock, brain death, leading to life support in ICU and eventually death"

Among the Medical staff of the Respondent specifically mentioned in the complaint include Dr. Byarugaba Racheal, Dr. Ezra Mugisha, Mr. Kirumira Noah and Nalwanga Phionah. The copy of the complaint is on file and has been considered by the Council in reaching the resolutions herein.

Upon receipt of the complaint, the Council on 21/12/2021, wrote to the Respondent to give her account of the events of 11/12/2021 but declined service of process.

On 11/03/2022, the Ethics and Discipline committee of the Council noted with concern that the Director of the Respondent was served on the 21st/12/2021 but shunned service as confirmed by a letter from M/S Lukwago & Co. Advocates dated 9th March 2022 written on behalf of the Respondent.

The committee then resolved to write to the Director of the Respondent to show cause why he shouldn't be charged with professional misconduct for contempt of council directives. The committee also resolved that the Respondent Hospital should be re-served with Council process.

Accordingly, on the 16/03/2022, a Notice to show cause why the medical Director shouldn't be held in contempt of Council directives in respect of alleged professional negligence & /or incompetence in the treatment and management of Joana Namutebi Wabwire leading to her brain death and eventual demise, was issued.

The same Notice also requested written response to the allegations within fourteen (14) days. The Notice was duly acknowledged by the Respondent on 23/03/2022.

On 6th /04/2022, the Council received Responses from Dr. Edward Tamale Ssali, the Medical Director & Consultant Obstetrician and Gynecologist; from the Managing Director of the Respondent; from Nalwanga Phionah, Registered comprehensive Nurse; from Dr. Byarugaba Racheal, a Medical Officer who conducted the procedure of the IUCD insertion; Ezra Mugisha, the anesthesiologist; and Mr. Kirumira Noah, Medical Sonographer.

These Responses were accompanied by the original patient's file from the respondent facility.

Note: The Council did not pursue disciplinary measures for contempt against the Medical Director of the Respondent hospital.

On the 22nd /12/2021, the Council also requested and received the Patient's file of the deceased from Victoria Hospital where the late Joanna was referred and admitted on the morning of 12/12/2021. She passed away on 17th/12/2021.

The Council considered the contents of the patient's file from Victoria Hospital in reaching its resolutions and conclusions herein.

The Council also received a copy of the toxicological and post-mortem reports from Uganda Police which were equally considered in reaching its decision herein.

On 1st/08/2022, the Council issued witness summons for the Council inquiry which was conducted on 30/08/2022 in the Council Boardroom.

The Inquiry

At the inquiry, Derek Jonathan Wabwire and Richard Wejuli Wabwire testified in support of the complaint.

Dr. Edward Tamale Ssali, Immaculate Mukagasana, Kisakye Fiona, Dr. Kifuuma Joseph, Nalwanga Phionah, Dr. Judith Atiang, Dr. Ezra Mugisha, and Dr. Byarugaba Racheal testified on behalf of the Respondent.

M/s. Lukwago & Co. Advocates comforted the Respondents while Mr. Kizito Fred Nsubuga, the deceased's father, and Dr. B.O Wabwire, the complainant's uncle; comforted the Complainant's side.

Witnesses adopted their respective written statements and also gave oral interactive testimonies under Oath.

The Complainant's case

The Council heard two testimonies in support of the complaint.

DEREK JONATHAN WABWIRE

Derek Jonathan Wabwire is the husband of the late Joana Namutebi.

He testified before Council that he is a banker by profession, a Christian by faith, resident of Nalya- Kyaliwajala and is aged 31 years.

That he lodged the complaint against Women's Hospital about the handling of Joana leading to her death.

It was his testimony he stated that a day after their wedding with the deceased (10/12/2021) at around 11:am, he and his newly wed wife attended the respondent facility for purposes of inserting an Intra uterine Contraceptive Device (IUCD).

That upon reaching the reception, they were advised on how to pay for the consultation which they did using a Pos machine. That they were then advised to go and do an ultrasound scan in the meantime since the queue to see the doctor was long and she(doctor) was still busy.

That the scan was taken, and results was received at about 3:00pm, but he didn't see the doctor until about 3:40 pm

That the doctor (Dr. Byarugaba Racheal) asked the deceased when she was expecting her next menstrual periods and the latter answered that she was expecting them that very day. The doctor then advised for the IUD to be inserted on 13th/12/2021 when the Cervix would be wider.

However, that this advice was not taken by the deceased and the witness since they were planning to go for their honeymoon on the same day that was suggested.

That the doctor then stepped out for a few moments to consult a colleague and when she returned, she confirmed that the procedure could be done but after carrying out a pregnancy test.

That the pregnancy test was paid for at about 3:34 pm but the lab technician surfaced between 4:00pm and 4:30pm. The results came out at around 5:00pm and they were negative.

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That the doctor then advised that the procedure of inserting an IUD should proceed and directed them to the scan room where the procedure was to be conducted. The deceased went in, but the witness stayed out.

The witness testified that he thought that the procedure would take about 10 minutes, but 30 minutes later the deceased was still inside.

He stated further that at this stage he didn't expect anything to have gone wrong as he could hear the deceased talking to the doctor.

That later on, the complainant saw the doctor fetching two disposable cups of water to give to the deceased.

That the doctor then told the complainant that she had found the deceased with a retroverted uterus and was trying to let her drink water to fill the bladder so that the womb gets into a better position to allow the insertion of the IUCD.

The doctor then told the husband to go into the room where the deceased was.

That upon entering, the complainant found that the deceased was not looking the same way as she had entered. That the deceased told him that the attempt to insert the IUD had failed because of the retroverted uterus. She also told him that she was feeling cold and had an upset stomach.

That the deceased also told the complainant that the doctor had given her a pain killer which was inserted in the rectum. That the doctor kept on bringing more water.

That the witness then asked the doctor why the deceased was feeling dizzy, had a headache and was having a running tummy. To this, the doctor replied that the running tummy was an effect of the pain killers.

That the deceased then asked to use the toilet to which the doctor advised her not to urinate. That the deceased used the toilet but still came out dizzy and with a headache.

That at this stage the doctor left the complainant and the deceased in the room where the procedure was being carried out to go and do some other work.

That the deceased was still shivering, and the complainant tried to give her some warmth. That the laboratory technician eventually came and switched off the air conditioner since it was making the deceased so cold.

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That the doctor returned and was asked why the deceased was not feeling well but she(doctor) replied that it was the side effect of the pain killers.

That eventually when the deceased told the doctor that she felt she wanted to urinate, the complainant stepped out and later learnt from the doctor that the second procedure of inserting the IUD was successful.

That this confirmation of success was told to the witness by the doctor herself. That thereafter the doctor went away.

He further testified that after the procedure, the deceased was looking worse than she had entered.

That she was on the bed and was on her knees as if she wanted to use the loos because she was feeling nauseated.

The complainant testified that he told the doctor that the deceased had not eaten since the day before, but the doctor replied that that wasn't the cause of the problem.

It is the complainant's case that after the doctor had gone, a nurse came with some IV bags and syringes. He could see from the half open door that the deceased was still weak.

That he also heard the deceased ask for a bucket to urinate and later to vomit.

That the doctor asked whether the complainant should go into the room, but the deceased answered in the negative.

That when the deceased finally came out of the room where the IUD had been inserted, she was looking very weak and had a canula on her right hand with an IV bag with some fluid.

That the complaint sat on the bed opposite that of the deceased in the recovery room. That he looked at the IV bag and it read glucose.

That the doctor promised that when the medication was done, she would come to check on the patient.

That the doctor then left and so did the nurse. That when the first IV was done, the nurse put a second one and also administered some injections to the deceased.

That the complainant stayed conversing with the deceased until she asked for a bucket which had been placed besides the bed. The complainant pulled it and she

vomited. That as the complainant was trying to wipe her mouth, she vomited the second time into the bucket and then she became stiff, and her eyes rolled backwards.

That the complainant got up, held her, called her name but she was just mumbling and convulsing.

That the complainant tapped at the doctor's window and stated that something was wrong but got no response. That he came back to the deceased and found that she was still convulsing. That he then rushed out to call for the doctor the second time and that's when she came in.

The doctor tried calling the deceased while shaking her, but this didn't yield any response and she kept asking the complainant whether the deceased had epilepsy to which he(complainant) answered in the negative.

That the doctor then gave the complainant the IV bag and tried to carry the deceased to where the IUD had been inserted. That the doctor failed to carry the deceased and the complainant held her by her arms and shoulders and the nurse rushed and carried the deceased's legs.

Then when they reached the deceased in the room where the IUD had been inserted, he came out to make a distress call to the driver and his sister.

RICHARD WEJURI WABWIRE

The witness is the father of the complainant and a father -in- law of the deceased.

At the inquiry, he testified that he was 57 years of age, a Christian by faith, resident of Namugongo and Judge of the High Court of Uganda.

He told the inquiry that on 11th/12/2021 between 7-8pm he received a distress call from his daughter, Juliet Habwoni that the deceased had a medical emergency. That however, Juliet's phone went off before the witness could establish the kind of emergency the deceased faced.

That he called the driver who had taken the deceased to hospital and was told that there was a problem. That he proceeded to the facility's reception whereat he was directed by his driver to the room where the deceased was.

He stated that he found the deceased lying motionless on the theater bed/table and being attended to by three medical personnel of the respondent hospital.

That his questions to the medical staff present and working on the deceased as to what had happened went an answered until one of them told him that they were trying to resuscitate and stabilize the deceased and take her to ICU.

That he was further directed to the doctor's room and found a female individual who identified herself as Dr. Racheal Byarugaba

That he asked Dr. Racheal what the deceased had been doing between 8:30am and 9:00pm.

That the doctor answered that the deceased had had the IUD fitted after the first attempt had failed. That thereafter, the deceased had passed out.

That the Doctor had administered glucose intravenous fluids after the procedure because the deceased looked weak.

That she(Dr. Racheal Byarugaba) had been called by the deceased's husband and found the deceased clenched with froth around her mouth and nostrils.

That the doctor had at first tried to clear the froth physically but later carried her to the theatre where she suctioned the froth and placed her on breathing support as she could not breath voluntarily.

That Dr. Racheal also told the witness that they were trying to stabilize her and take the deceased to ICU.

That the doctor told Mr. Wabwire that Women's Hospital did not have ICU and that he (Wabwire), contacted Kampala Hospital which allowed that the patient can be taken there for the same.

That however, one of the staff at the facility got another ICU at Victoria Hospital. Mr. Wabwire called City ambulance services and paid for the same to have the deceased transferred to ICU.

That along the way, Dr. Ssali came in with other people. That one of the lady doctors who came in was Dr. Judith who suggested that sometime back a patient had got a similar issue but when the IUCD was removed, the patient stabilized.

That she proceeded to remove the IUCD from the deceased, but nothing changed.

That when the ambulance came, the medical staff of the respondent entered the ambulance, and the witness went in his personal car to Victoria hospital.

That he was at Victoria Hospital when the patient arrived at about 11:00 pm and joined the team of Doctors from Women's hospital while handing over to deceased to the ICU team at Victoria Hospital.

That among the medical team from Women's Hospital who escorted the deceased he remembers Doctor Ssali, Dr. Judith, Dr. Ezra, and Dr. Racheal.

That he also remembered Dr. Ezra telling the team at Victoria that they (Women's Hospital) had administered a certain type of drug called Ketamine during intubation.

All the conversation was recorded using his phone and transferred to a compact disk that was admitted as an exhibit.

That when Racheal was asked to explain what had happened, she gave the same narrative which she had already given to Mr. Wabwire, who later found out that the narrative constituted a hand over report.

That the ICU team at Victoria asked if there were any other notes but the respondent's team answered that none were available.

That the ICU doctor at Victoria hospital carried out preliminary examination of the deceased at around 01:00am and told Mr. Wabwire and the biological father of the deceased that the deceased was non-responsive to stimuli and that she was clinically considered brain dead.

That on Sunday morning (12/12/2021) a brain scan was done that confirmed that she was brain dead. That a second scan was made but with the same results.

He further testified that the deceased stayed on life support until 17/12/2021 when she eventually died.

RESPONDENT'S CASE

The respondent's case was made through the following witnesses.

1. **Dr. Edward Tamale Ssali**

Dr. Edward Tamale Ssali told the Inquiry that he is the Medical Director and a Consultant Obstetrician and Gynecologist, Women Hospital International and Fertility Center.

At the inquiry, he testified that he was 74 years of age, a Christian and a resident of Kololo.

Concerning the subject matter of inquiry, he testified that he received a call from Dr. Byarugaba Racheal on 11/12/2021 around 6:30pm, that he was quickly wanted in the hospital because the patient Dr. Racheal was treating had difficulty in breathing and they were also calling the anesthetist.

That as he was driving, he thought that it was covid that had caused her failure to breathe and that he told Dr. Racheal to put the patient on Oxygen.

That he reached the hospital about 7:30 pm and found many people along the theater corridors.

That inside the theater, he found the deceased on the theater table being intubated and on life supporting machines and being monitored by their senior anesthesiologist.

That after about 30 minutes, they realized that Joana would need an ICU and his staff started contacting hospitals with ICU facilities and Victoria agreed it could accept the patient.

That he personally went in the ambulance with Dr. Ezra, Dr. Judith Atiang and Rachael Byarugaba.

That Ezra briefed the ICU team at Victoria Hospital about what had happened and Dr. Byarugaba added to the statement.

That he was in the ICU at Victoria for about 30-60 minutes, and he left at about 11:30pm because he had a flight to catch at 01:30 am.

He testified that he was not personally involved in the treatment of Joanna's Medical condition, but he takes responsibility because this was his facility.

He further told the Council Inquiry that IUCD is not an emergency contraception, and he would never advise it for a person who has never had children.

He stated that they don't have Standard Operating Procedures (SOP)for contraceptives in the institution but that the doctors get the experience through constant interactions in the hospital.

That there was nothing like a manual or protocol for the medical personnel but that they undergo training.

He told the inquiry that if he was there, he would have advised Joanna of other methods of contraception.

He further stated that in his experience of about 40 years as a consultant gynecologist he has never come across a patient dying from an insertion of a coil (IUCD). That even when perforation of the uterus has happened, it doesn't lead to death.

That he has removed many IUCD coils (via laparoscopy) which have perforated the uterus and that he can't record anyone dying from that procedure.

That he has not even seen somebody reacting against this IUCD (copper Device)

When asked about what could have happened in Joanna's case, he said that unless she had an allergic reaction like a chronic problem.

He also said that he doesn't know if Dr. Racheal took Joana's history regarding allergies.

That in the respondent hospital, all their staff are properly taught how the insertion of this device is done including both easy and difficult ones.

That they do more than 30 IUCDs per week and none of their patients has had any complications of this nature.

That he didn't believe the Doctor was the cause of death.

When asked whether the hospital carried out an audit as to what could have caused the deceased's death, he said that they did an audit but not in a written form.

That he believed the IUD didn't kill Joana and that she convulsed because she hadn't eaten in two days.

2. Dr. Byarugaba Racheal

Dr. Byarugaba, at the Inquiry adopted her written statement dated 28th March 2022 and received by the Council on 6th/04/2022.

She further testified that she was 34 years of age and a resident of Namugongo.

That she holds MBChB from Kampala International University obtained in 2014. That she has been working with the respondent hospital since 2016 as a doctor on ground in Kigali IVF and fertility center up to 2018 and thereafter, as part of the team on ground at women's hospital Bukoto to date.

That she holds no other specialty but does consultations, minor surgeries and IVF related matters.

That on 11th/12/2022 around 3:00 pm a couple came into consultation room No.2 for purposes IUCD placing. They had been referred to her by a mutual doctor friend called Dr. Kasirye.

They had already done a baseline transvaginal scan recommended by a doctor friend and it's standard procedure of the facility. Dr. Kasirye, also works at the facility.

That she informed the couple about the scan findings, that the uterus was retroverted in position and the endometrial lining was thick, measuring 15.8mm; with a corpus lutem cyst on the left, otherwise the ovaries appeared normal, and no features of pelvic infection were noted.

That the deceased told her (Dr. Byarugaba) that she was expecting her menstruation periods that day to which the doctor advised that the procedure could be done on day three of the menstrual periods, but the couple insisted that, that day is when they will be travelling for their honeymoon.

That she (Dr. Racheal) then Consulted Dr. Sanyu Dricilla who advised that the procedure could be done as long as the pregnancy test was negative and had no infection.

That she explained to the patient that given the scan results, the insertion would be done under ultrasound guidance and therefore they waited for the sonographer who became available around 5:30pm.

That under abdominal ultrasound scan, as they attempted the initial insertion of the IUCD, they noted that the patient's bladder was emptied possibly before the procedure, and the angle of retroversion was approximately 90 degrees.

That she demonstrated to the patient where the coil was stopping due to the noted angle of retroversion.

That since they couldn't procced, the solution was to get a full bladder by taking water and to retry insertion under ultrasound guidance after at least an hour.

That the patient sat up in bed and she helped her fetch water from the dispenser. That she invited the husband to the room since he had hitherto been seated in the lounge area. She informed him about the failed attempt at inserting the IUCD.

That after fetching about 4-5 disposable cups, she went to the procedure room and the couple informed her that the patient had got diarrhea of sudden onset but mild. That the patient used the bathroom about 2-3 times.

That the patient's bladder felt full around 7:30pm but when she(doctor) came back to the procedure room, the patient reported that she had a bit of headache and some dizziness. That this prompted her to ask the patient if she had had lunch that day. The latter answered in the negative.

She was also told that the patient hadn't had a proper meal in 3 days.

That she(doctor) then told the nurse on duty to put I.V glucose D5% since the random blood sugar was slightly low, and the symptoms were corelating with hypoglycemia.

That when the D5% was halfway, they had a full bladder and the angle of retroversion had almost disappeared and was approximately 180 degrees.

The 2nd procedure was then successfully performed and that it took about 10-15 minutes.

That the nurse helped the patient get off the procedure bed, but the latter said that because her bladder was full, she wouldn't make it to the bed.

That the nearest bucket was brought, she passed urine but also told the doctor that she had accidentally passed the loose stool.

That the patient then said that she was feeling nauseous and was advised to use the bucket if she felt like vomiting, though no bout of vomiting happened.

That she told the patient lie on the bed in the patient recovery room to complete the bottle of glucose with normal saline. That she was helped to get to the bed by the nurse and left comfortable with the husband keeping her company.

That about 8:10 pm Dr. Racheal brought the Couple's antibiotic oral prescription and found the nurse taking the patient's vitals which according to her were normal with BP 120/70mm/Hg; RBS was 13.0mm0l/L. That she then left to finish up what she went to finish up a medical report in consultation room No.2.

That about 20-30 minutes later, she had the deceased's husband calling through the window of consultation Room No.2 to the effect that the patient was not well and had had a bout of vomiting.

That she picked the nurse on duty from the Nurses station and rushed to the recovery room only to find the patient lying in bed teeth clenched, making groaning sounds, with hyper flexed lower limbs, with a lot of secretion from the mouth and nose and not responding to pain stimuli or verbal communication.

That the night nurse rushed to get the airway as herself was doing sternum rub and trying to elicit verbal response and clear nasal secretion using a piece of sterile gauze.

That she tried to lift the patient alone from the recovery bed to the IVF procedure room where there is an oxygen source and nasal prongs.

That by the time they reached in the procedure room, the night duty nurse had brought the mouthpiece and oxygen monitor.

That the mouthpiece was quickly inserted, and they used the nasal prongs and ambu-bag to provide oxygen since the patient didn't have her own respiratory effort. That oxygen saturation was noted to be 75% as per connected oxygen Monitor and pulse rate was 100b/m

That they were joined by Dr. Kifuma Joseph in the procedure room, continued bagging and auscultated Joanna's chest and cardiac activity was noted.

That since there was still a lot of secretion, a decision was made to transfer the patient to the main theater which had a bigger working space and a suction machine, and a vent machine could also be easily accessible.

That since she was distressed, she left the other medical team who responded to the emergency call to takeover and the patient was taken to the main theater.

That she however kept following the events.

That initial vitals taken using the theater monitor showed Blood pressure-96/57; and oxygen saturation-99% after suctioning of secretions and bagging using the vent machine ambu-bag.

That the medical team and the family took a decision to take the patient to the ICU at UMC Victoria Hospital.

That Dr. Ssali called the ambulance and escorted the patient to ICU, and handed over verbally but there was also a written referral.

Dr. Byarugaba testified that there is a protocol followed for intra uterine contraception device insertion.

Asked whether there was an audit of the death of Joanna, she told the Inquiry that there was a conference of all the doctors at Women's hospital but couldn't find the cause of death.

She also told the inquiry that in insertion of the IUCD, the major worries are to avoid perforation and vasal vagal reflex.

That they were told that the postmortem report was classified. When asked whether they had requested one from the Council, the answer was in the negative.

She further testified that the Respondent has a referral system, that they have referral notes but that the note was not used in this particular case.

3. Dr. Ezra Mugisha

Dr. Mugisha adopted his statement to the Council dated 28/03/2022 and testified that he was 35 years of age, a non-Christian and a resident of Namulonge.

That he holds Master of Medicine (anesthesia) Of Makerere University-2016 and MBChB from the same University acquired in 2011.

That he Works at Women's Hospital from Monday to Wednesday but he is on call. That he has an unlimited contract and in addition to the designated days, he can also attend to emergencies.

That on 11/12/2021 at about 8:45pm he got a phone call from Dr. Racheal Byarugaba asking for help concerning a patient who had got sudden onset of difficulty in breathing following placement of an IUCD.

That he arrived at the hospital at 10:00pm and proceeded to the theater.

He also testified that he found the deceased on theatre bed unresponsive and had already been intubated and having her breathing supported by the anesthesia machine ventilator.

That the patient had been intubated by Fiona Kisakye alongside Nalwanga Phionah with the help of 100mg of ketamine as narrated by Kisakye when giving a verbal report about the patient.

That he assessed the brain stem reflexes and found that they were absent, but the spinal reflexes were still present at that point in time.

That the pupillary light reflex wasn't responsive. He also did the corneal reflex and tried to tap the gag reflex. That all these reflexes were not responsive and the patient's Glasgow Coma Score was 3/15. That he concluded that the brain was dead.

He further testified that he was not sure of the cause of death but that a patient can get a vasal vagal attack due to delayed attendance to extreme reaction to an event.

That while in theater, he monitored the patient's vitals which were stable until the ambulance came to transfer her to ICU.

He states that this information was shared with the ICU admitting doctor at Victoria Hospital during the verbal handover report concerning the patient.

4. KISAKYE FIONA

Fiona Kisakye testified that she was 40years of age, Christian by faith and a resident of Ntinda.

That she qualified as anesthetic officer -2017 from Mulago paramedical school and works at Women's hospital as full-time member of staff.

She testified that she knew Joana Namutebi Wabwire when she was called to attend to her as an emergency case on 11/12/2022.

That on that day she was off duty, was called that there was a procedure in hospital that she needed to go and see what was happening.

That when she reached, she found the patient in the theatre unresponsive to stimuli, BP 108/74mmHg, PR-101bpm, SP02-99% with air way piece and air mask.

That there was Phionah Nalwanga who was bagging the patient.

That she did intubation but found when Nalwanga was going to intubate.

That she administered Hydrocortisone 100mg but didn't administer ketamine, which was administered by her junior, Nalwanga who is qualified as a nurse but is an anesthetic officer in Mulago.

That she called Dr. Ezra personally to assist to communicate with the ICU.

5. Immaculate Mukagasana

She was the day -duty nurse on 11th/12/2021 who assisted at the 1st failed attempt to insert the IUCD. Note that her name only appears in Dr. Racheal Byarugaba's notes, but she (Immaculate) didn't write anywhere in the patient's file.

At the Inquiry, she testified that she is aged 32 years and is a Nurse at the Respondent Hospital. She holds a Diploma in Midwifery from Mulago School of Nursing, obtained in 2013.

That she knew Namutebi Wabwire, came to the hospital for IUD and was the first contact for the preparation of the procedure.

That she received a file from Doctor Racheal to prepare for the IUCD placement.

That she arranged the instruments and Dr. Byarugaba came with sonographer to guide in the procedure.

That the procedure failed, and the doctor recommended filling the bladder to have proper insertion. That she Left Joana with the doctor and that was all.

That her colleague took over from there.

She stated that her instructions were to prepare the IUCD, Ultrasound, disinfectant and diclofenac to avoid pain.

6. PHIONA NALWANGA

Phionah Nalwanga, was the night duty nurse on the 11/12/2021.

She made a statement dated 4/4/2022 regarding the events of that day. She adopted her statement at the inquiry and also gave oral testimony on oath.

She testified that she was 28years of age, resident of Mulago, and holder of a Diploma in comprehensive Nursing obtained from Soroti Comprehensive School of Nursing. That she has worked at the respondent hospital since 2019.

That on 11/12/2021, she reported for night duty at about 7:15pm. That no sooner had she arrived than she received a call from Dr. Rachael Byarugaba to help with cannulation of a patient and administer dextrose 5%.

That she met the patient who was on the couch and Noah with a scan machine.

That she got to know that the patient was dizzy and feeling weak and that she (the patient) hadn't eaten a meal in three days. That her blood pressure was normal :110/88mmhg, Pulse rate :89b/m.

That the sample of random blood sugar was taken off which was 3.4mmol and that she accessed the IV line and put Dextrose 5% plus a bolus of 20mls dextrose 50% as per doctor's advice. (Note that the s bolus of 20mls dextrose 50% isn't reflected in Dr. Byarugaba's clinical notes!)

That although Joanna was feeling dizzy, she kept talking to the team throughout the procedure which was eventually successful.

That after the procedure, the patient needed to go to the toilet but she was so weak so she decided to bring her a bucket at the bedside so that she(patient) could help herself.

That she then took the patient to the recovery room to rest while she completes her fluids.

That she went to clean the table but when she returned to the recovery room, the patient complained of nausea, and she brought her a bucket with clean water, but the patient didn't vomit.

That she left the bucket at the bed side and went to the nurse's station to prepare a ward round.

That while she was there, Dr. Racheal shouted for her to go and see Joanna with her.

That they found Joana clenched with secretions in her mouth and nose and not able to breath and she was very stiff.

That she rushed to get the airway equipment from the IVF room for resuscitation. That Dr. Kifuma joined them and helped Racheal to bag.

The patient was put on oxygen but was not breathing spontaneously and she was ventilated by ambu-bag mask. That her blood pressure was normal, PR-100b/m and SPO2- 72%

That the oxygen circulation was not improving and so she was taken to the theater for further resuscitation. That on arrival, the Saturation was 33% but later improved to 99% after suctioning and more bagging.

That later a group of doctors arrived and together with the patient's relatives took a decision to take Joanna to ICU.

She also testified that she administered the ketamine to the patient, that Dr. Ezra was aware but hadn't prescribed it.

7. Dr. Kafuuma Joseph

He was the first Doctor to respond when Dr. Racheal Byarugaba called for help after being told that the deceased was convulsing and failing to breath.

He testified that he graduated from Makerere University in 2016, and has been working full time with Women's hospital since 2017.He is a medical officer.

That they are about six medical officers at the facility and that Dr. Ssali is the doctor in-charge although he isn't there all the time. That he (Ssali) is the supervisor although there are other Consultants like Dr. Judith Atiang.

He testified that the day the incident happened, he was on duty with Dr. Racheal.

That during day, he saw the couple at the reception but wasn't the one who was attending to them.

That then later that evening, he remembered Dr. Racheal asking him to help her do a scan because she was going to insert an IUD in the client.

That at that time he was still having patients he was seeing so he advised that the sonographer should do it since he was still around. That he didn't follow up afterwards.

He further testified that when he was done with what he was doing at around 8:00pm coming to 9:00pm, he heard a gentleman cry on the phone as he was calling people outside on the walkthrough.

That he ran downstairs to see what was happening and that is when he got to know that someone had blacked out.

That he went in and found Dr. Racheal trying to insert an airway and Joana was unresponsive, unconscious, and had an IV line with normal saline running.

That Joana was connected to a monitor, he saw that the BP was normal, and she had oxygen flowing through nasal prongs.

That by that time Dr. Racheal was resuscitating the patient.

That when he assessed the patient, she was unresponsive. He tried to do external rub, but she wasn't responding. That the patient was in a clenched position, with the arms and the teeth clenched. That Dr. Racheal was trying to insert an airway.

That they then realized the patient wasn't breathing. There was no spontaneous breathing, so they continued to bag after Dr. Racheal inserted the airway and bagged for about three minutes.

That they assessed again, and there was no spontaneous breathing, so they thought she needed to be intubated.

That in the main theatre they continued bagging as the rest of the team started arriving.

That Phionah did the intubation and the rest of the team, Dr. Ezra, Dr. Judith then joined them.

That then an arrangement to transfer the patient to Victoria hospital for ICU was made.

That, that was his involvement.

8. Dr. Judith Atiang

She testified that she is an Obstetrician and Gynecologist aged 43 years.

That she completed her undergraduate course at Makerere University 2010 and then her master's degree at the same University in 2018.

That she works fulltime at the Respondent Hospital and is on call in case of any emergency.

That she has worked at the Hospital Since 2019 July; but previously was also working at, Ssali International Hospital in Dar-es-Salam

She testified that on 11th of December 2021, she got a call from Dr. Racheal around 9:30pm to the effect that they had an emergency.

That Dr. Racheal informed her that there was a lady who came for an IUCD insertion and then had blacked out.

That she(witness)reached the hospital about 9:30-9:45Pm.

That when she arrived at the reception, she got Dr. Joseph there and asked him where the patient was and was told she(patient) had been transferred to the main theatre.

That she (Judith) rushed up to theatre while calling Dr. Ezra because since the patient had blacked out, she thought the issue could be related to air way.

That when she arrived in theatre, she got a lady lying on a theatre bed, on the source of oxygen.

That the vitals looked normal because her oxygen saturation was 99% and the blood pressure was about *100 and something over 70 something.*

That she got Dr. Racheal trying to tell the story to one of the staff, Phionah who had come in earlier.

That she found when they were trying to intubate the patient and asked whether the coil was still inside because she knew that anybody could react to any foreign body.

That after they finished the intubation, she requested that they should remove the coil because it could probably be an idiosyncratic reaction or something of the sort. That she removed the coil.

That the coil came out easily but was blood stained.

The witness told the Inquiry that when she arrived, the patient was lying on the table, didn't seem to have spontaneous breathing but they were giving her source of oxygen.

She further testified that at that point in time, as she was going to assess the patient, Dr. Ezra arrived, and they began assessing the reflexes together.

That he (Dr. Ezra) assessed the brain stem reflexes which he actually told the witness that the brain stem reflexes were absent, but the spinal reflexes were still present.

That Dr. Ezra listed the pupillary light reflex and he said it wasn't responsive to light and that also did the corneal reflex tried to tap the gag reflex. , they all didn't seem responsive.

That they had already given some premedication for the intubation and so there was an IV line.

Wabwire's Death analysis and ruling

Analysis of the facts and evidence.

From witness testimonies and statements; patient's files; post-mortem and toxicological reports and the body of known and available medical knowledge and procedure, Council's analysis of the case is as follows:

Ms. Joan Namutebi Wabwire was a healthy young adult that had just been wedded on the 10th of December 2021.

She chose to have a Long Term Reversible Intra Uterine Contraceptive Device from Women Fertility Hospital Bukoto, Kampala. This is a routine procedure.

She had no history of any documented medical condition affecting her health. On the 11th of December 2021 at 1500hrs, Dr. Byarugaba Rachael, an employee of the Respondent hospital noted a fully conscious, alert, and happy client.

The deceased's Blood pressure was noted as 100/60 mmHg and Pulse rate was 70 Beats per minute.

However, her respiratory rate was not captured nor was the Oxygen saturation documented.

Pregnancy test was done and turned out negative and the ultrasound scan that day from same facility showed a retroverted uterus. The corpus luteum was 1.4 x 1.6 centimeters and endometrial thickness of 15.8mm.

This anatomical finding of the uterus spelt out need for caution in handling this patient. However, scrutiny of the patient's file and the testimony of Dr. Byarugaba Racheal, showed there was inadequate appreciation of the risk and no preparation and caution by the medical officer.

The said Dr. Byarugaba Rachael consulted Dr. Sanyu Drucilla on phone as to whether the patient who was expecting her periods was eligible for the placement of an IUCD, but never consulted on how to handle the insertion of the IUCD in a patient where the ultrasound scan showed a retroverted uterus.

At this stage there is doubt as to whether Dr. Rachael Byarugaba who inserted the IUCD had knowledge on IUCD insertion or handy mitigative measures when she failed at sounding this non- gravid uterus and probably making a diagnosis of a partial cervical stenosis.

She exhibited lack of confidence in inserting an IUCD. The notes appear written way after a catastrophe and an attempt to reorganize events leading to it hence falsification of what really happened.

It is recorded in the patient's file that on 11th December 2021 at 17:00hrs, the minor theatre was prepared for the late Ms. Joana Namutebi Wabwire's procedure.

Ms. Immaculate and a sonographer were informed to assist with ultrasound guided IUCD insertion.

Rectal Diclofenac 100mg start was administered to the patient.

At 17:30 hrs., on the 11th of December 2021, while in the minor theatre, there was no effort to ask Ms. Joana Namutebi she had emptied her urinary bladder prior to

the procedure at first attempt. (Remember that she required a full bladder for the pre-insertion ultrasound scan way before 15:00hours).

Dr. Byarugaba Rachael noted prior to insertion procedure, that the cervix was not typically nulliparous, and that there was no need for dilatation.

She also noted cervical scar on the right aspect of the external cervical os. She questioned previous instrumentation as the cause of this scared cervix.

There is no mention whatsoever of the type of IUCD that was to be inserted neither was it noted in the patient file that of the process of informed choice done for the particular IUCD for insertion. Nor was she offered alternative contraception.

The antiseptic used to observe asepsis is not mentioned.

The cervix is said to have been stabilized using a tenaculum; uterus was sounded under ultrasound guidance, but resistance was met at 5 cms.

The explanation given is that this resistance was due to orientation of the uterus in the retroverted position. It is said to have been at 90 degrees and that the bladder was empty.

After this resistance with a uterine sound, the loaded barrel system was now attempted under ultrasound scan guidance.

It should be remembered that the uterine sounding device is tapered and can wedge along the external cervical os, cervical canal and then open the internal cervical canal while the close to a flat surface of the introducing IUCD barrel will require excessive manipulations, traumatic and higher chances of perforating the uterus at the cervix, anterior uterine wall if true that the uterus was retroverted.

The worst complication for this decision was the trigger for the Vaso- vagal reflex and Neurogenic shock.

Note: There is no mention of cervical block to numb the sensory pathway with mechanism of action very different from that of Diclofenac which couldn't achieve a nerve block!

Dr. Byarugaba Rachael again noted resistance at 5 cms and paused the procedure, then commented about the patient having emptied the urinary bladder prior the procedure.

Dr. Byarugaba then halted the procedure and the patient was advised to take at least 800mls of water until a full bladder was attained and an allowance of a grace period of an hour ensured before re -attempting IUCD insertion under sonographic guidance.

Note should be taken that after this first attempt, the patient is said to have developed diarrhea, headache, and nausea!

Further, there is no mention Dr. Byarugaba consulting a gynecologist to be present for the second attempt. The doctor only noted the need for the presence of the sonographer Mr. Kirumira Noah and Assisting Nurse, Immaculate Mukagasana.

At 19:30 hrs. a second attempt is documented to have taken place successfully.

However, the patient's file shows a lot of insertion of notes from original thought process This is a clear indication of a deliberate effort to conceal facts.

The record shows that ultrasound scan was done prior to the second attempt, and it was reported that the bladder was full and uterine cavity well aligned.

That the external cervix os was normal with mild spotting when visualized with the speculum.

The inserted notes at this stage show that the patient reported dizziness and had not had a proper meal since Wednesday of that week.

The I.V access was set up and dextrose 5% infusion started with not corrective Dextrose 50% to restore Blood sugar levels. It was noted that the RBS was at 3.4 mmol/L at 19:30 hrs.

Note should be made that Nurse Nalwanga Fiona asserts in her notes that she gave a bolus of 20ml dextrose 50% on the advice of the doctor. There is no such prescription in the doctor's notes. This is another clear indication of an attempt to conceal what exactly happened.

Despite Patient's state of nausea and dizziness, Dr. Byarugaba Rachael commenced with IUCD insertion procedure under ultrasound guidance.

The IUCD was visualized to be placed in situ at the uterine fundus and that no bleeding was noted with the patient left stable.

NOTE: There were no vital signs recorded for both attempts before insertion and after insertion of the IUCD.

It is recorded that Dr. Byarugaba Rachael then recommended AZITHROMYCIN 500MG od, tabs Secnidazole 2gms start for the husband while Joanna Namutebi Wabwire was to use cefixime 400mgs od for 5days, metronidazole tabs 400mgs tds for 5days, and tabs Brustan one tablet 250mgs? tds for 3days.

All these medicines were to be started the following day after Joanna Namutebi had a proper meal.

It is documented in the patient file that on the 11th of December 2021 at 20:40 hours the husband called the clinicians to check on/ review the wife who had a bout of vomiting and whose wellbeing was generally worsening /deteriorating.

The doctor noted that Joanna Namutebi was having difficulty in breathing, clenched fist, and teeth and the lower limbs were hyper flexed. She was having convulsions.

The patient was then moved with the help of Jonathan Wabwire to the IVF Theatre for oxygenation and resuscitation.

Air way piece was inserted and Dr. Byarugaba mobilized Dr. Kafuuma Joseph, Dr. Judith, Dr. Ezra, Dr. Robina, and Dr. Angela and other medical staff.

The patient was transferred to main theatre for proper Air Way Clearing by suction plus placed on the Anesthesia machine.

Byarugaba Rachael noted that the oxygen saturation for Joanna Namutebi before transferring her to the main theatre was at 33%, then 75% after bagging and oxygen administration through Nasal Prongs.

Anesthetic team stabilized and intubated patient in theatre. IUCD removed by Dr. Judith.

However, there is no mention of the Temperature, Blood Pressure, Pulse Rate, Respiratory Rate and Glasgow Coma Score at this juncture prior to intubation and any consultation or arrival of a Gynecologist to aide in the resuscitation effort.

A set of notes written by Ms. Fiona Nalwanga are written from 19:30hrs, 20:35 Hours, 20:40hrs, and 21:25 hours.

They indicate that at the time the patient was intubated, she oscillated from Random blood sugar 3,4 to13.0 mmol/L; Bp 110/88mmHg to 107/74 mmHg to unrecordable at 2040 hrs.; SPO2 at 33% with a PR 100 bpm, to 108/74mmHg.

On top of all that was written by Ms. Fiona Nalwanga, the evidence shows that all those who were called to resuscitate Joanna Namutebi Wabwire started arriving between 21:20 pm and 22: 30hours. This makes the recordings by Nalwanga Fiona suspect.

The other glaring discrepancy is in the evidence of Dr. Ssali. He stated that he got a call at about 6:30pm from Dr. Byarugaba about the emergency.

According to his written statement, he arrived at the hospital" 'within less than 10 minutes"

This would imply that he was at hospital by 6:40pm! In his testimony at the inquiry, he stated that he arrived at the hospital at 7:30 and went to the theater and found Dr. Ezra in theater and that the patient was already intubated.

But Dr. Ezra Mugisha stated in his statement that he arrived at the hospital at around 10:00pm. This was also in his testimony at the Inquiry!

Be that as it may the review team that reviewed Joanna Namutebi Wabwire while on the ventilator, noted: BP 107/73 mmHg, Pulse Rate 102 B/pm; CNS examination, unresponsive to stimuli, pupils dilated between 4- 5mm, unresponsive to light, No corneal reflexes, No Gag reflex, and GCS at 3/15.

The ambulance Call was then activated and transferred the patient to ICU at Victoria Medical Centre in Bukoto Nakawa for ventilator support and further management.

According to the Patient's file of Victoria Hospital, Joanna was received at Victoria Hospital and connected onto the ventilator on the 12th of December 2021.

The investigations and assessment done including EEG, confirmed Brain Death, ECG confirmed ischemic heart disease with borderline left ventricular systolic function.

Serial family conferences held with the close family of the late Ms. Joanna Namutebi Wabwire and counselling on the futile effort of any medical reversal of her being brain dead and failing spinal reflexes maintained on vasopressors, all medically justified disconnecting her off the ICU ventilator with pronouncement of her death.

These Family Conference sessions were conducted by Dr. Hussein Ssentongo a Neurosurgeon, Dr. Barbara Akande consultant cardiologists, Okello Erasmus anesthesiologist.

The vasopressors were disconnected on 17th December 2021 and Joanna was pronounced dead. a Postmortem requested.

This was carried out and findings pointed to "hemorrhagic stroke, following neurogenic shock extreme vasodilatation and tissue congestion with red cells mimicking a hemorrhagic stroke seen in the Brain tissue due to Cardiogenic shock".

Toxicological tests were carried out and all returned negative of lethal compounds while at Victoria Hospital.

From the foregoing, it is clear that:

1. Preliminary ultrasound gave important information about a retroverted uterus, but this was ignored by the Medical Officer, Dr. Byarugaba.
2. The fact that the ultrasound information was ignored led to poor preparation of the insertion in an empty urinary bladder. The doctor should have ensured that the bladder was full before the first and second attempts.
3. There was poor anticipation of complications in a complicated procedure of inserting an IUCD in a retroverted uterus. The procedure was handled by inexperienced medical officer who operated beyond her scope. There was no timely consultation

4. The several traumatic attempts at insertion of the IUD, triggered the vasal - vagal attack which complication was not anticipated. This was followed by poor monitoring of the patient who was left in the care of her lay husband. Nausea, headache, vomiting and loose stool were all ignored red flags.

5. The failure in emergency management of the crisis complicated the vasal - vagal attack. The low blood sugar was attributed to alleged lack of eating. There was poor understanding of symptoms and how to manage them. Shock and seizures were poorly managed.

6. There was poor understanding of cause of death. Whereas Dr. Byarugaba, Dr. Judith Atiang and Dr. Ezra Mugisha all mention the possibility of vasal vagal attack, they go ahead to testify that when they did the death audit as a team, they failed to understand the cause of death. It was even unbelievably suggested that the seizure was because she had not had a decent meal for three days. This was made worse by Dr. Ssali's denial, who claims that in his 40 years of practice he has never heard of someone dying from complications arising from insertion of an IUCD.

Medical care given and the possible underlying cause of Joanna's Death.

By definition, the underlying cause of Death is the disease or injury or poisoning that initiated the chain of events that led directly and inevitably to death.

Late Ms. Joanna Namutebi Wabwire had no prior life-threatening health conditions noted in her medical history by all those who evaluated her on the 11th December 2021, prior to the several attempts of inserting an intra-uterine contraceptive device starting from 19:30 hours. The contraceptive device was not specified, neither was the choice of contraceptives offered.

The different manipulations of the cervix triggered a vasovagal reflex

Unfortunately, the IUCD was taken out before anyone could prove that it was in the uterine cavity apart from self-reported ultrasound scan by Mr. Noah Kirumira.

The depth of the inserter was not mentioned after allegedly successfully inserting the IUCD in the uterine cavity.

Postmortem didn't comment on the traumatic lesions beyond the internal Os 0r any lesions left within the uterine cavity for evaluation of a possible full or partial

uterine perforation at the manipulative insertion, using a sharp barrel of the IUCD loader/ inserter.

This trigger of the Vaso vagal reflex unnoticed by the clinical team , having left the deceased unattended to, having allowed her to walk off the insertion couch before 15 minutes , all led to progressive and worsening vasodilatation of the major and peripheral blood vessels leading to poor pre - load cardiac failure and cardiogenic shock setting in, poor blood supply to the coronary artery system for the over one hour that the patient spent after the insertion of the IUCD without monitoring by any clinician. The brain will become dead once there is No oxygenated blood getting to it for just 5 minutes.

So, the vomiting and convulsions registered by the team that first got to her after more than an hour post insertion, were all indication of the irreversible Neurogenic and cardiogenic shock, all leading eventually to irreversible Brain Death due to brain hypoxia.

Findings &Conclusion

1) The Council finds that there was failure by the Respondent's staff to monitor, post insertion, the vital signs and to timely intervene to salvage the situation,

2) This exhibition of incompetence by the medical staff of the Respondent, fell below the standard of care expected of a specialized hospital like the Respondent and led to the death of Joanna Namutebi Wabwire.

3) Matters are not helped by the apparent attempts to alter information in the patients file after the event.

RESOLUTIONS.

In view of the findings and conclusions above, Council makes the following Resolutions for the reasons herein contained.

I). The Council shall constitute a task force to scrutinize all the deployed officers/practicing staff of the Respondent to establish the state of their knowledge and clinical skills in the specialized services offered to the public; and

asses the infrastructure and equipment at the different service points for functionality, and to assess utilization thereof.

2) Dr. Rachael Byarugaba, who was the main attending physician, be suspended from practice for a period of 6 months, after which she will be placed under an attachment for a period of three months at a National Public facility, to learn long term reversible family planning methods, management of emergencies and all other gynecological benign conditions and their management.

3) Dr. Edward Tamale Ssali's, the Medical Director of the facility, in which this incidence occurred, takes responsibility of the happenings at this facility. He shall be given severe reprimand. This will be followed by assessment of the suitability of the facility as recommended above, and that of the staff, including Dr Ssali himself.

Dated, signed and sealed at Kampala this 21st day of DECEMBER 2023

1. Assoc. Prof. Okullo Joel..... Chairperson
2. Prof. Sarah Kiguli ..... Vice Chairperson
3. Dr. Apollo Epuwat..... Member
4. Dr. Kaducu Felix Ocaka ..... Member
5. Dr. Maxwel Okello..... Member
6. Dr. Ayubu Twaha ..... Member
7. Dr. Yosamu Nsubuga..... Member