THE REPUBLIC OF UGANDA

IN THE MATTER OF AN INQUIRY INTO ALLEGED PROFESSIONAL MISCONDUCT AND OR MEDICAL NEGLIGENCE BY DR. JOCKNUS WALINA OF MARIE STOPES HOSPITAL LUGOGO IN THE TREAMENT OF MS. NASSALI DAISY, RESULTING IN THE DEATH OF HER BABY

1. KIRAIRE LEWIS
2. NASSALI DAISY CHRISTINE :::::::::::::::::::: COMPLAINANTS

VERSUS

1.DR JOCKNUS WALINA

2.MARIESTOPES HOSPITAL LUGOGO :::::::::::: RESPONDENTS

FINDINGS AND RESOLUTIONS OF THE COUNCIL

Complaint Summary

The complainants, Mr. Kiraire Lewis and Ms. Nassali Daisy Christine, allege that their newborn baby died as a result of improper treatment and negligence by the respondent, Dr. Jocknus Walina, at Marie Stopes Hospital & Maternity Lugogo. Dr. Walina is a registered and licensed medical doctor under the Uganda Medical and Dental Practitioners Council (hereinafter referred to as "the Council"). He was the attending doctor for Ms. Nassali during her admission.

Background

The complaint was formally lodged through Kakaire and Wanume Advocates on 18th March 2024, citing professional and medical negligence by the Respondent which allegedly led to the death of the baby. Dr.

Walina denied the allegations, asserting that Ms. Nassali 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 17th April 2025 to determine whether the Respondent was guilty of professional misconduct and/or medical negligence.

Proceedings

The inquiry took place in the Council's Boardroom. Both parties submitted witness statements and attended the session for cross-examination. The complainants were self-represented, while the Respondent was represented by S&L Advocates. The individuals cross-examined were:

1. Mr. Kiraire Lewis – 1st Complainant
2. Ms. Nassali Daisy Christine – 2nd Complainant
3. Ms. Ssali Annet – Complainants' Witness
4. Dr. Jocknus Walina – Respondent
5. Dr. Milton Awudo – Respondent's Witness

Complainants' Evidence

1. Nassali Daisy Christine (2nd Complainant – CW1)

Nassali Daisy Christine, an adult female resident of Kireka, and the mother of the deceased newborn baby, testified that sometime in January 2024, she began preparing for childbirth and decided to visit Marie Stopes Hospital, Lugogo, to make an appointment with a gynaecologist.

She stated that on 16th January 2024, she and her husband contacted the hospital via its WhatsApp platform to inquire about delivery packages and book an appointment with a gynaecologist to assist with the delivery.

On 19th January 2024, she and her husband visited the hospital and met a staff member identified as Christine Nalunga, who referred them to Dr. Jocknus Walina. Dr. Walina inquired about the age of her pregnancy, and she informed him it was 37 weeks. He discussed the different modes of delivery and conducted a fetal heart check, which was normal. They were shown the delivery rooms, which were clean, except for the theatre, which was out of bounds to non-staff.

On the night of 14th February 2024, she experienced mild labour pains but decided to wait until the next day to go for a medical check-up. On 15th February 2024, she called Dr. Walina's phone, but it was off. Nevertheless, they proceeded to Marie Stopes Hospital Lugogo, arriving around 3:00 PM. Although Dr. Walina was not initially present, he informed her via phone that he was stuck in traffic and would arrive shortly.

Dr. Walina advised them to undergo a scan for accurate diagnosis, which they did after paying the necessary fees. He arrived around 5:00 PM, examined her, found she was at 2cm dilation, and recommended admission. They agreed, paid a deposit, and began settling into the room. Her husband left to arrange additional items for the stay, and she called her mother to come attend to her.

She was given oral medication and water every two hours, which she was informed was to induce labour. The hospital was quiet, and nurses only returned around 3:00 AM to check the baby's heartbeat. On 16th February 2024, Dr. Walina did not show up. Instead, Dr. Galla came to the ward. When she requested an examination, Dr. Galla first consulted Dr. Walina, who declined and stated he was on the way. Dr. Galla only checked the baby's heartbeat and advised her to walk around to facilitate labour.

Around 11:30 AM, Dr. Walina arrived and examined her. When leaving in the evening, her mother pleaded with him to either administer medication or consider a caesarean section the next morning if labour had not

progressed. He reassured them that the baby was fine and small and that a normal delivery was expected.

On 17th February 2024, neither Dr. Walina nor any midwife attended to her initially. Instead, Dr. Amadriyo Emma checked the fetal heartbeat and found her still at 2cm dilation. He inserted a gel or liquid using a metal instrument and asked her to return to her room while waiting for Dr.Walina.

Later, she was called to the labour room by Sylvia Katushabe, a midwife on duty, who administered saline and oxytocin to induce labour. Katushabe placed a machine on Daisy's abdomen, which began beeping. When asked, Katushabe explained that it indicated the baby was changing position. Daisy informed her that the machine was uncomfortable. Katushabe removed it and left the ward. As the pain intensified, Daisy asked to speak to the doctor about a caesarean section, but the doctor was not present.

When she pleaded with Katushabe, she was mocked and told, *"mu labour room tebakaabiramu,"* meaning *"we don't cry in the labour room."*

Later, Dr. Walina arrived. Daisy asked again about a caesarean section, but he insisted she could deliver normally by 3:00 PM. Subsequently, Dr. Walina and Katushabe performed a painful vaginal exam and membrane sweep. When she protested, Katushabe threatened to abandon her.

While vomiting into a bucket, Daisy felt something between her thighs. She informed Katushabe, who ignored her and told her to keep sitting. In distress, Daisy asked another midwife, Racheal, to examine her. Racheal discovered the baby had descended into the birth canal and rushed to call the doctor.

Around 7:15 PM, the baby was delivered after an episiotomy. Several medical staff arrived and attempted resuscitation while rushing to bring an oxygen cylinder. Despite repeated inquiries, she was not informed about the baby's condition. Eventually, they were told that the baby might be referred to a nursery but were asked to wait.

After stitching, Daisy again asked about the baby. The staff remained silent. Later, they were informed that the baby had died. She was discharged the following day with the deceased newborn.

2. Kiraire Lewis (1st Complainant – CW2)

Kiraire Lewis, an adult male, advocate of the High Court, and husband to Nassali Daisy, testified that throughout his wife's pregnancy, they conducted several obstetric scans and medical tests at different facilities. The baby and mother were always in good health.

On 16th January 2024, he inquired about delivery packages via Marie Stopes Hospital's WhatsApp and arranged to meet a gynaecologist. On 19th January 2024, he and his wife visited the hospital at Forest Mall, Lugogo, and were introduced to Dr. Walina, who confirmed he would handle the delivery.

On 15th February 2024 at about 3:30 PM, he took his wife to the hospital and paid consultation and scan fees. The scan confirmed the baby was healthy. Dr. Walina examined her and found 2cm dilation, advising admission. A medical staff named Lilian began administering medication to induce labour.

On 16th February 2024, a midwife instructed them to walk around to facilitate labour. However, Dr. Walina was absent throughout the day.

On 17th February 2024, he returned and was told his wife was in the labour ward. Access was restricted, so he waited outside. His mother-in-law requested him to plead for a caesarean section, but the midwife declined, citing the doctor's absence.

Soon after, he observed hospital staff rushing downstairs and bringing a gas cylinder into the labour ward. Minutes later, his wife was wheeled out, crying that the baby had died.

When they requested medical documentation, staff refused to provide it. On 18th February 2024, they were discharged with the deceased baby after clearing hospital dues.

3. Ssali Annet (CW3)

Ssali Annet, an adult businesswoman from Kayunga, Mukono, and mother to the 2nd Complainant, stated that she was called by her daughter on 15th February 2024 around 7:00 PM to attend to her. She arrived at 11:00 PM and witnessed her daughter being admitted and started on labour-inducing medication.

On 16th February 2024, they were advised to walk to encourage labour. In the evening, Dr. Walina informed them he would administer more induction medication the next day due to reduced night staffing. However, he did not return as promised.

On 17th February 2024, a different staff inserted gel to soften the uterus. Labour intensified around 11:00 AM. Alarms from the monitoring machine began, but the staff ignored their concerns.

She asked her son-in-law to request an operation due to the prolonged labour, but the request was declined. The midwife ignored Daisy's complaints of feeling pressure in her lower body. Eventually, another midwife examined her and called Dr. Walina, who arrived just before delivery.

After delivery, the baby did not cry and was subjected to resuscitation without success. They were informed later that the baby was dead. They were discharged the next day and proceeded with the burial.

Respondents' Evidence

1. Dr. Jocknus Walina (Respondent – RW1)

Dr. Walina, testified that he is a medical practitioner duly registered and licensed by Uganda Medical and Dental Practitioners Council holding both annual practicing license and specialist registration certificate in the area of Obstetrics and Gynaecology. He testified that on 19th January 2024, Ms. Nassali came for her first antenatal visit at 35 weeks. She was examined and scheduled for a review on 9th February 2024.

She however returned on 15th February 2024, complaining of mild labour pains. He advised admission for closer monitoring, but she opted to return home to prepare the necessities she would be using while in the hospital.

She returned around midnight on 16th February 2024 and was examined by Dr. Charles Galla, who found early cervical changes. She was admitted and administered 8 doses of misoprostol from 12: 25 am up to 4: 36pm for induction. At 4:36 the patient was examined again and found to be dilated by 3cm with mild contractions. Fetal vitals were normal.

On 17th February 2024, Dinoprostone gel was applied to continue cervical ripening. Labour was monitored and later augmented with oxytocin. By 3:54 PM, labour had progressed with spontaneous rupture of membranes and clear amniotic fluid. They also noted that there was no prolapse of the umbilical cord and amniotic fluid was clear which was an indication that the labour was progressing normally and there were no identifiable issues regarding the health of the child or the mother.

Fetal heart rate remained between 130–146 bpm. By 6:45 PM, she was in active labour and delivered the baby at 7:15 PM. The baby was non-responsive with an Apgar score of 3/10 and a heart rate of 80 beats per minute.

Despite resuscitation attempts by a team including a pediatrician, midwives, anaesthesia team, and obstetrician, the baby was unresponsive and later pronounced dead. The patient declined a postmortem, making it impossible to determine the exact cause of death.

He testified that at all times since the patient's admission, she was consistently monitored both by the midwives, two obstetricians and himself. Each time one of them left their shift, the briefed the next medical personnel about the patient who was monitored around the clock and therefore neither himself nor the hospital was negligent.

2. Dr. Milton Awudo (RW2)

Dr. Milton Awudo, Director of Technical Services at Marie Stopes Hospital, testified that he reviewed the case and interviewed the staff involved. He concluded that the death was unfortunate but not due to negligence.

He stated that Ms. Nassali and her baby were fully monitored, and care was provided by qualified medical staff at all times. The delivery was

managed according to standard clinical procedures, and she was discharged in a stable condition.

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 the Respondents constituted professional misconduct and/or medical negligence.
2. What appropriate sanctions and recommendations should be made.

Resolution of issue Number 1

Section 33 of The Medical and Dental Practitioners Act cap 300 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.

Professional misconduct is defined by the Black's law dictionary as ***violation of some established and unambiguous rule of action, a prohibited act, failure to perform a duty, unlawful behavior, and improper or wrongful behavior.***

According to the evidence on record, Ms. Nassali Daisy, was a primigravida at term and was admitted to Marie Stopes Hospital Lugogo from 15th to 18th February 2024. She spent four days in labour, during which various methods were employed to induce labour. Though she eventually gave birth vaginally, the baby was born non-responsive and later pronounced dead.

It was the 1st complainant's testimony that Dr. Jocknus Walina introduced himself as a gynaecologist and the couple believed that he had enough expertise.

Complainant Witness 3 stated that she raised a concern regarding the baby's heart beat which was ignored by the midwife.

It was the complainants' evidence that since the 1st complainant was in labour for long, they requested for C-section which was ignored.

Dr. Jocknus Walina on the other hand stated that he had graduated with a Masters of Medicine in Obstetrics and Gynaecology in January 2024 and had enough experience though not yet registered with the Council as a specialist.

He further testified that the 1st complainant was well monitored during labour by a team of experienced doctors and all the parameters were lying in the normal range and there was no need to rush to do C- Section. He stated that the baby's pulse was 130 /140 bpm which was normal but wondered why it suddenly dropped to 80bpm and the baby got an Apgar score of 3/10 at birth.

He stated that he was part of the team that resuscitated the baby, the pediatrician was also called to join the team and they did what they could but unfortunately the baby did not make it.

Could the baby's life have been saved?

It is always advisable that Prior to induction of labour, proper assessment is done for the four P's (passenger, powers, passage and psyche). The Council observed that Ms. Nassali, a primigravida at term, remained in labour for a prolonged period from 15th to 17th February 2024. Despite multiple failed attempts at induction using uterotonics, there is no evidence on record that proper pre-induction assessment of the four Ps (Passenger, Powers, Passage, and Psyche) was adequately documented.

The use of multiple induction agents following failed induction should have alerted the attending doctor to labour dystocia. The failure to diagnose and manage dystocia, coupled with prolonged labour and delayed decision-making regarding caesarean section, exposed the fetus to intrauterine hypoxia and asphyxia.

Failure by the first respondent to detect dystocia depicted by signs of early rupture of membranes, Prolonged Latent Phase of labour and border line pelvis while mother was in active labour and allowing the progress of prolonged labour to asphyxia tantamount to medical negligence. If this baby had been delivered by a Caesarian-section, their life could have been saved.

The Council further noted that Ms. Nassali sought services of a specialist obstetrician/gynecologist but was directed to Dr. Walina Jocknus despite his lack of specialist registration and specialist practicing license at the time. Marie Stopes Hospital failed in its duty to verify and ensure that a duly registered specialist attended to the patient; which is un ethical.

Findings and conclusion

1. After carefully considering the evidence adduced, the patient file and applying principles of facts to the circumstances of this particular case, Council finds that Dr. Jocknus Walina failed to timely diagnose labour dystocia and did not perform a caesarean section when clinically indicated in order to save the life of the baby, thereby contributing to the death of the newborn.
2. The Council finds that Dr. Walina attended to the patient as a specialist obstetrician/gynecologist without holding a valid specialist registration and practicing license from the Council at the material time.
3. The Council finds that Marie Stopes Hospital, Lugogo, misrepresented a general practitioner as a specialist and failed to exercise due diligence in verifying the practitioner's credentials, rendering the hospital vicariously liable.

Resolution of Issue number 2

Recommendations by the Council

1. Dr. Jocknus Walina is found professionally negligent and is hereby suspended from medical practice for a period of six (6) months with effect from 1st January 2026. Upon expiry of the suspension, he may apply for reinstatement to the register in accordance with the law. Failure to comply with this sanction shall attract more severe penalties, including possible erasure from the register.

2. Marie Stopes Hospital, Lugogo, is directed to immediately cease the practice of presenting general practitioners as specialists and must ensure that only duly registered and licensed specialists provide specialist care. The hospital must strengthen internal credential verification mechanisms to safeguard patient safety.

Signed on this ....30th.....day of ....December...2025 by

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