THE REPUBLIC OF UGANDA

IN THE MATTER OF AN INQUIRY INTO ALLEGED PROFESSIONAL MISCONDUCT AND OR MEDICAL NEGLIGENCE BY MEDICAL PERSONNEL OF KALANGALA HEALTH CENTRE IV IN TREATING AND MANAGING MS. AYEBARE SANDRA LEADING TO THE DEATH OF HER NEWBORN BABY.

OCHWO MICHEAL JB LASTON :::::::::::::::::::::: COMPLAINANT.

VERSUS

1. DR. KYOMUHANGI RABECCA

2. DR. SSUNA MICHAEL

3.KALANGA HEALTH CENTRE IV :::::::::::::::::::: RESPONDENTS.

FINDINGS AND RESOLUTIONS OF THE COUNCIL

Complaint Summary

The complainant, Mr. Ochwo Micheal JB Laston, alleged that his newborn baby died and that his wife, Ms. Ayebare Sandra, suffered post-operative complications as a result of negligent treatment and improper management by medical personnel at Kalangala Health Centre IV.

The complaint alleged that Dr. Kyomuhangi Rebecca, who reviewed the patient and diagnosed her with pregnancy in latent labour, failed to timely recommend or perform an emergency Caesarean section despite the patient's prolonged labour. It was further alleged that Dr. Ssuna Micheal, who was then the Senior Medical Officer and In-Charge of the facility, failed to ensure adequate supervision and proper management of the patient.

Background

The complaint was formally lodged before the Medical Council on 7th June 2019 alleging professional misconduct and medical negligence by the Respondents, which allegedly resulted in the death of the complainant's newborn baby.

The Respondents denied the allegations and maintained that the patient received appropriate care within the available resources at the health facility. They contended that the baby suffered severe birth asphyxia and, despite resuscitation efforts by the attending midwives, the baby could not be saved.

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.

Pursuant to this mandate, the Council convened an inquiry on 24th March 2026 to determine whether the Respondents were guilty of professional misconduct and/or medical negligence in the management of Ms. Ayebare Sandra leading to the death of her baby.

Proceedings

The inquiry was conducted in the Council's Boardroom. The parties were duly served, filed their responses, appeared and testified before the Council.

The complainant was self-represented, while the 1st Respondent was represented by Counsel Muhwezi Ronald. The 2nd Respondent was self-represented and the 3rd Respondent was absent. The Council noted that the current In-Charge of the health facility and the nurses who attended to the patient had been duly summoned to testify but failed to appear before the inquiry without any sound reason thus no need for adjournment.

The following witnesses testified before the Council:

1. Mr. Ochwo Micheal JB Laston – Complainant
2. Dr. Kyomuhangi Rebecca – Respondent (R1)
3. Dr. Ssuna Micheal – Respondent (R2)

Complainant's Evidence

1. Mr. Ochwo Micheal JB Laston (Complainant)

Mr. Ochwo Micheal JB Laston, a resident of Lutoboka Landing Site in Kalangala District and father of the deceased newborn baby, testified that on 20th December 2018, his wife, Ms. Ayebare Sandra, developed labour pains and was rushed to Kalangala Health Centre IV for medical attention.

He stated that the medical personnel informed him that his wife was not yet due for delivery. However, according to him, she endured severe labour pains throughout the day and night without adequate medical intervention.

He further testified that on the following day at about 10:00 a.m., he inquired from Midwife Carolyn Nabwere about his wife's condition and was informed that the baby was oversized and that an operation was necessary. He was reportedly instructed to purchase medicine required for the operation and paid Uganda Shillings 100,000 for the same.

At about 4:15 p.m., his sister-in-law informed him that a doctor had recommended referral of his wife to Mulago Hospital in Masaka. Upon reaching the health facility, he found two other expectant mothers being prepared for referral, but his wife remained behind after he was informed that she would deliver normally.

He further testified that his wife was later placed on intravenous fluids and, upon making further inquiries, he was informed by Midwife Allen that the attending doctor had already left the facility and could not be reached despite efforts to call her back.

The complainant stated that he contacted the District Internal Security Officer (DISO) and the LCV Chairperson seeking assistance for referral of his wife but delayed to show up although they came at different intervals. Eventually, Midwife Allen and two off-duty midwives assisted the mother to deliver.

According to the complainant, the baby was born in a weak condition and was placed on oxygen. He further stated that the maternity ward had no electricity at the time and that the baby had to be transferred to the senior quarters of the health facility. Unfortunately, the baby later passed away.

He concluded by stating that his wife continued to suffer medical complications requiring further treatment and financial support.

Respondents' Evidence

1. Dr. Kyomuhangi Rebecca (Respondent – R1)

Dr. Kyomuhangi Rebecca testified that she is a Radiologist and previously served as a Medical Officer at Kalangala Health Centre IV from 2015 to 2020. She holds a Bachelor of Medicine and Bachelor of Surgery (MBChB) degree and an MMeD in Radiology.

She stated that, according to the medical records, the mother was admitted on 20th December 2018 by Midwife Carol and was documented to have been in false labour.

Dr. Kyomuhangi further testified that she reviewed the mother on 21st December 2018 at 10:00 a.m. and diagnosed her as a primigravida (PG) in the latent phase of labour. She counselled the mother to prepare for the progression of labour and advised her relatives to purchase essential delivery items, including gloves, cotton wool, and a catheter, which were unavailable at the health facility. She stated that, based on her assessment, she anticipated a normal vaginal delivery and therefore neither recommended nor performed an emergency operation at that time.

She further testified that the attending midwives, Carolyne Nabwere and Allen, reported that the mother had been taking unknown herbal medications. The mother was counselled against continuing their use because of the potential health risks to both herself and the unborn baby.

Approximately six hours later, the mother was reviewed by Midwife Nagingo Grace and was found to be in fair general condition, with a regular and strong fetal heart rate of 138 beats per minute.

Dr. Kyomuhangi stated that, as the mother was not experiencing labour pains at that time, she advised the attending midwife to encourage ambulation and ensure that the mother emptied her bladder. Later that

night, the mother developed mild contractions and, on 22nd December 2018 at about 2:00 a.m., she was reviewed by the midwife on duty, Allen. At that stage, she was found to be in the active phase of labour with a cervical dilatation of 4 cm, and labour monitoring was commenced using a partograph.

She testified that labour progressed to 6 cm, remaining to the right of the alert line. At approximately 6:00 a.m., the mother was commenced on one litre of Normal Saline intravenously. Dr. Kyomuhangi was notified of the progress of labour but informed the Council that she had travelled off the islands to attend to her sick child. She stated that she did not hand over the mother to a medical officer but left her with the midwives to manage her since she did not require caesarian section according to her examination findings.

She stated that she advised the midwife on duty to continue monitoring the progress of labour and to maintain the mother on intravenous fluids. Approximately three hours later, at 9:00 a.m., the cervix was fully dilated (10 cm), the membranes had ruptured, the liquor was meconium-stained, and the mother had commenced bearing down.

She testified that the second stage of labour lasted approximately one hour. An episiotomy was performed and, at about 10:00 a.m. on 22nd December 2018, the baby was delivered.

According to Dr. Kyomuhangi, the baby was delivered with a tightly wrapped umbilical cord around the neck and was suffering from severe birth asphyxia, evidenced by an APGAR score of 4/10 at one minute. Although resuscitation was immediately undertaken, the baby could not be revived and was pronounced dead. She further testified that she later received a telephone call from the District Internal Security Officer (DISO), who informed her that the baby had died.

In conclusion, Dr. Kyomuhangi denied any allegations of professional negligence describing the complaint as a false accusation. She maintained that the mother was appropriately managed and delivered by the attending midwife, that the baby was born with severe birth asphyxia associated with a tight nuchal cord and that all reasonable resuscitative measures were undertaken, albeit unsuccessfully. She expressed regret over the unfortunate loss of the baby but maintained that the patient received appropriate medical care throughout her management.

2. Dr. Ssuna Micheal (R2)

Dr. Suuna Michael testified that he is a Senior Medical Officer. He holds a Bachelor of Medicine and Bachelor of Surgery (MBChB) degree and a qualification in Emergency Medicine from the University of Cape Town, obtained in 2016. He worked at Kalangala Health Centre IV for approximately 15 years and served as the In-Charge of the facility from 2015 to 2020. His responsibilities included overseeing the provision of clinical services, supervising staff, ensuring accountability, financial management, and managing the facility's resources. He is currently working at Bukalasa Health Centre 1V.

He testified that the allegations against the health workers, including himself, were that they neglected a mother in labour for three days, resulting in the death of her baby and subsequent post-operative complications.

Dr. Suuna stated that he was not on duty during the month of December 2018 as he was on annual leave. Consequently, he could not be held personally liable for events that occurred during his absence. He returned from leave on 1st January 2019 and was then informed of what had transpired during the period he was away.

He stated that, upon receiving a copy of a letter written by Mr. Michael Laston Ochwo addressed to him in his capacity as the Health Facility In-Charge, he conducted a retrospective review of the patient's medical records and interviewed the team involved in the mother's care in order to establish the circumstances surrounding the incident. He also convened a meeting with Mr. Michael Laston Ochwo and his wife, Ms. Ayebale Sandra.

According to the medical records, the mother was admitted on 20th December 2018 by Midwife Carol, who documented that she was experiencing false labour. She was subsequently reviewed by the doctor on duty, Dr. Rebecca Kyomuhangi, on 21st December 2018 at 10:00 a.m., with a diagnosis of primigravida in latent labour. The mother was counselled to prepare for the progression of labour, and her relatives were advised to purchase items such as gloves, cotton wool, and a urinary catheter, which were out of stock but required during delivery.

Dr. Rebecca Kyomuhangi assessed that the mother was suitable for a normal vaginal delivery and did not indicate or perform an emergency Caesarean section at that time. The attending midwives, Carol and Allen, reported that the mother had been taking unknown herbal medications. She was counselled against continuing their use because of the potential health risks they posed to both the mother and the unborn child.

Approximately six hours later, the mother was reviewed by Midwife Grace and was found to be in fair general condition with a regular and strong foetal heart rate of 138 beats per minute. She had not yet developed labour pains and was advised to ambulate and empty her bladder. Later that night, she developed mild uterine contractions, and on 22nd December 2018 at 2:00 a.m., she was reviewed by the midwife on duty, Allen.

At that time, she was found to be in the active phase of labour with cervical dilatation of 4cm, and labour monitoring using a partograph was commenced. Labour progressed to 6cm, remaining to the right of the alert line. At approximately 6:00 a.m. she was commenced on one litre of intravenous Normal Saline, and Dr. Rebecca Kyomuhangi was informed of the progress of labour.

Dr. Suuna testified that although the mother's relatives became anxious, they were counselled that the labour was progressing normally. Three hours later, at about 9:00 a.m., the cervix was fully dilated to 10 cm. The membranes had ruptured, revealing meconium-stained liquor, and the mother had begun bearing down and pushing.He stated that the second stage of labour lasted approximately one hour. An episiotomy was performed, and at about 10:00 a.m. on 22nd December 2018, the baby was delivered. The baby was found to have a tightly wrapped umbilical cord around the neck and suffered severe birth asphyxia, with an APGAR score of 4/10 at one minute. The attending medical team immediately initiated resuscitation measures, but despite their efforts, the baby could not be revived. He stated that Dr. Kyomuhangi Rebecca did not inform him that she had got an emergency and was leaving the facility.

Dr. Suuna expressed that it was unfortunate that the midwives were unable to save the baby's life despite making every effort within the limits of the available resources and their professional skills. It was his opinion that, considering the level of care available at Kalangala Health Centre IV, the mother received appropriate medical attention and was attended to continuously throughout the labour process.

He further testified that the absence of critical resources such as an Intensive Care Unit (ICU), essential drugs, medical equipment, adequate personnel, and reliable electricity may have adversely affected the outcome. He stated that, had such resources been available, the outcome might have been different. However, given the limitations at the facility, he considered it unfair to attribute blame to either the health workers or the health facility for the baby's death.

In response to the allegations, Dr. Suuna stated that he wrote a letter dated 18th January 2019 to the Chief Administrative Officer through the District Health Officer, copying Mr. Michael Laston Ochwo. In that letter, he explained the circumstances surrounding the baby's death and, on behalf of the health workers, extended condolences to the family.He further testified that, by a letter dated 24th January 2019, Mr. Michael Laston Ochwo responded to his communication and acknowledged that Midwives Carol and Allen had attended to his wife and had successfully saved her life.

It was Dr. Suuna's understanding that the mother delivered at the health facility under the care of qualified health workers. However, owing to a combination of maternal and foetal factors, the baby suffered severe birth asphyxia. Appropriate resuscitation measures, commensurate with the level of care available at the facility, were undertaken but were unsuccessful. He reiterated that it was unfortunate that the baby's life could not be saved and stated that he personally conveyed his condolences to the bereaved family.

Dr. Suuna further emphasized the unique challenges faced by Kalangala Health Centre IV due to its location on an island. He explained that access to healthcare services was difficult, funding was limited, electricity supply was unreliable, and the facility frequently depended on a generator to conduct medical procedures. In addition, essential medical equipment and supplies were often inadequate. He stated that these systemic constraints significantly affected the facility's ability to provide higher levels of care and may have contributed to the unfortunate outcome. He therefore requested the Council to appreciate the difficult working environment under which the health workers operated and to consider these limitations when assessing their conduct.

Analysis by the Council

Upon reviewing the complaint, witness testimonies, medical records, and applicable standards of medical care, the Council identified the following issues for determination:

1. Whether the actions of the Respondents amounted to professional misconduct and/or medical negligence.
2. What appropriate sanctions or recommendations should issue.

Resolution of Issue No. 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.***

Professional misconduct includes failure to exercise the standard of care expected of a reasonably competent medical practitioner in similar circumstances.

The case of **Donoghue V Stevenson 1932 AC 562** laid the foundation for three essential elements of negligence as follows

1) The defendant owed the claimant a duty of care
2) The defendant breached that duty
3) The breach caused the claimant's injury or loss

The Council carefully considered the evidence on record and observed that the patient was continuously attended to by midwives from the time of admission until delivery. The medical records indicated progressive monitoring of labour and regular reviews by the attending staff.

It was also noted that there were two versions of events documented. One where the baby was recorded to have looked big compared to the pelvis, and subsequently the doctor was consulted, and another where the pelvis was adequate and there was no need to consult to the doctor.

The evidence demonstrates that Dr. Kyomuhangi Rebecca was the Medical Officer responsible for reviewing and managing the patient after she had been admitted to Kalangala Health Centre IV. She reviewed the mother on 21st December 2018 at about 10:00 a.m. and diagnosed her as a primigravida in latent labour. She further assessed the fetal heart rate, which was documented as normal, and ordered that the patient continue to be monitored for labour progress.

Although Dr. Kyomuhangi explained that she was compelled to leave the health facility because her child had become ill and required urgent medical attention, the Inquiry finds that the existence of a personal emergency did not extinguish her professional duty towards a patient who was in labour.

The duty of care owed by a medical practitioner extends beyond diagnosis and treatment. It includes ensuring continuity of medical care whenever the practitioner becomes unavailable. A reasonably competent medical officer faced with an emergency requiring departure from duty is expected to make reasonable arrangements to ensure that patients under his or her care continue receiving appropriate medical attention.

The evidence does not demonstrate that Dr. Kyomuhangi formally handed over the patient to another medical officer before leaving the health facility. There is also no evidence that she informed the Officer In-Charge, hospital administration, or any senior authority that she was leaving duty while a labouring mother remained under medical management. Although the Officer In-Charge was reportedly on leave, nothing prevented Dr. Kyomuhangi from notifying him by telephone or informing another senior member of staff so that alternative arrangements could be made.

Her failure to communicate her departure resulted in the patient remaining under the supervision of midwives without a designated medical officer available to review her should complications arise. Labour is inherently unpredictable, and a patient who initially presents in latent labour may deteriorate rapidly into obstructed labour or the fetus suffers distress requiring immediate medical intervention.

The Inquiry considers that a reasonably competent practitioner exercising ordinary skill and care would have appreciated the foreseeable risk associated with leaving a labouring mother on the Island without ensuring appropriate medical cover. The failure to hand over the patient or communicate her absence created a foreseeable risk of delayed medical intervention should complications develop.

The professional obligation to ensure continuity of patient care is recognized in medical ethics and professional practice. A practitioner who withdraws from a patient's care must ensure that another competent practitioner assumes responsibility. Failure to do so amounts to patient abandonment and may constitute professional misconduct or professional negligence.

Although Dr. Kyomuhangi's child's illness may explain why she left the facility, it does not justify abandoning her professional responsibility without taking reasonable steps to safeguard the patient. Personal emergencies mitigate the circumstances but do not excuse failure to ensure continuity of care.

The Inquiry therefore finds that Dr. Kyomuhangi breached the expected standard of care by:

i. Leaving the health facility while the patient remained in labour without formally handing over her management to another medical officer;
ii. Failing to notify the Officer In-Charge or another responsible authority that she was leaving because of a family emergency;
iii. Failing to ensure that adequate medical arrangements had been made to provide continuous clinical oversight of the patient;
iv. Exposing the patient to the foreseeable risk of delayed medical review in the event labour complications developed.

The above omissions constituted a breach of her professional duty of care and materially contributed to the breakdown in continuity of obstetric management.

The Council finds that Dr. Ssuna Micheal was on officially approved leave during the material time and therefore could not be held personally liable for the treatment decisions made during his absence.

The Council expressed concern regarding the apparent lack of adequate emergency preparedness at the facility, including shortages of essential supplies, unreliable electricity in the maternity ward, and limited emergency obstetric capacity. These systemic challenges may have contributed to the unfortunate outcome.

Resolution of Issue No. 2

In light of the findings above, the Council finds that Dr. Kyomuhangi Rebecca breached the expected standard of care by abandoning her professional responsibility without taking reasonable steps to safeguard the patient.

The Council further notes the operational challenges affecting service delivery at Kalangala Health Centre IV and emphasizes the need for the Government to improve emergency comprehensive obstetric care services.

Recommendations by the Council

1. Dr. Kyomuhangi Rebecca is hereby suspended for six (6) months with effect from 1st December 2026 to 31st May 2027.

2. The Council recommends that the Ministry of Health and the District Health Authorities strengthen emergency obstetric and neonatal care services at Kalangala Health Centre IV, including:

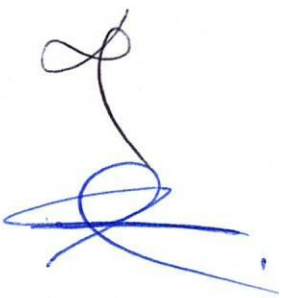
a) Ensuring constant electricity supply in maternity and theatre units;
b) Adequate stocking of emergency medical supplies and equipment;
c) Improving staffing levels;
d) Strengthening referral and emergency response systems for island communities.

Signed this 12th day of November 2026.

1. Assoc. Prof. Joel Okullo Odom – Chairperson 

2. Dr. Ayub Twaha – Vice Chairperson 

3. Dr. Okello Maxwell – Member 

4. Dr. Owaraganise Asiphas – Member 

5. Dr. Tumwine Daniel – Member

6. Dr. Muyanga Mark – Member 