THE REPUBLIC OF UGANDA

IN THE MATTER OF AN INQUIRY INTO ALLEGED PROFESSIONAL MISCONDUCT AND OR MEDICAL NEGLIGENCE BY THE MEDICAL PERSONNEL OF LIRA UNIVERSITY TEACHING HOSPITAL IN TREATING AND MANAGING MS. APIO RABECCA AGETTA LEADING TO THE DEATH OF HER NEWBORN BABY.

1. OOLA SAMUEL
2. APIO RABECCA AGETTA ::::::::::::::::::::::::::::COMPLAINANTS.

VERSUS

1. LIRA UNIVERSITY TEACHING HOSPITAL
2. DR. MARK NAKABAALE
3. ASSOC. PROF TOM RICHARD OKELLO
4. DR. KASULE MUSA.::::::::::::::::::::::::::::::::::::RESPONDENTS.

FINDINGS AND RESOLUTIONS OF THE COUNCIL

Complaint Summary

The complainants, Mr. Oola Samuel and Ms. Apio Rabecca Agetta, allege that their newborn baby died as a result of improper treatment and negligence by the respondents, at Lira University Teaching Hospital.

The complainant alleged that on 16th January 2026, she was admitted for child delivery after having attended all the antenatal services at Lira University Teaching Hospital. The doctor induced labour which led the baby to get distressed, exhausted and developed breathing problems resulting into death.

Background

The complaint giving rise to these proceedings was lodged before the Council by the Complainants through M/s F. Aogon & Co. Advocates, alleging professional misconduct and medical negligence in the management of the second complainant during labour and delivery at Lira University Teaching Hospital on 16 January 2025, resulting in the death of her newborn baby.

The Respondents denied the allegations of professional misconduct and medical negligence, maintaining that the second complainant received treatment consistent with accepted professional standards and that the adverse outcome occurred despite appropriate clinical management.

The matter proceeded to a full disciplinary inquiry before the Council on 26 March 2026 and 28 May 2026. The Complainants appeared in person, while the 1st Respondent was represented by Counsel Daniel Evans Olwoch. The remaining Respondents appeared in person.

During the inquiry, the Council received oral testimony from the parties and their respective witnesses, admitted documentary evidence and afforded each party the opportunity to examine and cross-examine witnesses in accordance with the rules of natural justice and procedural fairness.

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.

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; the 1st Respondent was represented by Counsel Olwoch Daniel Evans; the 2nd 3rd and 4th Respondents were self-represented. The individuals that testified were:

1. Mr. Oola Samuel – 1st Complainant
2. Ms. Apio Rabecca – 2nd Complainant
3. Ms. Stella Agetta – Complainants' Witness
4. Dr. Mark Nakabaale – Respondent.
5. Assoc. Prof. Tom Richard Okello- Respondent.
6. Dr. Kaule Musa- Respondent.
7. Acuma Tonny- 1st Respondent's Witness
8. Didan Jacon – 1st Respondent's Witness.
9. Dr. Gasthony Alobo. – Respondent.

Complainants' Evidence

1. Mr. Oola Samuel (1st Complainant).

Mr. Oola Samuel testified that he is, a lawyer by profession, and a resident of Ayere Village, Barapwo, Lira City West Division, Lira District. He is the father of the deceased baby and the husband of the 2nd complainant, to whom he is legally married under the Customary Laws of Uganda.

He testified that on 15th January 2025, he was informed by his wife that she had been admitted to Lira University Teaching Hospital in labour. She further informed him that the attending doctor had advised that labour induction would be the most appropriate management for her condition.

He stated that at about 11:00 p.m. on 16th January 2025, he received a telephone call from his mother-in-law informing him that the baby had been delivered but appeared feeble, weak, and exhausted and that several attempts were being made by the nurses to resuscitate the child.

Upon receiving this information, he formed the impression that something had gone wrong during the labour induction process because, in his view, the induction had taken an unusually long time. He stated that the procedure had commenced at about 7:00 a.m. and the baby was not delivered until approximately 11:15 p.m., a period of about 16 hours,

which he believed exceeded the expected duration of between 8 and 12 hours.

He further testified that on 17th January 2025, he travelled from Gulu to Lira University Teaching Hospital to check on his wife and his mother-in-law and to establish exactly what had transpired during the labour process. Upon his arrival at the hospital, his wife informed him that their baby had died shortly after delivery. He stated that he was devastated by the news and waited for the doctor, nurse and midwife who had managed the labour induction to explain the circumstances and the cause of his child's death.

He testified that the medical personnel informed him that the cause of death would only be communicated after a death review audit or meeting, which they indicated would be conducted within one week. He further stated that when he insisted on receiving an explanation immediately, he was referred to the mortuary attendant, who also declined to provide him with any information regarding the cause of death.

He further testified that he instructed his advocates, M/s F. Aogon & Co. Advocates, to issue a demand notice requiring the hospital to release the body of the deceased child and provide an explanation regarding the cause of death. However, he stated that the Hospital Director declined to receive the demand notice and continued to withhold the body.

He stated that after approximately one week, the hospital released both the body and the medical report to his father-in-law upon payment of mortuary fees. Upon reviewing the medical report, he observed what he believed to be several inconsistencies. In particular, he contended that the pregnancy was at term rather than post-term, that labour induction was not medically justified based on the available medical records and that there were discrepancies and inaccuracies in the clinical documentation which, in his view, affected the reliability of the records.

He further testified that there were reasonable concerns regarding inadequate monitoring during labour. He noted that the medical records referred to a borderline pelvis and a suspected large fetus on ultrasound examination, factors which, in his opinion, presented foreseeable obstetric risks requiring closer monitoring and more vigilant clinical management.

The Complainant therefore pray that the Council finds the Respondents professionally liable and imposes the appropriate disciplinary sanctions under the Act.

2. Ms. Apio Rabecca – (2nd Complainant).

Ms. Apio Rebecca Agetta is an adult Ugandan female, a businesswoman by profession and a resident of Ayere Village, Barapwo, Lira City West Division, Lira District. She testified that she is the 2nd complainant and the mother of the deceased baby.

She testified that she attended antenatal care at Lira University Teaching Hospital from 5th April 2024 until 12th January 2025. According to her antenatal records, both she and her unborn baby remained in good health throughout the pregnancy. During her final antenatal visit on 12th January 2025, the midwife on duty advised her to undergo an ultrasound scan. Following the scan, Dr. Musa informed her that the umbilical cord was wrapped around the baby's neck, which he described as "bad news," although he reassured her that the baby was otherwise healthy.

She stated that after reviewing the scan results, Dr. Musa discussed two options for delivery with her, namely induction of labour or delivery by Caesarean section. According to her testimony, the doctor advised against a Caesarean section on the ground that she was a first-time mother and recommended labour induction instead. Dr. Musa informed her that he would first perform membrane sweeping because her cervix was still closed. He then advised her to return home and await the onset of spontaneous labour. He instructed her to report back to the hospital within two days if labour did not commence naturally and to return with her personal belongings and a caretaker.

She testified that labour did not commence within the prescribed period and she subsequently returned to the hospital as instructed. Upon her return, the doctor explained the two available methods of labour induction, namely oral medication and vaginal insertion and requested her to choose one of the methods. She opted for the oral method.

She stated that at approximately 7:00 a.m., the doctor instructed the nurse to commence the induction process and she was given medication to take orally. However, she vomited shortly after taking the medicine. The nurse consequently informed her that the oral method had failed and proceeded with the second method by administering medication through

vaginal insertion. The labour pains gradually intensified and that additional vaginal insertions were administered during the course of the induction. She was later informed by the nurse that her cervix had started dilating.

According to her testimony, at about 5:00 p.m., Dr. Musa visited her before leaving the hospital for the day. He examined her, checked the baby's heartbeat, and informed her that the fetal heartbeat was normal. She further testified that while she remained in the labour ward, she overheard a member of the medical staff urging the attending nurse to hasten the delivery process so that they could finish their work and take some rest.

She stated that at about 8:00 p.m., another midwife assumed responsibility for her care following a shift change. The new midwife informed her that labour was progressing well and that the baby's heartbeat remained normal. At approximately 9:00 p.m., she started bleeding from her birth canal. Shortly thereafter, she heard the attending medical staff calling another colleague for assistance. At the same time, the nurse instructed her mother to bring her a bucket to enable her to relieve herself.

She further testified that at about 10:00 p.m., she was placed on an intravenous drip. While in labour, she heard the attending nurse urgently telephone the doctor and request him to return immediately because the baby's heartbeat had dropped. According to her testimony, the doctor arrived approximately thirty minutes later and, while he was putting on his protective medical attire, the baby was delivered.

That immediately after delivery, the baby was placed on her chest. She observed that the baby briefly opened its eyes before closing them again. From her observation, the baby was born alive but appeared weak, exhausted and distressed. The medical team immediately attempted to resuscitate the baby, but the efforts were unsuccessful.

At about midnight, the medical team began repairing the deep perineal tear she had sustained during the vaginal delivery. She stated that the nurses expressed concern that the severe tear might have caused injury to her internal organs due to its extent. She recalled that the attending doctor counselled her to remain calm and reassured her that she was still young and would have the opportunity to have more children in future.

3. Ms. Stella Agetta – Complainants' Witness

Ms. Stella Ageta Bua is an adult Ugandan female and a resident of Ober Village, Lira City West Division, Lira District. She testified that she is the mother of the 2nd complainant and was her designated caretaker during the material time.

She testified that the 2nd complainant called and requested her to come to Lira University Teaching Hospital, where she had been admitted to the maternity ward. The 2nd complainant informed her that she was expected to deliver vaginally through a special procedure known as labour induction, which was scheduled to commence the following day at about 6:00 a.m.

That the labour induction process commenced at approximately 7:00 a.m. The 2nd complainant was initially administered medication orally, but she vomited shortly thereafter. Consequently, the attending medical personnel advised that the oral method would not be effective and changed the mode of administration to vaginal insertion. She stated that additional medication was subsequently administered through vaginal insertion.

She further testified that at about 3:00 p.m., a midwife reviewed the 2nd complainant and informed them that both the mother and the baby were progressing well. The midwife also instructed her to provide the 2nd complainant with hot tea to help restore her strength. At approximately 5:00 p.m., the attending doctor examined the 2nd complainant and likewise informed them that labour was progressing normally.

She testified that at about 10:00 p.m., she was instructed to prepare the baby's clothes and other necessities in anticipation of the delivery. However, to her surprise, one of the nurses informed her that the baby's breathing or heartbeat was not satisfactory. She observed the nurse placing the 2nd complainant on an intravenous drip and asked why the medical team could not instead perform a Caesarean section. According to her testimony, she was informed that the medical team was monitoring the situation closely and that everything would be fine.

She further testified that shortly thereafter, the baby was delivered and briefly placed on the mother's chest. She was then requested by the

attending nurse to provide clothes for the baby while the medical team attempted to resuscitate the newborn. She stated that the resuscitation efforts lasted for approximately twenty minutes, after which the nurse covered the baby with a cloth and began making entries in the medical records. She testified that when she asked the nurse whether the baby was alive and healthy, the nurse did not respond to her inquiry. It was at that moment, she stated, that she realized something had gone wrong.

Respondents' evidence.

1.Dr. Mark Nakabaale – (Respondent).

Dr. Mark Nakabaale testified that he is a Medical Officer currently working at Ntinda Hospital. He holds a Bachelor of Medicine and Bachelor of Surgery (MBChB).

He testified that the 2nd complainant, Ms. Apio Rebecca Agetta, attended antenatal care at Lira University Teaching Hospital and was admitted on 15th January 2025 at 40 weeks and 5 days of amenorrhea. According to the medical records, following clinical evaluation by the attending Medical Officer, a decision was made to induce labour based on the obstetric assessment and the prevailing clinical indications at the time.

He stated that he was not the attending doctor when the decision to induce labour was made and, therefore, did not participate in the induction process. He further testified that he did not participate in the initial assessment of the mother, did not make any clinical opinion regarding the appropriate mode of delivery and was not involved in monitoring the progress of labour.

He testified that during the material time he was assigned to the Paediatric Ward on day duty and was not involved in the management of the labour until he was called during the night. He stated that at about 10:48 p.m., a nurse requested him to review the patient. Upon arrival, he found the mother in the second stage of labour and she delivered almost immediately after his review.

He further testified that he did not participate in recording the baby's birth weight. According to him, the baby's weight was recorded by the radiographer and the attending midwife in the medical records.

Dr. Nakabaale strongly denied the allegation that Lira University Teaching Hospital lacked oxygen or failed to attempt resuscitation of the baby. He testified that at approximately 10:50 p.m., during his review of the patient, the medical team anticipated that neonatal resuscitation might be required and accordingly prepared the necessary neonatal resuscitation equipment before delivery.

He testified that although the baby did not cry immediately after birth and no heartbeat was detected on the initial assessment, resuscitation was commenced without delay by the attending midwife, who was assisted by another midwife from the postnatal ward and the Night Superintendent. He stated that despite the resuscitation efforts, no heartbeat was detected throughout the process. He explained that, in his opinion, oxygen administration was not indicated because no heartbeat was ever established, although all the necessary resuscitation equipment, including oxygen, was readily available.

He further denied the allegation that he refused to release the patient's medical records. He testified that the release of medical records is governed by institutional procedures and patient confidentiality requirements and that such records can only be released upon compliance with the appropriate administrative and legal procedures.

He also denied the allegation that the duration for which the baby's body remained in the mortuary was attributable to him or was influenced by any improper administrative action on his part. He stated that the management of bodies in the mortuary is subject to established institutional administrative procedures.

He therefore prayed that the Uganda Medical and Dental Practitioners Council finds that there is no evidence of professional negligence against him, dismisses the complaint against him with no disciplinary action and grants any other orders that the Council may deem just and appropriate.

2.Assoc. Prof. Tom Richard Okello- (Respondent)

Associate Professor Tom Richard Okello testified that he is an Associate Professor of Surgery with twenty-nine (29) years of clinical experience. He is a Consultant Surgeon and the Director of Clinical Services at Lira University Teaching Hospital. He holds a Bachelor of Medicine and

Bachelor of Surgery (MBChB), a Master of Medicine (Surgery) from Makerere University and a Postgraduate Diploma in Project Planning and Management from the Uganda Management Institute (2008).

He testified that, as the Director of Clinical Services, his responsibilities include providing technical leadership and guidance to all health professionals, initiating and formulating policies aimed at promoting effective healthcare service delivery, directing and maintaining high standards of professional practice, ensuring observance of professional ethics, overseeing the provision of quality healthcare services, participating in the treatment and management of patients and teaching undergraduate and postgraduate medical students.

He testified that Lira University Teaching Hospital is a public teaching hospital owned by Lira University, a public university established by law. The hospital is licensed as a general hospital and provides a wide range of specialised services, including Urology, Paediatric Surgery, Ophthalmology, Ear, Nose and Throat (ENT) services, Internal Medicine, Chronic Disease Care, General Surgery, Paediatrics, and Obstetrics and Gynaecology, among others. He stated that all clinical departments are staffed by qualified and licensed healthcare professionals.

He further testified that the Department of Obstetrics and Gynaecology is headed by Associate Professor Otim Tom Charles and is staffed by a Senior Lecturer, Dr. Gasthony Alobo, Medical Officers including Dr. Musa Kasule, nurses with Master's degrees in Midwifery Sciences, Bachelor's degree holders and Diploma Midwives. He stated that the hospital maintains duty rosters to ensure that all clinical areas are adequately covered at all times.

He testified that the complaint before the Council arose from the Obstetrics and Gynaecology Department, specifically the maternity ward. He stated that the department comprises antenatal, labour, postnatal, gynecology, immunization and family planning units, with labour suites appropriately equipped and integrated into the maternity services. He further stated that ward protocols, including neonatal resuscitation guidelines, are prominently displayed within the department.

He testified that he first became aware of the fresh stillbirth that occurred on 16th January 2025 through the Night Superintendent's report and an email from the Head of the Department, Dr. Gasthony Alobo. He further

testified that Lira University Teaching Hospital holds a valid operational license, Certificate No. 2108.

He testified that on 15th January 2025, Ms. Apio Rebecca Agetta presented herself at Lira University Teaching Hospital seeking delivery services after her pregnancy had exceeded forty weeks without spontaneous onset of labour. He stated that, on that day, the maternity ward was fully staffed by qualified and licensed healthcare professionals.

He testified that upon admission, Ms. Apio Rebecca Agetta was initially assessed by Mr. Didan Jacob Opii, a qualified and licensed Bachelor of Midwifery holder. Following the assessment, Mr. Opii consulted with Dr. Musa Kasule, the ward Medical Officer and Ms. Acayo Caroline, a holder of a Master's Degree in Midwifery Sciences. According to the witness, the team assessed the patient and confirmed that she was at 40 weeks and 5 days' gestation. He testified that the patient was counselled on the available options for delivery, including awaiting spontaneous labour, labour induction and Caesarean section, after which she elected to undergo labour induction.

He further testified that, having found no contraindications to labour induction, the medical team admitted the patient and commenced the induction process on the morning of 16th January 2025 using standard clinical protocols. He stated that the progress of labour was monitored in accordance with approved obstetric guidelines and that appropriate interventions were undertaken as labour progressed.

He testified that throughout the labour process, the patient was attended to by skilled and competent midwives. He further stated that when the attending midwife, Mr. Didan Jacob Opii, detected signs of concern during labour, he immediately intervened and summoned the first on-call doctor, Dr. Mark Nakabaale, who responded within approximately ten minutes. He also testified that the attending midwife requested assistance from Ms. Vicky Akello, a qualified midwife holding both Diploma and Bachelor's qualifications in Midwifery.

He testified that the attending team opted to proceed with vaginal delivery despite the non-reassuring fetal heart rate. According to him, a female baby weighing 2.3 kilograms was delivered at 11:15 p.m. on 16th January 2025 with an APGAR score of zero. He stated that despite resuscitation efforts lasting approximately ten minutes, the APGAR score remained zero.

He further testified that the labour suite is permanently equipped for neonatal resuscitation and contains an emergency trolley, resuscitation protocols and all the necessary neonatal resuscitation equipment. He stated that the hospital had more than ninety large oxygen cylinders, two portable oxygen cylinders, oxygen concentrators and had never experienced a shortage of oxygen.

That following the baby's death, it was immediately documented and the body transferred to the hospital mortuary in the presence of Ms. Stella Agetta as the next of kin. He further stated that Mr. Samuel Oola reportedly instructed the mortuary staff to immediately embalm and preserve the body, which, according to him, eliminated the possibility of conducting a post-mortem examination.

He testified that the incident was discussed during the hospital's Monday morning clinical meeting held on 20th January 2025, where it was noted that the family wished to receive the medical report before collecting the body. The family eventually collected the baby's body from the hospital mortuary on 28th January 2025.

That in his opinion, the hospital managed the patient professionally and that the delay in collecting the body was solely attributable to the deceased's relatives. He stated that Mr. Samuel Oola initially declined to collect the body and reportedly informed the hospital that he was experiencing financial difficulties and lacked a stable source of income to facilitate burial arrangements.

That following the baby's death, both the hospital and its staff were subjected to considerable pressure and emotional distress arising from repeated allegations and legal demands made by Mr. Samuel Oola. These included verbal accusations that the hospital had caused the death of his child, requests for the medical report made on 20th January 2025, a demand notice and notice of intention to sue dated 24thJanuary 2025 and several police investigations into allegations of criminal negligence under SD Reference No. 31/17/01/2025 at Lira West Central Police Station.

He concluded by testifying that the hospital provided professional and appropriate care throughout Ms. Rebecca Apio's antenatal care, labour induction, labour management, delivery and post-delivery care. The hospital cooperated fully with the deceased's relatives and the relevant authorities. In his opinion, the birth asphyxia that resulted in the fresh stillbirth occurred despite the professional care rendered and was beyond

what an ordinarily competent healthcare professional could reasonably have prevented under the circumstances.

3.Dr. Kasule Musa- (Respondent).

Dr. Kasule Musa testified that he is a Teaching Assistant in the Department of Obstetrics and Gynaecology at Lira University Teaching Hospital. He holds a Bachelor of Medicine and Bachelor of Surgery (MBChB), registered and Licensed by UMDPC.

He testified that on 15th January 2025, Ms. Apio Rebecca Agetta presented to Lira University Teaching Hospital for delivery. She was initially received and assessed by Mr. Didan Jacob Opii, a Bachelor of Midwifery holder, who thereafter informed the obstetric team. Ms. Acayo Caroline, a holder of a Master's Degree in Midwifery Sciences, together with the clinical team, assessed the patient and established that she was at 40 weeks and 5 days' gestation.

He testified that the patient was counselled on the available options for delivery, including awaiting the spontaneous onset of labour, labour induction and Caesarean section. According to him, the risks and benefits of the available options were explained to the patient, who elected to undergo labour induction.

He further testified that the patient was admitted and the induction of labour commenced on the morning of 16th January 2025. He stated that the progress of labour was monitored in accordance with the approved standard obstetric protocols and that appropriate treatment and clinical interventions were provided as labour progressed, the patient was attended to by a team of skilled and competent midwives.

That when the attending midwife, Mr. Didan Jacob Opii, detected signs of concern during labour, he immediately intervened and called Dr. Mark Nakabaale, who was the first doctor on call. According to the witness, after reviewing the patient's condition, the attending team decided to proceed with vaginal delivery despite the presence of a non-reassuring fetal heart rate.

He testified that on 16th January 2025, a female baby was delivered. Immediately neonatal resuscitation was undertaken by the attending medical team but was unsuccessful. He stated that the death was

promptly documented and communicated, after which the baby's body was transferred to the hospital mortuary in the presence of Ms. Stella Agetta, who was recorded as the next of kin.

4. Acuma Tonny- 1st Respondent's Witness

Mr. Acuma Tonny is an adult Ugandan male and a resident of Amacor, Lira City West Division, Lira District. He testified that he is employed as a Mortuary Attendant at Lira University Teaching Hospital.

He further testified that following the death of the baby of Ms. Apio Rebecca Agetta, he was notified and the baby's body was transferred to the hospital mortuary. He stated that the body was not weighed because the mortuary did not have a weighing scale. He testified that the complainant paid Uganda Shillings One Hundred and Seventy Thousand (UGX 170,000) as mortuary charges through the hospital cashier's office, and an official receipt was duly issued.

5. Didan Jacob – 1st Respondent's Witness.

Mr. Didan Jacob Opii testified that he is a Midwife at Lira University Teaching Hospital. He holds a Bachelor of Science in Midwifery.

He testified that on 16th January 2025, he reported for night duty and found Ms. Apio Rebecca Agetta already admitted for induction of labour. By the time he assumed duty, the patient was already in active labour. He stated that he monitored the progress of labour in accordance with standard obstetric practice.

That the patient presented with bulging membranes, which he artificially ruptured. He observed that the liquor was clear and that the fetal heart rate was normal. At that time, the cervix was approximately 9 centimeters dilated, and the fetal head was at the level of the ischial spines. At about 9:40 p.m., the cervix had become fully dilated. He further stated that the patient complained of difficulty in walking and he observed that the baby's head was crowning. At approximately 10:00 p.m., uterine contractions were present but weak, lasting between 30 and 40 seconds. He noted that the fetal heart rate was 110 beats per minute and that the contractions were ineffective. He therefore decided to augment labour by administering oxytocin in 500 milliliters of normal saline.

He testified that despite the administration of oxytocin, the strength of the uterine contractions did not improve. A further dose of 10 units of oxytocin was subsequently administered after the first infusion had been completed, but there was still no significant improvement in the contractions. At about 10:30 p.m., the fetal heart rate had reduced to 100 beats per minute. In response, he discontinued the oxytocin infusion and immediately called the intern doctor on duty, Dr. Mark Nakabaale, to review the patient.

According to his testimony, Dr. Nakabaale arrived shortly thereafter and reviewed the patient at about 10:50 p.m, reviewed the clinical notes, noted that oxytocin had been administered without the desired effect, and observed that the baby was about to be delivered.

He testified that he asked Dr. Nakabaale whether a Caesarean section should be performed. According to him, Dr. Nakabaale advised that a Caesarean section was not appropriate because the baby was already crowning and vaginal delivery was imminent. Dr. Nakabaale instructed him to continue administering intravenous fluids after the oxytocin infusion had been discontinued.

He testified that he remained within the labour suite to continue managing the patient. He subsequently returned briefly to the duty room while continuing to monitor the fetal heart rate, which remained at approximately 100 beats per minute. The uterine contractions remained weak and ineffective.

He further testified that at about 11:15 p.m., he reassessed the patient to determine whether there was any obstruction to delivery since the baby's head remained crowning. Finding no significant progress, he informed Dr. Nakabaale, who indicated that he would return to review the patient.

He testified that at about 11:30 p.m., the fetal heart rate remained at approximately 100 beats per minute and the uterine contractions continued to be extremely weak and ineffective. He stated that he had earlier called Ms. Vicky Akello, a midwife who was working in the postnatal ward, to assist in managing the delivery. After 11:30 p.m., he did not reassess the fetal heart rate but instead concentrated on encouraging the mother to push because the uterine contractions remained inadequate.

He testified that he continued supporting and encouraging the mother throughout the second stage of labour. At approximately 11:45 p.m., he assisted her into a sitting position at an angle of about 45 degrees and encouraged her to push. The baby was then delivered and initially placed on the mother's abdomen. The umbilical cord was clamped and cut.

He testified that the baby was immediately stimulated, the airway was suctioned and the baby was observed to be floppy and unresponsive. The newborn was promptly transferred to the neonatal resuscitation table. Dr. Mark Nakabaale, another intern doctor and Ms. Vicky Akello attended to the newborn at the resuscitation table. According to him, the neonatal resuscitation team comprised Dr. Nakabaale, Ms. Vicky Akello and the other intern doctor.

While the neonatal resuscitation was ongoing, he proceeded to manage the third stage of labour. He examined the mother and found that she had sustained a first-degree perineal tear, which he repaired under local anaesthesia using 1% lignocaine and Vicryl Rapide 2-0 suture material. He did not receive any communication from the team that was resuscitating the baby regarding the outcome of the resuscitation efforts. After completing the repair, he went to review the newborn and observed that there were no signs of life.

He testified that he thereafter informed the mother that the baby had been delivered in a severely compromised condition, had collapsed shortly after birth and that despite the resuscitation efforts, the medical team had been unable to save the baby's life.

6. Dr. Gasthony Alobo. (Respondent).

Dr. Gasthony Alobo testified that he is a Senior Lecturer in the Department of Obstetrics and Gynaecology. He holds a Bachelor of Medicine and Bachelor of Surgery (MBChB) and a Master of Medicine in Obstetrics and Gynaecology.

He testified that his responsibilities include providing clinical services, teaching undergraduate and postgraduate students, supervising junior doctors and intern doctors, conducting staff appraisals and providing comprehensive obstetric and gynecological care, including outpatient services.

He testified that he did not participate in the treatment or clinical management of Ms. Apio Rebecca Agetta during her admission. However, he participated in the Maternal and Perinatal Death Surveillance and Response (MPDSR) review conducted approximately one week after the death of the baby.

He further testified that he later attended to Ms. Apio Rebecca Agetta following the delivery when she complained of numbness and weakness in her lower limbs. He stated that after assessing her condition, he advised her to undertake conservative management, including physical exercises and physiotherapy.

That according to the hospital's emergency response protocol, where complications arise during the management of a patient, the first person to be notified is the intern doctor on call, followed by the Medical Officer on duty, thereafter the specialist and where necessary, the hospital management.

Finally, he informed the Council that the Maternal and Perinatal Death Surveillance and Response (MPDSR) review meeting was attended by, among others, the Hospital Director, Dr. Musa Kasule, and Mr. Didan Jacob Opii.

Analysis by the Council

Summary of findings

In summary, the complainants allege that labour was improperly induced and allowed to continue for an unreasonably prolonged period despite identifiable obstetric risks that fetal distress was not recognized or managed promptly. That appropriate and timely clinical interventions including expedited delivery were not undertaken, that the newborn was inadequately resuscitated and that aspects of the clinical documentation and post-incident communication were inconsistent with accepted professional practice.

The Respondents denied all allegations of professional misconduct and medical negligence. They contend that the decision to induce labour was clinically justified, the second complainant was appropriately counselled and consented to the proposed management and that her labour was managed in accordance with accepted obstetric practice and applicable clinical guidelines.

The Respondents further maintain that the patient was continuously monitored by qualified healthcare professionals. That appropriate clinical interventions were undertaken as labour progressed and that neonatal resuscitation was commenced promptly upon delivery using the available equipment and personnel. They deny any shortage of essential equipment or oxygen and maintain that the unfortunate outcome occurred despite the exercise of reasonable professional skill and care.

The Respondents accordingly pray that the complaint be dismissed for lack of evidence of professional misconduct or medical negligence.

ISSUES FOR DETERMINATION

Having considered the pleadings and the evidence on record, Council identified the following issues for determination:

1. Whether the Respondents owed the second complainant and her newborn baby a professional duty of care.
2. Whether the clinical management of the second complainant during labour and delivery met the standard of care reasonably expected of competent medical practitioners.
3. Whether any Respondent committed professional misconduct or medical negligence in the management of the second complainant and her newborn baby.
4. Whether any established professional misconduct or medical negligence caused or materially contributed to the death of the newborn baby.
5. What are the appropriate sanctions or recommendations.

RESOLUTION OF ISSUES.

Issue 1 & 5 shall be resolved separately and issue 2,3 & 4 shall be resolved concurrently.

Issue 1: Whether the Respondents owed the second complainant and her newborn baby a professional duty of care

The existence of a professional duty of care is the foundation of every allegation of professional negligence. In disciplinary proceedings, the Council must first determine whether such a duty existed before considering whether it was breached.

It is common ground that the second complainant sought and received antenatal, intrapartum and delivery services at Lira University Teaching Hospital. The evidence further establishes that she attended antenatal care at the Hospital throughout her pregnancy and was admitted on 15 January 2025 for induction of labour after assessment by the obstetric team. During her admission, she was managed by the medical and midwifery staff of the Hospital, including the individual Respondents who participated in various aspects of her care.

The Council notes that none of the Respondents disputed the existence of a health worker-patient relationship. Their defense was not that they owed no duty of care but rather that they discharged that duty competently and in accordance with accepted professional practice. Similarly, there is no dispute that the unborn child was under the care of the Lira University teaching Hospital healthcare team throughout labour and delivery.

Under the Uganda Medical and Dental Practitioners Council Act and the Code of Professional Ethics, every registered practitioner owes a duty to exercise the degree of knowledge, skill and care reasonably expected of a competent practitioner acting in similar circumstances. That duty extends to appropriate clinical assessment, informed decision-making, timely intervention, accurate documentation, effective communication and continuity of care throughout patient management.

The Council further observes that although the 1st Respondent is a licensed health facility, disciplinary liability before the Council is founded upon compliance with professional standards governing the delivery of healthcare. The actions of individual practitioners working within the facility therefore remain subject to the Council's disciplinary jurisdiction.

Having considered the pleadings, the oral evidence and the medical records, the Council finds that a professional relationship existed between the second complainant and the Respondents throughout the material period. Consequently, each practitioner involved in her management owed her a professional duty of care commensurate with his or her respective role, while the Hospital bore a corresponding responsibility to ensure that professional services were delivered within acceptable standards of practice.

Accordingly, the Council answers Issue one in the affirmative.

ISSUE 2,3 &4

Issue 2: Whether any Respondent committed professional misconduct or medical negligence in the management of the second complainant and her newborn baby.

Issue. 3: Whether any Respondent committed professional misconduct or medical negligence in the management of the second complainant and her newborn baby.

Issue. 4: Whether any established professional misconduct or medical negligence caused or materially contributed to the death of the newborn baby.

Professional negligence arises where a registered practitioner fails to exercise the degree of knowledge, skill and care reasonably expected of an ordinarily competent practitioner in similar circumstances. Professional misconduct encompasses conduct that falls below the standards prescribed by the Uganda Medical and Dental Practitioners Council Code of Professional Ethics and Standards of Professional Conduct. The Council must therefore determine whether any Respondent departed from these standards.

The Council has already found that the decision to induce labour was clinically justifiable. The issue is therefore not whether induction should have been undertaken, but whether the labour was thereafter managed with the degree of professional care required by accepted obstetric practice.

The evidence establishes that Dr. Kasule Musa assessed the second complainant, counselled her regarding the available options for delivery, recommended induction of labour without expected assessment such as Bishop's score nor consultation of an obstetrician for a second opinion. Having initiated an intervention requiring continuous clinical assessment, Dr. Musa assumed professional responsibility for ensuring that the patient's progress was appropriately supervised until delivery or until responsibility was effectively transferred to another suitably qualified practitioner.

Although Dr. Musa reviewed the patient during the afternoon of 16th January 2025 and found that labour was progressing satisfactorily, the evidence demonstrates that he left the Hospital at approximately 5:00

p.m. without making adequate arrangements for continued medical review of a patient undergoing an induced labour that had not yet reached delivery. The Council accepts that hospitals operate on shift systems and that practitioners are not expected to remain on duty indefinitely. However, the obligation to ensure continuity of care is not discharged merely by leaving the patient in the labour ward. A practitioner who initiates a high-risk obstetric intervention must ensure that responsibility is clearly transferred to another competent medical officer and that appropriate supervision is maintained until the intervention is concluded.

The Council further notes that after Dr. Musa left the Hospital, the second complainant remained under the immediate care of midwives for several hours while labour continued. The evidence indicates that fetal compromise was only escalated after deterioration in the fetal heart rate had become apparent, prompting the attending midwife to summon the intern doctor on duty. By that time, labour had progressed to an advanced stage and the available management options had become significantly limited.

The Council wishes to emphasize that midwives play a critical role in obstetric care and are highly skilled professionals within their defined scope of practice. However, induced labour, particularly where labour becomes prolonged or fetal distress develops, requires ongoing medical oversight by the responsible medical practitioner.

Such responsibility cannot be delegated entirely to midwifery staff; however competent they may be. The supervising medical officer remains professionally accountable for ensuring timely review, reassessment and escalation where the clinical condition changes.

Therefore, Dr. Kasule Musa failed to provide the degree of medical supervision reasonably expected of the responsible medical practitioner after initiating induction of labour. His failure to ensure continuous medical oversight and timely reassessment of a patient undergoing prolonged induced labour constituted a departure from accepted standards of practice. That omission exposed both the mother and fetus to foreseeable risk and amounted to professional negligence and professional misconduct under the Medical and Dental Practitioners Council Act and the Code of Professional Ethics.

The Council has also considered the conduct of Dr. Mark Nakabaale. The evidence shows that he responded after being called by the attending midwife when fetal compromise was identified. While questions may arise regarding the clinical decisions made after his arrival, the evidence demonstrates that he became involved only after the deterioration had already occurred. The Council is therefore not satisfied that his conduct, viewed independently, amounted to professional misconduct.

Similarly, the evidence does not establish that Assoc. Prof. Tom Richard Okello personally participated in the clinical management of the second complainant during labour. His involvement was administrative and supervisory as Director of Clinical Services and no evidence was adduced demonstrating personal participation in the treatment decisions complained of. Accordingly, no finding of personal professional misconduct can properly be made against him.

The Council noted with concern, the absence of Obstetrician review throughout the two-days stay of the second complainant and her unborn baby despite Dr. Alobo Gasthony being in charge. His unexplained absence denied the mother and the baby a chance for specialist review. While his act of omission does not amount to professional misconduct, he fell short of his supervisory roles.

Council also finds no evidence that neonatal resuscitation was withheld or unreasonably delayed. The evidence consistently demonstrates that resuscitation commenced immediately following delivery. Although unsuccessful, the outcome alone does not establish professional negligence on the part of the practitioners who undertook those efforts.

Council further finds that the deficiencies in clinical documentation demonstrated by the medical records fell below the standard expected of registered practitioners. Although these deficiencies did not independently cause the adverse outcome, they constitute unsatisfactory professional practice warranting criticism and corrective measures by the Hospital.

Accordingly, the Council finds that the allegations of professional misconduct and professional negligence are proved against Dr. Kasule Musa. The allegations against Dr. Mark Nakabaale and Assoc. Prof. Tom Richard Okello are not proved.

Issue 5: What are the appropriate sanctions or recommendations

Recommendations

The Council hereby makes the following recommendations:

1. Dr. Kasule Musa is hereby suspended for six months with effect from 1st December 2026.
2. The Lira University Hospital Management is here by instructed to improve the clinical documentation practice, supervision of health workers, escalation protocols and communication with patients and their relatives.

Signed on this 12th day of November 2026 by

1. Dr. Ayub Twaha- Vice Chairperson.
2. Dr. Okello Maxwell- Member.
3. Dr. Owaraganise Asiphas- Member.
4. Dr. Tumwine Daniel - Member.
5. Dr. Muyanga Mark - Member