THE REPUBLIC OF UGANDA

IN THE MATTER OF AN INQUIRY INTO ALLEGED PROFESSIONAL MISCONDUCT AND OR MEDICAL NEGLIGENCE BY THE MEDICAL PERSONNEL AT NAKASERO HOSPITAL IN TREATING AND MANAGING ELIJAH ATANGAAZA LEADING TO HIS DEATH.

DR. ALLAN MPAIRWE ::::::::::::::::::::::::::::::::COMPLAINANT.

VERSUS

1. **DR. SHAMIM NAMUGERWA**
2. **DR. RACHAEL OWOMUHANGI**
3. **DR. SEMWOGERERE LAMECK**
4. **DR. SERUNKUUMA BRUNO**
5. **DR. CATHERINE NAMUTEBI**
6. **DR. PHILO NAMBOZE**
7. **DR. HAJJARA NAKAZIBWE**
8. **MUSIITWA PETER**
9. **DR. NINSIIMA LYNETTE**
10. **DR. SSALI FRANCIS**
11. **NAKASERO HOSPITAL LIMITED:::::::::::::::: RESPONDENTS.**

FINDINGS AND RESOLUTIONS OF THE COUNCIL

Complaint Summary

The complainant alleges that when the deceased was admitted to Nakasero Hospital on 20th November 2024 at 09:00 hours as a medical emergency requiring intensive care, Dr. Shamim Namugerwa provided inadequate initial care, and the hospital's medical team subsequently

committed several negligent omissions. These include: failing to assemble a multi-disciplinary team of specialists in haematology, nephrology, paediatrics, and critical care despite the patient's severe neutropenia, the attending paediatrician's failure to escalate the case to a senior colleague despite a clearly deteriorating condition, requested specialists' failure to examine the patient despite repeated calls from the attending physician, a missed opportunity for dialysis and haematology consultation, an unacceptable 13-hour delay in transferring the patient to the HDU/ICU after consent was given at 06:30 hours on 21st November and failure to refer the patient to a better-equipped facility once it was evident that Nakasero Hospital could not manage complications such as acute kidney injury; a failure the complainant says ultimately contributed to the patient's death.

Background

It is alleged that Elijah Atangaaza, the six-year-old son of Dr. Allan Mpairwe, died on 22nd November 2024 at Nakasero Hospital after a rapidly deteriorating illness. He first developed fever and thigh pain on 19th November and was seen at St Anne Marie Clinic, where he was misdiagnosed with a hernia and gastroenteritis and sent home on oral antibiotics despite an abnormally low white blood cell count. When his condition worsened, he was rushed to Nakasero Hospital on 20th November 2024 and was mismanaged, leading to his death.

On the other hand, the Respondents denied the allegations, asserting that Elijah received prompt, thorough, and clinically appropriate care.

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 21st July 2026 to determine whether the Respondents were guilty of professional misconduct and or medical negligence.

Proceedings

The inquiry took place in the Council's Boardroom. Parties submitted their responses and attended the session for cross-examination. The complainant was represented by Counsel Mbanza Emmanuel & Ogwang Kenneth of Amandla Advocates whereas the Respondents were represented by Counsel Nganwa Rodney of S&L Advocates. The individuals cross-examined were:

1. Dr. Allan Mpairwe – 1st Complainant.
2. Ms. Vyonne Natukunda Mpairwe-Complainant's witness.
3. Dr. Shamim Namugerwa- Respondent.
4. Dr. Rachael Owomuhangi- Respondent.
5. Dr. Semwogerere Lameck– Respondent
6. Dr. Serunkuuma Bruno– Respondent
7. Dr. Catherine Namutebi- Respondent
8. Dr. Philo Namboze- Respondent.
9. Dr. Hajjara Nakazibwe- Respondent.
10. Musiitwa Peter- Respondent's Witness
11. Dr. Ninsiima Lynette- Respondent.
12. Dr. Ssali Francis– Respondent

Complainant's Evidence

1. Dr. Allan Mpairwe – Complainant.

Dr. Allan Mpairwe testified that he is a male adult Ugandan, a medical doctor and the biological father of the late Atangaaza Elijah, who died on 22nd November 2024 at Nakasero Hospital.

He testified that on 19th November 2024, between 5:00–6:00 p.m., the deceased developed fever and right thigh pain after school and was taken to St Anne Marie Clinic, where a paediatrician suspected an inguinal

hernia, acute gastroenteritis, and inguinal lymphadenitis. Laboratory results showed a low White Blood Cell count (WBCC) (2.4×10^9), Haemoglobin (Hb) of 12.5g/dl, and C-Reactive Protein (CRP) of 0.9mg/l; he was treated with diazepam, ibuprofen, paracetamol, cefixime and metronidazole for five days, with review due in a week. That the fever persisted above 38°C until 6:00 a.m. on 20th November, prompting them to transfer him to Nakasero Hospital's Emergency Unit.

That he was received at Nakasero at 9:00 a.m. and seen by Dr Namugerwa Shamim at 10:00 a.m., who ordered further tests. At 11:00 a.m., results showed marked deterioration — WBCC 0.3×10^9, severe neutropenia (0.01×10^9), Hb 10.3g/dl, CRP 64mg/l, high Lactate Dehydrogenase (LDH) (457) and alkaline phosphatase (227); malaria Rapid Diagnostic Test (RDT) was negative, platelets normal, and urinalysis showed haemoglobinuria. He testified that this critical picture warranted urgent escalation to a senior consultant and multidisciplinary team, yet treatment was only instituted four hours after presentation and Dr Namugerwa ought to have adopted a more aggressive approach given these results.

That the deceased was started on Intravenous fluids (IV), antipyretics and Piperacillin/Tazobactam for suspected neutropenic sepsis, other causes having been ruled out, but was kept in the nursery room without a private room for close monitoring, despite the admitting team's advice. That a haematologist review was requested but never conducted, an omission he considered crucial because Dr Ssali Francis was unreachable.

That the deceased's condition worsened, with high fevers, inability to feed, and two collapses, yet no doctor attended despite urgent calls, nurses only assuring that the paediatrician would return.

That the paediatrician returned at 7:40 p.m. on 20th November, only after repeated calls including to external paediatricians, and added IV Fluconazole and Acyclovir to the regimen. He testified that even these medications were delayed — Esomeprazole by four hours, Acyclovir by eight, and Fluconazole by nine hours, per the treatment sheet .

That at 12:10 a.m. on 21st November, the deceased went into shock with cold extremities, collapsed veins, and incoherent speech; attempts to secure peripheral lines failed. As no doctor was reachable, the mother contacted Dr Lameck Ssemogerere, Head of Intensive Care Unit (ICU)), who summoned Dr Bruno Sserunkuuma, an intensivist, who assessed the child and suspected acute myeloid leukaemia, acute watery diarrhoea,

high-grade fever, and moderate dehydration. He recommended Oral Rehydration Salts (ORS), oxygen, laboratory monitoring, and an urgent haematology review which was not done. He testified that by then the cannula had infiltrated the tissue, halting medication delivery, while no High Dependency Unit (HDU) space was available, and that the Hb of 6.7g/dl was not acted upon despite warranting a transfusion, a missed opportunity in his care.

At 4:00 a.m., a central line was inserted by the nurse with no chest X-ray feedback given to the mother confirming placement, and no treatment administered in the interim between the IV line failing at midnight and the central line insertion at 4:00 a.m. That at 6:30 a.m., Dr. Sserunkuuma reviewed the patient again and ordered transfer to HDU, noradrenaline infusion, and a fluid bolus.

The deceased remained in hypovolemic shock, with CRP now 129.3mg/l, Hb 6.7, WBCC 0.17×10^9, neutrophils 0.00, low calcium and potassium, and elevated creatinine (145umol/l) indicating reduced kidney function. A whole blood transfusion, calcium gluconate and Potassium Chloride (KCl) were prescribed, but no urgent nephrology intervention was documented, raising concerns about adequacy of care.

At 9:00 a.m., Dr Namugerwa reviewed the still-sedated patient, diagnosed septic shock, electrolyte imbalance and acute kidney injury, and requested a nephrologist review who was unavailable, with no alternative offered, despite over five hours having elapsed since the central line insertion with no explanation for the prolonged sedation.

He stated that at 1:00 p.m., a review by Drs Catherine, Namugerwa and Rachel showed metabolic acidosis and low urine output (60mls); the nephrologist, Dr Batte, remained unavailable and the transfusion, ordered seven hours earlier, was only administered at that time. At 3:30 p.m., Linezolid was added, albeit late given the rising CRP, and from then until 8:00 p.m. no paediatrician was accessible, with a nurse unable to explain the patient's vitals or rising blood sugar.

That he personally raised the urgency of the kidney failure with the medical team, who admitted no nephrologist was available, prompting him to contact Dr Kalyesubula directly and to propose airlifting his son to Aga Khan or MP Shah Hospital in Nairobi for dialysis. That despite this explicit request, the hospital failed to act or clarify its capacity, which he considered a serious breach of duty and gross negligence.

At 7:00 p.m., the deceased showed slight improvement, recognising his parents and taking sips of water, yet no Nasogastric tube (NGT) had been inserted despite over 24 hours without oral intake; a significant supportive-care omission. That nurses later urged ICU transfer based on results he was never shown, and his requests to speak with the team lead went unanswered. upon a bed becoming available in the HDU, he consented to transfer, but his son's condition deteriorated further and he died on 22nd November 2024 at 12:54 p.m.

He testified that failure to convene a multidisciplinary team despite severe neutropenia, failure to escalate care to senior paediatricians despite worsening indicators, non-appearance of the required nephrologist and haematologist, missed opportunity for early dialysis and haematology input, delay in HDU/ICU transfer, denial of parental access to their conscious, distressed son from 7:45–9:00 p.m, failure to refer to a better-equipped facility despite the parents' willingness to evacuate him; and failure to conduct requested toxicology tests that could have influenced diagnosis and treatment could have contributed to death of Elijah.

That the hospital had falsely represented having an on-call nephrologist and haematologist and ought therefore to have recommended transfer to the parents once it became clear the required specialists were unavailable despite the child's ailments having been identified early.

2. Mrs. Vyonne Natukunda Mpairwe-Complainant's Witness

Mrs. Vyonne Natukunda Mpairwe testified that she is a business lady and resident of Kungu Village Ward, Kira and the biological mother of the late Atangaaza Elijah.

She testified that, on 19th November 2024, Elijah woke up in good health, attended school, and joined the skating club, which ran from 3:15 p.m. to 4:15 p.m. She arrived at school at about 4:15 p.m. to collect Elijah and his brother. After packing his belongings and visiting the washroom, Elijah complained of sudden pain in his thigh. He denied falling, being hit, or being knocked by anyone.

The pain persisted throughout the journey home. Near Bukoto, Elijah asked to be taken to their usual clinic. She agreed, and they arrived at St. Anne Marie Children's Clinic, Bukoto, at about 5:54 p.m. His weight was recorded at 23.9 kg and his temperature at 38.1°C. Dr. Nattimba examined him, ordered a blood sample, and referred him to Victoria Hospital for a

scan, which was carried out at 8:09 p.m. On reviewing the results, Dr. Nattimba found nothing serious, prescribed medication, and advised observation at home. They left the clinic at about 9:00 p.m.

At home, Elijah bathed, ate little, and went to bed, occasionally complaining of stomach discomfort. She monitored him through the night: at 12:10 a.m. she bathed him with lukewarm water and administered a rectal suppository. At 1:26 a.m. his temperature was 36°C, at 4:36 a.m. he vomited, at 5:38 a.m. his temperature was 38.8°C and at 5:40 a.m. he vomited a second time, bringing up yellowish matter.

That the next morning, after dropping Elijah's brother at school, she checked his temperature at 8:00 a.m, it read 38°C, and she administered a diclofenac suppository before proceeding to Nakasero Hospital. En route, Elijah spoke as though conversing with someone. They arrived at the hospital at 9:00 a.m.; by 9:30 a.m. his temperature exceeded 39°C, though he remained conscious and able to walk. He was seen by a paediatrician Dr. Shamim Namugerwa at about 10:00 a.m., who took his history, reviewed prior results, and ordered blood tests. Panadol was given between 10:00 and 10:20 a.m. By 10:38 a.m. he appeared drowsy. At 10:41 a.m. the laboratory reported an insufficient sample, requiring a second blood draw, during which Elijah protested. Nurses applied wet towels to reduce his temperature, which fell only from 39°C to 38°C by 10:51 a.m. He was then moved to Day Care.

Shortly after 11:00 a.m., results showed elevated CRP and low blood cell counts. Dr. Namugerwa informed her that Elijah was very sick and required admission. While awaiting a private room, Elijah's condition worsened; he collapsed twice while returning from the washroom and had to be carried.

She testified that she repeatedly asked nurses to call the paediatrician, but was told the doctor was occupied. From around 12:00 p.m., Elijah complained of stomach discomfort and, by 1:30 p.m., heaviness in his feet. Between 2:00 and 3:00 p.m., he was given an intravenous dose of Piperacillin-Tazobactam (Aristo Durataz 4.5g). Between 4:00 and 5:00 p.m., he complained of discomfort in his hands and feet. No paediatrician had returned to assess him by 6:00 p.m., and the promised private room remained unready. At around 6:20 p.m., she left the hospital briefly to collect items from home, leaving relatives with Elijah.

At 6:30 p.m., Elijah spoke by phone with his father, who noted he was drowsy but drinking water. By 7:00 p.m., his temperature had again risen above 39°C. He later developed diarrhoea, was showered by relatives, and continued to complain of discomfort in his extremities. His temperature was recorded at 39.7°C; a rectal suppository could not be administered due to the diarrhoea. He was given yoghurt and placed on a drip. Dr. Namugerwa reportedly spoke to Elijah's father by phone at about 8:00 p.m.

She returned to the hospital shortly after 10:00 p.m. and found Elijah being moved to Room 005. He ate some food though his temperature remained above 39°C and he exhibited unusual speech. She contacted Dr. Ssemogerere Lameck, Head of the HDU, who stated he was already monitoring the case. At 11:16 p.m., Dr. Sserunkuma Bruno of the HDU attached cardiac electrodes; by 11:56 p.m., four electrodes were in place and oxygen support was administered. Diarrhoea increased, requiring frequent diaper changes.

By midnight, further blood tests were ordered, revealing that Elijah's veins had collapsed. Between 1:00 and 2:00 a.m., doctors discussed transferring him to the HDU and inserting a central line. She consulted her husband, who spoke with Dr. Sserunkuma at 2:47 a.m. and agreed to the HDU transfer. A femoral line was ruled out due to infection risk from diarrhoea; a neck central line was proposed instead. She signed consent for the procedure, expecting recovery within two to three hours.

In the early hours of Thursday, 21st November 2024, Elijah was taken for a scan to guide the central line placement. At about 4:00 a.m., he was sedated; during injection, part of the sedative was lost when the needle dislodged, requiring re-calculation of the dose. The central line procedure was reported successful, but Elijah did not wake up as expected. By 9:25 a.m., doctors found him still asleep, and he remained unconscious past midday. He was not passing urine; a catheter was eventually inserted.

At 11:08 a.m., his oxygen saturation was recorded at 81%. Concerned, she consulted a private paediatrician by phone at 12:19 p.m., who arranged for a colleague to attend, though no feedback was given afterward. By 12:38 p.m., over five medical personnel were attending to Elijah, who remained unconscious. He received a blood transfusion (100ml, then more at 2:37 p.m.) and, following the catheterisation between 1:00 and 2:00 p.m., produced only 56ml of urine. Despite

repeated assurances from Dr. Namugerwa that a nephrologist and a bone marrow specialist had been called, neither arrived.

Elijah regained consciousness around 5:00 p.m., recognising and greeting his father, and was permitted only a drop of water. By 6:00 p.m., the promised HDU room remained unready. Staff explained the need for isolation due to his weakened immunity and assured the family that HDU differed from ICU. At about 7:30 p.m., a medical team arrived to transfer him; during the process, he vomited, and it was Elijah's father, not hospital staff, who positioned him to prevent aspiration. He was then taken directly to the ICU, and the door was locked, separating him from his family while he cried for them. Elijah was restrained on the bed due to distress. A hospital customer care officer was informed of the family's concerns. The family was permitted brief visits between 8:00 and 9:00 p.m. and periodically thereafter.

On Friday, 22nd November 2024, a bone marrow specialist examined Elijah at about 11:00 a.m. and stated that he was dying. Elijah was pronounced dead at 12:45 p.m.

Respondents' Evidence

1. **Dr. Shamim Namugerwa– (Respondent).**

Dr. Shamim Namugerwa stated that she is an In-house paediatrician at Nakasero Hospital since 2020. She holds a degree of MBChB and MMED in paediatrics, fully registered and licensed with the Council.

She testified that the child, Elijah Atangaaza, was received at the children's clinic and assessed by the paediatrician, and that a working diagnosis of neutropenic sepsis was established after review of his history and test results. She stated that the child was admitted, isolated, and placed on antimicrobials and supportive care, with a dedicated nurse monitoring him continuously.

She testified that although the child initially showed only fever and loose motions, he later developed vomiting, hypovolaemia and hypoperfusion, prompting an upgrade of his room to HDU level rather than physical transfer to ICU, owing to infection-control concerns for a neutropenic patient. His condition deteriorated further—with altered mentation, worsening breathing, and increasing need for catecholamine support—he was moved to the general ICU, where a multidisciplinary team of paediatricians, an intensivist, and a haematologist and nephrologist (consulted by phone) jointly managed his care.

That the child remained too unstable throughout for invasive interventions such as intubation, dialysis or evacuation, and that attempting these earlier would have hastened his death. That despite appropriate care, he progressed to septic shock and multi-organ failure. On 22nd November 2024, he was intubated with parental consent after worsening respiratory failure, suffered two cardiac arrests and was pronounced dead at 12:54 hours, with the cause recorded as septic shock and multi-organ failure secondary to neutropenic sepsis.

That the child had reportedly been treated for over a week for fever and cough at another facility before admission suggesting that the rapid deterioration could have been related to an undisclosed pre-existing condition.

Finally, she testified that while the hospital regretted the child's death, it maintained that his care had been professional and competent and that the outcome resulted from factors beyond its control.

2. **Dr. Rachael Owomuhangi– (Respondent).**

Dr. Owomuhangí Rachael is a holder of MBChB and MMED in Pediatrics. She has been at Nakasero Hospital since 2023 as an In-house paediatrician.

She testified that she was called in on a Wednesday at midday by Dr. Shamim, her colleague who requested her to attend to the patient, whose fever had developed and whose condition had subsequently worsened, and that the patient had been referred to her for further assessment and consultation.

That she had been informed of certain laboratory results and shared concerns which prompted her to review the child. She found Elijah already being managed, and that on examination, the child had fever and pain in the right thigh, while his other vital signs appeared stable at that time. she inquired into the patient's prior history and was briefed on the treatment already administered. She stated that laboratory results from Nakasero Hospital subsequently became available and that after reviewing them together with her colleagues, it was established that the patient had severe neutropenia.

That at about 6:30 p.m. she received information concerning the patient, that the patient had developed septic shock, following which she returned to the hospital and consulted Dr. Baate and continued to manage him.

She reviewed laboratory tests from St. Anne Marie and observed that his white blood cells were low. She contacted via telephone Dr. Ssali, a hematologist and Prof. Ndezi, a senior paediatrician who advised on the treatment plan.

3. Dr. Ssemogerere Lameck (Respondent).

Dr. Ssemogerere testified that he is a medical doctor specialized in intensive care medicine and critical care, works at Nakasero Hospital as the Head of Department critical care and works with Uganda Heart Institute as a senior consultant in cardiac anaesthesia.

He stated that his first involvement with the complainants began when Dr. Annet Alenyo called him at around midnight, requesting that he offers support to a colleague's relative who had been admitted to one of the paediatric wards. Dr. Alenyo informed him that the child's mother would call him directly, which he agreed to.

That before the mother of the deceased called, Dr. Ssemogerere Lamech had contacted his colleague, Dr. Sserunkuuma Bruno, and asked him to see the deceased on the paediatric ward and report back, since he had no information at that point. When the mother subsequently called, he informed her that a doctor was already on the way to assess the child and that she would receive an update afterward.

That Dr. Sserunkuuma assessed the child and reported that he was quite unwell but that the team was managing the situation. Dr. Lamech instructed Dr. Bruno to check on the child again later that night. Dr. Bruno reviewed the child twice overnight for a line insertion and when he was going to handover.

That Dr. Lameck had limited direct involvement the next day, as the child remained under the care of the ward team. He later learned that Dr. Bruno had advised the mother that the child might require escalation of care, but she needed time to consider the decision and asked to be kept informed of the mother's decision.

He stated that during that time, the hospital was in the process of transferring its ICU services from the old unit to a newly constructed wing. As a result, the former High Dependency (HD) unit had been upgraded to function as the ICU, while designated rooms in the new wing originally intended for HDU-level care were also equipped to provide ICU-level care when needed, since the main ICU was full. Given the severity of the child's condition, the risk of remaining on the general ward without adequate critical care outweighed the risk of moving him to common ICU and the decision was made to transfer him to the ICU.

That once in the ICU, the child's condition deteriorated rapidly, and the cause could not be identified despite extensive testing. Investigations aimed at identifying the cause of the falling cell counts which extended beyond neutrophils to other blood lines and the source of the fever showed no evidence of infection. He acknowledged that, given the rapid progression, the pace at which information was communicated to the family may have been too fast for them to fully absorb, though he noted that meetings were held throughout the process to keep them updated.

Dr. Lameck further testified that the decision to initiate emergency dialysis in critically ill patients rests with the treating physicians, who consult a nephrologist once the patient is stable enough for the procedure. He noted that although the child developed organ dysfunction, initiating renal replacement therapy became too risky once he became critically unwell. He also noted that the country has only one paediatric nephrologist, who works across multiple hospitals and provides remote guidance and appearing in person when required. He stressed that the decision not to proceed with dialysis was based on clinical contraindications, not on the unavailability of a nephrologist.

He testified that at around 5am on the morning the child died, he met the mother and informed her that the child's condition was critical and that the father could be called for a discussion. He met with his team to discuss the situation, noting that survival at that stage was highly unlikely, with mortality from multi-organ failure exceeding 95%. He informed the family that, despite all efforts, the medical team had been unable to determine the cause of the child's rapid deterioration and he recommended toxicology testing as a diagnosis of exclusion, noting that there had been no history suggesting poisoning.

That he suggested to the family to conduct a postmortem examination which would help clarify the cause of death, given how puzzling the case had been. He stated however that this suggestion was not documented in writing, and he was uncertain whether the family ultimately agreed to it or whether it was carried out in another facility.

He testified he was always available to the family throughout the process, given that the case fell within his area of expertise; he met with them repeatedly, helped arrange meetings with hospital management, and supported them as they sought answers, noting that he shared many of the same unanswered questions they did.

Dr. Lameck stated that it is standard international critical care practice to limit family presence during the initial hours of ICU admission, typically the first 24–48 hours, while the medical team stabilizes the patient. He explained that this period often involves invasive and distressing procedures that could traumatize the family members and interfere with the team's ability to respond quickly. Once the patient is stabilized, the family members are then invited in the ICU. He acknowledged that this policy may not have been clearly explained to the family at the time and stated that communication around this aspect of care should be improved going forward.

4. Dr. Sserunkuuma Bruno– (Respondent).

Dr. Bruno Sserunkuuma stated that he is a degreed holder of MBChB and MMED in Anaesthesia and Critical Care. He part-times at Nakasero Hospital as an intensivist since October 2022. He is also a Fellow of Cardiac Anaesthesia at Uganda Heart Institute (UHI).

He testified that at approximately 12:10 a.m., he was contacted by Dr. Lameck, who informed him that a child on the pediatric wing had presented with a history of recurrent convulsions and requested that he reviews the child. He attended promptly to the child as the intensivist on duty that night. He found the child to have fever, moderate diarrhea, a reduced level of consciousness, and a low oxygen saturation of 88%.

Based on the history of diarrhea and associated volume loss, together with those findings, he instituted the following management: Oral Rehydration Salts (ORS), with instructions given to the nursing staff to administer a specified volume after each episode of loose stool; zinc tablets; for the fever, tepid sponging and continuation of the paracetamol the child was already receiving; and, for the low oxygen saturation, supplemental oxygen at 2 litres per minute via nasal prongs. That concluded his first contact with the child.

That at approximately 2:00–3:00 a.m., he was called back by the nurse attending to the child, as the peripheral intravenous cannula had tissued (failed). On re-examination, he found the peripheral veins to be poorly accessible, and that attempts to secure a further peripheral line were unsuccessful. He discussed the situation with the child's mother and explained that central venous access would be required to allow adequate rehydration, given the ongoing fluid losses from diarrhoea. Subsequently discussed the plan with the child's father by telephone and explained the need for a central line.

He testified that the father raised the option of a femoral site, but that he advised against that, explaining that the femoral site was not advisable in a child with ongoing diarrhoea because of the associated risk of

contamination, and that he proposed the internal jugular vein (in the neck) as the preferred site instead. He explained the procedure to the father, including the use of ultrasound guidance and the need to sedate the child, and that the father's consent was obtained.

He testified that the central line was inserted by him under ultrasound guidance, using a 5.0 Fr catheter placed in the internal jugular vein. He stated that its position was confirmed on a post-procedure chest X-ray, which he reviewed and reported as satisfactory before authorising use of the line, and he instructed the nursing staff accordingly. He testified that he recorded a clinical note of the central line insertion in the patient file, he also clarified that the procedure had been documented in the system under another clinician's name for billing/administrative purposes, but maintained that the procedure was, in fact, performed by him.

That at approximately 6:00 a.m., he received a further call from the nurse attending to the child, and that the frequency of loose stools had increased while the child's perfusion had declined. During this period, he prescribed further intravenous fluids. That the child's blood pressure on his first assessment was low, recorded in the range of approximately 50–60 mmHg systolic, and that following fluid resuscitation, blood pressure improved into the 70s, though this improvement was not sufficient on its own. He stated that he therefore prescribed noradrenaline, commenced at a low dose, to support the blood pressure, and that blood pressure improved further with the combination of fluids and noradrenaline.

He testified that, having earlier requested laboratory investigations, he was called back by the nursing staff at around 7:00 a.m. to review the results which showed low potassium, that was prescribed/corrected; a low hemoglobin, recorded at 6.7 g/dL, for which blood transfusion was arranged; and low calcium, which was also prescribed/corrected and this marked the end of his shift, and that he formally handed over care of the child to the incoming doctor, Dr. Namutebi Catherine.

That he reported back to his consultant/senior and discussed the prior investigations. His consultant requested that a haematology referral be recommended, and that the consultant was in agreement with the management plan instituted during his shift (ORS, zinc, and antibiotics). He confirmed that the recommendation for haematology review arose from the clinical findings and the team's assessment, given the abnormal blood results.

He stated that there were some biochemical indications of renal impairment on review and his assessment was that this was attributable to the significant volume loss the child had sustained through diarrhoea, a pre-renal acute kidney injury (AKI). On this basis, the primary management priority during his shift was fluid replacement, on the understanding that renal function would be expected to improve once the underlying volume deficit was corrected. He stated that a nephrology referral was also made, and that the consulting nephrologist to be Dr. Batte Anthony.

He stated that he would ordinarily expect every patient to have a fluid balance chart maintained by the nursing staff, recording all fluids given and lost, as this was standard practice and a compliance requirement. He stated, however, that he did not specifically recall seeing a completed fluid balance chart in place on the night in question, and that, to his understanding, fluid balance began to be recorded once the child was admitted to the ICU the following day.

He stated that he does not usually work on weekends, and that he was later informed that the child had sadly passed away on the Friday and this information was relayed to him after the fact, and that he was not directly involved in the child's care after handover.

5. **Dr. Catherine Namutebi- (Respondent)**

Dr. Catherine Namutebi stated that she is an Anaesthesiologist and Intensivist. She holds an MBChB obtained in 2012 from Makerere University and an MMed obtained in 2015 from Makerere University. She

has been working at Nakasero Hospital since 2017 but her primary employer is Uganda Heart Institute.

It was her testimony that Dr. Bruno handed over the patient to her, and informed her that the child was in hypovolemic shock. She stated that fluids had already been given to resuscitate the child, but that the blood pressure remained low, prompting the doctor to start a vasopressor, noradrenaline, and to insert a central line towards the morning to facilitate administration of the various drugs required.

That she began her ward round in the Intensive Care Unit and proceeded to review the child. On examination, she found him to be very sick, with signs of hypovolemic shock, including delayed capillary refill and cold peripheries with blood pressure on the lower side. She called the pediatrician in charge to inform her how critically ill the child was and that together they decided to continue resuscitation.

She testified that a number of investigations were carried out, including a complete blood count, liver function tests and renal function tests. An arterial blood gas analysis was also performed, which showed some electrolytes to be on the lower side; these were not replaced at that time. Further fluids were given on the basis that the child remained hypovolemic. She noted that the child also had a low hemoglobin level, for which blood was transfused.

That because the child was too sick to be moved, resuscitation was continued at the bedside rather than in the room originally intended for his care. A urinary catheter was inserted, and it was noted that the child was not passing urine despite ongoing resuscitation, the blood pressure

was not responding as expected, noradrenaline was supplemented with dopamine and adrenaline to improve titration of the child's blood pressure.

She testified that the mother was kept updated on the child's condition throughout the day while the father was out of the country at the time but was informed as he was travelling back, and that he was able to join them later that afternoon, at which point he too was updated on the child's status.

The initial plan had been to transfer the child to a room designated for high-dependency care, and that the team present included two to three nurses together with Dr. Shamim, Dr. Rachael and herself, who remained at the bedside for most of the day. She stated that before the end of her shift the child's condition had deteriorated to the point that he could no longer safely remain in that room, and he was therefore transferred to the Intensive Care Unit for closer monitoring. She confirmed that this was documented in the file, and that she gave a detailed handover to the receiving team, including the intensive care chart used to record vital signs, fluid balance and medications running, which also had a section for the incoming doctor and nurse to record further notes.

She testified that the medications administered, including adrenaline and dopamine, were given on the recommendation of the outgoing shift doctor, and confirmed that those recommendations, including adjustments to treatment, were carried out. She explained that vasopressor doses were titrated to achieve a blood pressure adequate for the child, and that when the first agent used proved inadequate, a further agent was added in line with protocol.

That she was aware that a hematology consultation had been recommended, and stated that this had formed part of a wider multidisciplinary discussion given how critically unwell the child was. She explained that any recommendations made by the specialists consulted would be incorporated into the same management plan being carried out by the bedside team, although she could not recall specifically documenting this recommendation in her own notes.

She testified that neurology and nephrology were consulted later in the course of the day, after it was noted that, despite resuscitation and the various medications given, the child continued not to pass urine over several hours, and a trend was observed on the renal function tests. She stated that a phone consultation took place regarding these results, during which a sodium bicarbonate infusion was advised in view of a metabolic acidosis identified on arterial blood gas analysis, and that this was administered. She confirmed that arterial blood gases continued to be repeated to monitor for, and correct, further abnormalities.

The question of whether the child was to benefit from renal replacement therapy was considered, and that a trial of furosemide was given to challenge the kidneys, to which there was initially no response, though some improvement was noted later that evening. She explained that during her shift the child remained too unstable for dialysis to be safely undertaken, and that the team therefore continued with conservative management, including furosemide, while monitoring for improvement.

She further testified that, in her opinion, the physical presence of the nephrologist would not have altered the management plan or the

discussions that took place, as she believed that the care given was consistent with what would have been recommended in any event.

That on clinical assessment, the child showed features consistent with hypovolemic shock, and that fluid resuscitation was therefore given in excess of standard maintenance calculations to correct the estimated fluid deficit, while the team monitored clinically for signs of fluid overload such as crepitations or pulmonary oedema. She stated that the child was given initial fluid boluses of five to ten millilitres per kilogram, followed by further boluses, amounting in total to approximately twenty millilitres per kilogram, without measurable improvement. She testified that blood was subsequently given, both to support volume replacement and to achieve a hematocrit above ten.

She testified that she had a phone consultation with the oncologist, who provided input into management. On reviewing the file, she noted the child had severe neutropenia based on the investigations performed, and that a urology consultation had also been raised, though this consultation had been carried out by the primary treating pediatrician rather than by herself. She could not recall any specific haematology recommendations being carried out during her shift.

That she did not recall whether the team had considered consulting a more senior specialist, explaining that the child's condition was confusing at the time, that the team was attempting a number of interventions to achieve improvement, and that the child had become increasingly fluid-overloaded, with visible facial puffiness, over the course of that period.

6. **Dr. Philo Namboze-(Respondent).**

Dr. Philo Nambooze stated that She holds a MBChB degree and MMED in Critical Care and Anaesthesiology. She works at Mulago Specialised and Women's Hospital and part-time at Nakasero since 2022.

Philo testified that she was on night duty when the patient, Elijah, was admitted to the unit shortly before her shift began. On receiving him, she and her colleagues considered the concern of moving him from the High Dependency Unit (HDU) to the Intensive Care Unit (ICU) given the severity of his condition. They settled and stabilised him, and thereafter held a family conference with his parents to address the question of transferring him from HDU to ICU. At that point of care, Elijah was on respiratory support and was receiving three separate drugs to support his heart. He was very sick, and more than two of his organs were not functioning well.

She stated that the team spent the whole night of Thursday 21st November resuscitating Elijah and remaining at his bedside, working to bring him to a state in which his body could be adequately perfused and regain some organ function. During the earlier part of that night, she and her colleagues spoke with the attending doctor and with Elijah's parents about his condition.

They administered blood and fluids, carried out repeated blood gas analyses, and remained in continuous telephone consultation with the wider clinical team. She described the night as an evolving situation, in which each blood gas result required a further response; for example, sodium bicarbonate was given when a raised lactate and acidosis were identified, and the number and dosage of drugs being administered had

to be changed accordingly. The team worked through the night addressing issues as they arose.

On the composition of the night team, she testified that it consisted mainly of ICU nurses, together with a senior doctor Dr Lameck, and that they remained in communication with the pediatric team throughout. Communication also continued with the nephrologist, who had already been briefed on Elijah's case; however, because of the extent of cardiac support he was receiving, renal support was not a viable option at that stage, at least by mechanical means, and his kidneys continued to be managed through medical measures instead. The hematologist had likewise been consulted earlier and had already given his input, so that by this point the team's primary focus was critical resuscitative care aimed at restoring the function of Elijah's major organs.

She testified that the principal clinical challenge that night was perfusion. Elijah had already been started on vasopressor support, including noradrenaline, adrenaline and vasopressin, but his blood pressure could not be maintained even though these drugs had reached the maximum doses appropriate for his weight. He had received substantial fluid resuscitation during the day, and fluids continued to be given through the night, but he did not respond to this resuscitation: his blood pressure could not be raised above approximately sixty millimetres of mercury. This poor perfusion was evidenced clinically by cold extremities, a raised lactate level, and a markedly reduced urine output. She confirmed that adequate perfusion was never achieved that night.

Regarding intubation, she explained that because Elijah's heart was already being so heavily supported, positive-pressure ventilation was

expected to affect his cardiac function, and for that reason intubation was only carried out after the parents had been spoken to and their consent obtained. She stated that she did not consider intubation to have caused his deterioration, since without it, in her assessment, he would not have survived; the decision to intubate was taken to give him a chance and to see how he would respond, given that he was a child.

On the question of dialysis, she explained that in critical care a patient is started on dialysis whenever their condition requires it, as the clinical circumstances there differ from those on a general ward. However, given the extent of cardiac support Elijah was already receiving, he was not considered a candidate for dialysis at that point. She testified that this decision was made in consultation, but acknowledged that the discussion had not been documented, as it had taken place informally, and accepted that it could and probably should have been recorded.

On investigations, she testified that at this stage the team was treating Elijah for severe neutropenic sepsis, against a background in which his immune system was essentially not functioning. Investigations carried out included cell counts and blood cultures, which had been sent for analysis. From Elijah's history, the team suspected that a medication he had been given for a skin rash could be a possible contributing cause of his suppressed immunity and the sepsis, though she stated that she would need to consult further to establish whether specific tests existed to confirm this suspicion.

She confirmed that all consultations with Dr Lameck, including his name and his recommendations, were documented in Elijah's chart and remained on file, available to the team that took over his care.

She testified that she also had a separate, informal conversation with the nephrologist, held very early in the morning, in which she sought to establish whether any further intervention could be attempted; she was unable to state the precise time this took place. She was clear that this exchange should not be characterized as the nephrologist having approved the treatment plan, and she confirmed that it had not been documented. She distinguished this informal conversation from the formal family conference, which was convened once the team was able to step away from Elijah's bedside, his condition having reached a state that allowed them to do so.

7. Dr. Hajjara Nakazibwe-(Respondent).

Dr. Nakazibwe Hajjara testified that she is a medical officer and a degree holder of MBChB, currently not working but worked at Nakasero Hospital in 2024 and 2025.

She stated that on the morning of the 21st at approximately 4:40 a.m., she was called to review a chest X-ray that had been performed to confirm the placement of a central venous line, in accordance with standard post-procedural protocol. She testified that she was also requested to clinically review the child.

That upon examination, the child was unconscious, which she initially attributed to sedation following the previous medical procedure. However, she observed that the patient had moderate pallor, cold extremities, absent distal pulses, severe hypotension and tachycardia, although central pulses remained palpable but weak. Based on these findings, she concluded that the child was in hypovolemic shock secondary to severe diarrhoea, as the parents had reported more than ten episodes of loose stools within one hour.

She testified that she immediately initiated emergency resuscitation by administering an 800 ml bolus of normal saline to restore intravascular volume and stabilize the patient's circulation. She further testified that she promptly contacted the child's consultant paediatrician to report the patient's deteriorating condition and discuss the management plan.

That after reviewing the patient's medical records, she noted that the child had previously been reviewed by the intensivist during the night and that a central venous line had been inserted because the patient remained in shock. She testified that following consultation with the paediatrician, she was instructed to continue aggressive fluid resuscitation while informing the intensivist of the child's worsening clinical status.

That she contacted the intensivist, who returned to reassess the patient. Before the review, she ordered urgent laboratory investigations, including a complete blood count (CBC), renal function tests, and a comprehensive septic screen. After reviewing the patient, the intensivist considered acute leukaemia among the differential diagnoses and requested an urgent review by a haematologist while fluid resuscitation continued.

That the child's early warning score was critically high, warranting escalation of care and consideration for admission to the High Dependency Unit (HDU) or Intensive Care Unit (ICU). She testified that she attempted to contact several haematologists before successfully reaching one specialist, to whom she communicated the patient's history, laboratory findings, and clinical examination results.

She testified that the consulting haematologist recommended repeating the septic screen, performing an abdominal ultrasound scan, continuing antimicrobial therapy consisting of antibiotics, antivirals, and antifungals, correcting electrolyte abnormalities, managing the acute kidney injury, treating the anaemia where indicated, and reviewing the patient after obtaining the new investigation results.

Approximately 45 minutes after initiating shock management, she reassessed the child and noted an improvement in blood pressure and peripheral perfusion. Although distal pulses remained weak, they had become palpable. The child remained unconscious but was clinically more stable than during the initial assessment. Before handing over to the incoming paediatrician later that morning, she performed another review and documented that the child's circulation had improved despite the patient's continued critical condition.

Based on the consultant's recommendations, there was no significant alteration to the existing treatment plan apart from broadening the differential diagnoses and continuing close monitoring. She further testified that she completed a formal handover to the incoming medical

team after communicating with the haematologist regarding the patient's progress.

She testified that all relevant laboratory reports and clinical findings were communicated to the consulting haematologist by telephone. she was subsequently informed that the patient had been transferred to the ICU under the care of the paediatric consultant, although she could not personally confirm the exact timing of the transfer.

That the patient's initial haemoglobin concentration on admission was approximately 10 g/dL and that no repeat complete blood count had been performed until she reviewed the child at approximately 4:40 a.m. The repeat investigation later demonstrated a haemoglobin level of 6.7 g/dL. However, by the time those results became available, the patient was already under the care of the consultant paediatrician and intensivist.

She testified that although blood transfusion would ordinarily be considered for such a low haemoglobin level, she was also mindful that aggressive fluid resuscitation could result in haemodilution, producing falsely reduced haemoglobin values. She testified that if she had remained the primary treating physician, she would have carefully evaluated the possibility of true anaemia versus dilutional anaemia before proceeding with transfusion and where clinically appropriate, would have considered administering packed red blood cells with close monitoring for fluid overload.

She testified that subsequent review by the senior clinicians resulted in the prescription and administration of a blood transfusion after the patient's haemoglobin was confirmed to be 6.7 g/dL.

That the child had originally been admitted with fever, vomiting, diarrhoea, and neutropenic sepsis. Upon reviewing the patient, she diagnosed hypovolemic shock resulting from severe gastrointestinal fluid losses and immediately instituted fluid resuscitation while arranging urgent specialist review.

That the repeated laboratory investigations were requested because the patient's clinical condition had significantly deteriorated. She stated that changes in the patient's physical examination warranted repeat blood investigations to guide further management.

That the patient's severe sepsis was supported by markedly elevated inflammatory markers, profound neutropenia, and significantly raised

procalcitonin levels. She emphasized that sepsis constituted a medical emergency requiring the administration of broad-spectrum antibiotics within the first hour of recognition in accordance with accepted clinical practice.

She testified that although transfer to the HDU had been planned, admission required informed consent from the patient's caretaker because of the additional costs associated with higher-level care. That the patient was ultimately reviewed by the intensivist, who determined the most appropriate level of care based on the patient's evolving clinical condition.

She stated that during night duty she prioritized reviewing critically ill patients immediately after receiving handover from the outgoing team; although she was simultaneously managing other emergencies, she attended to the child promptly once informed of the deterioration and initiated all necessary emergency interventions without delay while ensuring timely referral to the appropriate specialists.

8. Musiitwa Peter- (11th Respondent's Witness).

Musitwa Peter stated that he is an enrolled nurse and had been working at Nakasero Hospital since 2024. He works in the paediatric department.

He stated that he received the patient from the resuscitation team in the morning and participated in the nursing care until the patient was transferred to HDU. He testified that Dr. Namugerwa Shamim, Dr. Namutebi Catherine and Dr. Owomuhangi Racheal reviewed the child when he was still on the pediatric ward.

9.Dr. Ninsiima Lynette-(11th Respondent's witness)

Dr Lynette Ninsiima is a director of clinical Services at Nakasero Hospital. She is a degree holder of MBChB and MMED Obs/Gyn. She testified that one of her roles as an administrator includes but not limited to overseeing clinical governance and implementation of the clinical strategy. She also practices as an Obstetrician/Gynecologist at Nakasero.

She further testified that on 20th November 2024 at around 9:40am, Elijah Atangaaza was received at the hospital complaining of fever and pain in the left thigh. He was sick-looking but fully conscious and not in distress.

His mother reported that he had developed high-grade fever two days earlier and had a cough for a week and that he had been treated the previous day at St Anne Marie Clinic and given antibiotics.

The initial concerns were his high temperature and the pain and swelling in his left femoral area. He was given paracetamol and started on IV fluids, as he had reportedly not been eating. The test results from St Anne Marie Clinic were inconclusive — the CBC count was missing parameters — so samples were taken for CBC, malaria, urinalysis and an inguinal ultrasound of the swelling.

At around 11:30am, Nakasero's own results showed leukopenia and severe neutropenia with indications of infection, confirmed by pathologist Dr Kawalya. The mother was informed immediately and advised that admission was necessary; she photographed the results to consult third parties before accepting, which took some time. The attending paediatrician, Dr Shamim Namugerwa, spoke by phone to a person the mother wished to consult, after which the mother agreed to admission.

Elijah was admitted at 12:10pm and started on antibiotics, with monitoring to determine whether anti-fungal or anti-viral cover would also be needed. Haematologist Dr Ssali Francis was contacted but was initially unreachable; a message was left and he responded later. Management focused on the fever, pain, antibiotic cover, and investigating the cause of the low white cell count and possible infection; treatment began in the treatment room. Further samples were taken to assess organ function, and the results were unremarkable at the time.

Nurses monitored his vitals throughout, updating Dr Shamim, who adjusted treatment as needed. By around 1:00pm his temperature had fallen to 37.5°C. At around 5:00pm he had diarrhoea for the first time, and by 6:00pm the fever had returned though his other vitals were normal; the mother was reassured. At around 7:00pm he had a further, non-severe loose stool; anti-fungal and anti-viral cover (Acyclovir and Fluconazole) was added for broader protection, and IV fluids continued to replace losses from the diarrhoea.

At around 10:00pm Elijah was moved from the treatment room to a private room in the paediatric ward, after the room had been fumigated following its previous occupant, for further management and monitoring. Through the night he was directly monitored by the ward team of nurses and a medical officer.

At around midnight, the Hospital's Head of Critical Care, Dr Lameck Ssemogerere, received a call from a third party outside the hospital raising concerns about Elijah's management, despite the ward team already attending to him. As a courtesy to the caller, Dr Ssemogerere asked the Intensivist on duty, Dr Bruno Sserunkuma, to review Elijah.

At around 12:10am, Dr Sserunkuma reviewed Elijah and endorsed the existing treatment plan, noting that the main concerns were fever and acute diarrhoea, already being managed. As a precaution he added ORS and zinc tablets to replace lost salts, and low-flow oxygen (2L/min) via nasal prongs, as his oxygen saturation was slightly low (88% on room air).

At around 1:00am the cannula tissued and attempts at a new peripheral line failed. Dr Sserunkuuma was called to assist and advised the mother that a central line was needed; she declined and asked him instead to try again for a peripheral line, which also failed. When he repeated the advice, she asked to consult the father on whether and where a central line should be inserted. The father was called and, after Dr Sserunkuuma explained the need for a larger line to resuscitate the child and why the femoral site was unsuitable given the risk of contamination from the diarrhoea, agreed to insertion in the right internal jugular vein, including sedation since the child would not otherwise remain calm and compliant. Elijah was given intramuscular ketamine and the central line was successfully inserted; a chest X-ray confirmed correct placement. Diarrhoea continued during this period.

At around 4:40am Elijah was noted to have cold extremities and was clinically in hypovolemic shock, likely from the diarrhoea, having had more than ten loose stools within an hour. The nursing team alerted Dr Hajarah Nakazibwe, covering the paediatric ward, who found low blood pressure consistent with hypovolemic shock and called Dr Shamim and Dr Sserunkuuma. It was agreed that fluids be administered per shock protocol and that the existing revised plan continue. Dr Hajarah also consulted haematologist Dr Christine Ssekajja by phone, who recommended repeating the septic screen, an abdominal ultrasound, continuing antibiotics, antifungals and acyclovir, and considering a bone marrow biopsy once the child was stable.

Between 6:30am and 7:00am, Dr Sserunkuuma again reviewed Elijah and prescribed a fluid bolus of 30ml/kg (700ml) over one hour and started noradrenaline infusion at 0.04mcg/kg/min. Further results showed low haemoglobin and potassium, prompting a prescription for blood

transfusion and calcium. He also advised transfer to the High Dependency Unit, which the mother initially declined, hoping the child would improve on the ward; by then the diarrhoea had stopped and his condition had improved. She agreed to HDU care at around 6:30am, but because of his vulnerable neutropenic-sepsis status requiring isolation, he could not be moved to the general HDU; instead, his private room was elevated to HDU level, with dedicated care from an Intensivist, two paediatricians, and monitoring/support equipment.

At around 9:00am, results showed liver malfunction, kidney injury and abnormal electrolytes, and a blood gas analysis showed elevated acidosis; haemoglobin was 10.1 and the planned transfusion was held. Paediatric nephrologist Dr Anthony Batte was consulted and advised continuing efforts to correct the acidosis and stabilise the child before further treatment. Dr Shamim then took further history from the mother, learning for the first time that Elijah had been treated for a skin rash for two weeks with dapsone and prednisone — information that did not change his immediate management but offered a clue to the cause of his neutropenia.

On this basis, management proceeded with serial arterial blood gas monitoring for metabolic acidosis, urinary catheterisation with fluid balance monitoring, continued antibiotic, antiviral and antifungal cover, increased calcium gluconate and IV potassium chloride, consideration of a bone marrow biopsy once stable, repeat serum electrolytes, and continued HDU-level care with barrier nursing and infection-control measures. By this stage, six staff — two Intensivists, two paediatricians, one nurse and one ICU nurse — were attending to him.

At around 11:00am, Dr Batte, updated again, advised introducing sodium bicarbonate to address the acidosis and continuing monitoring.

At around 2:00pm, a family conference was held with the mother and an uncle. She was told Elijah had sepsis, was being treated for possible infection, and was having electrolytes corrected after significant fluid loss from diarrhoea. Dr Shamim explained his breathing difficulty and the ABG findings of increased blood acidity, likely linked to the fluid loss, and that sepsis, acidosis and shock together had caused his reduced consciousness. Intensivist Dr Catherine Namutebi explained that he was receiving cardiac support medication for low blood pressure, fluids and electrolytes to correct blood pressure and acid-base balance, and blood to keep haemoglobin from falling below 8.8g/dl. She advised that a brain CT would be done to rule out structural causes of his reduced consciousness.

At around 4:00pm, Elijah regained consciousness but was agitated and confused, while under intensive support including three cardiac medications. Given his continued instability despite this high level of support, the decision was made to transfer him to the ICU because of the high risk of organ failure.

At around 7:00pm, Elijah was transferred to the ICU. His parents repeatedly asked why he had been taken from them and why they could not see him; they were told he was very unstable, on three pressor drugs, and being continuously resuscitated. At around 8:45pm, a further family conference was held with both parents, who raised questions about his condition, the reasons for the moves to HDU and then ICU, the involvement of the paediatric nephrologist, their limited contact with him, and the fact that dialysis could only be considered in consultation with the nephrologist; these were addressed by the doctors. Through the night the ICU team monitored him and he remained unstable, requiring support for multiple organs.

Having gone through the night, the ICU team determined that advanced respiratory support, and intubation, were necessary, Elijah being by then on high-dose catecholamine support. At around 8:00am, a family conference was held by Dr Lameck Ssemogerere, Dr Philo Nambooze and the mother, who was advised of the need for sedation and intubation and that the underlying insult had damaged his kidneys, liver and brain; she consented to intubation. The team also asked that the father return, since Elijah's mother was not comfortable making treatment decisions alone and the father's involvement was needed at what was a critical stage requiring quick decisions. By now both the night and day teams were working together given his instability, with three Intensivists, one paediatrician and ICU nurses attending to him exclusively.

Haematologist Dr Francis Ssali reviewed Elijah, was briefed on his history and treatment, and noted multiple skin bruises and scalding. Based on this and his examination, he suspected staphylococcal scalded skin syndrome with septic shock, and considered the neutropenia likely related to the dapsone Elijah had been taking for two weeks; a bone marrow biopsy was deferred as he was too unwell, to be reconsidered once stable.

At around 10:18am, while being connected to a ventilator, Elijah's heart rate dropped and he suffered a cardiac arrest; Cardiopulmonary Resuscitation (CPR) was successful, but he went on to suffer repeated cardiac arrests, with the ICU team continuing resuscitation attempts.

Concerning delayed transfer to HDU/ICU, she stated that there was no delay. The mother had been reluctant to move Elijah to HDU, hoping he would improve, but the Intensivists insisted on the need for multi-organ support and close monitoring. Rather than moving him to a general HDU room, his private room was elevated to HDU level, with dedicated care from an Intensivist, two paediatricians, and monitoring/support equipment. HDU-level care began at around 6:00am on 21st November, when organ support commenced and the mother agreed to the transfer. Having stabilised, albeit on heavy medication, by around 4:00pm on 21st November, he was moved to the ICU at around 7:00pm. She denied that he was seen by an Intensivist at 1:00pm having last been seen at 7:00am; rather, Dr Sserunkuuma's final review was at 7:00am, after which he handed over to Dr Catherine Namutebi, who together with Dr Shamim attended to Elijah from 8:00am throughout the day.

In regards to ethical concerns in HDU/ICU, she stated that it was not possible to allow the parents unrestricted access while Elijah was under resuscitation and intensive support. He was under close monitoring by his medical care team and as soon as he stabilised, the parents were briefed at a family conference and permitted to see him.

Several family conferences were held with the parents, particularly the mother, Ms Yvonne Ampaire, who was present throughout and kept informed; the father was also regularly updated by phone and the team remained available to him whenever he asked.

In response to the inexperienced medical team, she denied that the team of up to fifteen practitioners who attended to Elijah was inexperienced; all were adequately qualified and experienced, and their practice records could be obtained from the Council.

In response to insufficient communication with the child's attendants, she retaliated that Elijah's mother, present at the Hospital throughout, was consistently briefed and reassured, and his father was engaged by telephone with matters explained to him; in addition, three family conferences were held within 48 hours of admission.

In regards to failure to refer to a better-equipped facility, she stated that the hospital had adequate capacity to treat the child and there was no indication requiring referral elsewhere. Although the father raised the possibility of airlifting Elijah to Nairobi, he was advised that the child was

too ill and unstable for evacuation; the parents did not request referral to another facility.

In response to failure to perform toxicology tests, she informed the Council that there was neither an explicit request for toxicology testing nor any medical indication for it. All necessary tests were conducted and their results considered. On 22nd November 2024, despite there being no clinical indication, Dr Ssemogerere suggested toxicology testing to help rule out other causes by exclusion, since other tests had failed to establish the cause of Elijah's illness. Elijah passed away before such tests could be conducted, and it could not be said whether they would have been useful.

She denied the allegation of early detection of critical illness without attention due to absence of experts. She stated that although the patient appeared only mildly ill, he was in fact very sick on arrival, as shown by his low neutrophil count, and most of his time at the Hospital was spent managing the rapid decline in his condition and attempting to stabilise him for further investigation. On admission his complaints of fever, pain and left femoral swelling were examined and addressed. Despite an early diagnosis of neutropenic sepsis, the cause of the neutropenia could not be established despite extensive testing. All necessary expert input was obtained throughout his management, and it was denied that there was any lack of expert involvement.

In conclusion, she expressed sympathy to Elijah's parents and family for his death and regretted that he could not be saved, while maintaining that all necessary treatment and management was provided to him and that no lapse or gap in his care contributed to his death.

10. Dr. Ssali Francis- (Respondent)

Dr. Ssali testified that he is a medical doctor with MMED in internal medicine and fellowship in clinical haematology, retired but does clinical consultations at Nakasero Hospital. He stated that he was consulted by the paediatrician about the situation of Elijah and his management.

He stated the child had a febrile neutropenia and needed antibiotic therapy with or without fluid management. He added that the term did not have enough time to get to the root cause of the problem. The child had blood samples drawn, including cultures, to investigate the cause of a persistent fever, and that the child was then started on broad-spectrum intravenous antibiotics. He was asked to comment on whether the choice of antibiotics

given had been reasonable given the circumstances. He explained that treating a neutropenic child with related fever is inherently difficult, given the reality of antibiotic resistance.

In his opinion, the antibiotic chosen; a formulation covering a broad range of gram-positive and gram-negative organisms, similar to piperacillin-tazobactam was a reasonable first choice given that the fever appeared to have originated in the community rather than in hospital. He noted, however, that the clinical picture evolved very rapidly; the child developed skin changes, including blisters. The team wanted to see if he could do a bone marrow biopsy but the child was too sick to do such an invasive procedure.

He explained that children with low blood counts are generally advised to stay away from hospital settings, when possible, since exposure increases the risk of acquiring an infection that then becomes very difficult to treat. He noted that supportive measures — such as agents to raise blood counts — exist, but are not first-line in an urgent situation, since they can take around three days to take effect, which is time a critically ill patient often does not have. For that reason, the priority is always to start an appropriate broad-spectrum antimicrobial as early as possible, then reassess based on microbiology results, escalating treatment if there is no improvement within roughly 24 to 48 hours by adding or changing medication as needed.

He stated that decisions in cases like for late Elijah are made by a team rather than by a single clinician. Different specialists may reasonably propose different approaches but such differences typically reflect reasonable clinical judgment rather than error. He concluded that once a decision has been made by the team and acted upon, the central goal throughout remains the same: to get the child out of the acute infective crisis, since that infection was what was most likely to be fatal if not brought under control.

Analysis by the Council

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.***

Blyth vs Birmingham water works co. (1856) defined negligence as "doing something which a reasonable man would not do" or failing to do what a reasonable man would do.

In Doughue vs Stevenson (1932) court was of the view that, to successfully prove a negligence claim, the law requires four main elements to include (i) the existence of a duty of care; (ii) breach of that duty, assessed against the applicable standard of care; (iii) a causal link between the breach and the injury or death complained of and (iv) resultant damage.

The Council carefully considered the evidence on record and observed the following;

Elijah, a 6-year-old male was admitted to Nakasero Hospital on 20th November 2024 at 09:00hrs with a 2-day history of fever, pain and swelling in the right inguinal region. Prior to this, he had had cough and flu for a week from which he was improving on Amoxiclav and a cough expectorant. Notably on examination he had a fever of 39.6, small cervical and inguinal lymphadenopathy, a non-tender hepatomegaly of 4cm below the coastal margin

Laboratory investigations revealed a leukopenia of 0.3, severe neutropenia of 0.01, Hb 10.3, CRP of 64.03 and a negative malaria test.

An impression of Neutropenic sepsis was made, querying the cause and they were to rule out a viral illness, leukaemia, autoimmune cause ad any drug related cause.

More laboratory tests were ordered for, antibiotics (Piperacin-Tazobactam) started and were to consider antifungals and antivirals, maintenance I.V fluids prescribed. Haematologist's review requested and barrier nursing instructed.

A few hours later, the child still had fevers, 3 episodes of diarrhoea and 1

of vomiting, mildly dehydrated and fully conscious. The paediatrician added an antifungal and antiviral to the treatment, a normal saline bolus and encouraged feeding.

At around midnight, an intensivist reviewed the child who had reduced consciousness, still had a fever, saturating at 88% on room air, tachypneic at 48 beats per minute(bpm), hypotensive at 84/40mmHg, tachycardic at 154bpm with moderate dehydration, warm peripheries and a Capillary Refill Time (CRT) of <2seconds. He continued with maintenance fluids and added on 60mls of oral rehydration solution for each loose motion despite signs of hypovolemia, altered consciousness, ongoing diarrheal and vomiting. This deviates from the expected standard of care for such a child with sepsis and signs of hypovolemia requiring aggressive fluid resuscitation, mindful of fluid overload.

At 04:00hrs on 21st November 2024, a central line was inserted uneventfully and records show the cannular had tissued and the team had tried to place a peripheral line but failed, an intensivist called in to place a central line, the mother was hesitant but later agreed.

Later at 06:30 hours, child went into hypovolaemic shock, the intensivist called, child started on Noradrenaline and recommended admission to ICU to which the mother declined, hoping the child would get better.

The CRP had doubled, Hb to 6.7, WBCC to 0.17 and neutropenia of 0.00. A haematologist was consulted on phone and recommended a septic screen, correct electrolyte imbalances and the Acute Kidney Injury (AKI), abdominal ultrasound scan, continue the antibiotics, antifungal and antiviral, and that he would review later.

Further history indicated the child had been on Dapsone for about 2 weeks, a possible cause for the neutropenia

The child continued to deteriorate, with low level of consciousness and other signs of shock. More vasopressors were added, antibiotics, more laboratory tests taken and a nephrologist consulted over phone.

It is unclear when the mother consented to HDU/ICU admission but the child was later admitted to ICU where he continued to receive care but later died.

Internationally accepted protocols for febrile neutropenia (an absolute neutrophil count below 0.5×10^9/L accompanied by fever) treat the combination as a medical emergency requiring empirical broad-spectrum antibiotic cover — conventionally an anti-pseudomonal beta-lactam such as piperacillin-tazobactam — ideally within one hour of recognition, on the established rationale that an immunocompromised child can decompensate into septic shock within hours (www.thelancet.com). The initial care offered is in agreement with this internationally accepted protocol.

The subsequent additions of antifungal (Fluconazole) and antiviral (Acyclovir) cover is also in line with standard febrile-neutropenia algorithms which generally reserve empirical antifungal/antiviral escalation for persistent or recurrent fever despite antibacterial cover, rather than immediate simultaneous administration, so this component of the care was also reasonably offered.

Concerning multidisciplinary care, the admitting paediatrician is seen to have indicated need for other specialists from the mentioned areas, including phone calls. In Uganda where there are very few people in particular fields, Phone consultations are acceptable and recommended treatment plan was instituted. However, these telephonic consultations were informal, not documented nor recorded. Clinically, telephonic consultant input is an accepted and common modality in resource-constrained settings and does not, in itself, fall below a responsible body of practice; however, the absence of contemporaneous documentation of the substance and timing of that input is a material evidentiary and record-keeping deficiency that hampers, rather than assists, both the family's and the Council's ability to verify what was in fact advised and when.

Escalation of the level of care (ward → HDU → ICU)

On 21st November 2024 at 0630 hours records indicate that there was a discussion with the mother to have the child admitted to HDU/ICU but she objected hoping that the child would get better. The next intensivist's review is at 1300 hours and more vasopressors were added, indicating the child was very sick.

The subsequent escalation to the ICU after parental consent at approximately 1900hours, prompted by persistent haemo-dynamic instability despite maximal room-level support, is consistent with an incremental, response-driven escalation model rather than an unexplained delay.

Restriction of parental access and family communication

Restricting family presence during active resuscitation and immediately following invasive procedures is a recognized and defensible feature of international critical-care practice, adopted to protect both the safety of the intervention and the family from unnecessary distress. Dr Lameck's own evidence, however, that this policy "may not have been clearly explained to the family at the time" and that "communication around this aspect of care should be improved," is a fair and appropriate concession. The restriction of access does not, in itself, disclose negligence.

Failure to refer to a better-equipped facility

A decision to decline an inter-facility transfer of a child on multiple vasopressors and maximal organ support is ordinarily well founded in clinical practice, since transport of a hemodynamically unstable patient carries a materially elevated risk of deterioration or death in transit. On the evidence, by the point at which referral was actively raised by the father, the deceased's condition appears to have already been such that transfer was genuinely hazardous. This weighs against a finding of negligence on this specific issue.

Toxicology testing

There is no cogent evidence of a specific clinical indication for toxicological analysis at the material time; its suggestion by Dr Ssemogerere on 22 November 2024 was, on his own evidence, a diagnosis of exclusion proposed after other investigations had failed to establish a cause, and was overtaken by the child's death before it could be performed. No breach is established on this issue.

CONCLUSION ON LIABILITY

The Council notes that this patient presented with neutropenic sepsis but there delay in recognition of the condition and its subsequent management. The child was not reviewed by any medical officer between 7.30pm and midnight on day 1, until the parents called for outside help. There was no evidence of duty coverage during this period. A further gap in monitoring of the patient was noted between midnight and 4am on day 2 of admission.

There was inadequate fluid resuscitation of the patient at the point when the intensivist (Dr. Sserunkuuma Bruno) identified features of hypovolemia but did not escalate fluid therapy at midnight. This could have potentially led to the subsequent deterioration in the clinical condition of the patient.

Absence of adequate documented follow-up of a critical patient by doctors demonstrates a failure in hospital organization of patient care. The Council hereby finds Nakasero hospital Limited vicariously liable for negligent omission by staff acting in course of their employment.

Issue 2: What appropriate sanctions or recommendations should be issued.

RECOMMENDATIONS

In respect of the specific respondents

1. The Council hereby suspends Dr Serunkuuma Bruno for a period of six months with effect from 1st December 2026 to 31st May 2027.

2. The Council finds no acts of negligence or misconduct against Dr. Namugerwa Shamim, Dr. Owomuhangi Rachael, Dr Semwogerere Lameck, Dr Ssali Francis, Dr. Namutebi Catherine, Dr. Nambooze Philo and Dr. Nakazibwe Hajjarah.

3. **In respect of Nakasero Hospital Limited.** Nakasero Hospital should ensure continuous 24 hours physical clinical cover with a clear handover and back-up system when the responsible clinician is unavailable. Institute protocols and train its staff on management of neutropenic sepsis in children.

Signed on this .....12th.....day of .....November.....2026 by

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