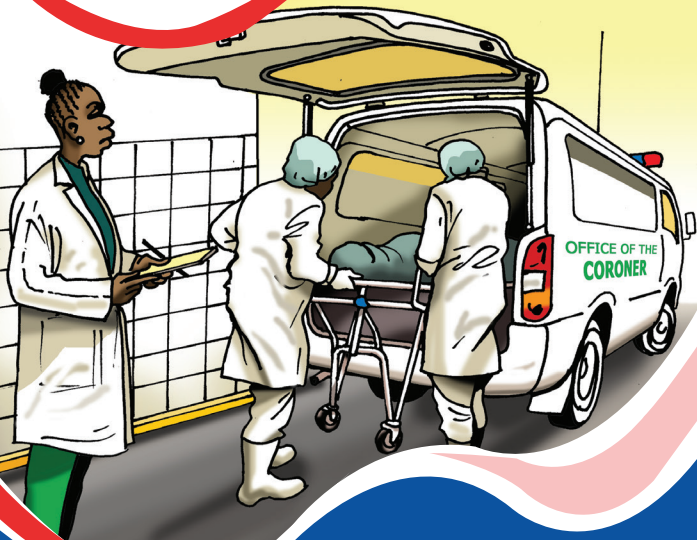


SUMMARIZED VERSION OF THE NATIONAL CORONER'S SERVICE ACT 2017



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Independent Medico-Legal Unit

A World free from Torture, Violence and Discrimination

ACKNOWLEDGEMENT

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FOREWORD

The Independent Medico-Legal Unit (IMLU) is a governance, health and human rights nonprofit organization, whose vision is A World Free from Torture, Violence and discrimination. Our work is underpinned by a holistic approach involving litigation, medical and psychosocial rehabilitation of survivors of torture, monitoring government adherence to its human rights obligations and advocacy for policy, legal and institutional reforms. Over the last two decades we have assisted over 5,000 victims of torture, cruel, degrading and inhuman treatment through the support of our national networks of professionals: doctors, trauma counsellors, lawyers, human rights monitors and journalists.

IMLU has been at the forefront of advocating for the enactment of this Act by bringing together the diverse technical

expertise of legal and other experts within government agencies, parliament and civil society. Securing the political good will to have the Act successfully go through the legislative process was the biggest challenge. Thanks to the tenacity and hard work of those championing the bill, including the Parliamentary Human Rights Caucus and the civil society.

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1

INTRODUCTION

WHAT IS THE STATUS OF DEATH INVESTIGATIONS IN KENYA?

Article 26 of the Constitution of Kenya 2010 provides that everyone has a right to life and prohibits the arbitrary deprivation of this right. However in spite of this, extrajudicial killings and arbitrary deprivation of the right to life is a common phenomenon in Kenya.

In the 2007/2008 post-election violence over 1100 persons died, 450 from police action, yet majority of these killings were never investigated nor perpetrators prosecuted. In a research report, *Guns: Our Security: Our Dilemma: Guns our security our Dilemma: Law Enforcement, Firearm Deaths and Community Perceptions of Violence*, the Independent Medical Legal

Unit documented 1873 deaths from use of firearms in seven mortuaries in Kenya from 2009-2013. Majority of the deaths (97.3%) were homicides, while suicides and accidental shootings accounted for 1.0% and 1.1 % of deaths respectively. Most gun deaths (67.0 %,) were by law enforcement agents, followed by robbers/thugs and an undetermined group in 13.9% and 17% of cases respectively. The circumstances of shooting fatalities were not determined for majority (46.7%) of cases or 867.

On the other hand, the overall quality of documentation of the circumstances of injury and the autopsy conduct was inadequate. Forensic features of gun wounds including, size, shape, muzzle imprinting and tattooing were undocumented in a majority of cases, thus rendering most of the autopsy reports unhelpful in criminal proceedings.

Prior to 2010 Kenya had a history of unresolved reportable deaths including the death of Josiah Mwangi Kariuki and

Robert Ouko among other cases. Before the enactment of the National Coroner's Service Act 2017, the police had the liberty to decide whether or not and how they will undertake investigations. Upon the conclusion of the investigations they would then decide whether they will proceed and open an inquest in Court or not.

Section 385 to 388 of the Criminal Procedure Code empowers a magistrate to hold inquests to seek information as well as try to establish the truth in cases where the cause of death is unclear or where the death is arising from an accident. Upon conclusion of the inquest the findings of the Magistrate are then forwarded to the Director of Public Prosecution for further direction mostly with a recommendation to charge the person(s) who have been adversely mentioned in the course of the inquest.

Given the fact that the police have a lot of discretion as to what goes into the evidence or not, in many cases where the suspect is

a 'powerful individual', a police officer or is a public officer then there would be a lot of cover up. This has meant no justice for many victims and their families.

The National Taskforce into Police Reforms (Ransley Task force) recommended the need for Kenya to establish a coroner system which would facilitate independent death investigations. After about 8 years of stakeholder engagement, lobbying and advocacy, the National Coroner's Service Act was finally enacted into law in June 2017.

2

DEFINITION OF IMPORTANT TERMS

Coroner General

This is the person in charge of conducting investigation of deaths in the whole country. He or she is however represented at the county level by Coroners. The Coroner-General is also the Chief Executive Officer of the National Coroner's Service.

Coroner

This is a person who is in charge of conducting investigation of deaths provided for under the National Coroner's Service Act within a County.

Forensic evidence

It is the application of scientific methods used in a court of law to aid in the investigation of a crime.

Reportable deaths

This is a special category of deaths that must be reported to the police and or the Coroner. They are deaths that arise from unnatural causes e.g. where a person dies after being discharged from hospital.

State Organ

A commission, office, agency or other body established by the Constitution of Kenya e.g. The Kenya National Commission on Human Rights.

A coroner is a qualified person or official whose duty is to investigate the cause of any death occurring due to non-natural cause. He/she will generally not be involved where a person died from some natural illness.

3

WHAT IS THE NATIONAL CORONERS SERVICE?

Section 6 of the National Coroner's Service 2017 establishes the National Coroners Service. It provides that the National Coroners Service will be a legal entity that will continue to exist in spite of for example the death, resignation or removal of the Coroner-General or any of the people working there. The Act further provides for the composition of the National Coroners Service which shall include: the Coroner-General; the Coroners and any other officers and members of the Service who have been properly appointed to serve.

3.1 What is the importance of the National Coroner's Service Act?

- (a) The Act establishes a Coronial Service which did not exist earlier. It creates a comprehensive legal framework that will guide death investigations in the country particularly those deaths that have been classified as reportable deaths.
- (b) The Act envisages that the National Coroner's Service will be independent i.e. free from any interference;
- (c) It has expanded the type of deaths that should be reported and investigated. Previously under the Criminal Procedure Code¹, only deaths arising from suicide, deaths occurring as a result of an accident, cases of murder, deaths in custody, deaths that occurred in the course of the commission of criminal acts and instances where a person has gone missing and is suspected to have died were reportable.

¹ Chapter 75 of the Laws of Kenya

Some other types of deaths that have now been included by the Act are

- 1) Cot deaths,
 - 2) Infanticide,
 - 3) Deaths that occur during a pregnancy
 - 4) Deaths that occur as a result of termination of a pregnancy,
 - 5) Deaths that arise out of sexual offences
 - 6) Where a person dies after being discharged from hospital,
 - 7) Deaths that result from negligence of a medical practitioner.
- (d) It gives the Coroner General/ Coroner, power to be in control of the body in the course of investigation and disposal of a body once the investigations are concluded;
- (e) It provides that all reportable deaths will be subjected to an investigations regardless of the person(s) faith;

- (f) The Act provides that the State will absorb the cost of conducting a post mortem examination. A person would only incur costs if they seek a second opinion.

3.2 What are the functions and powers of the National Coroner's service?

3.2.1 What are the Functions of the Coroner-General?

- a) Co-ordinate the services throughout the country;
- b) Ensure efficient delivery of the functions and services of the Service in accordance with the Constitution, this Act and any other written law;
- c) Ensure that all deaths which the Service has power to investigate are properly investigated and in a timely manner;
- d) Monitor and evaluate investigations of deaths by the Service;

- e) Issue guidelines to other coroners to assist them in the exercise or performance of their functions;
- f) Perform such other functions as are conferred or imposed by or under this Act or any other law

3.2.2 What are the Functions of Coroners?

The Coroner shall be in charge of the coronial services in the County where he or she is based. The Coroner will also be in charge of the reportable deaths which occur or are reported within the County he or she is based as directed by the Coroner-General.

3.2.3 What are Powers of the Coroner-General?

The Coroner has the power to approve the issuance of the following: burial permits; cremation permits; waivers of post-mortem; post-mortem permits and authority to move dead bodies into or out of Kenya. The Cabinet Secretary responsible for matters relating to justice has the responsibility to

develop regulations on how the documents will be issued. In making the regulations, the Cabinet Secretary responsible for matters relating to justice will also consider the other written laws that also provide for the issuance and registration of the documents.

3.2.4 What is the General responsibility of a Coroner?

The Coroner is required to: Undertake his or her duties without delay and in the performance of his or her duties and as he or she is exercising the powers provided by the Act must put in mind the regulations that have been developed and put in place by the Coroner-General.

4

WHAT ARE REPORT REPORTABLE DEATHS AND HOW ARE THEY INVESTIGATED?

4.1 Are there Obligations in law to report certain deaths?

A person who believes that another person died as a result of the following actions, has a duty to report that death to a police or a coroner:-

- The death occurred as a result of violence e.g. a person has been beaten to death in a domestic violence case; the death resulted from an accident such as a road accident or an accident in the home or at work;

- The death occurred as a result of a doctor failing to treat the person according to the right procedure or the police failed to take a detainee to hospital i.e. negligence;
- The death occurred during a pregnancy or after the mother has delivered the baby; the death occurred suddenly and unexpectedly;
- The death was as a result of a sickness for which that the person was not treated by a qualified medical professional
- Where the person died in the police cells, in prison, while being detained by the military. Once the police officer has been notified of such a death, then he or she has a duty to inform the Coroner immediately.

4.2 What happens when a person dies while in custody?

In the case of a death in custody;

- The officer in charge of a police station, prison, military or any other place of detention has the duty to report to the Coroner.
- The report must be made immediately or at least within 6 hours of the death occurring. Where the officer in charge of a place of custody is not able to report within the stipulated time, the officer shall also file a report giving reasons why there was a delay.
- The Coroner is required to forward a report of his investigation in the case of a death occurring in police or prison custody to the Independent Policing Oversight Authority (IPOA).

4.3 What happens when the deceased religious beliefs demand immediate burial?

The Coroner-General has a duty to perform medical investigations on bodies of all people who he or she suspects that they died as a result of criminal actions. The medical investigations will be conducted irrespective of the person's faith or other considerations.

4.4 What procedure will be followed where a death has occurred as a result of a criminal action?

Once the Coroner has established that the death of a person came about as a result of some criminal actions, he or she is required to forward the report of the medical investigations to the Director of Public Prosecution and the Inspector General. The report should be accompanied by the names and addresses of any witnesses who may assist in the case.

4.5 What are the deaths that should be investigated by the National Coroners' Service?

Deaths that should be investigated by the service include when;

- a) A person dies a violent or an unnatural death;
- b) A person dies suddenly and the cause is unknown;
- c) A person dies in police custody, prison or military custody;
- d) A person dies during or following an assault within twenty four hours following a surgical procedure(s);
- e) The death occurs during or following administration of anaesthesia;
- f) The death occurs within twenty four hours after a person is discharged from hospital or any health facility;
- g) A person suffers an injury and dies within one year and one day;
- h) It is a suspected maternal death,

termination of birth, cot deaths and sexual violence related deaths;

- i) It is a case of infanticides
- j) Reportable deaths as provided for in the Act or any other law.
- k) Death occurs in an institution with children facility e.g. a nursery school or day care or mental hospital;
- l) Death occurs during or while a person is in the care of any institution or person such as a hospital;
- m) The death was as a result of child abuse;
- n) It is in a place and in such circumstances as may require an investigation under any other law within the authority of the Coroner –General.

4.6 Who has the mandate to collect forensic evidence in a crime scene?

A coroner has the power to collect forensic and other evidence and to preserve it in the manner as the Coroner-General may from time to time specify.

5

INVESTIGATION AND REPORTING

5.1 Why undertake death investigations?

Reasons for undertaking death investigations include;

- i. Identifying the deceased person;
- ii. To understand the circumstances under which the person died. This includes knowing how the death occurred, when it occurred and where it occurred, the cause and manner of death;
- iii. The information particulars required under the Births and Deaths Registration Act to register the death;

- iv. The preventive measures that may be taken to prevent similar deaths and
- v. Any other particulars as may be required under any other written law.

5.2 When does the Coroner conduct of investigations?

Where a coroner becomes aware of the death of any person to which this Act applies or is notified of the existence of a body of a person in a place within his or her area of operation (jurisdiction) and there is reason to believe that the death is a reportable death or the death is as a result of a criminal action or it's a death that should be investigated by the service then he or she must investigate that death as soon as possible.

5.3 Is the Coroner required to make a report on investigations conducted?

A coroner is required to make a report of every investigation conducted under this Act; He or she is then required to forward

the report to relevant institutions such as the Inspector General of Police, the Office of the Director of Public Prosecutions and the Independent Policing Oversight Authority. The Coroner is also required to give a report to interested persons.

The Coroner should submit the report within seven (7) days from the date he or she was notified of the death. For purposes of criminal investigations and subsequent prosecution of an offence under any written law, the Coroner must submit an interim report to the National Police Service and the Director of Public Prosecutions or any other relevant Authority within twenty four hours (24) of notification of a death under the Act.

The Coroner is required to submit the final comprehensive report to the Director of Public Prosecution or the National Police within seven (7) days from the date the Coroner received notification that a death had occurred.

5.4 What Information should be contained in the Coroner's report?

It is important to note that the Coroner is required to sign every report of an investigation that he or she has with his or her name and details of the office they are holding. The report must have the following information:-

- i. Where, when and by whom the investigations were conducted;
- ii. Who the deceased person was;
- iii. Where the body of the deceased lies;
- iv. Where, when and how did the deceased person meet his or her death;
- v. Measures that can be taken by the authorities to prevent similar deaths from taking place;
- vi. Any other matter that the Coroner deems necessary.

Where the name of the deceased person is unknown the Coroner will describe the bodily features of the deceased. An investigation report will not be disqualified based on any

5.5 When is the Coroner's report legally sufficient to establish a fact or a case unless disproved evidence?

For purposes of investigation, prosecution and hearing of a matter before court, a report made by the Coroner under this Act with regard to cause of death shall be deemed legally sufficient to establish a fact or a case unless disproved and should be recognizable as such. A person who is not satisfied with the findings of the Coroner under this Act has the right to get a second or other opinion on the cause of death.

5.6 Does a person have right to a second opinion?

Any person who is not satisfied or who disagrees with the report or finding of the Coroner may, at his or her own cost,

seek second or other opinion from other qualified officers. Where second or other opinions are sought, the Coroner may attend or send his or her representative to be present during the investigation;

The Cabinet Secretary in consultation with the Coroner-General will make regulations to give full effect to this section and in particular provide for: A framework within which repeat post-mortems may be conducted; the implications of the second or other opinions sought; the process to challenge the decision of the Coroner with regard to his or her decision on reportable deaths; the person who may be present during the examination; and the format and process of lodging a complaint in relation to a complaint arising from a report of and conduct of investigations by the Coroner.

5.7 Does the coroner have power to hold investigation within local limits?

The Coroner has a duty to undertake medical investigations on a dead body

lying within his or her jurisdiction (**area of operation**) whether or not the cause of death arose within his or her jurisdiction.

The Coroner may conduct an investigation either in the territory of the Coroner in whose jurisdiction (**area of operation**) the body was found or where the death took place.

5.8 When should a Coroner General be notified of a death in Custody?

Whenever a person dies in a prison or in police custody: the officer in charge of the prison; or the Officer Commanding a police station, must inform the Coroner within whose jurisdiction the prison or police station is located. A Coroner who is informed of the death is required to conduct investigations into the death and prepare an investigation report.

5.9 Who has the duty to preserve the scene of crime?

A police officer or any person who is present at the time of death or who finds a dead body, is required to report the death to the Coroner and to preserve the scene of crime until the Coroner or a member of the Service arrives.

A police officer is also required to collect evidence necessary and relevant for purposes of investigation and prosecution of an offence.

A person including a police officer who interferes with or tampers with the evidence or the scene of crime commits an offence.

5.10 What is the procedure for transferring the body to the mortuary?

If a body is to be taken to a mortuary at the direction of a coroner or a police officer. A person who is involved in taking the body to the mortuary must comply with any direction of the Coroner or Police officer or the guidelines issued by the Coroner-

General about the dignity and respect to be accorded to persons who are at a place from which a body is to be taken, and their cultural traditions or spiritual beliefs and the way in which bodies are to be taken to a mortuary.

5.11 Who has the power to conduct a post-mortem?

If a coroner is of the opinion that it is important to find out and confirm the circumstances and the nature of death, he or she may conduct a post-mortem on the body. The Coroner may hire a qualified practitioner, qualified medical practitioner, medical provider or any other expert to conduct the post mortem. The process of hiring the person must follow the public procurement laws.

A person is a qualified medical practitioner if the person: is a registered medical practitioner with relevant qualification and experience in human pathology or has the kind of expertise and experience that the Coroner needs for the performance

of a particular kind of examination or test required by the Coroner.

Where a person informs a Coroner that in their opinion the death was caused by negligence of a registered medical practitioner or other person, the medical practitioner or that other person: will not conduct or assist in the examination of the dead body; can appoint someone to represent him or her during the examination of the body.

A person who has been hired by the Coroner to conduct the post mortem must as soon as possible forward the report on the results of the examination to the Coroner.

5.12 What is the process of exhuming a buried or cremated body?

In the case where the Coroner-General believes that the death is a reportable death he/she can go to Court and ask the Court to make an order to have the buried body be exhumed or in the case of

a cremated body, where the remains can be recovered, that they be recovered.

The Coroner must give at least two (2) days' notice of his or her intention to go to court and seek orders for exhumation or recovery of the remains of a cremated body to: the person in charge of the place where the body is, or the cremated remains are and any person who the Coroner considers has a sufficient interest in the autopsy.

The Coroner will not be required to provide the notice to go to Court where he or she is not able to contact the person in charge of the place where the body is lying or the cremated remains are and it is not in the public interest to give notice to the person.

If a person has raised a concern in relation to the Court order being made but after discussing the matter with the person, the Coroner considers it is in the public interest for the Court order to be made, the Court shall make the order as requested by the Coroner and give a copy of it to the person who had raised concern;

A police officer shall in compliance with the Court order, enter the place where the body or remains are being held. The police officer will be required to stay in such a place until the body is exhumed or the cremated remains are recovered. The police officer is then required to make arrangements for the exhumed body or cremated remains to be taken, to a place stated in the Court order. The Coroner shall, as soon as possible after the autopsy, order the body or cremated remains to be returned to the place from where they were taken.

5.13 Who can observe the post-mortem examination?

The Coroner, or a police officer who is investigating a reportable death, is entitled to observe and participate in the post-mortem/autopsy.

The Coroner may allow a person to observe and participate in a post-mortem/autopsy for his or her vocational or clinical education or training with the consent of

the doctor who is conducting the post-mortem/autopsy.

The Coroner may allow a person or his or her representative to observe the autopsy where the Coroner considers: whether the person has an interest in the autopsy; whether the deceased representative's presence will not compromise the integrity of the ongoing investigations e.g. in the case where there is a family dispute and the Coroner allows one party to attend and leaves out the other. It may seem that the Coroner is compromised hence may affect the integrity of the investigations and that it is appropriate for such a person to attend the autopsy. Before a Coroner decides whether or not to allow a person to observe a post-mortem examination he/she: must, whenever practicable, consult with and consider the views of: a family member of the deceased person or the doctor who is to conduct the post-mortem/autopsy. He may also consult with, and consider the views of, anyone else the Coroner considers appropriate.

If the Coroner allows a person to observe a post-mortem examination, the Coroner must give the person notice of the time and place where the autopsy is to be conducted.

5.14 Who prepares an Autopsy report?

The Coroner or the doctor who conducted the autopsy is required to as soon as possible prepare an autopsy report and give the report to the Coroner. If an investigating police officer asks for a copy of the autopsy report, or a copy of a test report, the doctor who conducted the autopsy or the person who did the test must give a copy of the report to the police officer.

6

MAKING COMPLAINTS AND APPEALS

6.1 Can a person make a complaint against a Coroner?

A person has the right to make a complaint against a Coroner, a Pathologist or any other person who has powers and duties under the National Coroners Service Act to the Complaints Committee. The complaint must be in **writing** and must clearly state what the complaint is about.

6.2 Can a person Appeal if they are dissatisfied with the decision of the Coroner?

An interested person who is not satisfied with the decision of the Coroner can appeal to the Coroner General;

(1) The decisions that an interested person may appeal against are where the Coroner decides to:

- a. Discontinue an investigation;
- b. Either resume or suspend an investigation;
- c. Request for a post-mortem examination;
- d. To request a post-mortem examination of a body that has already been the subject of a post-mortem examination, unless the decision is to request an examination of a different kind from the one already carried out.

(2) Where the appeal is allowed by the Coroner-General, he or she may make the following decisions:

- i. Change the decision of the Coroner and substitute it with another decision;

- ii. Do away the decision of the Coroner and remit the matter for a fresh decision.

(3) A person who made an appeal to the Coroner-General and is not satisfied with the decision of the Coroner-General can appeal to the High Court.

WHERE CAN A VICTIM REPORT A REPORTABLE DEATH?

National Police Service

Jogoo House "A"

Taifa Road +254-020-2221969

Any police station around the country or call the following police hotlines 999/112/911

The Independent Medico-Legal Unit

69 Mokoyeti West Road off Lang'ata Rd

P. O. Box 16035-00509 | Galleria | Nairobi

Tel: +254-2-4456048/9, 4450598, 4441833, 0724 256 800

Email: medico@imlu.org

Mobile App: 'RIPOTI'

Website: www.imlu.org

Kenya Human Rights Commission

Gitanga Road opp. Valley Arcade Shopping Center

P.O Box 41079-00100, Nairobi, Kenya

Mobile 0722264497 or 0733629034

Email: admin@khrc.or.ke

Website: www.Khrc.or.ke

Mathare Social Justice Centre

Email: matharesocialjusticecentre@gmail.com

The National Coalition of Human Rights Defenders-Kenya

P.O Box 26309-00100

Nairobi, Kenya

Mobile: +254-712632390 or +254716200100

Email: info@hrdcoalition.org

Website: <https://hrdcoalition.org>

The Independent Policing Oversight Authority

Head office:

1st Ngong Avenue, ACK Garden Annex

2nd floor P.O. Box 23035 – 00100

Nairobi, Kenya

Tel: 254 20 490 6000

E-mail: info@ipoa.go.ke or complaints@ipoa.go.ke

Website: <http://www.ipoa.go.ke>

Garissa County Office:

IPOA House, Off Kismayu Road behind Texas Petrol Station

P.O Box 1261-70100

Tel: 0777040400

Email:garissa@ipoa.go.ke

Mombasa County Office:

Jubilee Insurance Building (Arcade) along Moi Avenue

P.O Box 99758-80107

Tel: 0799019998

Email: mombasa@ipoa.go.ke

Kisumu County Office:

Central Square Building, Opposite Barclays Bank

P.O Box 3560-40100

Tel: 0799862244

Email:kisumu@ipoa.go.ke

Kakamega County Office;

Daroon Foundation Trust Building, Opposite
Nala Hospital

P.O Box 1642-50100

Tel:020-440 3549

Email: kakamega@ipoa.go.ke

**Eldoret Office: Kerio Valley Development
Authority Annex Plaza**

P.O Box 109-30100

Tel 020-4403548

Email: eldoret2ipoa.go.ke

Nakuru County Office:

Assumption Centre 5th Floor Opposite St. Paul
University

P.O Box 2400-20100

Tel: 020-4401076

Email: nakuru@ipoa.go.ke

Nyeri County Office:

County Mall Next to Veterinary Department and
behind Baden Powell

P.O Box 30-10100

Tel 020-2004664

Email:nyeri@ipoa.go.ke

Meru County Office:

Union Place Meru Makutano Junction Opp
Kenya Prisons

P.O Box 203-60200

Tel:020-201 7237

Email:meru@ipoa.go.ke

The Kenya National Commission on Human Rights

1st Floor, CVS Plaza,

Kasuku Road off Lenana Road


P.O Box 74359-00200,

Nairobi, Kenya

Email:haki@knchr.org

or

complaint@knchr.org

 22359

 0800-720-627

 www.knchr.org



Independent Medico-Legal Unit

A World free from Torture, Violence and Discrimination

INDEPENDENT MEDICO-LEGAL UNIT

69 Mokoyeti West Road, Off Lang'ata Road
Near Galleria Shopping Mall, Karen Estate, Nairobi

P.O Box 16035-00509, Galleria, Nairobi Kenya Tel: +254 724 256 800

Email: medico@imlu.org / Website: www.imlu.org



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