

KENYA NATIONAL COMMISSION ON HUMAN RIGHTS

**A HANDBOOK ON
THE NATIONAL
CORONERS
SERVICE ACT,
2017**



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on Human Rights**



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CONTACT INFORMATION

Kenya National Commission on Human Rights

Head Office,

P.O. Box 74359-00200, Nairobi, Kenya

🏠 1st Floor CVS Plaza, Kasuku Rd off Lenana Road,

✉️ haki@knchr.org / complaint@knchr.org

🌐 www.knchr.org

☎️ Tel: +254-020-3969000

📘 KNCHR 📱 hakiKNCHR 📺 KNCHR 📠 22359

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Preface

This booklet is primarily intended to assist citizens and law enforcement officials in understanding the new National Coroners Service Act.

It is hoped that this booklet will help members of the public to understand the new legislative provisions and in the end, help them to give effect to state obligations under the laws. This simplified version of the law is meant to give the main summary of the law without changing anything from its main provisions. In arriving at this version, there has been a deliberate attempt to identify the main elements of the law so as to provide to users the relevant and meaningful understanding of its broad requirements.

Coroners are part of a multi-faceted system involving pathologist services, mortuary and post mortem facilities, histology (tissue) and toxicology (fluid) testing, hospital administration. To work, however, many other related services including general medical practitioners and funeral home services must support it. The coroner service will be unable to function effectively in the absence of many of their core support services. This will require resources. However, there must be a commitment to resource the transformation in order to secure the overall strategic objectives of the coroners service. It is clear that the public sensitization on the coroners system and its implementation is where all this should begin so that public policy on such issues can be well addressed.

This handbook can assist users to understand how the coroner system is to be established in the country and give the broad support required to demand accountability on deaths from authorities or deaths occurring from non-natural causes. The public demand for an end to impunity, a big obstacle to eradicating extrajudicial executions in the country can benefit with a sustained and effective use of the law. With more awareness of the legal developments, increased public debate and sensitization on the role of professional coroner services can help to resolve the mysterious deaths in the country.

Dr. Bernard Mogesa,



**Chief Executive Officer/ Commission Secretary,
Kenya National Commission on Human Rights**

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List of Abbreviations

AI	Amnesty International
AP	Administration Police
CG	Coroner General
CS	Cabinet Secretary
CSO	Civil Society Organization
DPP	Director of Public Prosecutions
IMLU	Independent Medico-Legal Unit
IPOA	Independent Policing Oversight Authority
KDF	Kenya Defence Forces
KNCHR	Kenya National Commission on Human Rights
NCC	National Coroners Council
NGO	Non-Governmental Organization
NPS	National Police Service
PSC	Public Service Commission

Definition of Terms

“Autopsy” means an examination of a body after the death to determine cause, *same as post mortem*

“Accused” means a person who is charged with an offence

“Agency” means the Witness Protection Agency established under the law

“Cabinet Secretary” means the Cabinet Secretary in charge of justice

“Coroner” means a qualified person or official whose principal duty is to investigate the cause of any death occurring due to non-natural cause

“Custody” means detention or custody of a person in any place by the State and it includes custody of person while in transit;

“Inquest” means a judicial investigation into the circumstances of a violent, unexpected or unexplained death

“Interested Person” means a relative or representative of the deceased, or suspect in the death or a person appointed by government or the coroner to assist with investigations into an unexplained death

“Offender” means a person convicted of an offence of torture or cruel or degrading treatment

“Post mortem” means a medical examination of a dead body to establish the cause of death

Kenya's Quest For a Coroners' Institution: A Background

Human rights groups in Kenya have for a long time blamed the lack of a comprehensive framework to facilitate an effective investigation process on mysterious deaths especially at the hands of the police for promoting absence of transparency and accountability on such things. As a matter of fact, it contributed to the problem of lack of redress to victims of torture and ill treatment. The absence of a coroner's office to conduct independent investigations into the cause of suspicious deaths has been seen as hindering access to justice for the families of victims. After years of campaigns for independent and conclusive investigations into unexplained deaths, especially in the hands of the police, the National Coroner system has now been introduced, with a new legislation, the National Coroners Service Act, 2017 in toe.

Investigation of sudden and unexplained death takes many forms throughout the world and in Kenya; this has mostly been through a public inquest established under Sections 385-387 of the Criminal Procedure Code. The coroner service is one of the oldest public services in existence. In the UK, for example, the coroners legislation has been in existence since 1844, only getting updated in terms of assessing its adequacy for societal needs. Coroner services are associated with what are often tragic circumstances, something that may have done little to encourage the general public to urge for a special law on the services. The enactment of the new law therefore is a good development, also given the essential value placed by the constitution, 2010 on the right to life. It means that going forward; no death should be left uninvestigated unless there is a clear and certifiable reason for the death.

The coroner system in other jurisdictions is quasi judicial but at the same time independent from the medical profession, or any control of state agencies or any parties who might have an interest in the outcome of a death investigation. In other jurisdictions, such as Northern Ireland, UK and the USA, the coroner service

reassures society through a process of public hearing which can establish that nothing underhand has taken place. In general, he must hold an inquest if he believes that the death was violent or unnatural or happened suddenly and from unknown causes. This is not exactly how the Kenya's new National Coroners Service Act is modeled but it is a good starting point all the same.

According to section 3 of Act, there are multiple objectives as to why the legislation was necessary, These are mainly; - to provide for the establishment of the National Coroner Service and appointment of coronial officers; to provide for investigation of reportable deaths in order to determine the identities of the deceased persons, the times and dates of their deaths and the manner and cause of their deaths.

Other objects are to provide for the complementary role of forensic medical science services to the police in handling investigations involving decedent bodies and scene management and finally to provide for matters relating to exhumation of bodies at the order of the courts etc, provide for the mandatory requirement to report reportable deaths; establish the procedures for investigations, by coroners of reportable deaths; assist in policy formulation by advising the Government, by forensic study, on possible measures to help to prevent deaths from similar causes happening; and facilitate the participation of the coroner at inquests to advise on matters connected with reportable deaths, including matters related to public health or safety and the administration of justice.

What is the main objective of the new National Coroners Service Act?

The National Coroners Service Act outlines two main functions:

- It establishes the National Coroners Service, provide for its powers and functions;
- It establishes a framework for investigations and determination of the cause of reported unnatural deaths in the country.

Who is the Coroner-General and what are his functions?

The Coroner General is the overall head of the National Coroner Service. Under section 22, the Coroner-General has powers to approve the issuance of burial permits; cremation permits; waivers of post mortem; post mortem permits; and authority to move dead bodies into or out of Kenya. The Coroner-General must be a Kenyan citizen and a specialist in human pathology. He/she is the head of the service and the main authority on the issues requiring coroner services under the Act. The Service is established with a head quarter in Nairobi. He/She is required to perform his functions and duties without delay and in accordance with the approved regulations and constitutional values.

Who is a coroner?

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 or disease for which he was being treated.

How is the coroners' service organized?

The Act in part II establishes the National Coroners Service. This is an independent corporate body comprising of the Coroner-General, the regional coroners and other staff appointed by the Public Service Commission for the proper and efficient discharge of the functions of the Service.

What are the functions of the National Coroner Service?

The functions of the National Coroner Service are to;

- Co-ordinate coroner services throughout the country
- Ensure efficient delivery of the functions and services of the Service
- Ensure that all deaths which the Service has jurisdiction to conduct an investigation on are properly investigated and in a timely manner
- Monitor and evaluate investigations of deaths by the Service and issue guidelines to other coroners to assist them in the performance of their functions.

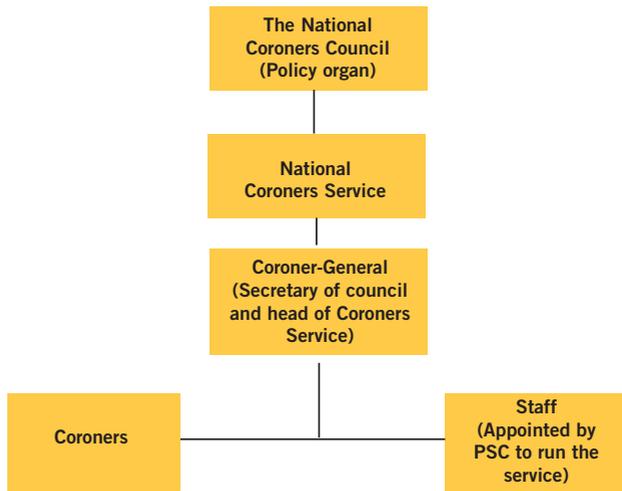
How is the National Coroners Service Managed?

Another institution, the National Coroners Council (NCC), is established by the Act in Section 68 under the last part of Act (Part VIII) to formulate and review policy relating to coronial services in the country and advise the Service generally on policies, administration and expenditures. Once a year, the Council is to prepare and submit to the President and Parliament a report on the activities of the Service and measures taken and the progress achieved in the realization of the functions of the Service as well as give statistical information relating to the its functions.

The Coroner-General is the Secretary to the Council which consists of representatives of relevant government ministries as well as the Inspector-General, the DPP and at least two representatives nominated by the Kenya Medical Practitioners and Dentists Board and the Clinical Officers Council

Understanding the coroner's institutions

The following is a graphic illustration of how the Coroner's Service is organized and managed.



What kind of death is reportable to a coroner?

Part IV of the Act provides for the public obligation to report certain deaths and the powers of investigations of the Service on the reportable deaths. Violent deaths, deaths by unfair means, or during pregnancy or sudden deaths, deaths in police or military custody are amongst those that should be reported to a coroner within the respective jurisdiction for investigations. This is provided for under section 24 and 25 of the Act.

Although the Coroner-General has powers to undertake full medical investigations of all deaths suspected to be of criminal nature, under Section 28 of the Act, at least fourteen situations of foul deaths are presented to be falling into the investigative jurisdiction of the Service.

They are listed below;

- the deceased person is reported to have died of a violent or an unnatural death;
- the deceased person is reported to have died of a sudden death of which the cause is unknown;
- the deceased person is reported to have died in police custody or military custody;
- death occurs during or following an assault within twenty four hours following a surgical or invasive or surgical procedures;
- death occurs during or following administration of anaesthesia;
- death that occurs 24 hours immediately after discharge from hospital or any health facility;
- a person who suffers an injury and dies within one year and one day;
- suspicious maternal deaths, termination of birth, cot deaths and sexual violence related deaths;
- it is a case of infanticides;
- death that occurs in circumstances prescribed by regulations under any written law and classified as reportable deaths;
- death occurs in an institution with children facilities or mental hospital;
- death occurs during or while in care of any institution or person;
- the death was a death in custody of any other person authorized in law to retain custody of a person for a specified period; and
- death as a result of child abuse.

Are there coroners in the counties?

The coroner is an administrative head of coronial services in the county and they work under the Coroner-General, who may also delegate some of the responsibilities to them. The Public Service Commission should appoint coroners to work in the counties.

How is the investigation of reported death done?

Under Section 29 of the Act, the coroner for purposes of investigations is given powers to collect forensic and other evidence and to preserve it as may be necessary. The reporting of a death triggers the coroner's involvement. Any person can report a death to a coroner or a police officer if the death falls under certain categories of suspicion set out by the legislation (section 24). A coroner will generally not be involved where a person died from some natural illness or disease for which he was being treated.

For how long should a coroner be in control of the investigations of the death of a deceased person?

Once a death has been reported a cycle starts from which an exit can be made at different points. In the simplest case, and where no blame or suspicion arises, a coroner's inquiries confirm that the death was in fact natural and he issues report, this is expected to end within a week of the report (section 32). In other circumstances, the investigation of the death is much more detailed and may go all the way to a formal inquest (sec 5). This process can involve retention of organs (or tissues) for special analysis which means that a post mortem report may not be completed for a number of weeks.

What does a coroners' investigation report cover?

Under the Act, investigations and examinations into any of these deaths are only for certain purposes. The coroner must investigate the reportable death and report back within a week of the report. According to section 30 of the Act, the main purpose of an investigation into a person's death is to ascertain;

- particulars of the deceased;
- how, when and where the deceased met his or her death;
- the cause and manner of death;
- particulars required under the Births and Deaths Registration Act to register the death; and
- Any preventive measures required to prevent similar deaths.

As soon as the report is concluded, it is shared with relevant authorities and interested persons such as relatives, personal representatives of the deceased, insurer or other demonstrated associates.

Further, Section 30 (4) provides that;

'For purposes of criminal investigation and subsequent prosecution of an offence under any written law, the coroner shall submit an interim report to the National Police Service and the Director of Public Prosecutions or any other relevant Authority within twenty four hours of notification of a death under this Act'. Within seven days, the coroner should submit the final report to the DPP and the National Police Service. The coroner's report can be relied on as primary evidence on the cause of the investigated death.

Can a person disagree with the coroner's report? What is the Appeals and Complaints mechanism open to people who disagree with the coroner?

The Act anticipates many situations of disagreement with the manner in which a coroner undertakes the investigations into a suspicious death or the coroner's report. Under Section 35, any person who is dissatisfied or disagrees with the report or findings of the coroner is allowed to seek a second opinion at his/her cost.

Under section 53, (1) (a) and (b), a coroner may discontinue an investigation into a death on the account that the cause of the death has become apparent or that it is not necessary to continue with the investigations but wherever this becomes the case, an interested person can demand for a written report with explanations as soon as practicable as to why the investigation was discontinued.

What is to happen if an investigation takes more than a year?

A coroner conducting an investigation into a person's death may take more than a year to complete the investigations. This may give rise to a situation of dissatisfaction by relatives of the deceased or other interested persons. If a coroner is taking more than a year to complete an investigation, he or she must notify the Coroner-General of that fact, or if it was ever discontinued (Sec 54). An interested person may also appeal to the Attorney General (sec 56) on the issues causing dissatisfaction such as discontinuation of an investigation, decision not to request for a post mortem examination, decision to repeat a post-mortem examination etc.

Where are the investigations to be undertaken?

The Coroner who receives a report of a death to be investigated may make the investigation in the territory under his/her jurisdiction or go to the place where the body was found or where the death took place.

What about investigations into deaths occurring in prison or police custody?

If the death occurred within a prison or in police custody, the authorities must inform a coroner who must investigate into the death and prepare an investigation report. A police officer or any person who is present at the time of death, or who finds a dead body, is required to secure and preserve the scene until a coroner arrives. If it is a police officer, he/she may collect and preserve relevant evidence without undue interference.

Is there an additional obligation for a coroner investigating death inside police custody?

Yes. According to section 25 (3), Where a coroner investigates a death occurring in police custody or prison custody, he/she must furnish a copy of the report to the Independent Policing Oversight Authority (IPOA)

How is a body under examination to be transferred from one place to another?

Under Section 40-42 of the Act, the Cabinet Secretary for the time being responsible for matters relating to coroners services in consultation with the Coroner-General is expected to make regulations to regulate and provide for rules and procedures for preservation of bodies and movement of bodies, and in the movement of such bodies to a mortuary or any place of temporary holding as directed by the Coroner-General or a police officer, the dignity of a dead body and cultural traditions or spiritual beliefs of the deceased must be recognized and protected. Nevertheless, the law does not establish any offence for a degrading behavior against a dead body during a transfer.

Can a coroner make a post mortem examination?

A post mortem can be ordered by a coroner for the purpose of establishing the cause of death. Under the law, a coroner has discretion to order a post mortem where he/she believes it to be essential. There is, however, no statutory requirement for a coroner to order a post mortem in every suspicious case of death. However, there is room for exhumation of a body where it may deem necessary to do a post mortem but it was previously overlooked (Sec 44). The coroner may make an application to court for an order of exhumation for a body that has been buried or recovery of cremated remains to enable an autopsy be conducted. The coroner must give a two days notice to the person in charge of where the remains are as well as persons interested in the autopsy before such an application can be made.

What is the procedure for conducting a post mortem?

According to section 43 (1) of the law, if the coroner is of the opinion that it is appropriate and essential to ascertain the circumstances and the nature of death, the coroner may conduct a post mortem on the body. A coroner or his/her representative may conduct the post mortem examination.

The coroner or a police officer who is investigating a death is entitled to observe and participate in the autopsy but the coroner may also allow another person, or person's representative to observe the autopsy (Sec 45). Educational trainees for instance may also be allowed to observe and participate in an autopsy, with the permission of the coroner and the doctor conducting it.

The coroner or doctor who conducted the autopsy should prepare the report within reasonable timelines and share it with authorities, particularly the investigating police officer where relevant.

Who pays for the post mortem?

The cost of undertaking post mortem or autopsy on reportable deaths is borne by the State (Cec 62).

How are tissues and parts of the body removed from a body during autopsy handled?

According to Section 47, if during an autopsy of a body, the doctor removes tissue from the deceased body; an elaborate procedure must be followed for the retention of the tissue for investigations and later, its disposal. Doing so would require the doctor to inform the coroner, who in turn may also inform a family member of the deceased. After six months, the coroner will decide whether the tissue may be disposed of through a burial. The coroner is expected to give permit for the disposal of the body after the investigations are closed (Sec 47, 6).

FACE
VOICE
AFRICA

NEWS WOMEN CULTURE NEWSLETTER

BY NDIYA WAWERU, at 10:45 am, April 20, 2015, NEWS

38 views

Kenya's former chief government pathologist accused of stealing body parts



Kenya's Former Chief Government Pathologist Moses Njue. Photo: Hushidion

Former Chief Government Pathologist Moses Njue, has been accused of stealing body parts and could soon be charged in court, the Daily Nation reports.

The Director of Public Prosecutions (DPP) has already directed the arrest and prosecution of Dr Njue. He has been accused of stealing body parts belonging to Benedict Karau, who died on March 2015, according to a report by the by the Assistant Director of Public Prosecutions, C. M Mwaniki.

It is an offence to remove body parts without permission

Can a person interfere with the work of a coroner?

It would be unlawful for anybody to disrupt or interfere with the work of a coroner. Under the Act, a person who interferes with or tampers with evidence or the scene of crime, commits an offence, Sec (39) 3. It is also an offence for a person to obstruct a coroner in due execution of his functions and the punishment upon conviction for the offence is a fine not exceeding five hundred thousand shillings or imprisonment for a term not exceeding one month (Section 69).

What are the main offences under the Act

- A person who interferes with or tampers with evidence or the scene of crime, commits an offence;
- Any person who obstructs a coroner in due execution of his functions under this Act commits an offence and is liable for conviction or a fine not exceeding five hundred thousand shillings or imprisonment for a term not exceeding one month;
- A person who makes a statement or omits any matter knowing that, or being reckless as to whether, the statement or omission makes the document false or misleading in a material particular, commits an offence;
- A person who fails or refuses to comply with a direction about the removal of a body or any other lawful direction by the coroner under this Act; or hinders or prevents any person from complying with a direction about the removal of a body or any other lawful direction under this Act, commits an offence.

How about people who may refuse to give information required by a coroner. Is this allowed?

It is an offence for a person, without reasonable excuse, not to comply with a written notice by the coroner requiring that the person supply information or documents or other things to the extent that the person is capable of complying with it. Further, according to Section 71 (1), a person who makes a statement or omits any matter knowing that, or being reckless as to whether, the statement or omission makes the document false or misleading in a material particular commits an offence.

Further, a public officer or a state officer who goes against provisions of the legislation, including the requirement to cooperate with the office of the coroner is held to be in contempt, and is to be punished accordingly. The punishment upon conviction is a fine of two hundred thousand shillings or imprisonment of not more than two years or both (Sec. 65).

Are there some things that the law does not permit but may go unpunished?

Under section 73 of the Act, a general punishment is given to offences under the Act to which no other penalty is provided. In case of a natural person, a fine not exceeding five hundred thousand shillings or imprisonment for a term not exceeding two years or both is to be levied while in case of a health facility or any other person, a fine of two million shillings and the director or person in charge of the health facility shall be liable to the penalty provided for a natural person.

Can a person be punished for cooperating with a coroner or supplying him/her with required information?

People who co-operate with a coroner and supply information, document or anything else in compliance with the coroner's requirement, confidential information enjoy legislative immunity under this law. The person is not to be held liable, civilly, criminally or under any administrative process, including professional misconduct (Sections 65, 67). This provision is helpful as it will ensure that a coroner is able to access information and materials they require for their investigations.

Are there additional legislations that relates to the work of a coroner, which you should be familiar?

The following are the main legal provisions that may relate to the National Coroners Service Act, which may have a bearing on its implementation;

Births and Deaths Registration Act: The Act requires that cause of death is established and noted in the registration of a death occurring to a person before issuance of a burial permit.

Criminal procedure Act: Currently, inquiries in to sudden deaths and missing persons believed to be dead are held under Sec 385-388 of the criminal procedure code, which provides that the nearest magistrate is empowered to hold an inquest into such deaths, and can also be moved to do so by the police or the DPP.

Commissions of Inquiry Act: The operation of the National Coroners Service Act is subject to this Act. This suggests that an inquest resulting from the Act is regulated under the Inquiry Act.

The Evidence Act: Coroners report is a prima facie evidence of the cause of a reportable death

The National Police Service Act: Coronial services under the Act places additional responsibilities and standards of performance for the police involved in forensic investigations on the cause of deaths resulting from unnatural causes.

Independent Policing Oversight Authority Act: Coroner's reports on deaths occurring in police custody are to be copied to the Independent Policing Authority (IPOA) established under the Act.

The Anatomy Act: creates offences for unpermitted movement of bodies in the country, or removal of body parts and tissues without permission of the relevant Minister or the Director of Medical Services.

HEAD OFFICE

CVS Plaza 1st Floor,
Kasuku Lane, Off Lenana Road
P.O. Box: 74359-00200 Nairobi, Kenya
Tel: Pilot No.: +254-020-3969000
Mobile: 0724 256 448 / 0733 780 000
Fax: +254-020-2716160
General Enquiries: haki@knchr.org
Complaints: complaint@knchr.org

North Rift Regional Office - Kitale

AFC Building, Mak Asembo Street,
opp. Mega Centre Mall
P.O Box 2999-30200 Kitale
Tel: 054-31773
Mobile: 0708271216 / 0786236683
Email: northrift@knchr.org
Twitter: @KNCHRKitale

Western Regional Office - Kisumu

Re Insurance Plaza, 3rd floor
Oginga Odinga Street
P.O Box 7768-40100 Kisumu
Tel: 057 2020078
Email: kisumu@knchr.org
Twitter: @KNCHRKisumu

North Eastern Regional Office - Wajir

Wagberi, Opp. former Al Shifaa Hospital
P.O Box 363-70200 Wajir
Tel: 046-4421512
Email: northernkenya@knchr.org
Twitter: @KNCHRWajir

Coast Regional Office - Mombasa

Panal Freighters Lane
Off Haile Selassie Road
P.O Box 90171-80100 Mombasa
Tel: 041-2220468 / 2220584
Email: coast@knchr.org
Twitter: @KNCHRMombasa

Center for Human Rights, Inside Laikipia University, Nyahururu

P.O Box 1100-20300, Nyahururu
Tel: 0705982617
Email: laikipia@knchr.org
Twitter: @KNCHRLaikipia

Facebook KNCHR Twitter hakiKNCHR YouTube KNCHR Email 22359

www.knchr.org

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