REPUBLIC OF KENYA

THE NATIONAL ASSEMBLY

****

TWELFTH PARLIAMENT

SECOND SESSION

REPORT OF THE DEPARTMENTAL COMMITTEE ON HEALTH ON THE ALLEGED SEXUAL ASSAULT, BREAKDOWN OF EQUIPMENT, SURGICAL MIX-UP AND GENERAL OPERATIONS OF KENYATTA NATIONAL HOSPITAL

DIRECTORATE OF COMMITTEE SERVICES,

THE NATIONAL ASSEMBLY,

PARLIAMENT BUILDINGS,

NAIROBI. MARCH, 2018

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ABBREVIATIONS

BTU	Blood Transfusion Unit
CEO	Chief Executive Officer
CS	Cabinet Secretary
DCI	Directorate of Criminal Investigations
GP	General Practitioner
KMPDB	Kenya Medical Practitioners & Dentists Board
KNH	Kenyatta National Hospital
MRI	Magnetic Resonance Imaging
MTRH	Moi Teaching and Referral Hospital, Eldoret
NHS	National Health Service
PHC	Primary Health Care
SOP	Standard Operating Procedure
UHC	Universal Health Coverage
UoN	University of Nairobi
WHO	World Health Organization

PREFACE

Mr. Speaker Sir,

The Departmental Committee on Health is established pursuant to the provisions of Standing Order No. 216(5) of the National Assembly and in line with Article 124 of the Constitution which provides for the establishment of the Committees by Parliament. The mandate and functions of the Committee is to;

a) *Investigate, inquire into, and report on all matters relating to the mandate, management, activities, administration, operations and estimates of the assigned Ministries and departments;*
b) *Study the programme and policy objectives of the Ministries and departments and the effectiveness of the implementation;*
c) *Study and review all legislation referred to it;*
d) *Study, assess and analyze the relative success of the Ministries and departments as measured by the results obtained as compared with its stated objectives;*
e) *Investigate and inquire into all matters relating to the assigned Ministries and departments as they may deem necessary, and as may be referred to them by the House;*
f) *Vet and report on all appointments where the constitution or any law requires the National Assembly to approve, except those under Standing Order 204; and*
g) *Make reports and recommendations to the House as often as possible, including recommendation of proposed legislation.*

The Departmental Committee is mandated to cover the functions of the Ministry of Health alongside seven Semi-autonomous Government Agencies (SAGAs) namely; Kenyatta National Hospital; Moi Teaching and Referral Hospital; Kenya Medical Training College; Kenya Medical Supplies Authority; National Hospital Insurance Fund; Kenya Medical Research institute; National Aids and Control Council.

This report is an outcome of the exercise of Standing Order No. 216 (5), on the allegations of sexual assault, breakdown of medical equipment, surgical procedure and the general operations of the Kenyatta National Hospital.

Committee Membership

The Committee comprises the following Honourable Members;

1. Hon. Sabina Chege, MP – **Chairperson**
2. Hon. Swarup Ranjan Mishra, MP – **Vice-Chairperson**
3. Hon. (Dr.) Eseli Simiyu, MP
4. Hon. (Dr.) James Nyikal, MP
5. Hon. Alfred Agoi Masadia, MP
6. Hon. (Dr.) James Kipkosgei Murgor, MP
7. Hon. Muriuki Njagagua, MP
8. Hon. (Dr.) Mohamed Dahir Duale, MP
9. Hon. Stephen Mule, MP
10. Hon. Chris Karan, MP
11. Hon. Esther M. Passaris, MP
12. Hon. Gladwell Jesire Cheruiyot
13. Hon. Kipsengeret Koros, MP
14. Hon. Martin Peters Owino, MP
15. Hon. Mercy Wanjiku Gakuya, MP
16. Hon. Prof. Mohamud Sheikh Mohamed, MP
17. Hon. Patrick Munene Ntwiga, MP
18. Hon. Tongoyo Gabriel Koshal, MP
19. Hon. Zachary Kwenya Thuku, MP

The Committee is facilitated by the following members of the Secretariat;

1. Mr. Victor Weke - Clerk Assistant II
2. Mr. Muyodi Meldaki Emmanuel - Clerk Assistant III
3. Mr. Ahmed Hassan Odhowa - Principal Research Officer
4. Ms. Christine Odhiambo - Legal Counsel II
5. Mr. Erick Kanyi - Fiscal Analyst
6. Ms. Winnie Kiziah - Media Officer

Appreciation

Mr. Speaker Sir,

The Committee wishes to thank the Office of the Speaker of the National Assembly and the Office of the Clerk of the National Assembly for the necessary support extended to it in the execution of its mandate and in conducting this inquiry. I wish to also thank the Members of the Committee for their expert, insightful and thoughtful participation in the inquiry process and their dedication to our tight work schedule. I also thank the secretariat for its technical service, dedication, and working round the clock to produce this report in good time.

The Committee further extends its appreciation to witnesses who appeared before it to submit information, and members of the public who forwarded their written views and proposals to the Committee for consideration.

Mr. Speaker Sir,

On behalf of the Members of the Committee, and pursuant to Standing Order no. 199(6), it is my distinguished honour and privilege to present this report of the Departmental Committee on Health, on the allegations of sexual assault, breakdown of equipment, surgical mix-up and general operations of the Kenyatta National Hospital for debate and adoption by the House.

Thank You

SIGNED ………………………………………………………………………………

HON. SABINA CHEGE, MP

(CHAIRPERSON)

DATE………………………………………………………………………………

ADOPTION OF REPORT OF THE COMMITTEE ON HEALTH ON THE OPERATIONS OF KENYATTA NATIONAL HOSPITAL

We, the Honourable Members of the Departmental Committee on Health, do hereby affix our signatures to this report on the operations of Kenyatta National Hospital, to affirm our approval and confirm its accuracy, validity and authenticity;

1. Hon. Sabina Chege, MP ……………………………………………………………
2. Hon. Swarup Ranjan Mishra, MP …………………………………………………
3. Hon. (Dr.) Eseli Simiyu, MP ……………………………………………………….
4. Hon. (Dr.) James Nyikal, MP ……………………………………………………
5. Hon. Alfred Agoi Masadia, MP …………………………………………………
6. Hon. (Dr.) James Kipkosgei Murgor, MP ………………………………………
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14. Hon. Martin Peters Owino, MP ……………………………………………………….

15. Hon. Mercy Wanjiku Gakuya, MP ……………………………………………………

16. Hon. Prof. Mohamud Sheikh Mohamed, MP ………………………………………..

17. Hon. Patrick Munene Ntwiga, MP ……………………………………………………

18. Hon. Tongoyo Gabriel Koshal, MP ……………………………………………………..

19. Hon. Zachary Kwenya Thuku, MP ……………………………………………………

EXECUTIVE SUMMARY

This report is a result of investigation into the allegations of sexual assault, breakdown of critical medical equipment, surgical mix-up and the general operations of the Kenyatta National Hospital. The Committee had scheduled an examination of the hospital, and indeed other agencies under its purview, in its work plan adopted during its induction retreat.

Occurrences at the hospital increased the urgency with which the Committee had to act, to address the issues, which were of great public interest affecting the biggest referral hospital in the country.

The inquiry covered the entire spectrum of health service provision at the hospital, from leadership and management to health personnel and auxiliary services like security. The Committee made a fact finding visit to the hospital to get first-hand experience and put matters into perspective. The Committee interviewed the hospital's board and management, medical personnel involved in specific cases, and the Cabinet Secretary.

This process also included an analysis into financial allocations to the hospital, the referral practice and human resource contingent deployed at the hospital.

The Committee did not find evidence to substantiate the allegations of sexual assault.
The Committee observed a breakdown of systems at the hospital, including non-adherence to standard operating procedures, obsolete equipment, overcrowding, inadequate medical personnel, failing and/or collapsed systems and overall leadership shortcomings at the hospital, all contributing towards the botched surgical intervention. The Committee also observed underfunding by Treasury, and a hospital overburdened by a failed lower level county managed health system.

The Committee recommends an overhaul of the leadership at the hospital, enforcement of the referral strategy and increased resource allocation. The Committee also recommends that relevant regulatory bodies update their operating standards and uphold utmost professionalism by health sector professionals.

Finally, the Committee urges the Ministry of Health to speedily operationalize the Health Act 2017 to address various areas of concern within the country's health care system.

PART I

1.0 BACKGROUND

1.1 Establishment of Kenyatta National Hospital

1. KNH was established in 1901 with a capacity of 40 beds. The Hospital operated as a department of the Ministry of Health until 1987 when its status changed to a State Corporation through Legal Notice No. 109 of 6th April 1987.
2. The Hospital works closely with The College of Health Sciences of the University of Nairobi and Ministry of Health, the leading tertiary healthcare training centres in Kenya and the East Africa region.
3. The Hospital was established under Legal Notice No.109 of 6th April 1987 and is mandated to:
   i) Receive patient on referral from other Hospitals/institutions within or outside Kenya for specialized health care.
   ii) Provide facilities for medical education for the University of Nairobi and for research.
   iii) Provide training facilities in nursing and other health and allied professions.
   iv) Participate in national health planning.
4. The Hospital established capacity is as summarized below: -
   a) Bed capacity of 2063 (bed occupancy can however go beyond 100% because of accepting patients beyond the capacity.
   b) There are 50 wards, 24 clinics and 26 operating theatres
   c) On average inpatients 2400 daily, 70,000 admissions annually
   d) On average outpatients 2500 daily, 600,000 annually

1.2 Chronology of the inquiry

1.2.1 Committee's work plan

5. During its induction retreat held in Mombasa in January, 2018, the Committee in its work plan resolved that as part of its oversight role will conduct fact finding visits to the two referral hospitals in country, Kenyatta National Hospital and Moi Teaching and Referral Hospital with a view of investigating on their operations and coming up with recommendations on how to revamp the facilities that have so far due to subsequent systemic failures hampered their abilities to deliver quality services to Kenyans.

1.2.1 Breakdown of essential machines

6. Before the Committee could embark on its usual oversight role at the hospital, a story appeared on the mainstream print media on 15th January 2018, painting a grim picture of the status of the country's largest public referral facility. It alleged that various critical clinical equipment at the hospital had broken down hence stalling service delivery at the facility.

1.2.2 Allegations of Sexual Assault

7. Soon after, on Friday, 19th January 2018, a viral social media post claimed that insecurity at hospital was at its peak. It further alleged that the security of the new mothers with babies in the nursery was wanting and that a mother who had twins through cesarean section was nearly raped at 0300 hours, while on her way to breastfeed her baby. The posts elicited widespread reactions in the country.
8. The two incidents accelerated the Committee's scheduling of investigation at the hospital, and immediately invited management to a meeting to respond to these grave allegations. The Committee then conducted an inspection visit to the facility on Wednesday 31st January, 2018. The objective of the fact finding visit to the hospital

was to tour critical service areas, as part of the investigations into general operations of the hospital.

1.2.3 Theft of baby at the hospital

9. In another demonstration of the general insecurity situation at the hospital, a couple lost one of their two-week-old twins in the Hospital on Sunday 18th, February 2018. The infant's father, Job Nyatiti Ouko said that he rushed his wife to the hospital at 2am on Sunday 18th, February, but they were forced to wait to see a doctor at the Accidents and Emergency section for more than 9 hours. Upon inquiring the reason for the delay he was told that room 108 where she was to be admitted in was yet to be cleaned.

10. When the room was finally available at 11.30 am, he was asked to wheel his wife to the room. He decided to ask the two women who were in the queue with him, to look after the children as he wheeled his wife to room 108. However, one of the two women took off with the other baby.
11. The baby was later found in Kawangware on 20th February, 2018 after a tip-off from the public.

1.2.4 Surgical mix-up at the hospital

12. The Committee attention was further drawn to media reports on the unintended surgical intervention that had happened in Kenyatta National Hospital.
13. The Committee learnt that, on 19th February 2018, at around 10.50 p.m. a wrong patient was inadvertently taken to the trauma theatre to undergo a craniotomy operation. The mistake was realised in the morning of 20th February 2018 at around 6.30 am, when the primary nurse reported on duty and realized that the wrong patient had been sent to theatre.

14. On 7th March, 2018 the Committee's Chairperson issued a press statement that it would speedily start and investigate operations at the hospital and the specific cases mentioned above and table a report to the House.

1.3 Public participation

15. The Committee was alive to provisions of the Constitution that called for involvement of the public in matters that affect them, particularly Article 118.
16. Not only did the Committee comply with provisions of the Constitution and Standing Orders, but also adopted an open door policy to any person who may have had information for the benefit of the inquiry. This was mostly extended to the end users, those who may have accessed the hospital for services, their relatives and/ or other interested parties.
17. Further, the Committee engaged patients at the hospital, and most importantly, the two patients involved in the surgical mix-up.

1.4 The hospital referral system

18. The Committee researched on the ideal referral system in other jurisdictions in an effort to draw parallels and identify gaps and pitfalls at KNH to be addressed. We established the following;
19. A referral is a process in which a health worker at a one level of the health system, having insufficient resources (drugs, equipment, skills) to manage a clinical condition, seeks the help of a better or differently resourced facility at the same or higher level to assist.
20. Referral system which is always typically pyramidal plays a vital role in management of diseases in any healthcare system. Primary healthcare centers (PHC) constitute the base, which is large in numbers. Less number of secondary centers are in the middle, and a fewer number of tertiary care centers constitute the top.
21. The PHC offer the minimum levels of essential tests and all basic treatments on an outpatient care basis, the secondary level centers are able to offer most of the

diagnostic tests and management facilities, including hospitalization, interventional procedures, surgery, and rehabilitation programs. Tertiary level centers usually restricted for complex interventions and surgical procedures, prescription of high end costly tests. Secondary and tertiary level centers are also important for appropriate for training programs to strengthen our health care workforce.

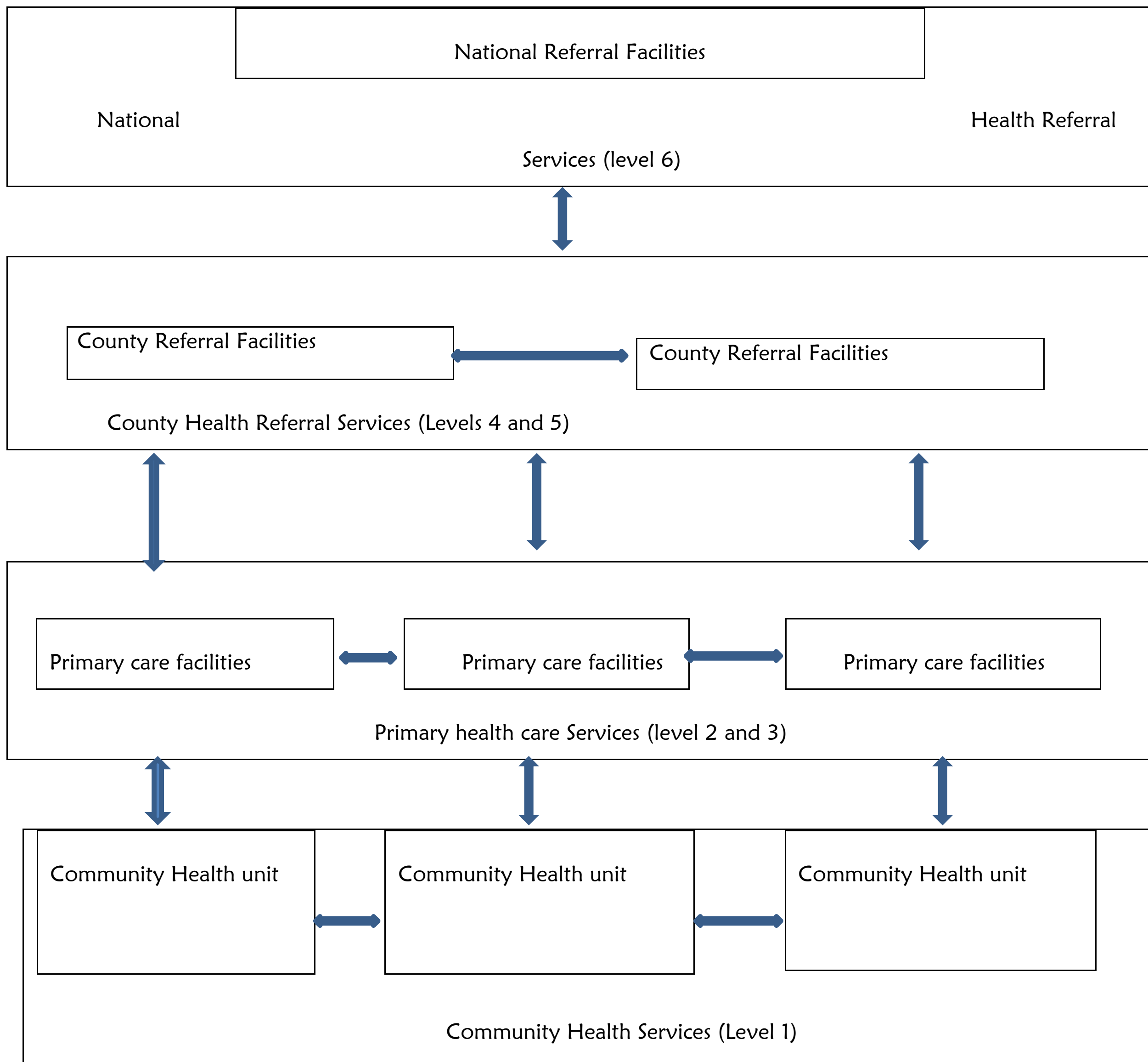
Organization of Health Care in Kenya

22. The Constitution of Kenya guarantees the right to the highest attainable standard of health, which includes the right to health care services such as reproductive health care. The Constitution further states that no person should be denied emergency medical treatment. The right to the highest attainable standard of health in a hierarchical health system can be possible only through an effective health referral system.
23. The Fourth Schedule of the Constitution on the distribution of functions between the national and county governments assigns the management of national referral health facilities, health policy development, capacity building to counties, and disaster management to the national government. The provision of health services at all other levels is assigned to county governments.
24. The health system in Kenya is organized around six levels of care based on the scope and complexity of services offered;
    - **The first level** comprises community units that are a collection of households staffed by volunteer community health workers. Activities at the community unit level focus mainly on promotive health through health education, treatment of minor ailments, and identification of cases for referral to health facilities.
    - **Levels 2 (dispensaries) and 3 (health centers)** offer primary health care services. These levels of care form the interface between the community and the higher level facilities. These facilities offer basic outpatient care, minor surgical services, basic laboratory services, maternity care, and limited inpatient facilities. They also coordinate the community units under their jurisdiction.

- **Levels 4 and 5**, the secondary referral facilities, form the county referral facilities. They offer a broad spectrum of curative services, and some are also health training centres.
- **Level 6** constitutes the tertiary referral facilities that offer specialized care and specialized training to health workers. The national government manages these facilities, but they are semi-autonomous organizations. Kenyatta National Hospital and Moi Teaching and Referral Hospital, Eldoret fall here.

The Referral chain

25. The referral system links up the different levels of care based on the expected services being provided through the system. The figure below shows the overall referral chain;



Referral Services in the Service Delivery Approach

26. A referral system is a mechanism to enable comprehensive management of clients' health needs through resources beyond those available where they access care.
27. The organization of service delivery into six levels of care is intended to rationalize the delivery of health services within the health system for efficient use of existing resources. This categorization also means that a client's direct access to health service delivery may not be able to adequately manage the client's health needs.
28. The referral system is what facilitates continuity of care across the different levels of care. The referral system is based on the premise that, while capacity for health

service delivery needs to be rationalized for different levels of care, those health services should not be determined only by the services available at the point of access, but rather by the full scope of care that the health system can provide.

29. An effective referral chain, therefore, provides the linkages needed across different levels of health system care. These linkages ensure that a client's health needs can be addressed, regardless of the level of the health system where the client physically accesses care. The referral system acts as a building elevator or lift to facilitate forward and backward management of a client's needs across different floors, or levels of care.

Ideal Framework for health referral Services

30. The full scope of referral services expected of the health services includes movement of clients, expertise movement, specimen movement, and client parameters movement

Requirements for Effective Referral Services

31. For effective functioning of the referral system, the overall health system needs to have basic provisions to adequately respond to referral needs. Some of the requirements for the health system building blocks to facilitate effective referral response:
    - Quality health services: Design and deliver systems that provide effective, safe, high-quality personal and non-personal health interventions when and where needed.
    - A well-performing health workforce: Retain sufficient, competent, responsive, and productive health staff.
    - A well-functioning health information system: Produce, analyse, disseminate, and use reliable and timely information.
    - An efficient system of access: Ensure availability of essential medical products, vaccines, and technologies of assured quality, safety, efficacy, and cost-effectiveness, and their scientifically sound and cost-effective use.

- A good health financing system: Make available adequate funds for health in ways that ensure people can use needed services and are protected from financial catastrophe or impoverishment associated with needing to pay for them.
- Leadership and governance: Ensure the existence of clear, comprehensive guidance to service delivery combined with effective oversight, coalition building, regulation, attention to system design, and accountability.
- Health infrastructure: Develop physical infrastructure, equipment, transport, and technology required for effective access of health services for each level of care.

Comparative analysis

United Kingdom

32. The National Health Service (NHS) is the publicly funded healthcare system for England and one of the four National Health Services of the United Kingdom. It is the largest single-payer healthcare system in the world.
33. The NHS is free at the time of use, for General Practitioner (GP) and emergency treatment not including admission to hospital, to non-residents.
34. In the UK, a certain number of people register under a GP. Say, service of 1000 populations is catered by one GP. One is entitled to ask for a referral for specialist treatment on the NHS. However, whether one gets the referral depends on what the GP feels is clinically necessary in that case. If a patient wishes to be referred to a specialist in any field, such as a surgeon, or a gynecologist, he or she has to see the GP they are registered with. This is because all medical records are held by the General Practitioner. The GP also generally understands one's health history and treatments better and will base any decision for a specialist referral on this knowledge. So in case any urgency or emergency they have to go to the GP first, if he/she thinks that the patient needs referral, only then he can go to the higher level facility. So there is a systemic pathway of referral which has to be followed by all.

35. Referral management centres are also used to help reduce inappropriate referrals.

New Zealand

36. An innovative referral system was developed by Canterbury Health Services in New Zealand in 2008 which they called “health pathways”. These “health pathways” were basically consensus statements on a written standard protocol whereby doctors and health workers have collectively planned “patient pathways” and “treatment protocols.” It is managed by the community. It integrates guidelines on referrals and existing resources for doctors, to avoid unnecessary referrals. Simultaneously they also perform proper investigations to be performed before making a referral.

PART II

2.1 WITNESS SUBMISSIONS; ALLEGED RAPE, INSECURITY AND BREAKDOWN OF EQUIPMENT

37. On the matter of sexual assault, insecurity and breakdown of equipment, the Committee received oral submissions from the board and management, whose account is detailed herein;

2.2.1 Management and Board of KNH

38. The Committee met with the entire Board and Management of the KNH at the time, on 26th January, 2018. The subject matter at the time was the allegations of sexual harassment and the general security situation at the hospital and the breakdown of essential equipment. The delegation comprised the following;

i) Mr. Mark K. Bor	-	Chairman, Board of Management
ii) Lily Koros Tare	-	Chief Executive Officer
iii) Ms. Grace Mullei	-	Board Member
iv) Dr. Hellen Yego	-	Board Member
v) Dr. Daniel Gathegi	-	Board Member
vi) Mr. Robert Mbune	-	Board Member
vii) Dr. R.T Kamau	-	Board Member
viii) Prof. Fred Were	-	Board Member
ix) Mr. Calvin Nyachoti	-	Corporation Secretary
x) Dr. Githae B.N	-	Director, Clinical
xi) Mr. Carylus Odiango	-	Director, Corporate Services
xii) Mr. Peter Odundo	-	Senior Chief Finance Officer

They submitted the following;

39. After the negative publicity that dogged the hospital on the allegations of breakdown of essential medical equipment, attempted rape of a new mother and general insecurity at the hospital, KNH embarked on internal investigations to establish the

veracity of these allegations. During the course of investigations, the KNH staff on duty on the night of 17th/18th January 2018 when the rape incident was alleged to have taken place were interviewed and statements recorded.

40. In addition, 11 patients/mothers in gynecology wards, including those with babies admitted in New Born Unit, were interviewed with some of them recording statements. The internal investigators also reviewed CCTV footage to try and corroborate the allegations. The CEO thereafter issued a press statement.

41. The Hospital vide letter ref: KNH/SEC/6/A/(30) dated 19th January 2018, invited Directorate of Criminal Investigations (DCI) to help with the investigations and their report was still awaited. An internal preliminary investigation report was also forwarded to Cabinet Secretary on 22nd January 2018.

42. The preliminary findings were that KNH had yet to receive any complaints or reports on rape or attempted rape incident against mothers with newborn babies, at the time or previously. The Newborn Unit (NBU) is on Level One and not on the Ground Floor as alleged in the social media. The breastfeeding schedule, which is done at an interval of three hours, has precipitated mothers with babies to always walk to and from NBU in groups, especially during the night. At night, mortuary attendants collect bodies at 0300 hours. Although there are service lifts serving the hospital separate from passenger/patient lifts, the service lifts are not configured to stop on level one and two. Therefore, mortuary attendants use other lifts allocated to patients, staff and visitors or the ramps, when collecting bodies from the wards on this levels.

43. Factually, findings indicated that post-natal mothers with babies in NBU are admitted in post-natal wards in Reproductive Health Department or in Pediatrics Wards Level 3. On the night in question 17th January, 2018 a total of 94 mothers from Reproductive Health and 29 mothers from level 3 had their babies in newborn Unit. On an average a total of 120-140 mothers attend to their babies in new born Unit every three hours. The mothers went to feed their babies as expected (three hourly). None of the mothers from level 3 had a caesarian section. Two mothers both in post-natal ward 1A which is on the 1st floor got their babies through caesarian section on dates specified in the table below. The two had attended to their babies on the night

of 17th January, 2018 as expected. None of the mothers either in reproductive health or Pediatrics Level 3 had raised any complaints.

IPNO	DOA	DODELIVERY	DOD	AGE
1923675	7/1/18	8/1/18	11/1/18	33
1923337	29/12/17	30/12/17	2/1/18	21

44. Arising from the facts presented in this preliminary inquiry, there was no evidence to confirm that the alleged rape incident occurred. However, the Hospital invited the DCI to commence investigations and which investigations are ongoing.

45. In view of the gravity of the allegations, the Board resolved to immediately implement the following recommendations;

(i) The Board fully endorsed earlier actions by the Hospital Management on 19th January 2018 to commence internal investigations into the allegations as well as the invitation of the DCI to expediently conclude the on-going investigations and take appropriate action.

(ii) Immediate engagement of additional security complement from private security firms and has also requested the National Police Service to increase their coverage of the Hospital to boost security.

(iii) The Board also toured the affected area, spoke to patients and staff on their experiences and also made suggestions relating to physical and functional infrastructural improvements.

(iv) The Board communicated to the public that the infants in the newborn unit are separated from their mothers for clinical reasons i.e. to offer the infants ICU support and control infection. The Board has however asked the Hospital Management to explore if functionally, the breastfeeding mothers could be relocated closer to the newborn unit for their convenience.

(v) The Board invited members of the public who may have been affected by these allegations to come forward and report any complaints directly to the Board or direct their complaints to the relevant external investigatory agencies.

(vi) The Board also assured the Hospital clients of their safety within the Hospital as well as optimal service delivery.

46. Other actions agreed upon included;

i) Improvement the lighting within the Hospital.
ii) Procurement of modern body carriage trolleys.
iii) Prioritizing and fast-tracking the sourcing and implementation of the remaining phases of CCTV installation and Integrated Security System.
iv) Increasing the number of operational Digital Radio Communications sets.
v) Review bodies collecting schedule at 0200hours and 0430 hours to avoid coinciding with the mother's breastfeeding times.
vi) Enhancing periodic debriefing to mortuary attendants.
vii) Health and safety awareness of the Hospital's patients.

47. On reports of breakdown of essential equipment, the hospital had one Magnetic Resonance Imaging (MRI) that had been in use since 2005 for advanced diagnostic imaging. Since its purchase, it had been under comprehensive service contract with Philips EA Ltd until it became technically obsolete in January 2016. Since then, the machine continued to be on service contract on best effort until August 2017 when it had a second quench (loss of helium which is used for cooling the Magnet). Ideally an MRI has a life expectancy of approximately 7 years according to Biomedical Engineering Advisory Group, 2004 guidance paper. KNH requested for funding from the treasury but this was not availed. Thus, the machine was completely rendered obsolete following lack of support from the manufacturer having been on operation for 12 years.

48. The Hospital initiated replacement of the MRI and an international procurement tender was advertised on 16th January 2018 and will close on 20th February 2018. Expected delivery is tentatively by end of June 2018.

49. The Laparoscopy tower comprising camera head, Endomart, Monitor, diathermy and light source is used for Laparoscopy surgery, which is a non-open surgical procedure. The Tower in theater 6 had been defective since 9th June 2016. The local agent, Philips healthcare Ltd was invited to assess and repair it and found a defective

Diathermy, Autocon II. It was taken for factory repairs the same year. During installation of the Autocon II, the machine did not work. It took the local agent long time to establish that the Camera Head and Endormart were also faulty. The defective parts were outsourced to the local agent in November 2017 for repairs at their Service Centre in Dubai and expected back by end of February 2018.

50. However, the Hospital acquired a new Laparoscopy tower through the East African Kidney Institute project in December 2017. Installation and commissioning is now complete and new tower is currently in use in theatre 6. The Hospital had also placed an order for two additional towers which are expected by March 2018.

51. The Hospital has only one Skin Grafting machine (Zimmer Electric Dermatome) used for harvesting skin parts for purposes of grafting elsewhere, which was donated by visiting team of doctors more 15 years ago as second hand equipment. It got defective in 2015 and spares could not be found locally since the equipment was not supported by any local agent. Towards the end of 2015, the faulty part of the machine was taken to US for the donors to repair and it is yet to be returned. However, the Hospital was currently using manual instrument set specifically for skin grafting. Also, the Hospital was in the process of purchasing a new Dermatome machine. A procurement tender is in the process, delivery will be expected within the financial year.

52. On laundry services, two laundry facilities, the main laundry cleans all patient linen. A second laundry located at the Sisters Mess cleans doctors' scrubs, staff uniforms and linen for external clients. In the month of October 2017, four of the washer extractors at the main laundry broke down due to lack of spares forcing the Hospital to outsource laundry service to Nairobi Hospital. The machines were repaired in November 2017 and have been operational since then.

53. The management and board also submitted information that demonstrated the hospital's predicament. These included underfunding by Treasury and overcrowding at the hospital largely stemming from failure of lower tier devolved hospitals to treat patients before considering referral. The former had restricted personnel numbers at the hospital as well as other operational priorities.

54. Further, incessant strikes witnessed in the recent past by medical personnel especially at the lower level hospitals doubled and even tripled patient numbers at the KNH.

2.2.2 Visit to the KNH by the Committee

55. The Committee made a fact finding visit to the hospital on 31st January, 2018 and toured various facilities and met the management in its boardroom.
56. The Hospital administration led the Committee on a guided tour of the facility's various departments i.e. Accident and Emergency (A&E) section, Trauma Centre, Maternity ward/New Born Unit and Theatre. The Committee also inspected some of the medical equipment i.e. Magnetic Resonance Imaging (MRI) scan, Laparoscopy tower machine and the management later presented status report of the laundry facilities.
57. During the tour, discussions with the personnel were held on the experiences and challenges they faced on daily basis and possible solutions to their problems. Thereafter, the Committee held a post-tour brief with the Hospital administration
58. Although Accident & Emergency unit was renovated in 2015 courtesy of Old Mutual Insurance and has ample space and well trained personnel, it is still overstretched since it attends to an average of 400 patients daily.
59. The MRI has been in operation since 2005 (for 12 years) and was rendered obsolete in January 2016. However, it has been on service contract until August 2017 when it was completely rendered obsolete due to lack of helium and lack of support from the manufacturer.
60. The hospital initiated replacement of the machine by advertising an international procurement tender on 16th January, 2018. The new MRI scan machine would be delivered by end of June, 2018.
61. The Committee visited the maternity ward and new born unit and found the following;
    i) Services at the unit are severely overstretched;

ii) Even after delivery some mothers are still lodged at maternity ward due to pending bills and this has partly been contributed by failure of Linda Mama program to cater for infants and also failure by some mothers to register for NHIF cover.

iii) The unit has a bed capacity of 50 but at time of visit held 132 babies;

iv) There are around 80 births a day and between 1200 and 2000 per month. This has stretched out and strained human resource at the facility since they are mainly referrals;

v) There are 20 incubators but only 10 are functional. Due to this babies share incubators hence the risk of cross infections;

vi) There are 9 Nasal continuous positive airway pressure but only 6 are functional;

62. The Committee visited the operating theatre ward and found the following;

i) The facility has 22 operating theatres and although some of the machines are functional they are ageing fast;

ii) The facility requires adequate number of heart and lung machines; currently it is using a borrowed one;

iii) Only one laparoscopic equipment that is used for keyhole surgery is functional, the hospital requires four (4) of this equipment for it to provide proper services to the patients;

iv) There are 21 beds at ICU unit. However, there is a huge number of patients staying longer than medically required hence taking up space needed by sick patients waiting for admission.

v) Almost all theatre tables, which are used to facilitate the correct orientation of patients for surgical procedures, are more than 3 decades old;

vi) The hospital lacks proper training facilities for students trainees, for example it's not yet possible to project what is happening in the operating theatre to lecture theatres at the facility;

63. The Committee visited the trauma center and found the following;

i) 400 out of 2000 patients admitted at KNH are trauma patients; translating to about 25% of the patients in the facility;
ii) The ward has a bed capacity of 36 but at time of visit held 113 patients;
iii) More than two patients share a single bed at the ward

2.2 WITNESS SUBMISSIONS; SURGICAL MIX-UP

On the matter of unintended surgery, the Committee received oral submissions from the board and management, 18 individual witnesses, and the KMPDB whose each account is detailed herein;

2.2.1 Medical Personnel involved in the surgery mix-up

64. The Committee met with the surgical team that conducted the surgery in which there was a mix-up of patients at the KNH on 14th March, 2018. The team comprised the following;

i) Dr. Micheal Magoha - Junior neurosurgical consultant
ii) Dr. Dave Mangar - Neurosurgery resident, UON
iii) Dr. Hudson Ng'ang'a - Junior neurosurgery resident
iv) Dr. Mose Moraa - General surgical resident, UON
v) Dr. Okedi Nelson - Registrar, orthopedic surgery
vi) Mr. Malachi Odhiambo - Assistant chief clinical officer (anesthetist)
vii) Ms. Linet Makori - Senior nursing officer
viii) Ms. Catherine Gakii - Senior nursing officer
ix) Ms. Mary Wahome - Nursing officer I

They submitted a chronological account of the mishap in three sets, the consulting doctor, nurses and neurosurgeons;

65. Dr. Nelson Okedi examined the patient, Mr. John Nderitu at the casualty. The patient had suffered a motor bike accident and was bleeding in the head. The CT scan showed that he had a blood clot in the head which would require surgery to remove.

66. He then consulted a colleague, Dr. Daniel Kanyatta who concurred with his assessment. They then recommended surgery, had a relative of the patient sign the consent form and it was at this point that he left the patient and his report to nurses to facilitate the next course of action as is the practice.

67. Ms. Mary Wahome, a surgery ward nurse, submitted that she was on duty on the evening of 19th February, 2018 together with a team of about four nurses including one Mr. Gideon Mwangi. It is Mr. Mwangi who received handover reports from the team in the previous shift, including one due for neurosurgery, belonging to a Mr. John Nderitu.

68. Ms. Wahome said the team of nurses was outstretched, handling about sixty patients in total, and also responding to customer care queries. The handover was therefore not done physically and bed to bed as should be the case.

69. At around 9.15 pm, a trauma theatre nurse called and asked for the patient John Nderitu, and sent a porter to collect him. Ms. Wahome then went to the ward and called out the name 'john Nderitu'. A patient nodded in response, after which she went back to the station, prepared a label, and collected the file and antibiotics. She went back to the ward with the porter, called out the name again and tagged the patient who nodded again in response. She informed the patient that he was going for surgery, of which the seemingly confused patient nodded.

70. At around 10 pm at the theatre, Ms. Wahome handed over the patient and file to nurse Catherine Gakii. Her job was done here. At 2 am of 20th February, 2018, her colleague Gideon Mwangi asked her of the whereabouts of patient John Nderitu of which he informed him he was in theatre. At 6.30 am, another nurse, Miriam Mbela reported to duty and asked Ms. Wahome if the patient was taken to theatre. It was at this juncture that Ms. Wahome discovered she had taken the wrong patient to theatre.

71. She immediately called trauma theatre and informed nurse Gladys Wanjala. Catherine Gakii then convened a meeting to discuss the mistake. At midday, she held discussions with the Assistant Chief Nurse, a Mrs. Okech, and subsequently met the board and management on 5th March 2018.

72. Ms. Catherine Gakii submitted that she reported to work on 19th February, 2018 at 5.30 pm.

73. She received a handover of seven pending emergencies. The report of a Mr. John Nderitu was among them and had been brought in theatre at around 2 pm but wasn't received since there was no blood. She was tasked to facilitate. She went about preparing other patients until around 9 pm when she called ward 5A to bring in John Nderitu since blood was now ready.

74. When the patient was brought, she greeted him but he only nodded in response. The patient was already labelled at this point, and together with the file and bio data, she ticked the pre-operative checklist and was certain the patient was the correct one. She then called the anesthetist to take over the patient pre-surgery.

75. It was only at around midnight that she was called to confirm if the patient was the right one because findings were at variance with the CT scan. She perused the file again and called ward 5A to confirm. Everything matched the profile of John Nderitu.

76. Later on, recovery ward nurse Gladys Wanjala received a call from Ms. Wahome informing her that they probably brought it the wrong patient. Ms. Gakii asked for the other file and discovered it belonged to a Mr. Samuel Kimani. She then immediately informed the surgeons and reported to her own supervisor. She then called a small meeting to establish what went wrong, and filled in a medical error form. Her supervisor, Ms. Ndula Makau asked her to write a report on the 21st February, 2018, held several meetings on the same and met management on 5th March 2018.

77. Mr. Malachi Odhiambo, the anesthetist, said that he reported to duty on 19th February, 2018around 5.30 pm. He was handed over to by his colleague, a Dr. Kinuthia after which they did an orthopedic case of another patient together.

78. At around 10.50 pm, the nurse team leader, Ms. Catherine Gakii called him to corroborate John Nderitu before surgery. He perused the file and tried to talk to the patient who could not converse. He checked all requirements, i.e. positively identifying the name of the patient through the label and file including the CT scan.

He then confirmed that blood was available, and checked pre-operative vital signs including blood pressure, pulse and blood sugar levels.

79. They then wheeled the patient into the theatre room and set up monitoring equipment and an intravenous access on the patient for fluids. He prepared medication and induced anesthesia. They displayed the CT scan on the board.

80. Dr. Hudson Ng'ang'a Kamau, the neurosurgeon in the presence of Dr. Mose Moraa consulted Dr. Micheal Magoha on the need for surgery and he concurred. Dr. Ng'ang'a and Dr. Moraa then shaved the patient and positioned him for surgery.

81. The surgery commenced and after opening the cranium, they could not locate the intracerebral hematoma (the clot). They reconfirmed on the CT scan and called the ward to confirm if indeed this was the right patient. Ms. Gakii responded in the affirmative.

82. They then called Dr. Mangar, a senior registrar on call, who reviewed the scan and file and affirmed that all was in order. He also could not find the clot.

83. They then called Dr. Magoha, a junior consultant on call, who also reviewed the CT scan and file, patient positioning and site of surgery and confirmed everything was correct. He proceeded to look for the clot and could also not find it.

84. The doctors then made a decision to close the wound, and do an urgent CT scan to establish the dilemma.

85. Before the scan was done, a ward 5A nurse called the trauma theatre and informed him that they had the wrong patient, a Mr. Samuel Kimani. They then reported to their supervisors Dr. Gichuru Mwangi, senior consultant and Prof. Nimrod Mwang'ombe, head of neurosurgery thematic unit.

86. After this discovery, Prof. Mwang'ombe led the neurosurgical team to review the two patients involved in the mix up, and based on current conditions, recommended conservative management for John Nderitu. Samuel Kimani was stable and doing well post-operatively.

2.2.2 Acting CEO, Management and Board

87. The Committee met with the acting CEO, Board and Management of the KNH first on 14th March, 2018. The board was neither fully constituted nor quorumed and the Committee rescheduled the meeting to 15th March, 2018. The delegation comprised the following;

i) Mr. Mark K. Bor	-	Chairman, Board of Management
ii) Dr. Thomas Mutie	-	Ag. CEO
iii) Ms. Grace Mullei	-	Board Member
iv) Dr. Hellen Yego	-	Board Member
v) Dr. Daniel Gathegi	-	Board Member
vi) Mr. Robert Mbune	-	Board Member
vii) Dr. Richard Kamau	-	Board Member
viii) Prof. Fred Were	-	Board Member
ix) Mr. Calvin Nyachoti	-	Corporation Secretary
x) Mr. Carylus Odiango	-	Director, Corporate Services
xi) Ms. Rosemary Mutua	-	Ag. Deputy Director, Nursing Services
xii) Mr. Peter Odundo	-	Senior Chief Finance Officer
xiii) Mr. John Anyira	-	Representative. KMTC

They submitted the as follows as regards the administrative action taken by management and the board in the wake of unintended head surgery;

88. After the surgical mishap, Prof. Mwang'ombe reviewed both patients – Samuel Kimani Wachira and John Nderitu Mbugua, and based on the patient's immediate state, a decision was made to change John Nderitu Mbugua's management, from operative management to conservative management owing to improved physical condition. Indeed, Patient Kimani was noted to be stable and doing well post operatively and a decision was made to undertake neuro-checks every two hours.

89. On 20th February 2018, Samuel Kimani Wachira's family members were informed of the surgery. On the same day, the Unit Heads (KNH and UoN) met and reviewed

both cases and subsequently reported the incident to the Acting Director, Clinical Services who then informed the substantive Director who was away on official business.

90. On 21st February 2018, the CEO Mrs. Lily Koros convened a meeting involving the Principal, College of Health Sciences – University of Nairobi Prof. Fredrick Were, the Director, Clinical Services Dr. Bernard Githae, the Deputy Director - Surgical Services Dr. John Ong'ech and the Deputy Director - Medical Services Dr. Thomas Mutie. In the meeting, various administrative actions were agreed upon. Specifically, it was resolved that;

    (a) Effective 23rd February 2018, to immediately withdraw the admission rights of Dr. Hudson Ng'ang'a pending investigations because of lack of doctor's return notes when John Nderitu Mbugua was returned to the ward and lack of a pre-operative checklist in the patient's file.

    (b) Effective 23rd February 2018, to place on interdiction pending investigations the following staff: -

    - Nurse Mary Wahome for erroneously labelling the patient, taking the wrong patient to theatre and lack of pre-operative checklist in the patient file.
    - Nurse Gakii Kabiti for absence of a pre-operative checklist in the patient's file.
    - Mr. Malachi Odhiambo Siwa, Clinical Anaesthetist, for failing to sign patient John Nderitu Mbugua's consent form, and absence of a pre-operative check list in the patient's file

91. The Board of Management was represented in the deliberations and kept updated through the Principal, CHS-UoN, Prof. Fredrick Were who is also the Chairman of the Clinical, Research and Standard Committee of the Board of KNH.

92. The Clinical Research and Standards Committee of the Board directed the Management to embark on investigations into the circumstances leading to the incident.

93. On 2nd March 2018, the Cabinet Secretary for Health directed the Board of Management to investigate the circumstances that led to the unintended surgical intervention and to sanction a system audit to evaluate the adequacy and effectiveness of the Hospital's internal controls.

94. The Board of Management on 3rd March 2018 sent the CEO and Director, Clinical Services on compulsory leave to facilitate investigations into the circumstances surrounding the incident.

95. Further, the Board appointed a Special Committee of the Board to spearhead the investigations process. The Committee has completed its task and presented the Cabinet Secretary with its report.

96. They added that the Hospital has in place a corporate quality manual which specifies Standard Operating Procedures (SOPs). The SOPs define practices which need to be followed in word and spirit by all employees strictly and without deviation. The following SOPs were operational preceding and during the surgery: -

(a) SOP/KNH/CORP/021 on Procedure for Admission
(b) SOP/KNH/CORP/023 on Procedure for In-patient Care
(c) SOP/KNH/CORP/024 on Procedure for Perioperative Management
(d) Nursing Council of Kenya Manual of Clinical Procedures, in particular:

- Admission of a patient
- Transfer of a patient
- Giving verbal and written reports.

97. Further, the Board submitted that they had taken various immediate actions going forward;

i) Strict enforcement of the use of arm/wrist bands to identify all patients on admission.
ii) Strict enforcement of the Corporate Standard Operating Procedures.
iii) The procurement of human marker pens to mark surgical sites on the patient and insert a template checklist of the human anatomy in all patient files for highlighting of the affected parts.

iv) Mandatory physical review of the patient by the attending doctor prior to surgery.

98. The Board further directed the Corporate SOPs be reviewed, specifically on:
    - Requirement on the use of arm/wrist bands to identify all patients on admission.
    - Requirement that pre-operative checklist be placed in all in-patient files on admission.

99. The Board had also engaged an audit firm to review the hospital internal control systems and make recommendations.

100. To manage the hospital reputation and stakeholder relationships, the Board engaged a Public Relations and Media Consultant and had directly released various press statements to allay fears and assure the public of its commitment to optimum service delivery.

101. The Board also prepared and submitted a report and individual statements to the Medical Practitioners and Dentist Board, Nursing Council of Kenya and Clinical Officers Council to facilitate investigations on the professional conduct of the clinicians involved.

102. In the medium to long term, the Board is taking steps to engage more staff and was reviewing the relationship with key stakeholders and in particular, the working relationship with the University of Nairobi. A review of the work schedule for registrars in consultation with the College of Health Sciences was also being done.

103. The Chairman of the Board, Mr. Bor, confirmed that it was indeed the full board that made the decision to suspend the CEO and Director Clinical Services and not the Cabinet Secretary. This action was not disciplinary but as an avenue to facilitate investigations.

2.2.3 Mr. John Nderitu

104. The Committee met the patient at the centre of the surgical mix-up, Mr. John Nderitu and his relatives on 14th March 2018.

105. Mr. John Nderitu was the patient to whom the surgical procedure had been presecribed by the doctors but did not receive it. He and his relatives gave an account of events leading to the mishap.

106. The sister, Ms. Pauline Njeri received a telephone call from a stranger on 18th February, 2018. The stranger, now good Samaritan, stated that her brother, John Nderitu had been found injured at Kahawa West, having been in a motor cycle accident. She demanded to speak to her brother to confirm the story.

107. Ms. Njeri then called her other sister, Esther Nderitu and her husband who lived not too far from the accident scene to rush and attend to their brother. The two took him to St. Francis Hospital in Kasarani where the medics examined him and conducted a CT scan. They established he needed urgent specialized attention and referred him to KNH.

108. They arrived at KNH around 9 pm, did not get adequate attention until around 6 am the following morning when a Dr. Nelson advised that John required surgery. After explanations she signed the consent form and paid a deposit of Kshs. 20,000.

109. After shuttling from room to room, they were told by nurses to look for a stretcher bed, after which they were told to wheel the patient to surgical ward 5A, without escort by any medical personnel. Once there, they were asked by nurses present to push him to the theatre entrance and were then asked to retreat. They were told the surgery would take 4-6 hours.

110. Two of John's sisters remained behind to monitor the situation. Two hours later, now around 6 pm, they were told the patient had been returned to the ward 5A due to lack of blood for surgery. Nurses advised that this was being arranged and the surgery would be done overnight. This comforted them and they left for the day around 7 pm, leaving the patient asleep in the wards.

111. The next morning of the 21st February 2018 at about 8.30 am, a cousin, Ms. Rachel Warumi went to check the outcome of the surgery. She was surprised to find John still in the wards, with the explanation from nurses that the blood was not forthcoming. She however heard from another doctor that blood was found and was not sure why the surgery was not done. It is then that a team of four doctors holding

John's file appeared to review the patient. After they left, Ms. Warumi enquired from the nurse what was happening and she was told that the doctors had reviewed the patient and he no longer required surgery.

112. The patient stayed in the hospital until 7th March, 2018, with unsatisfactory attention from the medical personnel with no drugs issued. All this time, no label was put on their patient. Medicine, adequate food and cleaning services were only issued when the Cabinet Secretary (CS) appeared two weeks later. On discharge, they received prescription to go buy medicine for the patient, to be reviewed on the 19th March 2018.

113. They heard about the mix-up of the two patients from a Dr. Gichuru Mwangi, who attempted to address their concerns. They added that doctors at the facility were generally responsive to patients and relatives; the same could not be said for nurses.

114. The family reported that they were tortured by fake reports by sections of the media that their patient had died. They were also apprehensive about returning to KNH for the review. They had also not received the full refund of their costs as ordered by the CS.

115. Mr. Nderitu submitted that he was unemployed but survived on informal menial jobs; after the accident he could not perform. He was generally slowly improving but still experienced bouts of headaches.

116. Nobody at the hospital or elsewhere had reached out to them since discharge.

2.2.4 Mr. Samuel Wachira

117. Mr. Amos Wachira, brother to Mr. Samuel Wachira, appeared before the Committee on 14th March, 2018 accompanied by advocate Isaac Wahome and submitted as follows;

118. A social worker from KNH by the name Bahati called his father on 22nd February, 2018 and informed him that an unidentified patient was admitted at the facility. The patient could only remember this telephone number off head.

119. His father dispatched him to rush and check up on Samuel. When he arrived at the hospital on the same day, he found him admitted at ward 5A with the head surgery already done. Samuel could talk but not constructively. The patient was not labelled at the time.

120. He was told that Samuel was received at the hospital on 19th March 2018 unconscious.

121. He then received a bill of Kshs. 98,425, and shortly after got information that the case was special and therefore the fee was waived.

122. The patient was set to be discharged on 5th March, 2018 but left the hospital two days later. He was given medication and was since recovering well. An appointment for review was set for 19th March, 2018.

123. Samuel was 37 years old and had no prior medical history; he worked at Pangani Girls School as a cook, and he could not remember what happened to him, or how he found himself at KNH.

124. The family had since reported to and filed a complaint with the Medical Practitioners & Dentists Board and were due to appear in its hearings. They were yet to file the matter before any court.

125. Nobody at the hospital or elsewhere had reached out to them since discharge.

2.2.5 Dr. Benard Githae

126. Dr. Githae, the Director Clinical Services at the KNH appeared before the Committee on 15th March 2018 and submitted as follows;

127. He had worked at the hospital since 1991. His duties as Director Clinical Services included ensuring adherence to laid down standard operating procedures.

128. As the isolated incident of the surgery mix up happened at the hospital, he and members of the board were in Mombasa validating the hospitals strategic plan. Dr. Etau whom he left in the office to act in his absence informed him on the matter on 20th February, 2018. Dr. Githae instructed him to investigate the matter of which Dr. Etau sent him an incidence report the next day.

129. On 22nd February, 2018 a meeting was held at the hospital comprising the CEO, Dr. Githae, Dr. Mutie the head of medical services, Dr. Ongech the head of surgical services and Prof. Were the Principal of College of Health Sciences, UON. A decision was to immediately do the following;

i) Suspend the admission rights of the registrar pending further investigations. This was due to lack of medical notes when he initially returned John Nderitu to the ward and a lack of a pre-operative checklist in the patient's file;

ii) Instruct the human resources department to send show cause letters to the following;

- Mary Wahome- nursing staff ward 5A for erroneous labeling, taking the wrong patient to theatre and lack of pre-operative check list in the patient's file.
- Gakii Kibiti- senior nursing officer at trauma theatre for absence of a pre-operative check list in the patient's file.
- Malachi Odhiambo Siwa- Anesthetist, for failing to sign the patient consent form and absence of pre-operative check list in the patient's file

They were all given seven days to respond in writing.

130. On 2nd March, 2018, before receipt of responses from the involved officers, the Cabinet Secretary advised him to proceed on compulsory leave pending investigations.

131. He disputed reports by the relatives of the two patients on neglect and stated that doctor rounds were done twice a day, away from visiting hours, and thus the relatives may not have seen this.

2.2.6 Ms. Lily Koros

132. Ms. Koros was the CEO of the KNH since 24th February, 2014 and was sent on compulsory leave on 2nd March, 2018, following the surgical mishap. She was serving her second and last term. She appeared before the Committee on 15th March 2018 and submitted as follows;

133. She first and foremost regretted the isolated incident of the surgical mix-up and appreciated the Committee efforts to get to the bottom of it.

134. As the CEO her main roles included providing leadership and implementing board decisions, long term strategies and prudent management of resources. She was also to promote compliance to standards and ensure sound corporate governance.

135. She received reports of the matter on 20th February, 2018 and immediately consulted Dr. Githae who was the Director Clinical Services, in Mombasa on official business at that moment.

136. The following day, they held a meeting with Dr. Githae, Dr. Mutie the head of medical services, Dr. Ongech the head of surgical services and Prof. Were the Principal of College of Health Sciences, UON. They made the decision to suspend the registrar, two nurses and anesthetist and further resolved the following;

- An advisory committee meeting be held after the show cause responses had been received back by the 2nd March, 2018
- The hospital disciplinary and advisory committee to comprehensively investigate the matter
- The outcome of these investigations be submitted to relevant regulatory bodies including the Medical Practitioners & Dentists Board and the Nursing Council, as this was a matter of professional misconduct.

137. On the 1st March, 2018, a journalist called her around 7 pm informing her that the story would go to press by 7.30 pm. She prepared a statement and sent it to all newsrooms at 9.00 pm.

138. The next day, the story appeared in the papers and while at the NYS headquarters on official duty, she was called and informed that the Cabinet Secretary would be visiting the hospital at 2.30 pm.

139. The CS was briefed by the management and board members present. She said the matter was beyond the board and that a decision had been made. She then asked management to step out of the meeting; they returned after 20 minutes and were informed of the decision to suspend the CEO and Director of Clinical Services. They were to clear and hand over by the following day.

140. She did not immediately inform the board of the matter because she was awaiting outcome of investigations after due process. Further, Prof. Were, a board member, was aware of the matter. Being a professional mishap, she felt this was a matter for the regulatory boards and did not see the need to inform the CS.

141. She denied being hands off but admitted that as CEO, she could not be involved in the numerous medical procedures at the hospital. These were matters directly handled by respective heads of the units and directorates.

142. She did not directly suspect foul play in the matter but was curious at the sequence of revelations of these incidences and bad press all happening on or around January 2018. This was especially since most of the matters had happened several months before and had in fact been resolved.

143. She added that she had made attempts at streamlining procurement at the institution by systematically moving supplies to government agencies for cost effectiveness. This especially affected fuel for the furnace steam boiler and the hospital's vehicle fleet.

144. She stated the hospital had made numerous strides in improvement of services and that the board was supportive. This was in spite of the numerous challenges already well documented.

2.2.7 Mrs. Sicily Kariuki, CBS

145. Ms. Kariuki is the Cabinet Secretary (CS), Ministry of Health. She appeared before the Committee on 16th March 2018 accompanied by the board of KNH, and the following officers of the ministry;

    i) Mr. Peter Tum - Principal Secretary
    ii) Dr. Kepha Ombacho- Director Public Health
    iii) Mr. Ibrahim Abdi- Undersecretary, Administration
    iv) Dr. Annah Wamae- Deputy Director of Medical Services

146. Ms. Kariuki, the substantive head of the ministry and its agencies, including the KNH, publicly waded into the matter when she was reported to have announced the

suspension of the CEO and the Director Clinical Services, on 2nd March, 2018. She submitted as follows;

147. The CS clarified that she did not suspend the CEO and Director Clinical Services. The two officers were sent on compulsory leave by the board on 3rd March, 2018, as per the letters signed by the board's Chairman.

148. She visited the hospital on 2nd March, 2018 at around 2.30 pm when she received a letter via email from the CEO, on the matter of the surgery mix-up. She had earlier heard of the matter from a journalist who called her during a private visit to the hospital earlier in the week.

149. During the visit of the 2nd March, she went round the wards accompanied by chairman of the board and a few of his members. She met the two victims and conveyed her apologies, and arranged for NHIF enrolment for them.

150. During a meeting with the board members present, the CEO gave a briefing of the sequence of events leading to the unintended surgery and the state of investigations.

151. It is at this time that the board agreed with the CS that there was indeed a crisis and that decisive action had to be taken. It was at this juncture that it was found necessary to send the CEO and Director Clinical Services on compulsory leave to allow for investigations. This was in line with the hospital's human resource regulations and procedures. The board nominated Dr. Ongech and Dr. Mutie as acting CEO and Director Clinical Services respectively.

152. The full board met on 3rd March 2018 to ratify the earlier decision and agreed on the action. Dr. Ongech however declined the offer for personal reasons and the board appointed Dr. Mutie and Dr. Masinde as acting CEO and Director Clinical Services respectively.

153. The CS clarified that she stepped into the matter in performance of her duties as stipulated in a government circular requiring her to exercise policy oversight to safeguard public investment, performance and service delivery. It was an exercise to jolt the board into pro-activity, having noted certain weaknesses in it, including poor communication channels.

154. Moving forward, the CS said that to redeem public confidence, the board had constituted a Special Board Committee to investigate the matter. A preliminary report was submitted.

155. Further, the board had engaged an audit firm to review the hospital internal control systems and make recommendations in 30 days for improvement.

156. The CS also convened a meeting on 8th March, 2018 attended by the board, Kenya Medical Practitioners and Dentists Board, and senior ministry officials in which it was resolved to rescind suspensions and interdictions of the registrar and nurses, to allow the KMPDB, Nursing Council of Kenya and the Clinical Officers Council to conduct professional investigations as is their mandate.

157. The board was also in the process of finalizing its strategic plan 2018-2023 to guide the institution with the main focus being service improvement through effective resource mobilization.

158. The Ministry had also formed a task force which included the County Government of Nairobi to address congestion at the hospital. Nairobi was settled on because it contributed up to 70% of patients at KNH. Other stakeholders would however be involved at different levels.

159. She added that the ministry had begun consultations on provision of Universal Health Coverage (UHC) with the Council of Governors, and would also involve the National Assembly's Committee on Health.

160. The ministry had earmarked KNH to be a regional referral hospital to benefit from funding under the 10 year East African community health framework signed by the region's Heads of State in Kampala in February 2018.

161. Finally, the ministry had a Kenya Quality Model for Health that guides the organization of health services to deliver positive health impacts by addressing quality issues. A comprehensive policy on quality of care and patient safety was also under development.

2.2.8 Other medical personnel involved in the surgery mix-up

162. The Committee invited more medical personnel deemed to have come into contact preceding and after the surgical mix-up as mentioned by their colleagues who had earlier appeared. Prof. Nimrod Mwang'ombe, a neurosurgeon, and ward nurses Ms. Mariam Mbela, Ms. Rita Akinyi and Mr. Gideon Mwangi were interviewed on 16th March, 2018.

163. The Committee heard from Ms. Akinyi that she was the receiving nurse on 19th February, 2018 during the shift of 7.30 am to 5.30 pm. Patient John Nderitu was brought to the ward by a porter around 2.30 pm accompanied by two relatives. She then went through the patient file and attempted to engage the patient who was unresponsive until called the third time.

164. She admitted Mr. Nderitu, labelled him on the chest and filled the patient check list. It was at this time that theatre called for the patient and sent a porter to collect him. She then handed over the file and patient to Ms. Mariam Mbela, her colleague to take it from there.

165. Ms. Mbela submitted that the theatre porter came and wheeled the patient into the trauma theatre. At the entrance of the theatre she asked the two relatives to remain behind as they were not allowed into the theatre. She then went for blood at the blood transfusion unit (BTU) and found that it wasn't ready.

166. She returned the patient to the ward 5A and settled him in the middle of the room. His labelling was still on. A Dr. Mokua then took blood samples from Mr. Nderitu and sent it to BTU.

167. At 5.30 pm, Ms. Akinyi whose shift was ending handed over 61 reports to Mr. Gideon Mwangi. The rest of the team of nurses in the evening shift had not arrived. Mr. Nderitu was among those handed over. Ms. Akinyi asked Mr. Mwangi to follow up on Nderitu's blood.

168. Mr. Mwangi said that when the handover was almost done, Ms. Mary Wahome, his colleague arrived. Ms. Wahome asked if there were any special reports for theatre, of

which Mr. Mwangi gave her three, including that of Nderitu. In fact, all these patients were in Ms. Wahome's shift the previous evening except that of Mr. Nderitu.

169. Mr. Mwangi informed Ms. Wahome on Nderitu's blood situation after which Ms. Wahome went to the wards with the nursing registers and called out patient names. They noticed one patient was missing and they reported to security as an abscondee.

170. Later on in the night, theatre called Mr. Mwangi to ask if they had sent the right patient. He asked Wahome who affirmed that Nderitu was in theatre.

171. At 6.30 am, Ms. Mbela arrived for her day's shift. Because she remembered the lack of blood the previous evening, she was interested to know if the patient in the middle of the ward, Mr. Nderitu, had finally been operated on. It was at this moment that Ms. Wahome realized she had wheeled in the wrong patient.

172. The three nurses noted that patients not for surgery usually did not have labels. Ms. Wahome, who was diabetic and was recovering from a road accident herself, must have not remembered this and simply called out the patient, a wrong one (Mr. Samuel Kimani) responded and she proceeded to tag him and wheel him into theatre.

173. They added that they faced massive challenges at work including threats from patients, a high nurse to patient ratio, inadequate linen, patient gowns and equipment like beds. They also performed non-nursing functions including billing on discharge, customer service and responding to patient and relatives' enquiries. They were also forced to personally go for blood at the BTU.

174. They had not come into contact with management or the board in their 2-5 year careers and had not undergone any trainings save for inductions at employment. The SOP manual was filed at the nurse station.

175. Prof. Mwang'ombe submitted that on 20th February, 2018 at 7am, they had a departmental meeting to receive usual briefs. It was here that he was informed of difficult cases the previous night including one of a wrong patient operated on.

176. He went to review the wrong patient operated on, Mr. Samuel Kimani who at this time still had the wrong label of John Nderitu. He reviewed the patient and discussed with nurses. The patient was recovering well and he concluded he would fully recover with conservative management.

177. He also reviewed the real John Nderitu and found that his Glasgow Coma scale had improved and would no longer require surgical intervention. He therefore revised his management to conservative management as well.

178. The surgeons then held a meeting to review the mishap. Prof. was briefed on the chronology of events, and he advised his juniors to make copies of the files and take photos of the patients. This act came in handy when he later heard that the patient files had mysteriously disappeared. They were to reappear later, probably because whoever was involved realized copies were available.

179. Prof. Mwang'ombe then received a call from Dr. Etau, the acting Director Clinical Services in the absence of Dr. Githae who was in Mombasa at the time. He gave a briefing of what had happened.

180. Professor added that this mishap was bound to happen sooner or later because of weak systems at the hospital. He told the Committee that a study at the hospital found that implementation of the WHO checklist was a paltry 19%.

2.2.9 The Medical Practitioners and Dentists Board

181. The board's CEO, Mr. Daniel Yumbya, appeared before the Committee accompanied by board member, Dr. Elly Nyaim Opot on 19th March 2018 and submitted the report of the outcome of investigations by the board. The report found the following with specific findings and recommendations;

182. The competency of the Dr. Hudson Ng'ang'a Kamau, who undertook the surgery of the patient while being assisted by Dr. Mose Moraa, could not be questioned as his team reviewed the documents presented to them in theatre appropriately and thereafter undertook the proper procedure that would have been expected in a proper scenario.

183. The capability of one nurse, Mary Wahome, to work in specific units of the hospital needs to be considered by the body that licenses and regulates her, the Nursing Council of Kenya, as she testified that she had been unwell for several months after being involved in an accident, and had not recovered fully. During the inquiry she

requested to be allowed to give her evidence while seated stating that she was not able to stand for a long period of time.

184. The Committee finds that the appropriate regulator should consider whether the said nurse is fit to practice under such an environment.

185. Kenyatta National Hospital had Standard Operating Procedures for the various processes but there was a challenge on their implementation, monitoring and evaluation.

186. The Medical Advisory Committee of the Hospital existed only on paper as it was dormant

187. There are glaring gaps on the admission process at the Kenyatta National Hospital. It was noted that the neurosurgery patients were spread in different wards within the facility and as a consequence there is a potential risk to proper management and follow-up of the patients.

188. There was a challenge on the chain of command and communication between the Hospital and the University of Nairobi, School of Medicine.

189. A review of the patients' files submitted to the Board and noted that there was poor documentation by different cadres involved in the management of the patient. The nurse's cardex had poor records and missed the times when certain interventions were undertaken.

190. At the material time Kenyatta National Hospital appears to have had challenges in the supply of resources including patients' identification materials for the user Departments. As a consequence thereof the nurses had at the material time improvised and were using strappings which may have contributed to the mix up of patients.

191. In view of the above findings the Committee holds that a surgical procedure was done on a wrong patient as a result of systemic lapses at the Kenyatta National Hospital thus affecting the functioning of the different professional cadres who were working at Hospital at the material time.

192. Committee made the following orders;

(i) The Medical Practitioners and Dentists Board do constitute a Professional Conduct Committee under the provisions of Rule 4 A of the Medical Practitioners and Dentists (Disciplinary Proceedings) (Procedure) Rules within the next three (3) days to undertake an inquiry on the role played by Kenyatta National Hospital and the doctors involved in the treatment and management of the two patients, John Mbugua Nderitu and Samuel Kimani Wachira.

(ii) The Professional Conduct Committee to be constituted under (1) above, shall convene its sitting in Nairobi within the next Fourteen (14) days.

(iii) The Medical Practitioners and Dentists Board shall forward a copy of this decision to the Nursing Council of Kenya within the next three (3) days to enable the said Council initiate an inquiry under Section 18B of the Nurses Act on the role played by nurses in the treatment and management of the two patients, John Mbugua Nderitu and Samuel Kimani Wachira, leading to the mix up and the mistaken surgery. The said inquiry shall be commenced within the next fourteen (14) days and the Council shall take appropriate action under the circumstances of the case.

(iv) The Medical Practitioners and Dentists Board shall forward a copy of this decision to the Clinical Officers Council of Kenya within the next three (3) days to enable the said Council initiate an inquiry on the role played by Clinical Officers in the treatment and management of the two patients, John Mbugua Nderitu and Samuel Kimani Wachira, leading to the mix up and the mistaken surgery. The said inquiry shall be commenced within the next fourteen (14) days and the Council shall take appropriate action under the circumstances of the case.

2.2.10 Written submissions

193. The Committee received two written submissions from concerned members of the public who heeded the Committee's public call for any information. They were the following;

Ms. Wambui Muya

194. Ms. Wambui Muya wrote an email to the Committee on 7th March, 2018, from Canada and submitted the following;

195. She was a registered nurse in Ontario, Canada and she felt patient safety was a shared responsibility of all health care team members. This was crucial in preventing such mishaps as was experienced at KNH.

196. Her practice and research had exposed her to a 'systems approach' to prevent or at least reduce frequency surgical errors. This approach involves all the team members and is led by the primary surgeon and involves communication between the team and the patient during the preoperative assessment of the patient.

197. This process is facilitated by a predetermined checklist rechecked by the entire surgical team before surgery. An introduction of everyone present in the operating room is essential.

198. As far as is possible, the patient, or his/her designee should be involved in the process of identifying the correct surgical site, both during the informed consent process and in the physical act of marking the intended surgical site in the preoperative area.

199. A process of 'time out' involving final confirmation of the correct patient and surgical site, plus review of medical history, allergies, administration of appropriate preoperative antibiotics and deep vein thrombosis prophylaxis, may be helpful.

Better Kenya Team

200. Mr. Peter Mugo Mokua on behalf of his colleagues under the banner 'Better Kenya Team' submitted the groups views vide a letter dated 9th March 2018. The team

congratulated and saluted the committee on health for boldly launching the inquiry, and for inviting public feedback.

201. Their views were that the surgical mix-up was or may have been occasioned among others by:

i. Lapse in the control and feedback system;

ii. Congestion and crowding in the wards;

iii. Inadequate treatment infrastructure;

iv. Exhaustion, motivation and health aspect of KNH staff themselves.

202. They proposed the following measures to sort, solve and prevent such issues at this very critical national facility.

i. Computerizing doctor's treatment process for better, efficient, faster, easier management and follow-up. The doctors will be keying information on the computer as they interview the patient. This will enable flawless tracking of patient treatment;

ii. All patients to have (probably instead of name tags) smart cards with all the patient's details complete with photo. This way it will be impossible to switch patients. It will also improve efficiency in patient management;

iii. Make Kenyatta National Hospital strictly referral .A patient must have a referral letter from a hospital of the next lower level;

iv. Establish Kenyatta General Hospital adjacent to KNH to where patients other than referral ones will be directed.

v. Decongest the hospital by (a) reducing road accidents (ref. our petition bill on amendment to traffic act 2012 already in Parliament) (b) By actualizing 3&4 above(c) establishing alternative facility for patients whose Medicare/treatment according to doctors opinion e.g. cancer patients will take longer than say 6 months .This will free more space.

vi. Have specially trained staff doctors, nurses and support staff with special certification to deal with referral cases

vii. Make KNH absolutely free treatment facility being our national Hospital.

viii. Establish SMART (Specific Measureable Achievable Realistic Timely) awards scheme for the staff as a motivation tool.

ix. Carry out A-Z patients test and examination before commencing treatment akin to what happens at Apollo Hospitals India. This way they will thoroughly establish the patient's ailment and have a multipronged treatment program.

x. Improve staff welfare;

- convert KNH staff clinic into KNH staff medical Centre for better, efficient, comprehensive medicare for these very crucial national facility staff;
- ensure staff are housed as close to the facility as possible including building more housing to minimize staff exhaustion .This will enable staff work hours to be limited to max 8 per day because it will possible to have more shifts than struggling with 14 hour night shift probably for fear of staff security when they leave duty mid night;
- Introduce internal customer service systems and programs so that inter - staff relationship are boosted and always be at its best.

203. Information dissemination system where KNH and all the other stakeholders are well updated on regular basis so that challenges are arrested and mitigated on time

PART III

3.0 OBSERVATIONS OF THE COMMITTEE

204. The Committee examined the KNH referral practice, conducted a situational analysis at the hospital, received witness accounts on the specific cases of rape, breakdown of equipment and surgical mix-up, and observed the following;

3.1 Leadership and management at KNH

205. There exists a culture of reaction and unresponsiveness rather than proactiveness, characterizing the hospital. Indeed, the Cabinet Secretary submitted that her presence at the hospital on the 2nd of March, 2018 was to jolt a board that did not respond to public emotion to action.

206. The systemic failures witnessed at the hospital are partly a result of non-compliance with laid down guidelines and standard operating procedures. The KMPDB noted with concern that top management at the institution provided contradictory responses to matters of implementation, monitoring and evaluation of the SOPs. Further, the Medical Advisory Committee that is crucial in ensuring clinical services, procedures or interventions are provided by competent health care professionals in an appropriate and timely manner was dormant. The chain of events eliciting public outcry were not adequately addressed, with the hospital in constant firefighting mode. Past cases of transgressions at the hospital, for example a patient who was stabbed and bludgeoned to death a few years back, were not addressed to conclusion, neither are these cases used as lessons for the future. Some supplies like tagging labels for patients were reported to be lying in stores while patients were unlabeled, a clear case of breakdown of medical and administrative compliance to systems.

207. The board and top level management lacked clear communication channels with junior staff, patients and members of the public.

3.2 Allegations of sexual harassment

208. An interim report reviewed by the Committee revealed that there had been neither a formal complaint nor statement. During its visit to the hospital, patients interviewed complained of a general lack of privacy due to overstretched facilities, and a general sense of fear from the scary reports.

209. The mothers complained of the distance they had to walk to breastfeed, every three hours, coinciding with the time mortuary attendants ferried bodies.

210. The Committee finds that the hospital did not handle the matter well, leaving the public to feed on unsubstantiated rumours.

211. The hospital had written to the DCI to conduct investigations and had not received a response. The Committee finds that the DCI is slow in its investigations as it had itself written to the DCI on 1st March, 2018 vide a letter ref. NA/DCS/DC.H/2018/20 requesting for expeditious investigations and a report to be submitted to it for purposes of this report. No response had been received as at time of writing this report.

3.3 Security arrangements at the hospital

212. The hospital's general security is unsatisfactory. Members of the public walk in and out of the facility unfettered, visiting hours and numbers of visitors per patient is not strictly enforced.

213. CCTV installations are inadequate, and do not cover critical areas of the hospital which in some instances have poor lighting.

214. The hospital shares its compound with other government institutions and therefore lacks total control of the ground security.

215. Security personnel at the hospital are inadequate.

3.4 Status of medical equipment at the hospital

216. The hospital has no functioning MRI scan since the only one available has since been rendered obsolete and procurement of its replacement is incomplete as a result of slow procurement process.
217. Patients at KNH have not been getting services of MRI scan machine for over a year.
218. It has become impossible for doctors at the hospital to conduct scans hence the patients are being referred to private hospitals where the costs are high.
219. The hospital also has one Laparoscopy Tower machine in theatre 6. This is after operating without one for more than 6 months. The procurement process of two more machines has been slow.
220. The hospital has no skin grafting machine as that donated by well-wishers has since broken down. Doctors have resorted to manual means.
221. The hospital's plant and equipment replacement plan notes that 45% of its equipment and machinery is obsolete.
222. Provision of medical services at KNH is severely hampered by lack of crucial equipment. The heart lung machine is not working and the KNH depends on a borrowed one.

3.5 Mix-up of surgical patients

223. The mix-up was a result of failed systems including lack of labeling patients on admission and patients transiting to admission wards unaccompanied by medical personnel. Patients are not tagged or labelled on entry, making the mistakes highly likely to happen.
224. The mix-up was as a result of labelling of a wrong patient. The labelling was done at the ward level rather than on admission. Moreover, this tagging is only done for theatre patients and the Committee notes with concern that this is not even a requirement in the nursing SOPs.

225. Ms. Mary Wahome erroneously labelled the wrong patient, as she admitted calling out the patient by name, tagging him after he had erroneously grunted in response, and wheeled him to the theatre.

226. The patient John Nderitu was initially taken to the theatre and returned to the ward after discovery that blood for transfusion was not ready. Further, during the operation, the anesthetist did not sign the consent form and doctor's notes were lacking.

227. The confusion was aided by the fact that the operating doctors had no prior communication or contact with the patient, as those who assessed him and recommended surgery were not the ones who eventually conducted the operation.

228. Handover of patients at the hospital is haphazard and is not done physically, from one patient to the other. This gives room to confusion and probable mix up. Moreover, patients requiring different interventions are kept in the same ward. Nurse Wahome did not attend the handover on the day of the mix up.

229. Mr. John Nderitu was reported to be recovering well after the varying of his treatment to non-surgical conservative management. However, during his appearance, he looked weak and had not recollected his full memory.

3.6 Human resource contingent

230. A job evaluation exercise done at the hospital in 2015 revealed that the hospital had a shortage of 172 doctors, 808 nurses, 62 security personnel and another 414 staff engaged in other sections of the hospital indicating a total shortage of 1456 staff.

231. Nursing personnel at the hospital are extremely overstretched with the WHO recommended ratio of nurse to patient of 1:5 not attained. The reality is much worse peaking at 1:30 at times. Further, these nurses are overwhelmed with other auxiliary tasks including billing of customers, customer service and handling of general enquiries. This can lead to subordinate staff performing specialized functions.

232. The hospital heavily relies on student registrars to provide services to patients due to a lack of its own staff. The arrangement with the UoN means KNH lacks total control of these registrars; since they can withdraw services at any time.

233. The registrars engaged by the hospital are not paid, despite dedicating up to 70% of their time to actual working. This obviously leads to disgruntlement and probable poor service.

234. Constrained by inadequate personnel, shifts at the hospital are very long. Nurses on night duty work for more than 12 hours with less than 6 hours to go home, rest and resume shifts. Doctors on the other hand reported to conducting surgeries more than 24 hours nonstop at any given time. Quality of services offered in such circumstances are bound to deteriorate.

235. Incessant industrial action in the country's health sector has greatly hampered service provision. At lower levels of the country's health facilities, it leads to a surge in patient numbers to KNH, and at the hospital itself, compounds the already outstretched services.

3.7 Financial status of the hospital

236. KNH budget allocation has been on an upward trend albeit marginally. For instance in the last four (4) years, the budget allocation had increased from Kshs 8.64 billion in 2014/15 to Kshs 9.1 billion in the current financial year 2017/18. This represents a marginal increase of 5.8% in the last four years.

Resource Allocation to KNH (Kshs Mlns)			
FY	**Budget Allocation**	**Resource Requirement**	**Deviation**
2017/18	9,108	16,599	(7,491)
2016/17	9,127	15,204	(6,077)
2015/16	8,751	10,447	(1,696)
2014/15	8,642	9,327	(685)

Source: MOH

237. The budget allocation to KNH has been way below the resource requirement by this Institution. These budgetary challenges to some extent explains and contributes to the deplorable state of some of the critical medical equipment and medical facilities as well as human resource inadequacies in this national referral institution. This has the negative effect of making the hospital operate below optimal levels and offer services which are below standards required for a referral facility.

238. KNH has high incidences of pending bills involving varying amounts accrued in various financial years. Pending bills are largely attributed to late or lack of exchequer releases by the government. The Committee is concerned that pending bills are an obstacle towards full and effective budget implementation in this Institution which ultimately has a negative effect on delivery of service.

239. The hospital resources are strained as a result of medical bills waiver which is sometimes extended to patients who are unable to settle their medical bills due to financial challenges. Further, the hospital finds it difficult to recover the arrears from patients who have been discharged from the hospital due to lack of a policy to guide such grant of medical waivers.

240. There is a possibility of leakages of various user fees charged to patients as a result of a weak billing system which is largely undertaken manually. Further, health personnel such as the nurses are involved in billing and receipting patient's medical bills which is not part of their responsibilities and this exacerbates the revenue leakages.

3.8 Referral practice at the KNH, and in the country

241. The referral strategy of the hospital, and good practices noted elsewhere, are not followed. The KNH has slowly morphed into a first access non-specialized hospital where patients walk in with all manner of ailments.

242. This situation is a result of failed lower level hospitals managed and run by counties. The committee found that the neighbouring counties of Kajiado, Machakos and Kiambu, including Nairobi were the source of the overburdening and overstretching of facilities at the KNH.

3.9 Other cases of professional misconduct and medical negligence

243. The KMPDB reported that between 2003 - 2018, 27 cases specific to the KNH had been handled by the Board with varying outcomes.

4.0 RECOMMENDATIONS

244. The Committee makes the following considered recommendations that will streamline operations at the Kenyatta National Hospital;

4.1 Management at the hospital

245. In recognition of the Board's failure to carry out its functions in the national interest, the appointing authority in accordance with Section 7(3) of the State Corporations Act, Cap 446, constitutes a new Board.
246. The new board appraises the top level management with a view to placing the right personnel with the right qualifications in these positions.
247. The hospital should employ proper patient support services and customer service. Alongside this, KNH should device proper communication and information systems.

4.2 Alleged sexual harassment

248. The DCI should expeditiously complete its investigations and submit its report to the National Assembly within 14 days of adoption of this report by the House. Also to be submitted within the stipulated time is its report on the patient who was stabbed and bludgeoned to death at the hospital a few years back.

4.3 General security arrangements at the hospital

249. The hospital should engage an expert in security management and review the security arrangements within the hospital.
250. The Inspector General of Police should take charge of security in the compound hosting the hospital and other public institutions within the precincts.

251. The hospital should strictly enforce a fixed number of visitors per patient and adhere to visiting hours. This should be done with an automated patient and visitor information management system.

252. All sections of the hospital should be properly lighted, and all crucial areas covered by CCTV surveillance.

253. The hospital should as a matter of urgency engage with the National Youth Service to provide additional security within the hospital to augment existing security measures at the facility.

4.4 Medical equipment at the hospital

254. The hospital, the Ministry and the National Treasury should undertake a comprehensive costing of all the medical equipment that the hospital requires to guide resource allocation for purchase of the medical equipment which the institution is lacking.

4.5 Surgical mix-up and professional misconduct

255. The government through the Ministry should consider appropriate remedial action on the two patients.

256. The hospital should take full responsibility for the full recovery of the two patients. Further reviews should be conducted on the patients with the possibility of a second opinion explored.

257. The recommendations of the report by the KMPDB on this matter be expeditiously implemented including but not limited to;

    - The Nursing Council of Kenya should immediately review the conduct and practice of nurses involved in the case;
    - The Clinical Officers Council of Kenya should immediately review the conduct and practice of clinical officers involved in the case.

258. All medical regulatory bodies including the KMPDB, Nursing Council of Kenya, Clinical Officers Council of Kenya and the Pharmacy and Poisons Board, should

immediately review their Standard Operating Procedures and align them to emergent good practices in the world.

259. Regulatory bodies should meet punitive measures on any health personnel reported and proved to have mishandled any patient in this and any other cases.

4.6 Referral and health systems in general

260. The hospital should strictly enforce the referral strategy, and ensure proper referral documentation on admission.

261. The hospital should digitize its systems to ensure adherence to standards and avoid lapses and minimize human error.

262. The Ministry of Health in conjunction with county governments should spearhead efforts to improve service delivery by lower level hospitals run by county governments. This will reduce the influx of patients to referral hospitals.

263. The Ministry of Health should expeditiously roll out full operationalization of the Health Act 2017, which has solutions to many of the problems plaguing the health sector. Further, with almost a quarter of patients admitted in KNH being trauma patients as a result of road accidents, there is need for the country to consciously develop road safety guidelines with a view of enhancing safety in our public transportation system

4.7 Financials and Human Resource

264. The government should adequately support KNH in terms of resource allocation considering the critical role this referral facility play in provision of referral and curative services in the Country.

265. The Kenyatta National Hospital and all the referral facilities in the country should invest and put in place robust financial monitoring systems to ensure that fees collected in the course of offering various services are well captured and accounted for.

266. The hospital should strengthen existing partnerships and creating new linkages with development partners to support the institution. This will supplement the resources allocated to KNH by the government to support delivery of service to the public.

267. The Ministry of Health should commission an audit of all pending bills accrued at KNH as well as develop a clear roadmap on settling the genuine pending bills to improve on service delivery at the Institution.

268. Further, the KNH and the Ministry of Health should pro-actively develop their budget and cash flow plans in the course of the financial year to ensure that resources are released on time to ensure full implementation of their budgetary allocations.

269. KNH, the Ministry of Health and Treasury should immediately recruit doctors, nurses, clinical officers, pharmacists/ pharmaceutical technologists, paramedics, billing clerks and other medical and non-medical staff to address the shortfall witnessed at the hospital.

270. The hospital should avail enough non-medical supplies including linen, uniforms and proper visible staff name tags.

271. The Ministry of Health should devise a way of ring fencing health funds reimbursed to counties by NHIF to be strictly used for health purposes.

272. The hospital in collaboration with the Ministry of Health should develop policy guidelines on handling of medical bills waivers for indigent patients to cushion the Institution against revenue leakages which arise from such waivers.

273. The Committee will engage the hospital and ministry in policy discussions on the engagement of registrars, and in general the arrangement between the hospital and UON.

274. Further, the Committee will hold policy discussions with the Ministry, Treasury and other stakeholders on policy discussions to fully implement Universal Health Coverage.

Minutes