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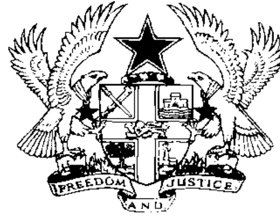

MINISTRY OF HEALTH
P O BOX MB-44,
ACCRA.

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REPUBLIC OF GHANA

PRESS RELEASE

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PHONE: O244-842979/O302665651 **IMMEDIATE RELEASE**

The Ministry of Health would like to announce to the general public that it has received the final report from the three (3) institutions who were asked to investigate the unfortunate incident that happened a few months ago at the Komfo Anokye Teaching Hospital (KATH) in Kumasi.

The institutions were; the Nursing and Midwifery Council, Medical and Dental Council and the Komfo Anokye Teaching Hospital.

It will be recalled that a 42 year old mother, Suwaiba Mumuni, who was carrying her second term pregnancy, was referred to the Komfo Anokye Teaching Hospital from Amaamata Memorial Maternity Clinic in Kumasi for further treatment.

She was admitted eventually had a still birth but hours later she requested for the still born baby for burial or otherwise but the KATH authorities would not produce the still born baby.

During that trying moment, the Ministry of Health assured the general public; especially the families of the mother and other mothers who lost their babies that, it will not rest on its effort of carrying out an investigation into the

allegation. We also assured the families that, we would be seeking justice in the matter.

The Ministry has accepted the recommendation from the Medical and Dental Council, Nursing and Midwifery Council and the Komfo Anokye Teaching Hospital Management as follows:

1. **CONDUCT OF THE MIDWIFE ON DUTY WHO ATTENDED TO MADAM SUWAIBA MUMUNI AT THE KOMFO ANOKYE TEACHING HOSPITAL, FROM 4TH - 5TH FEBRUARY, 2014**

No professional negligence or misconduct was found against Ms. Sophia Addai by the professional regulatory council. However, it is recommended that her final exoneration should await completion of the forensic investigation by the police.

The Council however, found professional negligence on the part of Ms. Patience Amposah (Midwife who was head of the night shift on the 4th and 5th February, 2014) and Ms. Marian Asare (Midwife in charge of A1 labour ward).

Ms. Patience Amposah failed to hand over the three still born babies in the utility room at the end of her shift physically to Ms. Asare who inturn failed to ascertain the presence or other wise of the still born babies before taking over.

2. **SANCTIONS RECOMMENDED BY THE REGULATORY COUNCIL**

- Ms. Marian Asare, Principal Midwifery Officer, the Midwife in charge of the labour ward should be suspended from midwifery practice for four (4) weeks without pay.

- Ms. Patience Amposah, Senior Staff Midwife and the Midwife who was the head of the night shift on the A1 labour ward should be suspended from the practice of midwifery for two (2) weeks without pay.

It is worth noting that the two Midwives would have to undergo an orientation programme prescribed by the council and submit evidence in this regard before their licenses will be restored.

3. SANCTIONS RECOMMENDED BY THE ENQUIRY COMMITTEE FOR THE ORDERLY

The Orderly, Baba should continue to be on leave until the police complete their investigation into the case.

4. KOMFO ANOKYE TEACHING HOSPITAL (KATH) MANAGEMENT

- The management of the hospital should establish well defined channels of communication between the hospital and the media/bereaved families;
- The orderlies and other hospital staff should be excluded from private arrangements for the burial of still born babies;
- All stillbirths should be certified and death certificates issued;
- There should be fluid communication between Doctors and Midwives in attending to patients and prompt discussion of adverse findings to facilitate best practices;
- Security should be beefed up at the maternity unit of the hospital;
- The DDNS in charge of Obstetrics/Gynaenacology Department must intensify her supervisory duties and ensure the provision of adequate logistics and staff for the labour ward;
- The Management of the hospital should organize customer care training for all cadres of the hospital staff;
- The hospital management should device ingenious ways to collaborate with referring hospitals to decongest the maternity unit, while efforts are being made to solicit funds to complete the maternity and children’s block at the KATH;

5. MADAM SUWAIBA MUMINI

- That Madam Suwaiba and family should be provided emotional support through the services of a Clinical Psychologist;
- That she should be offered further assistance for her infertility treatment if necessary

6. MINISTRY OF HEALTH

- The Ministry of Health will develop Standard Operation Procedure (SOP) manuals for maternal and child health including neonatal care and ensure compliance;
- Specifically, Standard Operation Procedure should be developed for the following:
  a. Labour, Deliveries and Discharges
  b. Management of still births and neonatal deaths
  c. Bereavement and Burial of dead babies
  d. Protocol on baby theft
  e. Development of protocols and guidelines for clinical audit
  f. Redesign still births and mortuary registers to capture more vital information for better identification
- The Ministry will strengthen supportive supervision, monitoring and evaluation of clinical practices;
- The Ministry will institute awards to motive hard working institutions and apply sanctions where necessary;

7. GENERAL RECOMMENDATIONS FOR ALL HEALTH SERVICE INSTITUTIONS

- Management of all hospitals should set up committees to review existing systems to improve performance;

- Management should ban all hawkers from clinical areas including wards;
- Records on each patient from both Doctors and Midwives should be contained in the same folder. These on the labour ward should be part and parcel of the partograph for monitoring the laboring woman;
- The still births and mortuary registers should be redesigned to capture more vital information for better identification;
- All support staff within the lower cadre employed by hospitals such as orderly and mortuary attendants must have acquired basic education. They must be able to read and write;
- There should be effective and efficient communication between the midwives and the doctors with doctors having oversight responsibility on their activities.
- Job description should be clearly spelt out and new staff supervised in the initial stages to ensure adherence to standard operation procedures;
- The use of ultrasound scans to clarity uncertainties if intrauterine fetal death is suspected;
- Whenever a still birth occurs, the mother before discharge should inform the hospital authorities on the family's decision about burial or disposal of the body;
- Creating awareness and regular training of staff on protocols and guidelines will create the necessary awareness to minimize the deficiencies that led to substandard care and patient dissatisfaction;
- Continuing professional development (CPD) programmes should organized periodically for all cadres of health workers based on local needs assessment;
- The hospitals should incentivize hard working staff.

8. MEDICAL AND DENTAL COUNCIL

The investigation of the Medical and Dental Council cleared Dr. Michael Adow of negligence or professional misconduct on his part in the case of Madam Suwaiba.

The Ministry therefore request that Management of Komfo Anokye Teaching hospital should recall him from Leave.

Additionally, the Minister will ensure that every health facility delivers quality health care to the people of this country. The Ministry will also intensify its effort to improve attitudes and behavoural change of health personnel, any health worker found culpable or going contrary to its mission, aim and objectives will face full rigors of the laws.

The Ministry wishes to commend the media for its reportage of the issue and other issues in the health sector in its quest to promote quality health care.

Thank you