IN THE COURT OF APPEAL **Civil Appeal**
OF THE REPUBLIC OF VANUATU **Case No. 17/2720 CoA/CIVA**
(Civil Appellate Jurisdiction)

BETWEEN: MONIQUE JOSEPH AND

KALFATAK KALNAURE

Appellants

AND: THE REPUBLIC OF VANUATU

Respondent

Coram: ***Hon. Chief Justice Vincent Lunabek***
Hon. Justice John von Doussa
Hon. Justice Ronald Young
Hon. Justice Oliver A. Saksak
Hon. Justice Daniel Fatiaki
Hon. Justice David Chetwynd
Hon. Justice Paul Geoghegan

Counsel: ***Eric Molbaleh for Appellants***
Sammy Aron for Respondent

Date of Hearing: *10th November 2017*
Date of Judgment: *17th November 2017*

JUDGMENT

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1. On 20 May 2014 Monique Joseph was admitted to the maternity ward of Port Vila hospital. She was expecting her second child and labour pains had begun. Tragically the next day her baby died in utero.

2. The baby's parents, the appellants, sued the Republic of Vanuatu, representing the midwives and hospital, for negligence in the treatment of Ms Joseph resulting in the death of their baby.

3. After trial on liability only, the Judge in the Supreme Court concluded there was no breach of duty of care and dismissed the appellants' claim.

4. Monique Joseph and Kalfatak Kalnaure now appeal this judgment. They say the evidence established the mid-wives looking after Ms Joseph failed to adhere to standard medical procedures and were negligent. Their failure, on the balance of probabilities, resulted in the death of their baby.

The Evidence

5. Ms Joseph became pregnant with her second child in 2013. Her earlier pregnancy had been uneventful. Ms Joseph's midwife had told her she was due to give birth about 15 May 2014. Ms Joseph made regular visits to her mid-wife and had been well during her pregnancy.

6. On 20 May 2014 in the morning Ms Joseph had begun regular contractions. She went to the maternity ward of the hospital accompanied by a cousin Ms T. Ms Joseph was examined by a mid-wife at the hospital and was told the heartbeat of the baby was normal and she was sent home and told to return about 3.30pm. At 3.40pm Ms Joseph returned to the hospital with contractions and some blood spotting. Ms T accompanied her. The mid-wife checked Ms Joseph and noted she was having mild contractions; her cervical dilation was below 4 cm and fetal heartbeat normal.

7. The midwife who admitted Ms Joseph (Mrs AB) said in her sworn statement that given Ms Joseph's maternal assessment was "normal" standard medical procedures used in Vanuatu meant she would be checked after 8 hours.

8. The midwife Ms AB said there was no fetal assessment of the heart rate every hour because Ms Joseph's pregnancy

> *"was still in latent first stage of labour with mild vaginal contraction. According to the standard procedure in Chapter 17, page 17 we check the fetal heart rate after each strong contraction or around a time a contraction is stopping".*

The reference to Chapter 17 is to the Standard Emergency Management in Obstetrics, Gynaecology and Neonates (known as SEMOGN). We will return to this document later in this Judgment.

9. Ms Joseph's evidence was that she had been told by the mid-wife that she would be checked every four hours but that did not happen. About 7:30pm- 8:00pm she had a painful backache and Mrs T asked the nurses to come and see her. The nurses said they could not do so because they were too busy although Mrs T said the nurses did not seem to be attending to other patients at the time.

10. At 11:00pm the first midwife Mrs AB ended her shift. The evidence is that although a second midwife Mrs CD was due to begin her duties at 11pm she was not present at that stage. Mrs AB left the ward at 11pm.

11. Mrs CD did not arrive at the hospital until sometime between 1.00am – 1.30am. By 1.00am no midwife had examined either Ms Joseph or the baby for 9 ½ hours after he admission. At about 1.30am Ms Joseph was in such pain she and Mrs T walked to the nurses' station and asked one of the nurses to check her. The mid-wife checked the baby's heart beat but none could be found.

12. Between 1.30am and 2.00am the midwife contacted the on-call Obstetrics and Gynaecology Registrar to come to the hospital. The Doctor arrived somewhere between 2.00am and 3.30am. The exact time does not seem to be known. The Doctor said that when she examined Ms Joseph there was no fetal heartbeat. The baby was born dead.

13. Many of the precise details relating to Ms Joseph's care are not known. It seems that the hospital file relating to Ms Joseph's care has been lost.

Evidence Admission

14. The appellants wished to produce as evidence at trial a letter from Dr Basili a consultant Obstetrian and Gynaecologist. The Judge refused to admit the letter on the basis that the Doctor had not personally examined Mrs Joseph and therefore his evidence was hearsay, and that the Doctor had not been made available for cross-examination at trial.

15. We are satisfied the Doctors evidence was admissible. The Respondent did not object to its admission at trial. The evidence of Dr Basili as an expert in Obstetrics was admissible hearsay. His evidence was based apparently on hospital records and written shortly after the baby died. We will refer to the contents of that letter later in this judgment.

The Judgment Appealed from

16. The Judge said that the Respondent accepted the nurses and Doctors at the hospital owed a duty of care toward Ms Joseph. The Judge concluded, relying upon the evidence of the two mid-wives and the Doctor that the appellants had not proved *"that the procedures contained in the SEMOGN were not complied (sic) or that the examination, treatment or diagnosis was wrong."*He concluded that the appellants had not proved the treatment of Ms Joseph was negligent and he dismissed the claim.

This Appeal

17. The appellants' case on appeal is that the midwives on their own evidence did not carry out their duties in accordance with SEMOGN or with the appropriate standard of care. These failures included a failure to adequately check the health of Ms Joseph and the baby between 3.40pm and 1.30am and the absence of any midwife assigned to check Ms Joseph between the critical hours of 11.00pm to 1.30am when a midwife failed to arrive at work on time.

18. The Republic's case was built around the proposition that the midwives had not been negligent because they had complied with the relevant provisions of the SEMOGN requirements. The evidence of the midwives was that SEMOGN only required examination of a patient in Ms Joseph's condition as observed at 3.40pm after 8 hours admission. As to the monitoring of the fetal heartbeat rate this was to only be done hourly when strong contractions were occurring. There were no strong contractions at 3.40pm and so no monitoring of fetal heartbeat was required. By the time further examination took place at 1:30am there was no fetal heartbeat. The Doctor who attended Ms Joseph that night confirmed the mid-wives had carried out their duties in accordance with the

SEMOGN guidelines and so the Supreme Court judgment was correct. Moreover the Republic submitted that the on-duty midwives applied the same standard procedures in treating Ms Joseph as applied to all other patients admitted to the maternity ward.

Discussion

19. We are satisfied the standard of care provided by the hospital to Ms Joseph on 20/21 May 2014 fell below what was required and was negligent. This was in part because of a failure to adhere to the SEMOGN standards and partly because of other failures.

20. Chapter 17 of SEMGON sets out the appropriate standards for midwife treatment of woman in labour. Once a woman is admitted to hospital in labour (as with Ms Joseph) there is an initial examination which includes a check on fetal heart rate and cervical dilation. Under the heading "**Admission of Woman in Labour**" the standard provides:

> ***Admission of woman in Labour***
>
> *Remember that every woman that comes into the labour ward needs your help, regardless of who they are, where they come from or how many times they have had their babies there before.*
> *This means that, all women and their families MUST be greeted and show them where to sit and put their belonging. We must not shout at women who come for our help, regardless of how busy we are.*
> *Then only the admission process should follow,*
>
> 1. *Advise on personal hygiene*
> 2. *Be aware of all antenatal risk factors (use antenatal record/clinic ward)*
> 3. *Palpate the abdomen and determine:*
>   - *Clinical assessment of foetus (fundal height)*
>   - *Presentation*
>   - *Level of head in 5th above the symphysis pubis, record with a circle on partogram.*
> 4. *Check vital signs. If she has a fever, cool-spongeher and then start chloroquine course and broad spectrum antibiotic such as IV Ampicillin (in hospital) or Amoxcillin if in the rural centres. It is also okay to give a full ampoule of Benzyl Penicillin to those in labour (as absorption in the gut is slow when the women are in labour).*
> 5. ***Check fetal heart rate 1 hourly throughout labour, best taken around the time a contraction is stopping.*** *If it is < 110 or> 160 this could be fetal distress, consult a midwife or doctor and recheck with the women is on her left side. If it is over 160 check her temperature, an give 500ml N/Saline fast by TV, then continue*

the IV at 40 dpm. Also give chloroquine course and antibiotics as above.

6. *If no APH antepartum haemorrhage) do a VE (virginal examination) to assess*
   - *Cervical dilatation(record with an 'x' on partograph at 4cm).*
   - *Effacement (cervical length), uneffaced, 25%, 50%, 75% , or fully effaced.*
   - *Moulding (+sutures together, ++ sutures overlapping but reducible, +++ sutures overlapping but not reducible) Severe moulding is definite sign of CPD.*
   - *State of membranes and colour of liquor, (Meconium, + green colour fluid, Meconium ++ with particles seen in the fluid, Meconium +++ thick green fluid). Change of clear liqor to Mec +++ usually indicates fetal distress.*

All the above must be recorded on the partogram and labour progress notes.

(Emphasis added in guideline 5)

21. The evidence given by the midwives was that this standard did not require hourly checking of the fetal heart rate while Ms Joseph was in the latent first stage of labour (as she was when she first arrived at 3.40pm).

22. We are satisfied that the mid-wives have misinterpreted or misunderstood the obligations in SEMOGN in relation to monitoring of fetal heart rate. The SEMOGN standard is explicit and clear. Once a woman is admitted to hospital in labour (at whatever stage) the standard requires fetal heart rate be monitored hourly. Ms Joseph had been admitted to hospital, and was experiencing mild contractions. The standard does not exempt a woman in latent labour from this monitoring. The standard does not require strong contractions before such monitoring. The fact fetal heart rate was only monitored once at 3:40pm before the baby's death 10 hours later was a serious failure.

23. It is common ground that Ms Joseph was not examined by a mid-wife from 3.40pm until 1.30am. During that time her dilation went from 3cm to 7-8cm, well past the latent stage of labour. And so even on the mid-wives' misinterpreted standard of monitoring of fetal heart rate their care fell below standard. Given the failure to examine Ms Joseph for 10 hours the mid-wives would not have known whether, even on their own standard, fetal heart monitoring was required.

24. These failures meant the hospital failed to provide an adequate standard of care and was negligent in its care of Ms Joseph.

25. The midwives evidence was that the standard of care set out in SEMOGN did not require them to examine Ms Joseph for 8 hours after her admission to hospital. This was because they said she was only then 3 cm dilated and in the latent stage of pregnancy. They said this was the standard set in such circumstances by SEMOGN. They had complied with this standard.

26. Under the hearing "**Admission of Woman in Labour**" there are two relevant standards in the SEMOGN guidelines in these circumstances at paragraphs 7 and 8.

27. They state:-

> *"7. If the cervix is less than 4cm dilated on admission, wait up 8 hours. This means the woman cannot be sent home for another 8 hours. After 8 hours have elapsed, it is necessary to decide if the woman is in established labour or not. If in active labour, she would have progressed in terms of strength and increasing behavior of contractions and improving status of cervix. The woman should be followed on the partogram.*
> *If no signs of active labour (ie. No change in the state of the cervix and membranes are intact nor signs of illness), send home to await the onset of active labour and complete any medications if prescribed.*
>
> *8. In normal labour, when the cervix reaches 4 cm dilated plot on the partogram and observe by further VE every 4 hours. Normal dilation proceeds at least at the rate of 1cm an hour, thus the woman's graph will stay above the alert line. If the action line is crossed, dilation is definitely too slow and specific action must be taken. Therefore, talk to a Senior Midwife or a doctor who will decide on next course of action."*

28. We are satisfied the mid-wives and Doctor have also misinterpreted or misunderstood the guidelines in 7 and in 8.

29. These guidelines do not say a woman in labour admitted to hospital can be left for 8 hours without further examination. Guideline 7 says that after admission a patient cannot be sent home for 8 hours. It is only where, after 8 hours, and there is no sign of active labour then the woman may be sent home. A woman will need to be examined during the 8 hours to see if the cervix is further dilated and to see if labour is progressing.

30. Guideline 8 requires 4 hourly examination after 4cm dilation. The guide notes a dilation rate of 1cm per hour is normal. And so in Ms Joseph's case 4cm dilation could have been expected by about 4.40pm an hour after admission. This required an examination to ascertain the stage of dilation. And thereafter at least 4 hourly examinations. Guideline 8 is clear that this monitoring of the woman's state of labour, at least 4 hourly, is designed in part to check as to whether further medical intervention is required.

31. We repeat guidelines 7 and 8 do not mean or indeed say that a woman admitted to hospital in labour at admission in the latent stage can be left without examination for 8 hours.

32. Dr Tarere in her sworn statement said:-

> *"Ms Joseph was monitored by the on-duty mid-wives and examined her (sic) with accordance (sic) to the standard Procedures we used in hospitals."*

For the reasons we have given this statement is wrong.

33. We are satisfied these failures to examine Ms Joseph also fell below the required standard of care. There were also other failures by the hospital.

34. Even on the mid-wives interpretation of SEMOGN their care fell below the required standard. On their assessment Ms Joseph should have been examined by 11.30pm (8 hours after admission).She was not examined until 2 hours later at about 1.30am and then only at her insistence. These 2 hours were likely to have been vital to the baby's survival.

35. Dr Basili in his report said:-

> *"This event (the death of the baby) would have been averted by doing an emergency caesarean section if an abnormal fetal heart rate pattern was detected earlier..."*

36. A further failure in the care of Ms Joseph occurred. The first mid-wife Mrs AB who cared for Ms Joseph ended her shift at 11.00pm. Her replacement was due to commence her shift at 11.00pm. The evidence established that the second mid-wife, Ms CD, did not arrive at the hospital until sometime between 1.00am – 1.30am. There was therefore a 2

hour period when there was no mid-wife available or attending to Ms Joseph. It seems probable this was a crucial period for her labour.

37. During the course of her hospital stay from 3.40pm until 1.30am Ms Joseph and Ms T gave evidence that they asked the nurses to examine Ms Joseph as she was in significant pain. Ms T said between 9.30pm – 11.45pm she had asked the nurses to examine Ms Joseph but they had refused to do so and again later in the evening. Ms Joseph in her sworn statement said that during the evening the nurses had been asked to examine her because of the pain she was having but they had not done so.

38. So finally at about 1.30am Ms T had taken Ms Joseph, then in considerable pain, to the nurses station at the maternity ward and had asked the nurses to check her. It was only then they had done so. The sworn statements of the midwives did not dispute any of this evidence.

39. These failures also contributed to the hospital's failure to provide an adequate standard of care for Ms Joseph.

40. There was some suggestion by the respondent that the mid-wives were too busy to attend to Ms Joseph after her admission. There was no adequate evidence to establish what work the mid-wives were performing during the relevant 10 hours and why that workload prevented them from adequately attending to Ms Joseph and her baby.

41. In any event as we have said the midwives did not understand the treatment obligations toward a woman in labour as detailed in SEMOGN. And so whatever the workload of the mid-wives they would not have complied with the required standard of treatment.

42. We wish to emphasize we are not suggesting in a busy maternity ward every patient must be checked precisely 4 hourly or less or that fetal heart beat be monitored exactly each hour. Some sensible leeway is likely to be necessary. But the leeway should only be for a short period before there is compliance with the standard. And if not busy or circumstances require patients might be needed to be checked more often. No doubt when the one hourly fetal heart rate checks are made those women who require earlier examination will be able to be identified.

43. In her sworn statement Dr Tarere said she was called by the mid-wife between 1.30am – 2.00am. The Doctor said she arrived at the ward at between 2.00am – 3.30am. This is a remarkably imprecise arrival time. While it seems nothing arises from this imprecision in this case it raises another issue of concern. Neither the trial court nor this Court have the hospital file nor Ms Joseph's patient notes. Counsel for Ms Joseph did not ask for the notes pretrial and counsel for respondent says he has inquired but the hospital says the file is lost. And so important evidence has been lost including the precise time the Doctor arrived on the ward and more importantly the record of Ms Joseph's treatment from admission to discharge. We cannot over- emphasis to the hospital the importance of securely keeping patient notes and files.

44. We are satisfied for the reasons we have outlined that the hospital was negligent in its treatment of Ms Joseph. We are satisfied that it is more probable than not that if the mother and baby had been monitored in accordance with SEMOGN-Requirements the baby would have survived.

45. Ms Joseph had a straight forward pregnancy with no health difficulties. Dr Basili's said that the most likely cause of death was asphyxia.

> *"Secondly to meconium aspiration as a result of a tightly wound umbilical cord around the neck."*

46. As we have noted, Dr Basili said that if the mother and baby had been more closely monitored the situation might have been averted. We have concluded the mother and baby would have been more closely monitored if a proper standard of care had been provided to them. In those circumstances we are satisfied that it is a reasonable probability that fetal stress would have been earlier identified and there could have been medical intervention to save the life of the baby.

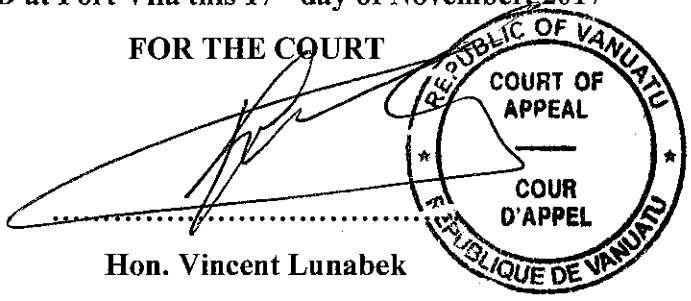
47. We are therefore satisfied the Judge was wrong to have concluded the respondents did not act negligently. The appeal is therefore allowed.

48. The Judge's orders in the Supreme Court are set aside. Judgment as to liability is entered for the appellants. The case will need to be referred to the trial judge for a damages hearing.

49. We award costs to the appellants on a standard basis.

DATED at Port Vila this 17th day of November, 2017

FOR THE COURT



Hon. Vincent Lunabek

Chief Justice