IN THE SUPREME COURT OF
THE REPUBLIC OF VANUATU
(Civil Jurisdiction)

Civil Case No. 331 of 2014

BETWEEN: MONIQUE JOSEPH AND KALFATAK KALNAURE
Claimants

AND: REPUBLIC OF VANUATU
Defendant

Coram: Justice Aru

Counsel: Mr. E. Molbaleh for the Claimants
Mr. S. Aron for the Defendant

JUDGMENT

Background

1. The claimants Kalfatak Kalnaure and Monique Joseph are a husband and wife. Monique Joseph gave birth to their first child a little girl on 29 May 2010 without any complications. Hoping to have a son, sometime in 2013 Monique became pregnant again with their second child. On 20 May 2014 she was taken to the maternity ward after feeling some labour pain. She was admitted to the maternity ward. The pains continued after her admission. Before giving birth very early the next morning, Monique was told by the doctor on call that the baby had died inside her. The baby was a little boy. This is what gave rise to this proceedings.

The claim

2. The claim was filed on 29 October 2014 and later amended. The amended claim was filed on 27 May 2015. The gist of the claim is that the nurses were negligent by not attending to Monique on time which resulted in the death of her baby. The claimants plead their claim at paragraph 3, 4 and 5 as follows:-

> *"3. On 20 May 2014 between 330pm and 400pm in the afternoon the claimant Ms Joseph accompanied by her cousin sister Leipakoa Tarip went to Vila Central Hospital for Ms Joseph to give birth as she started to see blood and feel pain as signs of giving birth .*
>
> *Particulars*
>
> *i) the claimant Ms Joseph presented herself to the mid wives at the Vila Central Hospital that afternoon between 330pm and 400pm*
>
> *ii) the midwives checked her and said that she and the baby were normal and safe and referred her to the maternity ward and told her that they will check her in every four hours ;*
>
> *iii) the mid wives did not even check her until 130am the next day , duration of about 10 hours despite the constant reminder ;*
>
> *iv) the claimant called the mid wives on duty between 930pm and 1145pm as she was feeling more pain but they never checked her ;*
>
> *v) Ms Joseph's cousin who was with her at that time noticed that Ms Joseph was more painful and so she called the mid wives and asked them to check her but one of the nurses replied that that they cannot keep checking her every four hours as they might disturb the labouring process;*
>
> *vi) the claimant Ms Joseph was left unattended until about 130am the next day when the pain was most severe and her cousin walked her to where the nurses were in the ward and insisted that the nurses should check Ms Joseph;*
>
> *vii) the nurses then checked her but could not find the baby's heart beat ;*
>
> *viii) the nurses then used an ultra sound machine but still could not find the baby's heart beat .*

4. the nurses called Doctor Magret Tarere between 130am and 145am who was on call at that time who came to the hospital at about 200am and 230am that morning 21 May 2014 and checked the claimant Ms Joseph.

Particulars

i) Doctor Tarere turned up and checked Ms Joseph and declared that the baby was dead and left ;

ii) the nurses (mid wives) the took Ms Joseph to the labor room and injected oxytocin in her to ease the laboting process ;

iii) the baby boy was born at 707 am on 21 May 2014 but was already dead ;

iv) the baby was fully formed and looked very healthy .

5. the claimant Ms Joseph and her sisters do not have sons and Ms Joseph son was the first son in her extended family but her son died due to the ignorance and negligence of the nurses (mid wives)."

3. And they claim the following relief:-

"1. Damages for medical negligence to be assessed;

2. compensation for the loss of the child of the claimant to be assessed ;

3. VT1, 500, 000 for punitive damages;

4. VT 500,000 for general damages;

5. interest;

6. Costs."

Defence

4. The defendant, Government of the Republic of Vanuatu filed a defence denying any negligence on its part. It says that it exercised reasonable care and skill in treating the claimant Monique Joseph and that the risk of the fetal heart beat not functioning in the treatment of the claimant's maternal condition was an inherent risk arising despite the exercise of reasonable care and skill.

Summary of evidence

5. The evidence for the claimants is contained in the following sworn statements:

    - sworn statement of Monique Joseph filed on 29 October 2014 and tendered as **Exhibit 'C2'**;
    - sworn statement of Monique Joseph filed on 4 November 2014 and tendered as **Exhibit 'C3'**;
    - sworn statement of Leipakoa Tarip filed on 29 October 2014 and tendered as **Exhibit 'C1'**.

6. Mrs. Joseph said during her pregnancy she made regular visits to the antenatal clinic to make sure her baby was safe and during those visits she was told that she was fine and the baby was also fine. She ate healthy food all the time in preparation for the birth of the baby. On 20 May 2014 she says that she started feeling her contractions in the morning and went to the hospital at 9.30 am. She was examined by a mid-wife from the Solomon Islands working at the hospital who told her that the baby's heart beat was normal and that everything was alright and told her to go home and come back at 3.30 pm in the afternoon the same day. She went home and about 3.00 pm she started seeing blood and went back to the hospital at around 3.40 pm. She was then checked by a midwife before admitting her to the maternity ward. She was told that she will be checked every four hours but she was unattended for 10 hours and no midwife came and checked her. Between 7.30 pm and 8.00 pm she was in pain. Mrs. Tarip called one of the midwives to check her but was told that they could not check her every four hours. She says that from then on she was ignored and the nurses attended to other would be mothers who came in after her. When the pain became so severe she walked to where the nurses were and one of the nurses checked

her at about 1.30 am. The nurse could not find the baby's heartbeat. After checking with the ultra sound scan the assessment was that there was no fetal heart activity. Before delivering her baby Dr Tarere who was the doctor on call told her that the baby inside her had died and when the baby was delivered at 7.07 am on 21 May 2014 the baby was already dead.

7. Mrs. Leipakoa Tarip's evidence confirms what Monique said in her sworn statement as she was with Monique all throughout from the time Monique first went to the hospital at 9.30 am on the 20 May 2014 and again at 3.30 pm in the afternoon and remained with her until the baby was delivered. Both witnesses were cross examined on their evidence.

8. The evidence for the defendant is contained in the following sworn statements:-

   - Sworn statement of Harriet Mani filed on 22 September 2015 and tendered as **Exhibit 'D1'**;
   - Sworn statement of Roslinda Omawa filed on 22 September 2015 and tendered as **Exhibit 'D2'**; and
   - Sworn statement of Dr Margret Tarere filed on 22 September 2015 and tendered as **Exhibit 'D3'**.

9. Harriet Mani is a graduate of the Fiji National University and attained a postgraduate diploma in midwifery in 2012 and has been working as a midwife at the Vila Central Hospital since then. On 20 May 2014 she was on duty from 3.00 pm to 11.00 pm. She says that when Monique Joseph was admitted at 3.40 pm that day a vaginal examination was done by a mid-wife from the Solomon Islands. The assessment after the examination was that there was a mild contraction, presentation of the cervical dilation was below 4

cm and the fetal heart was normal. She says that according to the Standard Emergency Management in Obstetrics, Gynecology and Neonates (SEMOGN) used in hospitals in Vanuatu as annexed to her sworn statement (**Annex 'HM2'**), Monique Joseph will be checked again after 8 hours has lapsed to allow time for the vaginal contraction to progress to the stage of delivery. She says that Monique's fetal assessment of the heart rate was not checked every hour because at that time Monique's pregnancy was in the latent first stage of the labour with mild vaginal contractions. The fetal heart rate is only checked after each strong contraction. As an on duty mid wife at the time she says that she treated Monique Joseph and her baby in accordance with the standard medical procedures.

10. Mrs. Roslinda Omawa is also a graduate of the Fiji National University and attained a postgraduate diploma in midwifery in 2012 and has been working as a midwife at the Vila Central Hospital since then. On 20 May 2014, she was on duty from 11.00 pm until 7.00 am in the morning. She says that when Monique Joseph was checked at 3.40 pm on 20 May 2014 by the midwife from the Solomon Islands, Monique's condition was normal which is why when her shift ended at 11.00 pm the midwife form the Solomon Islands recorded on the white board with a red marker that the claimant was not yet ready to deliver and that she will be checked again after 8 hours in accordance with standard procedure. She says that on 21 May 2014 at around 1.30 am which was after 8 hours had lapsed, Monique Joseph was experiencing backaches. When she checked Monique's fetal heart rate she found that the heart beat was not active and she contacted Dr. Margret who was the doctor on duty to check the baby's heart beat by ultra sound scan. At 2.00 am to 3.30 am Dr Margret arrived and did the ultra sound scan and found that the bay's heart beat was not active. The doctor declared that the baby was dead and arranged normal delivery with augmentation of labour to

increase labour intensity as it was difficult for Monique Joseph to deliver unassisted. She says that as an on duty midwife she treated the claimant and her baby in accordance with the SEMOGN.

11. Dr Margret Tarere is the Obstetrics and Gynecology Registrar at the Vila Central Hospital. She says that when a patient on admission is in latent phase of labour, it is categorised as a low risk pregnancy. When Mrs Monique Joseph was admitted at 3.40 pm on 20 May 2014, she was in a low risk pregnancy. She says that in the hospitals in Vanuatu they use the SEMOGN as the standard procedure. According to this standard procedure, when a patient is admitted with cervix less than 4cm dilated they must wait up to 8 hours. At 3.40 pm when Monique Joseph was admitted her cervix was less than 4cm dilated and was informed that she will be reassessed after 8 hours. On the 21 May 2014 she says that she was the only on duty obstetrics Registrar at the Vila Central Hospital. Around 1.30 am to 2.00 am. She was contacted by the on duty midwife Roslinda Omawa that she had checked the fetal heartbeat of Monique's baby but it was not functioning. When she (Dr Margret) arrived at the ward at around 2.00 am to 3. 30 am and examined the claimant her cervical dilation had progressed to 7 to 8 cm cephalic at station 2.1. She undertook a mobile ultra sound scan assessment and found that there was no fetal heartbeat. She then declared that the baby was dead and arranged normal delivery by augmentation of labour. She says that as an experienced doctor in obstetrics and genecology especially in the care of women and their children during pregnancy, child birth and post natal care her assessment was that the cause of the baby's death was unexplained still birth as the claimant was monitored by the on duty midwives and examined her in accordance with the standard procedures used in hospitals.

Submissions

12. The claimants submit that the defendant could not rely on the SEMOGN as it is only a draft document. Furthermore it was submitted that the midwives were negligent in not checking Monique Joseph for more than 10 hours after being admitted. Despite her pleas for help as she was in pain the midwives refused to check her. Relying on what this Court said in **Qualao v. The Government of the Republic of Vanuatu** [1999] VUSC 45, the claimants submit that Mrs. Omawa was late for work that night and had the nurses called Dr. Tarere earlier the baby could have been saved.

13. The defendant on the other hand relies on what the High Court of Australia said in **Roger v Whitaker** [1992] HCA 58 in relation to the duty of care owed by a medical practitioner which was applied in **Tarilongi v. Minister of Health** [2014] VUSC 64 and **Ranbel v. Republic of Vanuatu** [2017] VUSC 12.

14. It was submitted that the midwife on duty exercised reasonable care and skill in treating Monique Joseph when she was admitted at 3.40 pm. At that time the examination of Monique Joseph showed no signs of bleeding, mild contractions with cervical dilation below 4 cm and normal fetal assessment. It was submitted that at 3.40 pm Monique Joseph was in the latent phase of labour and her situation was categorised as low risk pregnancy and in accordance with SEMOGN used in hospitals in Vanuatu, her next maternal examination was to be done after 8 hours. After that it would be decided whether she was in active labour and further steps would be taken.

15. It was further submitted that the evidence of Omawa and Leipakoa confirm that Monique Joseph was examined again at 1.30 am. She was in second stage of labour as cervical dilation was 7 to 8 cm. The fetal heart rate was

irregular and after checking with the ultra sound scan it was noted that the fetal heart beat was not active and Dr. Tarere was called .It was submitted that the on duty midwives applied the same standard procedures in treating Monique Joseph as applied to all other patients admitted to the maternity ward. The midwives exercised reasonable care and skill in treating Monique Joseph. It was submitted that the risk of the fetal heart beat not functioning in the treatment of Monique Joseph's maternal condition was an inherent risk arising despite the exercise of reasonable care and skill.

16. It was further submitted that there was no breach of duty as the claimants have not established that the defendant was negligent. That even if the court were to find that there was a breach of duty, the onus is still on the claimants to show that such breach was the cause of the baby's death.

17. On the question of damages it was submitted that the damages claimed are not particularised as required by rule 4.10 (2) of the Civil Procedure Rules therefore the claimants are not entitled to any damages.

Discussions

18. The parties accept that the defendant, its nurses and doctors at the Vila Central Hospital (VCH) owe a duty of care towards their patients .The central issue in this case is whether that duty of care was breached in relation to Monique Joseph. If a breach of duty is established, the claimants must also prove that that breach of duty resulted in the death of the baby.

19. The onus is on the claimants to prove their case on the balance of probabilities. The totality of the claimants' evidence **Exhibit 'C1'** , **Exhibit 'C2'** and **Exhibit 'C3'** which is the evidence of Monique Joseph and Leipakoa Tarip is that after Monique was admitted at 3.40pm to the maternity ward, she was

ignored for 10 hours although she was in pain. Their evidence is that Monique was only checked again at 1.30 am and it was then discovered that there was no fetal heart beat and the midwife called Dr Tarere who came and checked Monique again before declaring that the baby was dead.

20. The defence case is that in carrying out their duties they are guided be specific standards of care which are applied throughout Vanuatu in all the hospitals contained in the SEMOGN. Chapter 17 paragraph 7 provides:

> *"7. If the cervix is less than 4 cm dilated on admission, wait up to 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 behaviour 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."*
> *(emphasis added)*

21. Harriet Mani, Roslinda Omawa and Dr Magret Tarere all confirm in their evidence **Exhibit 'D1', Exhibit 'D2'** and **Exhibit 'D3'** respectively that when Monique Joseph was admitted at the hospital she was assessed as having mild contractions with cervical dilation of less than 4cm and in accordance with the above procedure she was to be assessed again after 8 hours had lapsed to decide if she is in active labour. If there were no signs of active labour she could be sent home to await the onset of active labour.

22. After 8 hours had lapsed Monique Joseph was checked first by Roslinda Omawa who could not detect the fetal heartbeat. She then called Dr. Tarere

who was the on call duty doctor who also checked the fetal heart beat before declaring that the baby had died. The cause of death is unknown. Neither could the claimants establish the cause of death by their evidence.

23. Under cross examination Monique Joseph agreed that at 3.40 pm she was treated well by the midwife and referred to a room with a bed to lie down. She agreed that after 8 hours had lapsed, she was checked three times by the midwife and three times by Dr. Margret Tarere. Monigue Joseph agreed that Dr. Tarere treated her well and tried her best to provide her with better treatment.

24. Despite attaching a report from Dr Kevin Bisil, **Annex 'MJ (1)'** to **Exhibit 'C3'** he was not called as a witness by the claimants. Furthermore, at the relevant time Monique Joseph was never checked by Dr Kevin. Any reliance on that report as prove of negligence is hearsay and is rejected.

25. The claimants have not shown in their evidence that the procedures contained in the SEMOGN were not complied or that the examination, treatment or diagnosis was wrong. [see: **Roger v. Whitaker** [1992] HCA 58 and **Tarilongi v. Minister of Health** [2014] VUSC 64]. The claimants rely on **Qualao v. Government of the Republic of Vanuatu** [1999] VUSC 45 but the factual circumstances of that case are distinguished from this case. The brief facts of the case are that Mr. Qualao a young boy of 19 years was admitted to the VCH after suffering a head injury from a sporting incident. At the relevant time, he was in the care of the nurses when he fell from his bed and suffered additional injures to his head which were fatal as he had earlier undergone surgery to reduce the collection of blood in his brain. The court found that the defendants were negligent and ordered damages to be assessed in favour of the claimant. For Monique Joseph she was checked after 8 hours. She was

then in active labour as her pain was getting stronger and the cervical dilation was 7 to 8 cm.

26. She says in her evidence that she walked to the nurses to ask to be checked. No evidence was called by the claimants to show whether walking by herself unassisted by the nurses resulted in the death of her baby.

27. Appropriate screening was done by the midwife and redone by the doctor on call but nothing could be done as the baby had died.

28. I am not satisfied that the claimants have proved that the defendant was negligent or that there was a breach of duty by the defendant and its servants. The claim is therefore hereby dismissed with each party to bear their own costs.

DATED at Port Vila, this 7 day of September, 2017

BY THE COURT

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D. ARU

Judge.