Before:  Judge Jean-François Cousin

Registry:  Amman

Registrar:  Laurie McNabb

HAMED

v.

COMMISSIONER GENERAL OF THE
UNITED NATIONS RELIEF AND WORKS
AGENCY FOR PALESTINE REFUGEES

JUDGMENT

Counsel for Applicant:
Self-represented

Counsel for Respondent:
Rachel Evers (DLA)
Introduction

1. This is an application by Afaf Ahmad Hasan Hamed (the "Applicant") against the decision of the United Nations Relief and Works Agency for Palestine Refugees in the Near East, also known as UNRWA (the "Respondent"), to terminate her appointment in the interest of the Agency.

Facts

2. Effective 1 October 2002, the Applicant was employed by the Agency as a Senior Practical Nurse ("SPN") at Qalqilia Hospital (the "Hospital") on a fixed-term appointment at Grade 2A, Step 1. Following a number of renewals, effective 1 January 2012, the Applicant's appointment was converted to a temporary indefinite appointment as a SPN Grade 6, Step 10 at the Hospital.

3. On 25 February 2013, the Patient was referred by the Qalqilia Health Clinic to the Hospital as an "Alert Pregnancy". The Patient was expected to deliver on 24 March 2013.

4. On 1 April 2013, at approximately 00:40 hours, the Patient arrived at the Hospital with labour pains. Upon admission she was assessed by the Applicant and the Junior Resident Doctor ("JRD") as being in the first stage of labour. The Patient's condition was considered normal; however, the JRD noted the following risk factors for cord prolapse in the Patient's medical file:

   (i) Multipara 6 (meaning the Patient has given birth six times previously);

   (ii) Spontaneous rupture of membranes (meaning the amniotic sac has ruptured on its own, i.e. "broken water"); and

   (iii) High head (meaning the head of the foetus has not descended toward the pelvic floor and is not engaged in the pelvis).

5. At approximately 02:30 hours the first episode of foetal distress was detected and reported to the JRD by the Applicant. The Patient was treated by the JRD until the foetal heart rate ("FHR") recovered.
6. A second episode of foetal distress occurred from 04:10 to 04:50 hours ("second episode"). The Applicant did not report the incident to a resident doctor. A third episode of foetal distress started at 05:40 hours ("third episode") and persisted until cord prolapse was detected by the Applicant at 06:30 hours, who then informed the Senior Resident Doctor ("SRD"). The Patient was not assessed or seen by a doctor between approximately 03:00 and 06:30 hours.

7. The SRD provided manual care to the head of the foetus to relieve pressure on the umbilical cord, and an urgent caesarian section was ordered. In the interim, the FHR worsened until the cardiotocography machine ("CTG") stopped detecting a foetal heart beat at approximately 07:00 hours. The operation began at approximately 07:10 hours. A stillborn male foetus was delivered by caesarian section and did not respond to resuscitation procedures.

8. The Patient filed a complaint on 29 May 2013 alleging, negligent medical treatment leading to the death of her child.

9. On 29 July 2013, the West Bank Field Office ("WBFO") established a Board of Inquiry ("BoI") to investigate the complaint. On 2 April 2014, the BoI issued its report and concluded that the Applicant was negligent when she failed to: 1) stay awake and be fully alert while on duty; and 2) continuously monitor the FHR and notify a resident doctor regarding the second and third episodes of foetal distress. The BoI also found that the negligence of the JRD and the SRD contributed to the child’s death.

10. In terms of causation, the BoI found that the Applicant’s failure to report the second and third episodes of foetal distress was a significant contributory factor in hindering timely lifesaving actions from being taken.

11. On 3 September 2014, the Director of UNRWA Operations, West Bank ("DUO/WBFO") provided the Applicant with a due process letter containing the summary of the BoI’s findings and the supporting evidence gathered in the course of the investigation. The DUO/WBFO noted that if the Applicant’s conduct was substantiated, it would constitute misconduct. The Applicant was given 14 days to respond to the BoI’s findings and conclusions.
12. By letter received by the DUO/WBFO on 30 September 2014, the Applicant responded to the 3 September 2014 due process letter. In her response the Applicant explained that the Administration and the Hospital should be held liable for the incident because of their “futile work system” and inadequate procedures.

13. By letter dated 3 February 2015, the DUO/WBFO informed the Applicant that, having reviewed her response and the BoI’s report, there was evidence that her conduct constituted misconduct and that he had decided to terminate her employment in the interest of the Agency.

14. By letter received on 25 March 2015, the Applicant requested review of the decision to termination her in the interest of the Agency. On that same day the Deputy Commissioner-General (“DCG”) affirmed the decision.

15. On 11 May 2015, the Applicant submitted her application to the UNRWA Dispute Tribunal (the “Tribunal”). The application was transmitted to the Respondent on 12 May 2015.

16. On 8 June 2015, the Respondent filed his reply. Annex 3, the Report of the BoI, was filed ex parte. The reply was transmitted to the Applicant on 9 June 2015.

17. By Order No. 093 (UNRWA/DT/2015) dated 16 August 2015, the Tribunal ordered the Respondent to translate his reply into Arabic by 16 September 2015. On 26 August 2015, the Respondent filed a Motion for an Extension of Time to file a translation of his reply. The Tribunal granted this request by Order No. 099 (UNRWA/DT/2015) dated 8 September 2015.

18. On 9 October 2015, the Respondent filed a translation of his reply.

19. By Order No. 031 (UNRWA/DT/2016) (“Order No. 031”) dated 13 April 2016, the Tribunal transmitted a redacted version of Annex 3, the Report of the BoI, to the Applicant. The Applicant was given two weeks to file her comments. The Applicant did not respond to the Order.

20. By Order No. 040 (UNRWA/DT/2016) (“Order No. 040”) dated 10 May 2016, the Respondent was given 48 hours to produce the Applicant’s response to the 3 September 2014 due process letter.

**Applicant's contentions**

22. The Applicant contends:

i) Her functional title is “Senior Practical Nurse” and not “Midwife”;

ii) As a nurse, her job description does not include the duties of a midwife; therefore, she should not be held responsible for the incident;

iii) The Patient’s allegation that the Applicant fell asleep while on duty is defamatory and illogical;

iv) The decision to terminate her appointment was arbitrary as the same measure was imposed on the SRD and JRD; therefore, her case was not individually reviewed on the merits;

v) The doctors were informed of the Patient’s critical condition; and

vi) The hospital’s procedures are inadequate.

23. The Applicant requests to be reinstated in her position as SPN.

**Respondent’s contentions**

24. The Respondent contends:

i) The facts on which the sanction is based have been established by clear and convincing evidence. After an in-depth investigation, the BoI concluded that the Applicant was negligent when she fell asleep while on duty, and she failed to continuously monitor the FHR and report the second and third episodes to a resident doctor. Accordingly, her conduct was a significant contributory factor in hindering timely lifesaving actions from being taken;

ii) The established facts amount to misconduct;
iii) The sanction is proportionate to the offence. In fact, termination in the interest of the Agency is a less severe disciplinary measure than termination for misconduct or summary dismissal;

iv) The Applicant’s argument that she should not be held responsible because she is a nurse and not a midwife should be rejected. The Applicant has been a certified midwife for over 30 years and has consistently performed the functions of a midwife during her career at UNRWA; and

v) The relief sought by the Applicant has no legal basis.

25. The Respondent requests the Tribunal to dismiss the application in its entirety.

Considerations

26. In the present case, the Applicant contests the decision to terminate her appointment in the interest of the Agency. The Respondent submits that the decision was properly effected and proportionate based on the established facts that the Applicant had been negligent by failing to carry out her duties and to take sufficient, timely action to safeguard the life of a foetus while on duty.

27. The Tribunal recalls the administrative framework and existing jurisprudence in the case at bar.

28. Area Staff Regulation 1.4 provides that:

Staff members shall conduct themselves at all times in a manner befitting their status as employees of the Agency.

29. Area Staff Regulation 9.1 provides that:

The Commissioner-General may at any time terminate the appointment of any staff member if, in his opinion, such action would be in the interest of the Agency.

30. Area Staff Regulation 10.2 states:

The Commissioner-General may impose disciplinary measures on staff members who engage in misconduct.
31. Area Staff Rule 110.1(1) states:

Disciplinary measures under staff regulation 10.2 shall consist of written censure, suspension without pay, demotion, or termination for misconduct.

32. The Tribunal recalls the jurisprudence of the United Nations Appeals Tribunal (the "UNAT") in Haniya 2010-UNAT-024 at paragraph 30 when it stated:

[Where a termination of service is connected to any type of investigation of a staff member's possible misconduct, it must be reviewed as a disciplinary measure, because that is what it in reality is.

33. Pursuant to Area Staff Personnel Directive A/10, paragraph 3.2, the Commissioner-General's authority to impose disciplinary measures, other than summary dismissal, is delegated to the Field Office Directors.

34. The Tribunal notes that the decision to terminate the Applicant's appointment in the interest of the Agency was connected to allegations of misconduct against the Applicant. In this regard, the Tribunal will follow the UNAT in Portillo Maya 2015-UNAT-523, referring to Kamara 2014-UNAT-398 and Haniya, when reviewing the Applicant's termination in the interest of the Agency and consider: (i) whether the facts on which the sanction is based have been established; (ii) whether the established facts qualify as misconduct; and (iii) whether the sanction imposed is proportionate to the offence. Noting, however, as held by the UNAT in Abu Hamda 2010-UNAT-022, that:

As a normal rule Courts/Tribunals do not interfere in the exercise of a discretionary authority unless there is evidence of illegality, irrationality and procedural impropriety.

35. Moreover, in Molari 2011-UNAT-164 the UNAT held that when termination is a possible outcome, misconduct must be established by clear and convincing evidence.

Have the facts been established?

36. The record shows that, in response to a negligence complaint filed by the Patient, the WBFO established a BoI consisting of the Acting Deputy Director of Health ("Health/HQA"), an Obstetrician/Gynaecologist ("OB/GYN"), a Field Nursing Officer ("Health/WBFO"), and a Legal Officer ("FLO/WBFO"). From 29 July 2013 until 2 April 2014, the BoI conducted a total of 28 interviews with 16 witnesses and subjects, including the
Applicant, and recorded more than “25 hours total of viva voce interviews and 100 pages of testimony”. The BoI set out its findings in a 66-page report issued on 2 April 2014. In part, the BoI concluded that the Applicant was negligent when she failed to: 1) stay awake and be fully alert while on duty; and 2) continuously monitor the FHR and notify a resident doctor regarding the second and third episodes of foetal distress.

*Failure to stay awake and be fully alert while on duty*

37. According to the Patient’s written complaint and statement to the BoI, after being admitted to the Hospital, she was left under the supervision of the Applicant who fell asleep in the chair next to her sometime around 05:00 hours. This allegation was corroborated by the Maternity SPN’s statement to the BoI that she observed the Applicant sleeping in a chair by the Patient’s bed at around 05:00 hours.

38. When interviewed by the BoI and asked if she had slept at all in the night in question, the Applicant responded “Maybe I slept briefly while sitting on the chair … [f]or a second”. However, in her application the Applicant refutes this allegation as being illogical and defamatory. Based on the two witness statements and the Applicant’s own admission to the BoI, the Tribunal finds that the Respondent has established that the Applicant failed to stay awake and be fully alert while on duty.

*Failure to continuously monitor the FHR and report the second and third episodes of foetal distress to a resident doctor*

39. The BoI also concluded that the Applicant failed to continuously monitor the FHR and report the second and third episodes of foetal distress to a resident doctor. According to the Normal Childbirth Procedures (“NCP”) as set out by the Palestinian Ministry of Health with regard to the standard of care applicable at the Hospital, if the FHR rises above 160 beats per minute (“bpm”) or drops below 100 bpm, a doctor should be notified. The Tribunal notes that the BoI’s investigation confirms that during the second episode the FHR rose above 160 bpm and then dropped below 100 bpm during the third episode. However, the Applicant did not report any variance in the FHR to a resident doctor per the NCP.

40. When the Applicant was asked why she did not report the second and third episodes to a resident doctor in accordance with the NCP, the Applicant asserted that the FHR did not
drop below 100 bpm and that the CTG machine “sounded good”. The BoI disproved the Applicant’s explanation by showing her the CTG print-out, which verified that the FHR had dropped below 60 bpm during the third episode. When asked to interpret the CTG print-out, the Applicant responded that it was a “good FHR” and admitted that she might need further training on CTG interpretation.

41. The record also shows that the Applicant did not record any observations in the variance of the FHR during the second and third episodes in either her notes or on the partograph from 05:20 hours until 06:10 hours in breach of the NCP, which requires notes to be made every 5-15 minutes when a patient is entering the second phase of labour. When asked by the BoI why she did not record the changes in the FHR, she responded that “she did not know”. The Tribunal recalls that both the Patient and a Maternity SPN observed the Applicant sleeping at around 05:00 by, which can be one explanation as to why she did not observe and report the third episode of foetal distress that started around 05:40 hours. In light of the above, the Tribunal finds that the Applicant failed to continuously monitor the FHR and report the second and third episodes of foetal distress to a resident doctor in accordance with the established NCP.

42. Accordingly, the Tribunal is satisfied that the facts on which the termination was based have been established by clear and convincing evidence.

Misconduct

43. The Tribunal reviewed the evidence collected and the analysis conducted by the BoI in its investigation report and finds that the established facts regarding the Applicant’s conduct legally support the characterisation of misconduct. Indeed, the Applicant’s failure to: 1) stay awake and be fully alert while on duty; and 2) continuously monitor the FHR and notify a resident doctor regarding the second and third episodes of foetal distress breached the NCP with regard to the standard of care applicable at the Hospital.

44. Moreover, the Tribunal finds the Applicant’s defence that her functional title is “Nurse” and not “Midwife” unconvincing, as the Applicant has been a qualified midwife for over 30 years and has consistently engaged in the duties of a midwife during her career at UNRWA. Based on the above, the Tribunal finds that the established facts amount to misconduct.
Proportionality

45. As determined by the UNAT in Agel 2010-UNAT-040, the level of the sanction falls within the ambit of the Administration and can only be reviewed in case of “obvious absurdity or flagrant arbitrariness”.

46. When considering proportionality, the Tribunal takes special note of the nature of the Applicant’s post. Referring to the conduct of a staff member, the UNAT held in Haniya 2010-UNAT-024 that:

His misconduct is particularly grave in light of the position he held, and the responsibilities he was entrusted with […].

47. As a SRN and an experienced midwife, the Applicant was entrusted with the responsibility to assist the Patient throughout her labour, and she held a duty of care towards the Patient and the foetus. The Applicant not only fell asleep while on duty, but also failed to properly monitor the Patient and report the second and third incidents of foetal distress to a resident doctor. Furthermore, the Tribunal notes that the Applicant was present when the JRD assessed the Patient as “at risk” for cord prolapse. With regard to causation, the Applicant’s negligence was a contributory cause that hindered timely or appropriate lifesaving interventions. If the Applicant would have acted according to the NCP, the death of the foetus may have been prevented.

48. The Tribunal notes that termination in the interest of the Agency is a less severe measure that preserves certain financial termination benefits not payable if a staff member is terminated for misconduct. The BoI specially cited the Applicant’s weak skills, lack of supervision and lack of Hospital procedures as mitigating factors with regard to the Applicant’s failure to monitor the Patient. In light of these mitigating factors, the Tribunal finds that the Respondent’s decision to terminate the Applicant’s appointment in the interest of the Agency was not disproportionate.

Was the Respondent’s decision taken arbitrarily?

49. The Applicant contends that the decision to terminate her appointment was arbitrary since the same measure was imposed on the SRD and JRD; therefore, her case was not individually reviewed on the merits. The Tribunal recalls that under section VI at page 23 of the investigation report, the BoI specifically addressed the Applicant’s involvement in the
incident and carefully analysed her individual fault in paragraphs 97 to 112 before concluding that her negligence contributed to the death of the foetus. The DUO/WB was provided the report of investigation on 2 April 2014 and concluded that it was in the interest of the Agency to terminate the Applicant's appointment for negligence to carry out her duties and to safeguard the life of the foetus. Accordingly, the Tribunal finds that the decision was properly reviewed based on the Applicant's individual fault, and therefore was not taken arbitrarily.

50. As the Applicant has not provided any evidence refuting the conclusions of the DUO/WB, the Tribunal finds that there is no reason for it to interfere with the discretionary authority of the Respondent to terminate the Applicant's appointment in the interest of the Agency. Furthermore, the Tribunal finds that the Respondent's decision to terminate the Applicant's appointment was unbiased, procedurally sound and well-documented.

Conclusion

51. In view of the foregoing, the Tribunal hereby DECIDES:

The application is dismissed.

(Signed)
Judge Jean-François Cousin
Dated this 31st day of May 2016

Entered in the Register on this 31st day of May 2016

(Signed)
[Signature]
Laurie McNabb, Registrar, UNRWA DT, Amman