BARAKAT

v.

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

JUDGMENT

Counsel for Applicant:
Amer Abu-Khalaf (LOSA)

Counsel for Respondent:
Rachel Evers (DLA)
Introduction

1. This is an application by Khaled Wasfi Barakat (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 his appointment in the interest of the Agency.

Facts

2. Effective 1 September 2011, the Applicant was employed by the Agency as a Medical Officer ‘B’ (“Junior Resident Doctor” or “JRD”) at the Qalqilia Hospital (the “Hospital”) on a fixed-term appointment at Grade 13, Step 1.

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 Senior Resident Nurse (“SRN”) as being in the first stage of labour. The Patient’s condition was considered normal; however, the Applicant noted the following risk factors for cord prolapse in the Patient’s medical file:

   (i) Multipa 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 Applicant by the SRN. The Applicant treated the Patient until the foetal heart rate (“FHR”) recovered.
6. A second episode of foetal distress occurred from 04:10 to 04:50 hours (“second episode”). A third episode of foetal distress started at 05:40 hours (“third episode”) and persisted until cord prolapse was detected by the SRN 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 caesarean 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 caesarean 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 in his duties when he failed to: 1) report the Patient’s case to the SRD; and 2) adequately follow-up the case and supervise the work of the SRN, despite the fact that he had identified the Patient’s case as a “risk case” and was not busy attending to other patients. The Board also found that the negligence of the SRN and the SRD contributed to the child’s death.

10. In terms of causation, the BoI found that the Applicant’s negligence was a contributory cause to the second and third episodes going undetected and unmanaged, and therefore hindering timely lifesaving actions from being taken.

11. On 1 September 2014, the Applicant’s appointment was extended until 31 August 2017.

12. 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. The Applicant received the letter on 12 September 2014.

13. By letter received by the DUO/WBFO on 24 September 2014, the Applicant responded to the 3 September 2014 due process letter. In his 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.

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

15. On 11 February 2015 the Applicant requested review of the decision to terminate him in the interest of the Agency. The Agency did not respond to the request.

16. On 27 May 2015, the Applicant submitted his application with the UNRWA Dispute Tribunal (the “Tribunal”). The application was transmitted to the Respondent on 1 June 2015.

17. On 30 June 2015, the Respondent filed a Motion for Extension of Time to file his reply.

18. By Order No. 078 (UNRWA/DT/2015) dated 13 July 2015, the Tribunal granted the Respondent’s request.

19. On 23 July 2015, the Respondent submitted his reply. Annex 7, the Report of the BoI, was submitted ex parte. The reply was transmitted to the Applicant on 27 July 2015.

20. By Order No. 108 (UNRWA/DT/2015) dated 11 October 2015, the Tribunal ordered the Respondent to translate his reply into Arabic. On 23 October 2015, the Respondent filed a translation of his reply.

21. By Order No. 032 (UNRWA/DT/2016) (“Order No. 032”) dated 13 April 2016, the Tribunal transmitted a redacted version of Annex 7, the Report of the BoI, to the Applicant. The Applicant was given two weeks to file his comments. The Applicant did not respond to the Order, but confirmed receipt.
Applicant’s contentions

22. The Applicant contends:

i) The Hospital’s procedures are inadequate and it is the Hospital that should be held liable for the incident;

ii) The decision to terminate his appointment in the interest of the Agency was arbitrary;

iii) Contrary to labour laws, physicians work an average of 27 hour shifts;

iv) The CTG machine does not work properly;

v) Per the Hospital Instruction dated 21 August 2012, he is responsible for the Emergency Room (“ER”) and admitting cases, while the SRD is responsible for the Hospital wards during the night shift, in particular the maternity ward;

vi) When he attended to the Patient during the first episode there was no evidence of cord prolapse;

vii) He asked the SRN to inform the SRD in the event of the FHR’s deceleration or other complications; and

viii) He was in the ER throughout the night to receive patients.

23. The Applicant requests:

i) Reinstatement to his former post;

ii) Compensation for lost salary from the date of his termination until reinstatement; and

iii) Moral damages for defamation.

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 he failed to: 1) report the Patient's case to the SRD; and 2) adequately follow-up the case and supervise the work of the SRN, despite the fact that he had identified the Patient's case as an "at risk" case and he was not busy attending to other patients. Accordingly, his conduct was a significant contributory factor in hindering timely lifesaving actions from being taken;

ii) He failed to meet the standard of care outlined in Health Instruction 2009, Standard 1.5;

iii) The established facts amount to misconduct;

iv) 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;

v) Contrary to the Applicant's claim that he was busy in the ER during the second and third episodes, the BoI's investigation revealed that the Applicant did not admit any patients into the ER from 03:00 to 07:00 hours, and by his own admission he spent that time preparing the morning briefing and resting in a chair; and

vi) 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 his 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 his duties and to take sufficient, timely action to safeguard the life of a foetus.

27. The Tribunal recalls the administrative framework and the existing jurisprudence applicable 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 Moya 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 he failed to: 1) report the Patient's case to the SRD; and 2) adequately follow-up the case and supervise the work of the SRN, despite the fact that he had identified the Patient's case as "at risk" and he was not busy attending to other patients.

*Failure to report the Patient's case to the SRD*

37. According to the evidence in the file, at 00:40 hours the Applicant admitted the Patient into the Hospital and assessed her as "at risk" for cord prolapse based on several factors. The Patient's file also noted that on 25 February 2013, she had been categorised as an "Alert Pregnancy". At approximately 02:30 hours the first episode of foetal distress was reported to the Applicant, who treated the Patient until the FHR recovered. Despite identifying the Patient as "at risk" for cord prolapse and subsequently treating her two hours later during the first episode, the Applicant did not report the Patient's case to the SRD. In fact, according to the Patient's medical file, and as confirmed by the record, the Patient was not seen or treated by a resident doctor between 03:00 to 06:30 hours in the night in question.

38. When the BoI asked the Applicant whether it was routine for a resident to inform the SRD of cases in the maternity ward, the Applicant replied, "[n]ot everything, but things that are serious in my opinion". The Tribunal finds the Applicant's explanation perplexing given the fact that he had: (1) assessed the Patient as "at risk"; (2) noted that she was categorised as
an "Alter Pregnancy"; and (3) attended to her during the first episode. Yet, he still did not believe that the Patient's case qualified as "serious" enough to inform the SRD.

39. In his defence, the Applicant stated that the normal Hospital routine is for the nurses and/or the midwife to inform the SRD when a new patient is admitted. According to the testimony of the Hospital Director, when a resident doctor admits a new patient, it is the resident doctor's responsibility to inform his supervisor, i.e., the SRD.

40. Both the Applicant and the SRD also testified that they did not speak to or see each other at all in the night in question. Based on the witness testimony and the Applicant's own admission to the BoI, the Tribunal finds that the Respondent has established that the Applicant failed to report the Patient's case to the SRD.

Failure to adequately follow-up the case and supervise the work of the SRN

41. The applicant also asserts that it is the responsibility of the nurses to inform the residents of any fluctuations with the FHR. In fact, the Applicant explained that, following the first episode, he ordered the SRN to notify a resident "if anything happens". However, it must be noted that the Applicant admitted that the SRN was "almost sleeping" when he instructed her to inform the SRD of any changes in the FHR. The Tribunal notes that additional witness testimony corroborated that the SRN fell asleep while monitoring the Patient.

42. When asked by the BoI where he was during the hours of 03:00 and 07:00, the Applicant stated that he was preparing his morning briefings, he may have treated one case in the ER and he rested in a chair. According to the ER register, not a single patient was admitted from 03:00 to 07:00 hours. In light of the above, the Tribunal finds that the Applicant failed to adequately follow-up the Patient's case and supervise the work of the SRN, despite the fact that he had identified the Patient's case as "at risk" and he was not busy attending to other patients.

43. Accordingly, the Tribunal is satisfied that the facts on which the measure was based have been established by clear and convincing evidence.
**Misconduct**

44. Upon review of the investigation report, it is clear that the Hospital’s procedures are deficient; however, the Tribunal finds that the Applicant breached his duty of care when he admitted the Patient and classified her as “at risk”; yet, he still did not report the Patient’s case to his supervisor, the SRD. The Tribunal dismisses the Applicant’s excuse that it is the nursing staffs’ responsibility to notify the SRD, given that the Applicant knew of and observed the Patient’s severe condition and admitted that he should inform the SRD of “serious” cases.

45. Moreover, the fact that the two resident doctors did not communicate at all on the night in question breaches Hospital Instruction 2012, which provides that “cooperation between the two residents must be continuous”.

46. The Bol also found clear and convincing evidence that the risk of cord prolapse was medically foreseeable, and as a high-risk case, the delivery should have been monitored and managed more closely. The Bol also concluded that the Applicant failed to adequately follow-up the case and supervise the work of the SRN.

47. When asked by the Bol why he did not follow-up with the Patient despite admitting her as “at risk”, the Applicant referenced Hospital Instruction 2012 and stated that it was the SRD’s responsibility to follow-up on all Hospital wards during the night shift. As noted above, the Applicant breached Hospital Instruction 2012 when he failed to speak to the SRD and inform him of the Patient’s case on the night in question. The Applicant also explains why he did not personally follow-up with the Patient stating that he instructed the SRN, who was “almost sleeping”, to notify a resident “if anything happens”. For the Applicant to attempt to justify his failure to follow-up with the Patient by stating that he believed the SRN, who was sleeping, would inform the SRD, is implausible.

48. Given that the Applicant was not busy attending to other patients, and his admission that the SRN was “almost sleeping”, the DUO/WB found that the Applicant was negligent by failing to follow-up with the Patient and supervise the SRN, therefore breaching Hospital Technical Instruction 2009, Standard 1.5 (“HTI 2009, Standard 1.5”), which requires that
residents “provide regular feedback...on the health status of women who need special attention and care” and “to provide support and technical assistance and to ensure that the proper standards of care are implemented”. In light of the evidence provided, the Tribunal agrees with the DUO/WB’s conclusion that the facts established legally support the characterisation of misconduct.

49. Based on the above, the Tribunal finds that the established facts amount to misconduct.

Proportionality

50. 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”.

51. 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 that:

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

52. As the admitting resident doctor on the night in question, the Applicant was entrusted with the responsibility to attend to the Patient throughout her labour, and he held a duty of care towards the Patient and the foetus. The Applicant not only failed to report the Patient’s case to the SRD after assessing the Patient as “at risk”, but also failed to follow-up with the Patient after treating her during the first episode of foetal distress. The Tribunal recalls that the Patient was not seen or assessed by a doctor from 03:00 hours until 06:30 hours, during which time the Applicant was not busy with other patients, rather he was sitting in a chair and preparing his morning briefing notes. With regard to causation, the Applicant’s negligence was a contributory cause that hindered timely or appropriate lifesaving interventions, and perhaps if the Applicant had acted in accordance to the HTI of 2009 and 2012, the death of the foetus may have been prevented.

53. Moreover, 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 specifically cited the Hospital’s dearth of formal policies and procedures to regulate the performance of case follow-up by the resident
doctors, and the SRN's failure to notify the Applicant of the second and third episodes, as mitigating factors to the Applicant's negligence to inform the SRD and follow-up with the case. In light of these mitigating factors, the Tribunal finds that the decision to terminate the Applicant's appointment in the interest of the Agency was not disproportionate.

Was the Respondent's decision taken arbitrarily or motivated by prejudice?

54. The Applicant contends that the decision to terminate his appointment was arbitrary based on the absence of a medical committee and the length of the investigation. Recalling that the BoI was comprised of medical experts, the Tribunal notes that the Applicant's involvement in the incident was carefully analysed in paragraphs 113 to 121 before the BoI concluded that his 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 failure to carry out his responsibilities and 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.

55. The Applicant also contends that it is the Hospital that should be blamed for the death of the foetus. In support of this contention, the Applicant explains that the seven resident physicians work 27-hour days and are responsible for 63 patients. Therefore there is not an assigned doctor to the maternity ward. The Tribunal has already acknowledged the BoI's finding that the Hospital's procedures and practices are inadequate. However, in the case at hand, the Tribunal recalls that, despite the Applicant's alleged heavy workload and long shift hours, on the night in question, the Applicant admitted only one Patient into the hospital. Therefore, he had only one case to monitor and follow-up with. Accordingly, the Tribunal dismisses this contention.

56. The Applicant also contends that the CTG device was not working properly. Despite the Hospital Director's testimony that the CTG machine was functional at the time of the incident, the Tribunal notes that a number of the medical professionals, including the SRN, SRD and OB/GYN, all noted that the CTG machine was unreliable. Nevertheless, the Tribunal recalls that the CTG machine print-outs, which were reviewed by the BoI, reflected three episodes of foetal distress that should have been detected by a medical professional. If the Applicant would have complied with HTI 2009 Standard 1.5 and regularly followed-up
with the “at risk” Patient, he would have observed the CTG print-outs that indicated the FHR was under distress.

57. As the Applicant has not provided any evidence refuting the findings 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-scrutinized.

Conclusion

58. 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)

Laurie McNabb, Registrar, UNRWA DT, Amman