REPUBLIC OF VANUATU

OFFICE OF THE OMBUDSMAN

# PUBLIC REPORT

## ON THE

## PREMATURE BIRTH AND DEATH

## OF NEWBORN TWINS

## AT

## VILA CENTRAL HOSPITAL

**28th May 1997**

# ADDENDUM

**THE FOLLOWING CORRECTIONS ARE MADE IN THE REPORT ON THE PREMATURE BIRTH AND DEATH OF NEWBORN TWINS AT THE VILA CENTRAL HOSPITAL**

**IT SHOULD READ AS FOLLOWS :**

| | | |
|---|---|---|
| Page 3 | 3.1 | The scope *of this investigation* and not "of this premiminary report" |
| Page 5 | Chapt 6 | Inclusion of Parag. 6.46 (see below) as an introductory note |
| Page 6 | 6.16 | The Annex C enclosed shows a jump from 22 deaths to 75 *between 1991 and* 1993 |
| Page 12 | 6.46 | This paragraph is shifted to page 5 as a preliminary note in Chapter 6. Findings of Facts |
| | 6.47 becomes 6.46 entitled **Administrative error by former Prime Minister insuccessive reinstatements of M. Y. Niowenmal.** | |
| Page 14 | 7.6 | To grant such *provisional* certificate instead of "provincial certificate" |
| Page 17 | 8.11 | Title is changed to "*Professional error of*" the members of the Health Practitioners Board |

# TABLE OF CONTENTS

## *PREAMBLE*

*"We then that are strong ought to bear the infirmities of the weak, and not to please ourselves"* Romans 15 v 1.

This report is concerned with the operation of the service provided at Vila Central Hospital, where the investigation revealed a shockingly low standard of care and supervision.

Although it is concerned with only one case the conditions which emerged involve the entire operation of hospital services in the capital, and one of our main findings was that there has not been any gynaelogist/obstetrician from 1993 till now despite the offer from the British for no cost for Vanuatu which was repeatedly ignored by the Director of Health.

What furthermore emerged is a dramatic increase of number of deaths at births tripling between 1991 and 1994 and very little improvement till today.

Appointments to senior positions have been made for personal reasons, instead of medical competence and inexperienced persons have been placed in positions of responsibility which are entirely beyond their competence. Not only so, but administrative procedures have been ignored, and offers of outside financial help have been rebuffed, either through laziness or indifference. Large sums of money have been lost to the people of Vanuatu and foolish needless expenditure has been allowed.

While the excuse of "no funds" has been offered it is clear that the lack of personal ethics and a firm grasp of priorities has resulted in the examples given where it was assessed that there was no money available to pay Vt 1.5 million vatu for a Gynaecological/Obstetrician, appointment, for example, while 2.2 million vatu was allocated for a new hospital sign "because it was flash"! At the same time 25 million were budgeted for the overseas care of families of the top leaders including Ministers and President.

A thorough and serious overhaul of the entire provision of hospital services is a matter of the greatest urgency, and it is to be hoped that action will be taken urgently by those with the power and authority to do so.

## 1 *INTRODUCTION*

1.1 A complaint was received from Joe Sarai ("**Mr Sarai**") and Regina Batick ("**Ms Batick**") about the premature birth and death of their newborn twins at Vila Central Hospital ("**the Hospital**") on 07.02.96. They claimed that Ms Batick was not given proper medical care on her visits to the prenatal clinic and at the time of the delivery of the twins, who died in the maternity ward shortly after birth.

1.2 The complaint was directed against:

- Yves Niowenmal, Director of Health ("**Mr Niowenmal**")
- Len Tarivonda, Acting Medical Superintendent ("**Mr Tarivonda**")
- Thomas Sala, maternity ward and prenatal clinic ("**Dr Sala**")
- Staff nurses : BJ, BA, TJ & SM.

1.3 The investigation revealed serious problems in the prenatal clinic and maternity ward. These problems increased the risk of getting poor medical treatment. Ms Batick suffered poor medical care. This was the responsibility of Dr Sala and the staff nurses, and indirectly to the incompetent administration of Mr Tarivonda in the Hospital and Mr Niowenmal in the Department of Health.

She suffered polyhydramnios which is likely to have been the cause of pregnancy not reaching its full term, and her condition was only diagnosed when it was too late and she never got any special or specialised care during the term of her pregnancy. Polyhydramnios is a medical term used for excessive amniotic fluid in the uterus during pregnancy.

1.4 There has been no gynaecologist/obstetrician ("**G/O**") at the Hospital since Mr M. Panos ("**Dr Panos**") left at the end of his contract with the Government of Vanuatu from the end of **December 1993 till today in May 1997**. From 1994 to 1996, when the Department of Health was unable to come up with approximately 1.5 million vatu per annum to recruit a G/O on local contract for the Hospital, the Council of Ministers approved a budget of 25 million vatu over the same three-year period for the overseas medical treatment of Government Ministers and their families.

In 1994, two G/Os applied to the Department of Health for the position. One applicant already lived in Port Vila and was working as a private medical practitioner. However, there is no evidence that the applications were ever processed by Mr Niowenmal for recruitment. The Hospital is still operating without a qualified G/O.

1.5 The investigation revealed that in 1994, the British Government had offered to fund the G/O position at the Hospital for a three year period. The Prime Minister, Maxime Carlot Korman ("**Mr Korman**") approved the offer on 14.07.94. The offer was in the form of a project document for medical staffing. However, Mr Niowenmal failed to formalise and implement the project (i.e he did not sign the project forms). The British Government, after holding many discussions and meetings with the National Planning Office and the Department of Health, withdrew the offer on 30.11.95. Therefore it appears that Mr Niowenmal is directly to be blamed for the withdrawal of the funds offered to finance this vital G/O position at the Hospital, and for the absence of G/O from at least mid 1994.

1.6 The investigation also revealed that Dr Sala had no qualification or experience in Gynaecology and Obstetrics. He graduated as a general doctor in December 1994 and was to work under supervision for 12 months. However in August 1995, when he was still supposed to be doing supervised internship training, he was put in charge of the maternity ward and prenatal

clinic by Mr Tarivonda, the then Acting Medical Superintendent. Moreover on 20.04.95, Dr Sala was wrongly granted the full certificate of registration to practise medicine in Vanuatu by the Chairman of the Health Practitioners Board (**"HPB"**), Edward Tambisari (**"Dr Tambisari"**). The granting of this certificate was in breach of the Health Practitioners Board Act (**"HPB Act"**). Dr Sala's lack of knowledge and experience in Gynaecology and Obstetrics may have contributed directly to this case as Ms Batick's visits to the prenatal clinic were made during the same period that he was head of the prenatal clinic and maternity ward.

1.7 Expert opinion was sought from Sue Belgrave (**"Dr Belgrave"**), a consultant G/O at the National Women's Hospital in Auckland, New Zealand. According to her, the twins had little chance of surviving once the process of birth had started.

1.8 However, this investigation has uncovered a great deal of maladministration by several leaders in this country. Their improper actions and administrative errors appear to have indirectly contributed to the premature birth and death of the newborn twins on 07.02.96, and to the maladministration in the maternity ward and the hospital since 1993, aggravated by the dismissal of competent mid-wives during the strike of 1993.

## 2 *JURISDICTION*

2.1 Pursuant to article 62 of the Constitution and section 14 of the Ombudsman Act No. 14 of 1995, the Ombudsman has jurisdiction to enquire into the conduct of certain public bodies or persons on receiving a complaint or on the Ombudsman's own initiative. Mr Sarai and Ms Batick's complaint against the Hospital administrators, doctor and nursing staff falls within the Ombudsman's jurisdiction, because they are all employees of the Hospital, which answers to the Department of Health.

## 3 *SCOPE OF INVESTIGATION*

3.1 The scope of this preliminary report is to enquire:

(a) Why Mr Niowenmal did not carry out his responsibility to liaise with appropriate authorities and donor agencies, as a matter of urgency, to recruit a G/O for the country's main referral hospital, and why did he not sign the project document between July 1994 and November 1995, which would have brought a British G/O into the country, at no cost to Vanuatu.

(b) Why Mr Tarivonda assigned the responsibilities of a G/O head of prenatal clinic and maternity ward to a newly graduated general doctor, Dr Sala?

(c) Why Dr Tambisari decided to grant a full certificate of registration to Dr Sala without a decision of the Health Practitioners Board, and why he allowed a meeting of the Health Practitioners Board to convene on 06.06.95 without a quorum?

(d) Whether the staff nurses carried out their responsibilities and whether it was within their ability to deal with the situation?

(e) Why Ms Batick was unable to get proper medical care for herself and her infants?

## 4 *METHOD OF INVESTIGATION*

4.1 Under art 62 (3) of the Constitution, and s 17 (2) of the Ombudsman Act No. 14 of 1995, the Ombudsman is empowered to request any person or organisation likely to assist in providing the information and documents for the enquiry. Based on these powers, information and documents were obtained from the following health institutions and officers:

- Department of Health
- Mr Edwin Tari ("**Mr Tari**"), Acting Medical Superintendent
  Staff Nurse BJM
- Staff Nurse BJ
- Staff Nurse BA
- Staff Nurse TL
- Staff Nurse SM
- Staff Nurse TJ
- Dr Sala
- Mr Sarai
- Ms Batick
- Agnes Thouvenin **(Dr Thouvenin)** private medical practitioner, New Caledonia
- Dr Belgrave

## 5 *COMMENTS BY THOSE AFFECTED BY THE PRELIMINARY REPORT*

5.1 Under s16(4) of the Ombudsman Act No.14 of 1995, preliminary reports were sent on 27.01.97 to those being affected by the report to give them opportunity to make their comments and replies to allegations made against them. The preliminary reports were therefore sent to the following persons:

- Mr Niowenmal
- Mr Fanua
- Dr Sala **
- Dr Tambisari
- Dr Bador **
- Mr Tarivonda **

5.2 Only the people with an "** marked" answered to our report. The others did not reply including Mr Niowenmal and Dr Tambisari, the former Minister of Health and now Acting Medical Superintendent of the Hospital.

5.3 The replies received from Dr Sala, Mr Tarivonda and Dr Bador are attached as appendices to this report. Extracts of the comments from their replies on this case have been commented on by the Ombudsman later on in this report.

## 6 *FINDINGS OF FACTS*

6.1 Ms Batick made six visits to the prenatal clinic from 26.09.95 to 07.02.96 when she gave birth at the Hospital. On the first three visits, Nurse BJ diagnosed her as normal, but on the fourth visit, recommended a scan due to a sudden increase in the size of her abdomen (Appendix A).

6.2 The ultra sound test carried out on Ms Batick by the Radiographer, Mr MB on 18.12.95 on her fourth visit confirmed that they were twins and both twins were alive. Their foetal hearts were beating normally and the amniotic fluid level was normal at that time.

6.3 Nurse BJ said that an average of 40 to 50 mothers visit the clinic every day and only two nurses are assigned to consult them. Ms Batick therefore spent only five or six minutes with a nurse on each visit. In Dr Belgrave's view, the prenatal clinic was understaffed—a routine check could be done in 5 minutes, but would leave no time for discussion or education.

6.4 Nurse BJ also said that in the past, when there was a G/O at the Hospital, expecting mothers came to see the G/O on Monday and Tuesday afternoons. When Ms Batick made her visits to the prenatal clinic, there was no G/O, and consultations with Dr Sala occurred only on Monday afternoons. Ms Batick saw neither Dr Sala nor a G/O during her entire pregnancy.

6.5 Ms Batick started feeling tired near the end of December 1995. Discomfort, severe tiredness, mild contractions, and minor backaches soon followed. According to Dr Belgrave, although these were some of the symptoms of polyhydramnios, they were not specific and are common symptoms in pregnancy. Ms Batick reported these feelings on her last two visits to the clinic, but nothing was done.

6.6 On 05.02.96 at about 6 or 7 p.m., Ms Batick went to the outpatient clinic complaining of discomfort, tiredness, and backache. After a brief examination, Nurse BA prescribed 4 panadol tablets and sent her home. In Dr Belgrave's view, even if the diagnosis of polyhydramnios had been made by this date, the labour and delivery may still have occurred, but she could have been treated for her condition increasing her chances to deliver her twins close to the due date.

6.7 On 07.02.96, Ms Batick went into the maternity ward at about 6 or 6:30 p.m with the same complaint. She was admitted on arrival by Nurses SM and TJ. A routine check revealed that she was in moderate labour and that her cervix was already 5 cm dilated. She was diagnosed with twin pregnancy.

6.8 At 6:35 p.m, Nurse SM telephoned Dr Sala about their findings. He instructed her to scan urgently to see the parts presenting, and to try to stop labour by giving ventolin to the patient. However, Dr Sala stated in an interview with the Ombudsman that he knew that once the cervix had dilated more than 3 cm, the labour process could not be stopped.

6.9 Nurse TJ prescribed 4 mgr of ventolin to Ms Batick between 6:40 and 6:50 p.m to try to stop labour. The nurses too knew it would not work because ventolin is proven medically not to have any effect at such an advanced stage of labour. It did not work and the membranes ruptured at 6:54 p.m, discharging clear liquid.

6.10 Dr Sala was aware, after being told by Nurse SM, that the mother was in danger of losing the babies. Yet Nurse SM did not ask him to come, and he did not come. This is most surprising, given that both knew the danger. Indeed, Dr Sala in his evidence before the Ombudsman agreed that he was aware of the danger at the time.

6.11 A scan carried out by Mr MB at 7 p.m. confirmed twin pregnancy, polyhydramnios and the presenting parts as oblique and transverse. Both foetal heart beats were normal (Appendix B).

6.12 According to Nurses TJ and SM, the scan was not done urgently as instructed by Dr Sala. This is because only Mr MB was authorised to operate the machine, and they had to look for him for about 25 minutes.

6.13 The first twin went through a normal vertex delivery at 7:52 p.m. He was a male infant weighing 700 g. He was transferred to the incubator but died at 12:15 p.m. The second twin went through a breech delivery at 9:50 p.m. The infant was a male weighing 600 g. He was also transferred to the incubator but had only gasping respiration. The second infant died at 1:00 p.m (Appendix B).

6.14 Dr Edward Tambisari's Medical Report (acting then as doctor in the hospital) on the case in his letter to the Ombudsman on 23.05.96 stated that *"an urgent scan done at 7.30 p.m revealed polyhydramnios and twin pregnancy"* and, *"pregnancy had not reached full term. The infants were not mature and hence their lungs would not have been able to sustain normal respiration."* (Appendix B)

6.15 Nurses TJ and SM stated that there were two other deliveries on that particular evening, with only the two of them on duty in the maternity ward. They indicated that they needed help but there were not enough nurses working. The procedure in the maternity ward of having only one midwife and one registered nurse working on a night shift has been an on-going practice. The same procedure was still in use when Ms Batick was admitted to the maternity ward.

6.16 The Hospital's maternity ward statistics showed that 285 infants died within 24 hours after birth from the total of 4598 registered births between 1994 and 1996, when there was no G/O and fewer qualified midwives (due to the dismissal of strikers) in 1993.

The contribution of the strike and the dismisal of qualified midwives and nurses in the maternity ward has caused a great increase in the number of deaths of babies at birth. The Annex C enclosed shows a jump from 22 deaths to 75 deaths in 1993 for a similar number of births. In fact the number

of deaths doubled after the strike and tripled the following year and has remained at a high level never known in the years 1985 to 1991 because of the departure of the G/O in 1993 and his non-replacement, and before the strike.

| Year | Number of deaths of babies at birth | Total number of births | % of number of deaths |
|---|---|---|---|
| 1988 | 29 | 1286 | 2.2% |
| 1989 | 29 | 1261 | 2.2% |
| 1990 | 29 | 1350 | 2.1% |
| 1991 | 22 | 1482 | 1.4% |
| 1992 | 50 | 1456 | 3.4% |
| 1993 | 75 | 1489 | 5.0% |
| 1994 | 85 | 1546 | 5.5% |
| 1995 | 56 | 1527 | 3.6% |
| 1996 | 67 | 1526 | 4.4% |

In this case the maternity ward has never regained the standard that it had before from 1988 to 1991.

Other mothers have had experiences similar to Ms Batick's resulting in the loss of their infants. (see appendix C)

6.17 Nurse TJ telephoned the paediatrician, Hensly Garae ("**Dr Garae**"), at 10:45 p.m. to ask him to come to the maternity ward to explain the twins' condition to the parents. The nurses may have decided not to contact Dr Sala again as in the first place he did not come to assist them.

OBSTETRICAL INFORMATION FROM EXPERT SOURCES

The following expert information provided facts and evidence that may have contributed to the preterm labour, delivery and death of the twins on 07.02.96.

6.18 According to Dr Belgrave, it is usual practice for women carrying twins to be referred to an Obstetrician for prenatal care and delivery. However, Ms Batick in 31 weeks of pregnancy was never referred to a G/O.

6.19 Dr Belgrave stated that preterm labour is a complication of twin pregnancy and that the risk is further increased if polyhydramnios is present. Ms Batick was unfortunate not to have been diagnosed with polyhydramnios and not to have been referred to an experienced doctor. When it was discovered it was too late.

6.20 During an interview with the Ombudsman, Dr Sala stated that one cause of preterm labour is called cervical incompetence—for some unknown reason, the cervix opens up, usually during the second trimester of pregnancy (13 to 27 weeks). However, there is no evidence of cervical incompetence in Ms Batick's case.

6.21 Dr Belgrave went on to say that polyhydramnios is mainly suspected when there is a sudden increase in the size of the mother's abdomen, abdominal discomfort, and difficulty in feeling foetal parts. It can be diagnosed from about 20 weeks of pregnancy. The diagnosis is confirmed by ultrasound.

6.22 In Ms Batick's case, it appears from the above facts that polyhydramnios should have been suspected and diagnosed at around 20 weeks of her pregnancy. The signs and symptoms were noticeable then: she was diagnosed with a sudden increase in the size of her abdomen and was continuously complaining of abdominal discomfort. However, due to a lack of professional and technical knowledge and experience on the part of Staff Nurses BA and BJ and of Dr Sala, and in the absence of a G/O, polyhydramnios was never diagnosed or even suspected.

6.23 Dr Belgrave also stated that, polyhydramnios can occur for a number of reasons including twin-to-twin transfusion. This can happen in the case of monozygotic (identical) twins, gestational diabetes, or foetal abnormality. Ms Batick's twins were identical. The preterm labour and delivery of Ms Batick's twins may be assumed to have been mainly caused by the twins being identical.

6.24 In an interview with Dr Sala, he stated the lungs of twins were not mature. There is a substance in the lungs of infants called surfactant which lines the air bags of the lungs. When an infant is born before this substance is present in the lungs, he or she cannot survive. The twins were born prematurely with foetal lungs not mature.

6.25 Dr Belgrave went on to explain that a drug such as salbutamol can delay delivery long enough for steroids to be administered to reduce the incidence of hyaline membrane disease caused by lack of surfactant in premature infants. This could also buy time for a mother's transfer to a hospital with intensive care facilities for newborns.

6.26 Dr Belgrave also said that Ms Batick's preterm labour and delivery would have been easier to delay if treatment had started before the cervix dilated more than 3 cm. However, there is no evidence that labour could have been prevented on 07.02.96.

6.27 **In summary, preterm labour and delivery could only have been prevented if polyhydramnios had been identified and treated earlier**. The only hope for the twins to survive would have been for Ms Batick to have travelled out of Vanuatu to a centre with neonatal intensive care facilities.

6.28 Dr Belgrave added that the babies would not have survived at the weights of 600 and 700 g. These weights suggest that the pregnancy was either much earlier than 31 weeks gestation or that there was severe intrauterine growth retardation. Normal birth weight for a baby at 31 weeks gestation is more than double the twins' weights. Therefore, it is likely that there was intrauterine growth retardation given the weights of the babies and the fact that the mother had had an earlier scan.

6.29 Dr Thouvenin suggested that periodic vaginal examinations during pregnancy might have revealed an abnormality of the cervix and a risk of premature delivery. Strict rest in supine position together with appropriate medication might have prevented the evolution towards premature delivery. Also, hospitalisation from as early as 05.02.96 with perfusion of salbutamol would have been in order. This type of examination is usually done by a G/O.

6.30 In response to the preliminary report, Dr Belgrave added that, *"it is important to realise that even if the polyhydraminios had been suspected and labour diagnosed earlier, the outcome would probably have been the same. This is true even if you had an obstetrician in Port Vila, as you don't have the facilities for neonatal intensive care. Unfortunately, we cannot prevent preterm labour. The vast improvement in the outcome of preterm infants has come from the Neonatologists and their intensive care facilities rather than the Obstetricians."*

MALADMINISTRATION

This investigation also revealed that a number of administrative errors made by certain leaders and officers have contributed indirectly to this complaint.

6.31 **No Gynaecologist/Obstetrician from December 1993 until March 1997**

From records obtained from the Hospital and the Department of Health through interviews and documents, the G/O position at the Hospital was left vacant in December 1993, when Dr Panos left at the end of his contract. Former Director of Health, Dr George Bule, made a request on 13.10.93 to the Public Service Department to consider employing Dr Kaiva Tulimanu (**"Dr Tulimanu"**), a private medical practitioner already in Vila, on temporary basis as a matter of urgency until a new G/O was recruited. The Public Service Department did not formalise this request.

6.32 **Applications for G/Os not dealt with**

Two other applications from qualified G/Os were received by Hospital management, who passed these applications to Mr Niowenmal in 1994 and 1995. However, there are no documents from the National Planning Office or the Public Service Department concerning the two applicants for the vacant position to show that Mr Niowenmal followed them up.

6.33 **British project to finance a G/O approved by former Prime Minister**

The National Planning Office and AID Management Office of the British High Commission were liaising with the Department of Health and the Public Service Department for the recruitment and funding of G/O for the Hospital since July 1994. This followed a project memorandum for medical staffing support between the governments of the United Kingdom and Vanuatu. The project document was sent on 21.03.94 to the Prime Minister, Mr Korman, who approved it for implementation on 14.07.94.

6.34 **Mr Niowenmal destroyed the project of bringing a gynaecologist for 3 years by not signing the application form**

According to documents from the AID Management Office, the offer of funding for a G/O at the Hospital was on the table for more than 12 months. The offer originally was to expire by 31.03.95, but the British Government extended the deadline to 01.11.95. Although the National Planning and AID Management Offices tried hard to help the Health Department to fill the G/O position, **Mr Niowenmal did nothing, resulting in the withdrawal of the funds budgetted for the position on 30.10.95.**

6.35 **The Ombudsman enquired into why the position of G/O had been vacant for a long time**

In August 1996, the Ombudsman wrote to the former Minister of Health, Cyriaque Metmetsan (**"Mr Metmetsan"**), Mr Niowenmal, and Mr Tari, asking them why the position had not been filled and what progress had been made so far in getting a G/O recruited for the position.

6.36 **Former Minister of Health responds that there is no funding**

Mr Metmetsan in his reply in August 1996, informed the Ombudsman that the position should have been filled at the beginning of 1996. He stated that it was because of budget constraints faced by the Health Department that the position was not filled. The matter of the G/O position is the subject of another enquiry. As a related matter, there was no problem for Mr Niowenmal to find 2.2 million vatu in 1995 to pay for some signs to decorate the Hospital, which is also the subject of another enquiry.

6.37 **Request for Private Practitioner to work temporarily as G/O for VCH**

On 21.10.96, the then acting Director of Health, Morrison Bule, wrote to Dr Tulimanu and asked him to work temporarily for two days per week as a G/O. This was to solve the problem of the delayed recruitment of a G/O, as a matter of urgency. There is no evidence that Dr Tulimanu accepted the offer.

6.38 **Appointment of a young graduate General Practitioner as G/O**

Mr Tarivonda, as Acting Medical Superintendent appointed Dr Sala in August 1995, to be in-charge temporarily for 3 months whilst doing his internship training. Dr Sala graduated as a general doctor in December 1994 and was working under supervision in internship when he was appointed to look after the maternity and antenatal wards. In an interview with the Ombudsman, he stated that he had an interest in Gynaecology and Obstetrics, but had not get any specialised training in this field of medicine.

6.39 **Young graduate doctor has not done his medical internship training**

Dr David Philips, the Senior Clinical Tutor at Fiji School of Medicine **("FSM"),** informed the Ombudsman that under the medical training rules Dr Sala should work under supervision for one year. He could do his one year

internship in Vanuatu provided it was within the requirements of the law of Vanuatu. Section 5 (a) of the Health Practitioners Act provides for a person wanting to practise medicine in Vanuatu must be entitled to practise medicine in the country in which the degree was granted. In this case, according to the Vanuatu law, Dr Sala should have done his internship in Fiji and be registered with the Fiji Medical Board before he could be allowed to register and practise in Vanuatu.

6.40 **Appointment of doctor to supervise young graduate doctor for internship training not in line with proper procedures.**

Dr Philips also mentioned that Dr Sala could do his internship in Vanuatu provided he was supervised by officers who were recommended by the FSM. According to official records, there are no official supervisors recommended by FSM for medical students to do internships in Vanuatu. In 1993, FSM issued certificates to Dr Timothy Vocor, Dr Garae and Mr Elison S. Bovu, recommending them to be official supervisors of primary care practitioners and paramedical students doing internship training in Vanuatu but not medical students.

6.41 **Young G/P acting as G/O has never been supervised by any specialised G/O**

It was revealed in my investigations that Dr Sala was never supervised by any recommended or appropriate supervisor. Although he is now working in the maternity and antenatal wards, he had never been supervised by a specialised G/O to work in the wards since his appointment, and during our enquiry.

6.42 **Illegal full registration as doctor granted to young doctor in internship**

The investigation also revealed that Dr Sala was illegally granted a provisional certificate on 10.01.95 and a full registration certificate on 20.04.95 to practise in Vanuatu before any meetings of the Health Practitioners Board. The full certificate (Appendix "H") and approval letter of provisional registration (Appendix "I") was signed and issued by Dr Tambisari and Mr Tiro Fanua **("Mr Fanua")** who was the Secretary to the Board. However, section 3(3) of the Health Practitioners Act provides that the decisions of the Health Practitioners Board shall be made by a majority of votes of members present at the meeting. Therefore the decisions to grant provisional and full registration to practise as a doctor are void and invalid.

6.43 **Meeting of Health Practitioners Board did not have quorum**

My investigation too found that the Health Practitioners Board meeting held on 06.06.95 (see Appendix "D") and attended only by Dr Tambisari, Dr Jean Luc Bador ("**Dr Bador**") and Mr Fanua lacked a quorum. The Act provides that the Chairman and four appointed members shall constitute a quorum.

6.44 **Denial by a HPB member of decision to grant registration to new graduate doctor**

In his reply to my preliminary report, Dr Bador said that during this Board meeting, they did not agree to grant Dr Sala the registration certificate.

6.45 **Illegal appointment to the position of G/O at VCH by Acting Medical Superintendent**

On 02.08.96, in an interview with the Ombudsman, Dr Sala stated that whilst doing his internship training at VCH, he was appointed by Mr Tarivonda to be in charge of the prenatal and maternity ward in August 1995. He stated that he had only an interest in Obstetrics and because there was no G/O at the Hospital, he was appointed as first-on-call doctor for the two sections. It was during this period, from August 1995 to 07.02.96, that Ms Batick paid six visits to the prenatal clinic leading up to the premature birth and death of the twins on 07.02.96.

6.46 **The complainant's personal information**

Ms Batick is a mother of 22 years old. Her last monthly period was recorded to have been on 7.07.95. This is her first pregnancy with no records of miscarriages or history of medical diseases that she might have suffered before this pregnancy. Her pregnancy with the twins did not reach full term and she had a polyhydramnios condition confirmed by Dr Tambisari which was not discovered during her pregnancy.

6.47 Successive re-instatements of Yves Niowenmal by former Prime Minister Maxime Carlot Korman, even though he was suspended repeatedly by different successive Ministers of Health for his misconduct and incompetence. This matter is the subject of another enquiry.

## 7 *REVIEW OF THE REPLIES TO THE PRELIMINARY REPORT*

7.1 In his reply to my preliminary report, Dr Sala made the following comments (see Appendix "E"):

> ***I was never assigned by Mr Tarivonda to head the Maternity Ward and the Antenatal Clinic.***
> *I stated in the interview that I am only doing first on-call.* ***This was made official in the memorandum by Dr Garae on 20.03.96.*** *The second on-call were to be Drs Leveque, Fei, Garae, and Mcnamara*
>
> *I have three clinics every week, Monday afternoons for antenatal high risk cases, Wednesday afternoons is for gynaecology and follow-up clinic and Tuesdays is antenatal booking clinic which I help out when I am not busy.* ***High risk cases are referred to me by the antenatal nurses.*** *It is impossible for me to see every single pregnant women who visit Vila Central Hospital.*

7.2 **Comments of the Ombudsman**

Dr Sala argued that he was not appointed to be in-charge of the maternity and antenatal wards. But this statement contradicts the duties he was fulfilling in the two wards as mentioned by him above in the second paragraph. It, in fact, appears that the duties he has been performing in the maternity and antenatal wards belong to a G/O in-charge of these two wards.

7.3 **Mr Tarivonda** made the following comments to the Preliminary Report (see Appendix "F"):

> ***I appoint Dr Sala on a temporary basis*** *and on the advice of Dr Garae his supervisor. In 1995 Dr Sala was doing his internship and he was required to do Obs and Gynae for 3 months under supervision. Since there was no G/O at VCH, Dr Garae advised me to do a memo and inform the relevant sections of the hospital that Dr Sala would look after Maternity and Antenatal for 3 months and that he would be first on call for those wards.*
>
> *Dr Sala did not understand his limitations in the field of Obs and Gynae.* ***Many occasions he failed to call for help when he should****; these culminated in the problem you're investigating.*
>
> *I was only in the medical superintendent's office for 3 months when all this problem happened. The hospital was without a G/O for a long time and even I submitted requests for a G/O to the Department of Health. The civil servants strike also took its toll on the VCH workforce and you know that.* ***There is never enough nurses at VCH. Also the business of nurses is the matron's responsibility, not mine as the Med Sup.***

7.4 **Comments of the Ombudsman**

Mr Tarivonda confirmed above that he appointed Dr Sala only on temporary basis for 3 months in 1995. It would now probably appear that Dr Sala remained on the job upon receiving the above appointment which was only to last on a temporary basis for 3 months as from August 1995.

Mr Tarivonda claimed that Dr Sala did not understand his limitations and did not seek advice when supervising the two wards. This might explain why he did not attend Ms Batick's case on 07.02.96, when he was phoned and given the details of the case (see Annex "B").

It is quite astonishing to learn from Mr Tarivonda that as Chief Administrator of the hospital, he did not concern himself with the problem of shortage of nurses for the hospital but left it as the matron's responsibility.

7.5 In **Dr Bador's** response to my preliminary report (see Appendix "G"), the following information was stated:

*" Concerning Thomas Sala, there was a letter stating that* ***provisional*** *registration* ***for 6 months*** *was given, dated 10/1/95, signed Tiro Fanua."*

*"As usual in these matters, this decision was taken solely by the Minister of Health".*

*"At this meeting, 6/6/95, we were only 3, for reasons I can't remember, apart of the short notice given to us. ...* ***The question of the quorum was not raised,*** *as far as I can remember, or was not deemed important enough to prevent us to screen the files,..."*

*" The meeting endorsed the decision taken by the minister<<Provisional registration >> for Dr Thomas Sala. ...* ***But it refused to grant registration under the HPB Act****, until internship would have been completed, end of 1995."*

7.6 **Comments of the Ombudsman:**

According to the above comments by Dr Bador, Dr Sala was granted provisional certificate on 10/01/95 by the Minister of Health and he stated that this is a usual practise. However, their is no provision in Section 7 of the HPB Act for Minister to grant such provincial certificate without the Board's decision.

I also would like to repeat that the provisional certificate being issued to Dr Sala on 10.01.95 and full certificate of registration on 20/04/95 prior to any decision by the Board, the Act was breached.

## 8 *FINDINGS OF WRONGFUL CONDUCT AND DEFECTIVE ADMINISTRATIVE PRACTICES*

**MALADMINISTRATION OF FORMER DIRECTOR OF HEALTH MR YVES NIOWENMAL**

FINDING NO.1 : FAILURE TO PREPARE AND FORMALISE DOCUMENTS FOR THE RECRUITMENT OF A GYNAECOLOGIST/OBSTETRICIAN FOR VCH WHEN FUNDS WERE AVAILABLE

8.1 The Ombudsman finds through this inquiry and other complaints that Mr Niowenmal was incompetent to be Director of Health. He failed to ensure that a specialised G/O was appointed to work in the Hospital, and therefore deprived half of the adult population of proper maternity ward services from the end of 1993 till the end of his appointment in 1996. He failed to honour the official document agreed upon between the British and Vanuatu Governments to submit a formal request, as required, to proceed with recruitment for the G/O position at the Hospital. He is directly responsible of the absence of a G/O in the maternity and prenatal wards, and

for the increase of the percentage of babies dead at birth from 4.2% to 6.2% between 1992 to 1994. The British Government left the offer of G/O open for more than one year, but Mr Niowenmal was not interested and never answered.

FINDING NO.2 : FAILURE TO ORGANISE A SELECTION PANEL TO SELECT INTERESTED APPLICANTS.

8.2 Apparently two applicants who knew about the British offer applied for the job but Mr Niowenmal was also found to have neglected to organise a selection panel to select the successful candidate for recruitment and when funds were already made available. His improper actions then led to the withdrawal of the funds on 01.11.95 by the British Government after the deadline was extended. It was a terrible waste and loss for all the women in Vanuatu. The premature birth and death of the twins can be seen as the indirect result of the poor management and decisions taken by Mr Niowenmal. The increase of deaths at births can only been seen as a result of this maladministration.

FINDING NO.3 : FAILURE TO ASSESS THE IMPORTANCE OF HAVING A G/O IN VANUATU

8.3 It also appears that Mr Niowenmal was unaware of the importance of having a G/O in the Hospital, and thus failed to regard the recruitment of a G/O as an urgent matter. He failed to follow up on the earlier request to recruit Dr Tulimanu temporarily during the lengthy vacancy of this specialist position.

Mr Niowenmal failed to assess that the absense of a G/O at the Hospital might be responsible for the increase of deaths at birth (within 24 hours of birth) from an average of 27 deaths per year (1988 - 1991) to an average of 67 deaths per year (1992 - 1996) at the Vila Hospital.

FINDING NO.4 : FALSE EXCUSE GIVEN FOR FUNDS NOT AVAILABLE LOCALLY

8.4 The response that funds were not available locally for a G/O does not appear to be a proper justification by the Department of Health or the Ministry of Health. It looks more like Mr Niowenmal did not have his priorities straight, considering that in 1995, he ordered and paid for two panel signs for the hospital for a cost of 2.2 million vatu. According to Mr Niowenmal, the reason for this was that it would be "flash". This is the subject of another enquiry.

**MALADMINISTRATION OF THE FORMER ACTING MEDICAL SUPERINTENDENT MR LEN TARIVONDA**

FINDING NO.5 : APPOINTMENT OF A NEWLY QUALIFIED GENERAL DOCTOR, DR SALA, WITH ONLY A TRAINING OF G/P TO BE IN-CHARGE OF THE MATERNITY AND ANTENATAL WARDS.

8.5 The Ombudsman finds that Mr Tarivonda was also incompetent to have held the position of Acting Medical Superintendent of VCH. He failed to ensure that the medical staffing (nurses & doctors) of the Hospital were properly organised so that health services were delivered readily to the general public,

in this case, the antenatal and maternity wards. He overlooked more experienced doctors at the Hospital and assigned responsibility of a G/O to a young and inexperienced doctor, still in internship training. His choice was unfair to Dr Sala as it deprived him of the proper and appropriate evolution of his career by putting him in a position he was not prepared to hold yet.

FINDING NO.6 : IMPROPER MANAGEMENT OF THE HOSPITAL SERVICES

8.6 Mr Tarivonda's management of the Hospital was called into question on certain occasions by some doctors at the Hospital and is the subject of another enquiry. Also, Mr Tarivonda did not ensure that there were enough nurses on duty in the wards, after so many qualified nurses were dismissed by the Government when they took part in the public servants' strike in November 1993. It is quite astonishing to find that Mr Tarivonda regards the shortage of nurses at VCH as not his responsibility when acting medical superintendent of the hospital.

**IMPROPER ACCEPTANCE OF RESPONSIBILITY DOCTOR IN-CHARGE OF THE MATERNITY & ANTENATAL WARDS DR THOMAS SALA**

FINDING NO.7: ADMINISTRATIVE AND PROFESSIONAL ERROR IN ACCEPTING A POSITION WITHOUT QUALIFICATION AND EXPERIENCE.

8.7 The Ombudsman finds that Dr Sala made an administrative and professional error in accepting the responsibility of a G/O at the Hospital while he was still doing his internship training. It appears that his lack of knowledge in Gynaecology and Obstetrics may have contributed directly to the poor organisation of the prenatal and maternity wards. This therefore may have created a situation whereby Nurses BJ and BA did not have a better chance to make a proper examination and diagnosis of Ms Batick during her visits to the Hospital.

FINDING NO.8 : POOR ORGANISATION DUE TO INEXPERIENCE

8.8 It also appears that professionally, Dr Sala was not qualified and experienced enough to be doctor-in-charge of the maternity ward and prenatal clinic. He failed to properly organise weekly and daily clinics so that high risk cases like Ms Batick could receive proper health care for their unborn babies. His non qualification in this field of medicine led to polyhydramnios in Ms Batick going undiagnosed and unsuspected as early as 20 weeks during her pregnancy.

FINDING NO.9 : PROFESSIONAL ERROR AND INSTRUCTION

8.9 The Ombudsman also finds that Dr Sala made a professional error in instructing the nurses by telephone to try to stop labour even though he was aware that, medically, the process of labour could not be stopped when the cervix has dilated beyond 3 cm. He also failed in his duty to attend to Ms Batick when he knew that she and the babies were in danger.

**POOR SUPERVISION GIVEN TO NURSES BJ, BA, TJ AND SM**

FINDING NO.10 : THE ADMINISTRATIVE ERRORS MADE BY THEIR SUPERIORS DO NOT ALLOW THEM TO PROPERLY PERFORM THEIR DUTIES

8.10 The Ombudsman finds that Nurses BJ, BA, TJ and SM were placed in a situation in which the administrative errors made by Mr Niowenmal, Mr Tarivonda and Dr Sala did not allow them to fully provide the proper medical care and advice to Ms Batick in her prenatal months of pregnancy and on 07.02.96 at the maternity ward.

FINDING NO.11 : FAILURE TO INSIST FOR THE DOCTOR TO COME DUE TO SEVERITY OF THE CASE

8.11 The investigations also found that Nurses TJ and SM failed to insist on Dr Sala to come to the ward, as they were well aware that the mother and the infants were in danger. They should have also called Dr Garae to come earlier to the maternity ward.

**THE MEMBERS OF THE HEALTH PRACTITIONERS BOARD DR TAMBISARI MR FANUA & DR BADOR**

FINDING NO.12 : ILLEGAL GRANTING OF PROVISIONAL CERTIFICATE TO DR SALA

8.12 It appears that **Mr Fanua**, the 1st Secretary, breached s3(3) of the HPB Act in granting provisional certificate to Dr Sala under s7. There is no provision under the above section which permits this certificate to be granted without the decision of the Board as specifies in s 3 (3) of the said Act.

FINDING NO.13 : ILLEGAL GRANTING OF FULL REGISTRATION CERTIFICATE TO DR SALA

8.13 The Ombudsman finds that **Dr Tambisari** and **Mr Fanua** misconducted themselves in exercising their powers under the Health Practitioners Act. They acted contrary to s3 (3) of the Act in issuing full registration certificate to Dr Sala to practise medicine and surgery prior to any Health Practitioners Board meeting. The s3 (3) provides that decisions of Health Practitioners Board shall be made by a majority of votes of members. As more experienced leaders, they carry a heavier responsibility. They could have prevented Dr Sala's posting in a job he was not qualified enough and experienced enough to occupy. By appointing and registering Dr Sala, they treated him unfairly, and gave Dr Sala responsibilities he was not experienced and qualified to handle, therefore jeopardising the evolution of his career.

FINDING NO.14 : UNLAWFUL GRANTING OF REGISTRATION CERTIFICATE DURING PERIOD OF INTERNSHIP TRAINING AND BEING SUPERVISED BY UNAUTHORISED SUPERVISION

8.14 **Dr Tambisari** and **Mr Fanua** should not have awarded a full certificate of registration to Dr Sala without having him completed his internship training.

They failed to require him to undergo a proper internship under the recommended supervisor from FSM. Apparently, Dr Garae was supposed to supervise Dr Sala, but he was not able to carry out this extra task for three reasons: (1) Dr Garae was only recommended by FSM to supervise primary care practitioners and not medical students; (2) he had his own responsibilities as a paediatrician at the Hospital and (3) he is not a specialised G/O.

FINDING NO.15 : BREACH OF SECTION 3 (1) OF THE HEALTH PRACTITIONERS BOARD ACT BY **DR TAMBISARI, MR FANUA** AND **DR BADOR**

8.15 The investigation also revealed that Dr Tambisari, Mr Fanua, and Dr Bador acted contrary to section 3(1) of the Health Practitioners Act. They held a meeting of the Health Practitioners Board on 06.06.95 without a quorum. The Act specifies that the Minister (Chairman) and four appointed members shall constitute a quorum. However, on 06.06.95 only three members were present. This therefore appears that all decisions made on 06.06.95 by the 3 board members at the HPB meeting were invalid and void, therefore Dr Sala was unlawfully registered to practise as a doctor in Vanuatu.

FINDING NO.16 : BREACH OF THE LEADERSHIP CODE BY **DR TAMBISARI** AND **MR FANUA**

8.16 It also appears that Dr Tambisari and Mr Fanua abused their office by ignoring the Health Practitioners Board Act in illegally registering Dr Sala to practise and holding a HPB meeting without a quorum. They have disregarded Article 66 (1) of the Constitution in that, they have placed themselves in the "position in which fair exercise of their public or official duties has been compromised". They have also demeaned their position, allowed their integrity to be called into question and endangered the health services of the hospital. In doing so, they have diminished respect and confidence in the integrity of the Government of the Republic of Vanuatu and therefore were in breach of the Leadership Code.

**THE PAEDIATRICIAN AT VCH DR GARAE**

FINDING NO.17 : HE WAS NOT RECOMMENDED BY FIJI SCHOOL OF MEDECINE TO BE SUPERVISOR OF MEDICAL STUDENTS DOING INTERNSHIP IN VANUATU.

8.17 Dr Garae was found not to have been recommended by FSM to officially supervised medical students for internship training in Vanuatu. His recognition as supervisor of Dr Sala at VCH was not proper. He should have refused this responsibility for the reasons mentioned in paragraph 7.13 above.

## 9 *RECOMMENDATIONS*

### 9.1 Urgent need for the recruitment of Gynaecologists/ Obstetricians

It is very unusual and almost uncredible for the Department of Health and the Government to let Vila Central Hospital, the main referral centre in the country operate without a specialised Gynaecologist/Obstetrician for a 4 year period. I therefore call on the Government to take all necessary steps to recruit someone fully qualified for this essential position at the Vila Central Hospital, and for the rest of the country (Santo and the outer islands), and to contact the aid donors to apply for such specialists as a most urgent matter as it appeared that Vanuatu has not yet fully produced a qualified G/O. We understand that there is no qualified ni-Vanuatu for these positions.

### 9.2 Former Director of Health Mr Yves Niowenmal not to be re-appointed to the Director's position again

Because of this case and others still the subject of other enquiries, I recommend that the former Director of Health, Mr Yves Niowenmal not be appointed again to the position of the Director of Health, or any position of public responsibility, as he has shown himself incapable of holding such a post, and such responsibilities for the good of the public.

### 9.3 Former Minister of Health Dr Edward Tambisari and Former Secretary to the Minister of Health Mr Tiro Fanua not to hold position of public responsibility again

Due to the facts and evidence found of the breaches of the law, I recommend that Dr Edward Tambisari and Mr Tiro Fanua are not appointed again to hold any position of public administrative responsibility, as they were shown not to respect the existing laws of Vanuatu and to take decisions that have endangered the lives of their people by appointing a student doctor to be the only gynaecologist obstetrician in the whole country.

### 9.4 Further training for Dr Sala

With Dr Sala being involved in this maladministration case, I therefore recommend that he seeks further training if he wants to be specialised in obstetrics and gynaecology, but that he ceases to accept being put in-charge of the maternity and antenatal wards.

### 9.5 Urgent need to review the Health Practitioners Board Act

With the recent breaches of the Health Practitioners Board Act, I recommend that the Department of Health and the Ministry of Health review certain Sections of this Act and forward to Parliament to make amendments to cater for the increasing numbers of Ni Vanuatu students returning with medical and paramedical qualifications to work in different health professions in Vanuatu.

### 9.6 Decisions by the Board Meeting of 06.06.95 to be considered null and void

I recommend that all decisions of the Health Practitioners Board that convened on 06.06.95 without a quorum be considered null and void.

### 9.7 Recruitment of dismissed qualified and experienced nurses, and especially midwifes

From facts and evidence revealed in this report about the shortage of nurses at Vila Central Hospital since the civil servants' strike, and the fact that effective health services can only be provided by qualified and experienced nurses, I urgently call on the Department and Ministry of Health and the Government to review their recruitment and appoint qualified personnel and reinstate if necessary, many of the dismissed technical health officers for the betterment of health services in this country.

The personnel available in the Maternity Wards should be increased as our report shows that there is insufficient staff to handle the growing numbers of pregnant women and deliveries. This should be considered urgently as lives of mothers and babies are at stake.

### 9.8 Cancellation of care fund for top leaders

We recommend that the Vt 25 million budget for the care of the Ministers, President and family be cancelled and reduced to a minimum and instead invest in the overall improvement of the hospital including the hiring of overseas specialists.

## 10 *CONCLUSION*

In accordance with S23 of the Ombudsman Act No.14 of 1995 and S63(4) of the Constitution, I am forwarding a copy of this report to the President, the Prime Minister, and the relevant public authorities. According to the Constitution their duty is to "decide upon the findings of the Ombudsman within a reasonable time and the decisions, with reasons, shall be given to the complainant forthwith".

I therefore request all the appropriate authorities to decide upon these findings within 21 days upon the date of receipt of this report:

- President of the Republic of Vanuatu
- The Minister of the Ministry of Health
- The Director of the Department of Health
- Public Service Commission.

Dated this 28th day of May 1997.

MARIE-NOËLLE FERRIEUX PATTERSON
**OMBUDSMAN OF THE REPUBLIC OF VANUATU**

REPUBLIC OF VANUATU

OFFICE OF THE OMBUDSMAN

# PUBLIC REPORT

## ON THE

## PREMATURE BIRTH AND DEATH

## OF NEWBORN TWINS

## AT

## VILA CENTRAL HOSPITAL

**28th May 1997**

# ADDENDUM

**THE FOLLOWING CORRECTIONS ARE MADE IN THE REPORT ON THE PREMATURE BIRTH AND DEATH OF NEWBORN TWINS AT THE VILA CENTRAL HOSPITAL**

**IT SHOULD READ AS FOLLOWS :**

| | | |
|---|---|---|
| Page 3 | 3.1 | The scope *of this investigation* and not "of this premiminary report" |
| Page 5 | Chapt 6 | Inclusion of Parag. 6.46 (see below) as an introductory note |
| Page 6 | 6.16 | The Annex C enclosed shows a jump from 22 deaths to 75 *between 1991 and* 1993 |
| Page 12 | 6.46 | This paragraph is shifted to page 5 as a preliminary note in Chapter 6. Findings of Facts |
| | 6.47 becomes 6.46 entitled **Administrative error by former Prime Minister insuccessive reinstatements of M. Y. Niowenmal.** | |
| Page 14 | 7.6 | To grant such *provisional* certificate instead of "provincial certificate" |
| Page 17 | 8.11 | Title is changed to "*Professional error of*" the members of the Health Practitioners Board |

# TABLE OF CONTENTS

## *PREAMBLE*

*"We then that are strong ought to bear the infirmities of the weak, and not to please ourselves"* Romans 15 v 1.

This report is concerned with the operation of the service provided at Vila Central Hospital, where the investigation revealed a shockingly low standard of care and supervision.

Although it is concerned with only one case the conditions which emerged involve the entire operation of hospital services in the capital, and one of our main findings was that there has not been any gynaelogist/obstetrician from 1993 till now despite the offer from the British for no cost for Vanuatu which was repeatedly ignored by the Director of Health.

What furthermore emerged is a dramatic increase of number of deaths at births tripling between 1991 and 1994 and very little improvement till today.

Appointments to senior positions have been made for personal reasons, instead of medical competence and inexperienced persons have been placed in positions of responsibility which are entirely beyond their competence. Not only so, but administrative procedures have been ignored, and offers of outside financial help have been rebuffed, either through laziness or indifference. Large sums of money have been lost to the people of Vanuatu and foolish needless expenditure has been allowed.

While the excuse of "no funds" has been offered it is clear that the lack of personal ethics and a firm grasp of priorities has resulted in the examples given where it was assessed that there was no money available to pay Vt 1.5 million vatu for a Gynaecological/Obstetrician, appointment, for example, while 2.2 million vatu was allocated for a new hospital sign "because it was flash"! At the same time 25 million were budgeted for the overseas care of families of the top leaders including Ministers and President.

A thorough and serious overhaul of the entire provision of hospital services is a matter of the greatest urgency, and it is to be hoped that action will be taken urgently by those with the power and authority to do so.

## 1 *INTRODUCTION*

1.1 A complaint was received from Joe Sarai ("**Mr Sarai**") and Regina Batick ("**Ms Batick**") about the premature birth and death of their newborn twins at Vila Central Hospital ("**the Hospital**") on 07.02.96. They claimed that Ms Batick was not given proper medical care on her visits to the prenatal clinic and at the time of the delivery of the twins, who died in the maternity ward shortly after birth.

1.2 The complaint was directed against:

- Yves Niowenmal, Director of Health ("**Mr Niowenmal**")
- Len Tarivonda, Acting Medical Superintendent ("**Mr Tarivonda**")
- Thomas Sala, maternity ward and prenatal clinic ("**Dr Sala**")
- Staff nurses : BJ, BA, TJ & SM.

1.3 The investigation revealed serious problems in the prenatal clinic and maternity ward. These problems increased the risk of getting poor medical treatment. Ms Batick suffered poor medical care. This was the responsibility of Dr Sala and the staff nurses, and indirectly to the incompetent administration of Mr Tarivonda in the Hospital and Mr Niowenmal in the Department of Health.

She suffered polyhydramnios which is likely to have been the cause of pregnancy not reaching its full term, and her condition was only diagnosed when it was too late and she never got any special or specialised care during the term of her pregnancy. Polyhydramnios is a medical term used for excessive amniotic fluid in the uterus during pregnancy.

1.4 There has been no gynaecologist/obstetrician ("**G/O**") at the Hospital since Mr M. Panos ("**Dr Panos**") left at the end of his contract with the Government of Vanuatu from the end of **December 1993 till today in May 1997**. From 1994 to 1996, when the Department of Health was unable to come up with approximately 1.5 million vatu per annum to recruit a G/O on local contract for the Hospital, the Council of Ministers approved a budget of 25 million vatu over the same three-year period for the overseas medical treatment of Government Ministers and their families.

In 1994, two G/Os applied to the Department of Health for the position. One applicant already lived in Port Vila and was working as a private medical practitioner. However, there is no evidence that the applications were ever processed by Mr Niowenmal for recruitment. The Hospital is still operating without a qualified G/O.

1.5 The investigation revealed that in 1994, the British Government had offered to fund the G/O position at the Hospital for a three year period. The Prime Minister, Maxime Carlot Korman ("**Mr Korman**") approved the offer on 14.07.94. The offer was in the form of a project document for medical staffing. However, Mr Niowenmal failed to formalise and implement the project (i.e he did not sign the project forms). The British Government, after holding many discussions and meetings with the National Planning Office and the Department of Health, withdrew the offer on 30.11.95. Therefore it appears that Mr Niowenmal is directly to be blamed for the withdrawal of the funds offered to finance this vital G/O position at the Hospital, and for the absence of G/O from at least mid 1994.

1.6 The investigation also revealed that Dr Sala had no qualification or experience in Gynaecology and Obstetrics. He graduated as a general doctor in December 1994 and was to work under supervision for 12 months. However in August 1995, when he was still supposed to be doing supervised internship training, he was put in charge of the maternity ward and prenatal

clinic by Mr Tarivonda, the then Acting Medical Superintendent. Moreover on 20.04.95, Dr Sala was wrongly granted the full certificate of registration to practise medicine in Vanuatu by the Chairman of the Health Practitioners Board (**"HPB"**), Edward Tambisari (**"Dr Tambisari"**). The granting of this certificate was in breach of the Health Practitioners Board Act (**"HPB Act"**). Dr Sala's lack of knowledge and experience in Gynaecology and Obstetrics may have contributed directly to this case as Ms Batick's visits to the prenatal clinic were made during the same period that he was head of the prenatal clinic and maternity ward.

1.7 Expert opinion was sought from Sue Belgrave (**"Dr Belgrave"**), a consultant G/O at the National Women's Hospital in Auckland, New Zealand. According to her, the twins had little chance of surviving once the process of birth had started.

1.8 However, this investigation has uncovered a great deal of maladministration by several leaders in this country. Their improper actions and administrative errors appear to have indirectly contributed to the premature birth and death of the newborn twins on 07.02.96, and to the maladministration in the maternity ward and the hospital since 1993, aggravated by the dismissal of competent mid-wives during the strike of 1993.

## 2 *JURISDICTION*

2.1 Pursuant to article 62 of the Constitution and section 14 of the Ombudsman Act No. 14 of 1995, the Ombudsman has jurisdiction to enquire into the conduct of certain public bodies or persons on receiving a complaint or on the Ombudsman's own initiative. Mr Sarai and Ms Batick's complaint against the Hospital administrators, doctor and nursing staff falls within the Ombudsman's jurisdiction, because they are all employees of the Hospital, which answers to the Department of Health.

## 3 *SCOPE OF INVESTIGATION*

3.1 The scope of this preliminary report is to enquire:

(a) Why Mr Niowenmal did not carry out his responsibility to liaise with appropriate authorities and donor agencies, as a matter of urgency, to recruit a G/O for the country's main referral hospital, and why did he not sign the project document between July 1994 and November 1995, which would have brought a British G/O into the country, at no cost to Vanuatu.

(b) Why Mr Tarivonda assigned the responsibilities of a G/O head of prenatal clinic and maternity ward to a newly graduated general doctor, Dr Sala?

(c) Why Dr Tambisari decided to grant a full certificate of registration to Dr Sala without a decision of the Health Practitioners Board, and why he allowed a meeting of the Health Practitioners Board to convene on 06.06.95 without a quorum?

(d) Whether the staff nurses carried out their responsibilities and whether it was within their ability to deal with the situation?

(e) Why Ms Batick was unable to get proper medical care for herself and her infants?

## 4 *METHOD OF INVESTIGATION*

4.1 Under art 62 (3) of the Constitution, and s 17 (2) of the Ombudsman Act No. 14 of 1995, the Ombudsman is empowered to request any person or organisation likely to assist in providing the information and documents for the enquiry. Based on these powers, information and documents were obtained from the following health institutions and officers:

- Department of Health
- Mr Edwin Tari ("**Mr Tari**"), Acting Medical Superintendent
  Staff Nurse BJM
- Staff Nurse BJ
- Staff Nurse BA
- Staff Nurse TL
- Staff Nurse SM
- Staff Nurse TJ
- Dr Sala
- Mr Sarai
- Ms Batick
- Agnes Thouvenin **(Dr Thouvenin)** private medical practitioner, New Caledonia
- Dr Belgrave

## 5 *COMMENTS BY THOSE AFFECTED BY THE PRELIMINARY REPORT*

5.1 Under s16(4) of the Ombudsman Act No.14 of 1995, preliminary reports were sent on 27.01.97 to those being affected by the report to give them opportunity to make their comments and replies to allegations made against them. The preliminary reports were therefore sent to the following persons:

- Mr Niowenmal
- Mr Fanua
- Dr Sala **
- Dr Tambisari
- Dr Bador **
- Mr Tarivonda **

5.2 Only the people with an "** marked" answered to our report. The others did not reply including Mr Niowenmal and Dr Tambisari, the former Minister of Health and now Acting Medical Superintendent of the Hospital.

5.3 The replies received from Dr Sala, Mr Tarivonda and Dr Bador are attached as appendices to this report. Extracts of the comments from their replies on this case have been commented on by the Ombudsman later on in this report.

## 6 *FINDINGS OF FACTS*

6.1 Ms Batick made six visits to the prenatal clinic from 26.09.95 to 07.02.96 when she gave birth at the Hospital. On the first three visits, Nurse BJ diagnosed her as normal, but on the fourth visit, recommended a scan due to a sudden increase in the size of her abdomen (Appendix A).

6.2 The ultra sound test carried out on Ms Batick by the Radiographer, Mr MB on 18.12.95 on her fourth visit confirmed that they were twins and both twins were alive. Their foetal hearts were beating normally and the amniotic fluid level was normal at that time.

6.3 Nurse BJ said that an average of 40 to 50 mothers visit the clinic every day and only two nurses are assigned to consult them. Ms Batick therefore spent only five or six minutes with a nurse on each visit. In Dr Belgrave's view, the prenatal clinic was understaffed—a routine check could be done in 5 minutes, but would leave no time for discussion or education.

6.4 Nurse BJ also said that in the past, when there was a G/O at the Hospital, expecting mothers came to see the G/O on Monday and Tuesday afternoons. When Ms Batick made her visits to the prenatal clinic, there was no G/O, and consultations with Dr Sala occurred only on Monday afternoons. Ms Batick saw neither Dr Sala nor a G/O during her entire pregnancy.

6.5 Ms Batick started feeling tired near the end of December 1995. Discomfort, severe tiredness, mild contractions, and minor backaches soon followed. According to Dr Belgrave, although these were some of the symptoms of polyhydramnios, they were not specific and are common symptoms in pregnancy. Ms Batick reported these feelings on her last two visits to the clinic, but nothing was done.

6.6 On 05.02.96 at about 6 or 7 p.m., Ms Batick went to the outpatient clinic complaining of discomfort, tiredness, and backache. After a brief examination, Nurse BA prescribed 4 panadol tablets and sent her home. In Dr Belgrave's view, even if the diagnosis of polyhydramnios had been made by this date, the labour and delivery may still have occurred, but she could have been treated for her condition increasing her chances to deliver her twins close to the due date.

6.7 On 07.02.96, Ms Batick went into the maternity ward at about 6 or 6:30 p.m with the same complaint. She was admitted on arrival by Nurses SM and TJ. A routine check revealed that she was in moderate labour and that her cervix was already 5 cm dilated. She was diagnosed with twin pregnancy.

6.8 At 6:35 p.m, Nurse SM telephoned Dr Sala about their findings. He instructed her to scan urgently to see the parts presenting, and to try to stop labour by giving ventolin to the patient. However, Dr Sala stated in an interview with the Ombudsman that he knew that once the cervix had dilated more than 3 cm, the labour process could not be stopped.

6.9 Nurse TJ prescribed 4 mgr of ventolin to Ms Batick between 6:40 and 6:50 p.m to try to stop labour. The nurses too knew it would not work because ventolin is proven medically not to have any effect at such an advanced stage of labour. It did not work and the membranes ruptured at 6:54 p.m, discharging clear liquid.

6.10 Dr Sala was aware, after being told by Nurse SM, that the mother was in danger of losing the babies. Yet Nurse SM did not ask him to come, and he did not come. This is most surprising, given that both knew the danger. Indeed, Dr Sala in his evidence before the Ombudsman agreed that he was aware of the danger at the time.

6.11 A scan carried out by Mr MB at 7 p.m. confirmed twin pregnancy, polyhydramnios and the presenting parts as oblique and transverse. Both foetal heart beats were normal (Appendix B).

6.12 According to Nurses TJ and SM, the scan was not done urgently as instructed by Dr Sala. This is because only Mr MB was authorised to operate the machine, and they had to look for him for about 25 minutes.

6.13 The first twin went through a normal vertex delivery at 7:52 p.m. He was a male infant weighing 700 g. He was transferred to the incubator but died at 12:15 p.m. The second twin went through a breech delivery at 9:50 p.m. The infant was a male weighing 600 g. He was also transferred to the incubator but had only gasping respiration. The second infant died at 1:00 p.m (Appendix B).

6.14 Dr Edward Tambisari's Medical Report (acting then as doctor in the hospital) on the case in his letter to the Ombudsman on 23.05.96 stated that *"an urgent scan done at 7.30 p.m revealed polyhydramnios and twin pregnancy"* and, *"pregnancy had not reached full term. The infants were not mature and hence their lungs would not have been able to sustain normal respiration."* (Appendix B)

6.15 Nurses TJ and SM stated that there were two other deliveries on that particular evening, with only the two of them on duty in the maternity ward. They indicated that they needed help but there were not enough nurses working. The procedure in the maternity ward of having only one midwife and one registered nurse working on a night shift has been an on-going practice. The same procedure was still in use when Ms Batick was admitted to the maternity ward.

6.16 The Hospital's maternity ward statistics showed that 285 infants died within 24 hours after birth from the total of 4598 registered births between 1994 and 1996, when there was no G/O and fewer qualified midwives (due to the dismissal of strikers) in 1993.

The contribution of the strike and the dismisal of qualified midwives and nurses in the maternity ward has caused a great increase in the number of deaths of babies at birth. The Annex C enclosed shows a jump from 22 deaths to 75 deaths in 1993 for a similar number of births. In fact the number

of deaths doubled after the strike and tripled the following year and has remained at a high level never known in the years 1985 to 1991 because of the departure of the G/O in 1993 and his non-replacement, and before the strike.

| Year | Number of deaths of babies at birth | Total number of births | % of number of deaths |
|---|---|---|---|
| 1988 | 29 | 1286 | 2.2% |
| 1989 | 29 | 1261 | 2.2% |
| 1990 | 29 | 1350 | 2.1% |
| 1991 | 22 | 1482 | 1.4% |
| 1992 | 50 | 1456 | 3.4% |
| 1993 | 75 | 1489 | 5.0% |
| 1994 | 85 | 1546 | 5.5% |
| 1995 | 56 | 1527 | 3.6% |
| 1996 | 67 | 1526 | 4.4% |

In this case the maternity ward has never regained the standard that it had before from 1988 to 1991.

Other mothers have had experiences similar to Ms Batick's resulting in the loss of their infants. (see appendix C)

6.17 Nurse TJ telephoned the paediatrician, Hensly Garae ("**Dr Garae**"), at 10:45 p.m. to ask him to come to the maternity ward to explain the twins' condition to the parents. The nurses may have decided not to contact Dr Sala again as in the first place he did not come to assist them.

OBSTETRICAL INFORMATION FROM EXPERT SOURCES

The following expert information provided facts and evidence that may have contributed to the preterm labour, delivery and death of the twins on 07.02.96.

6.18 According to Dr Belgrave, it is usual practice for women carrying twins to be referred to an Obstetrician for prenatal care and delivery. However, Ms Batick in 31 weeks of pregnancy was never referred to a G/O.

6.19 Dr Belgrave stated that preterm labour is a complication of twin pregnancy and that the risk is further increased if polyhydramnios is present. Ms Batick was unfortunate not to have been diagnosed with polyhydramnios and not to have been referred to an experienced doctor. When it was discovered it was too late.

6.20 During an interview with the Ombudsman, Dr Sala stated that one cause of preterm labour is called cervical incompetence—for some unknown reason, the cervix opens up, usually during the second trimester of pregnancy (13 to 27 weeks). However, there is no evidence of cervical incompetence in Ms Batick's case.

6.21 Dr Belgrave went on to say that polyhydramnios is mainly suspected when there is a sudden increase in the size of the mother's abdomen, abdominal discomfort, and difficulty in feeling foetal parts. It can be diagnosed from about 20 weeks of pregnancy. The diagnosis is confirmed by ultrasound.

6.22 In Ms Batick's case, it appears from the above facts that polyhydramnios should have been suspected and diagnosed at around 20 weeks of her pregnancy. The signs and symptoms were noticeable then: she was diagnosed with a sudden increase in the size of her abdomen and was continuously complaining of abdominal discomfort. However, due to a lack of professional and technical knowledge and experience on the part of Staff Nurses BA and BJ and of Dr Sala, and in the absence of a G/O, polyhydramnios was never diagnosed or even suspected.

6.23 Dr Belgrave also stated that, polyhydramnios can occur for a number of reasons including twin-to-twin transfusion. This can happen in the case of monozygotic (identical) twins, gestational diabetes, or foetal abnormality. Ms Batick's twins were identical. The preterm labour and delivery of Ms Batick's twins may be assumed to have been mainly caused by the twins being identical.

6.24 In an interview with Dr Sala, he stated the lungs of twins were not mature. There is a substance in the lungs of infants called surfactant which lines the air bags of the lungs. When an infant is born before this substance is present in the lungs, he or she cannot survive. The twins were born prematurely with foetal lungs not mature.

6.25 Dr Belgrave went on to explain that a drug such as salbutamol can delay delivery long enough for steroids to be administered to reduce the incidence of hyaline membrane disease caused by lack of surfactant in premature infants. This could also buy time for a mother's transfer to a hospital with intensive care facilities for newborns.

6.26 Dr Belgrave also said that Ms Batick's preterm labour and delivery would have been easier to delay if treatment had started before the cervix dilated more than 3 cm. However, there is no evidence that labour could have been prevented on 07.02.96.

6.27 **In summary, preterm labour and delivery could only have been prevented if polyhydramnios had been identified and treated earlier**. The only hope for the twins to survive would have been for Ms Batick to have travelled out of Vanuatu to a centre with neonatal intensive care facilities.

6.28 Dr Belgrave added that the babies would not have survived at the weights of 600 and 700 g. These weights suggest that the pregnancy was either much earlier than 31 weeks gestation or that there was severe intrauterine growth retardation. Normal birth weight for a baby at 31 weeks gestation is more than double the twins' weights. Therefore, it is likely that there was intrauterine growth retardation given the weights of the babies and the fact that the mother had had an earlier scan.

6.29 Dr Thouvenin suggested that periodic vaginal examinations during pregnancy might have revealed an abnormality of the cervix and a risk of premature delivery. Strict rest in supine position together with appropriate medication might have prevented the evolution towards premature delivery. Also, hospitalisation from as early as 05.02.96 with perfusion of salbutamol would have been in order. This type of examination is usually done by a G/O.

6.30 In response to the preliminary report, Dr Belgrave added that, *"it is important to realise that even if the polyhydraminios had been suspected and labour diagnosed earlier, the outcome would probably have been the same. This is true even if you had an obstetrician in Port Vila, as you don't have the facilities for neonatal intensive care. Unfortunately, we cannot prevent preterm labour. The vast improvement in the outcome of preterm infants has come from the Neonatologists and their intensive care facilities rather than the Obstetricians."*

MALADMINISTRATION

This investigation also revealed that a number of administrative errors made by certain leaders and officers have contributed indirectly to this complaint.

6.31 **No Gynaecologist/Obstetrician from December 1993 until March 1997**

From records obtained from the Hospital and the Department of Health through interviews and documents, the G/O position at the Hospital was left vacant in December 1993, when Dr Panos left at the end of his contract. Former Director of Health, Dr George Bule, made a request on 13.10.93 to the Public Service Department to consider employing Dr Kaiva Tulimanu (**"Dr Tulimanu"**), a private medical practitioner already in Vila, on temporary basis as a matter of urgency until a new G/O was recruited. The Public Service Department did not formalise this request.

6.32 **Applications for G/Os not dealt with**

Two other applications from qualified G/Os were received by Hospital management, who passed these applications to Mr Niowenmal in 1994 and 1995. However, there are no documents from the National Planning Office or the Public Service Department concerning the two applicants for the vacant position to show that Mr Niowenmal followed them up.

6.33 **British project to finance a G/O approved by former Prime Minister**

The National Planning Office and AID Management Office of the British High Commission were liaising with the Department of Health and the Public Service Department for the recruitment and funding of G/O for the Hospital since July 1994. This followed a project memorandum for medical staffing support between the governments of the United Kingdom and Vanuatu. The project document was sent on 21.03.94 to the Prime Minister, Mr Korman, who approved it for implementation on 14.07.94.

6.34 **Mr Niowenmal destroyed the project of bringing a gynaecologist for 3 years by not signing the application form**

According to documents from the AID Management Office, the offer of funding for a G/O at the Hospital was on the table for more than 12 months. The offer originally was to expire by 31.03.95, but the British Government extended the deadline to 01.11.95. Although the National Planning and AID Management Offices tried hard to help the Health Department to fill the G/O position, **Mr Niowenmal did nothing, resulting in the withdrawal of the funds budgetted for the position on 30.10.95.**

6.35 **The Ombudsman enquired into why the position of G/O had been vacant for a long time**

In August 1996, the Ombudsman wrote to the former Minister of Health, Cyriaque Metmetsan (**"Mr Metmetsan"**), Mr Niowenmal, and Mr Tari, asking them why the position had not been filled and what progress had been made so far in getting a G/O recruited for the position.

6.36 **Former Minister of Health responds that there is no funding**

Mr Metmetsan in his reply in August 1996, informed the Ombudsman that the position should have been filled at the beginning of 1996. He stated that it was because of budget constraints faced by the Health Department that the position was not filled. The matter of the G/O position is the subject of another enquiry. As a related matter, there was no problem for Mr Niowenmal to find 2.2 million vatu in 1995 to pay for some signs to decorate the Hospital, which is also the subject of another enquiry.

6.37 **Request for Private Practitioner to work temporarily as G/O for VCH**

On 21.10.96, the then acting Director of Health, Morrison Bule, wrote to Dr Tulimanu and asked him to work temporarily for two days per week as a G/O. This was to solve the problem of the delayed recruitment of a G/O, as a matter of urgency. There is no evidence that Dr Tulimanu accepted the offer.

6.38 **Appointment of a young graduate General Practitioner as G/O**

Mr Tarivonda, as Acting Medical Superintendent appointed Dr Sala in August 1995, to be in-charge temporarily for 3 months whilst doing his internship training. Dr Sala graduated as a general doctor in December 1994 and was working under supervision in internship when he was appointed to look after the maternity and antenatal wards. In an interview with the Ombudsman, he stated that he had an interest in Gynaecology and Obstetrics, but had not get any specialised training in this field of medicine.

6.39 **Young graduate doctor has not done his medical internship training**

Dr David Philips, the Senior Clinical Tutor at Fiji School of Medicine **("FSM"),** informed the Ombudsman that under the medical training rules Dr Sala should work under supervision for one year. He could do his one year

internship in Vanuatu provided it was within the requirements of the law of Vanuatu. Section 5 (a) of the Health Practitioners Act provides for a person wanting to practise medicine in Vanuatu must be entitled to practise medicine in the country in which the degree was granted. In this case, according to the Vanuatu law, Dr Sala should have done his internship in Fiji and be registered with the Fiji Medical Board before he could be allowed to register and practise in Vanuatu.

6.40 **Appointment of doctor to supervise young graduate doctor for internship training not in line with proper procedures.**

Dr Philips also mentioned that Dr Sala could do his internship in Vanuatu provided he was supervised by officers who were recommended by the FSM. According to official records, there are no official supervisors recommended by FSM for medical students to do internships in Vanuatu. In 1993, FSM issued certificates to Dr Timothy Vocor, Dr Garae and Mr Elison S. Bovu, recommending them to be official supervisors of primary care practitioners and paramedical students doing internship training in Vanuatu but not medical students.

6.41 **Young G/P acting as G/O has never been supervised by any specialised G/O**

It was revealed in my investigations that Dr Sala was never supervised by any recommended or appropriate supervisor. Although he is now working in the maternity and antenatal wards, he had never been supervised by a specialised G/O to work in the wards since his appointment, and during our enquiry.

6.42 **Illegal full registration as doctor granted to young doctor in internship**

The investigation also revealed that Dr Sala was illegally granted a provisional certificate on 10.01.95 and a full registration certificate on 20.04.95 to practise in Vanuatu before any meetings of the Health Practitioners Board. The full certificate (Appendix "H") and approval letter of provisional registration (Appendix "I") was signed and issued by Dr Tambisari and Mr Tiro Fanua **("Mr Fanua")** who was the Secretary to the Board. However, section 3(3) of the Health Practitioners Act provides that the decisions of the Health Practitioners Board shall be made by a majority of votes of members present at the meeting. Therefore the decisions to grant provisional and full registration to practise as a doctor are void and invalid.

6.43 **Meeting of Health Practitioners Board did not have quorum**

My investigation too found that the Health Practitioners Board meeting held on 06.06.95 (see Appendix "D") and attended only by Dr Tambisari, Dr Jean Luc Bador ("**Dr Bador**") and Mr Fanua lacked a quorum. The Act provides that the Chairman and four appointed members shall constitute a quorum.

6.44 **Denial by a HPB member of decision to grant registration to new graduate doctor**

In his reply to my preliminary report, Dr Bador said that during this Board meeting, they did not agree to grant Dr Sala the registration certificate.

6.45 **Illegal appointment to the position of G/O at VCH by Acting Medical Superintendent**

On 02.08.96, in an interview with the Ombudsman, Dr Sala stated that whilst doing his internship training at VCH, he was appointed by Mr Tarivonda to be in charge of the prenatal and maternity ward in August 1995. He stated that he had only an interest in Obstetrics and because there was no G/O at the Hospital, he was appointed as first-on-call doctor for the two sections. It was during this period, from August 1995 to 07.02.96, that Ms Batick paid six visits to the prenatal clinic leading up to the premature birth and death of the twins on 07.02.96.

6.46 **The complainant's personal information**

Ms Batick is a mother of 22 years old. Her last monthly period was recorded to have been on 7.07.95. This is her first pregnancy with no records of miscarriages or history of medical diseases that she might have suffered before this pregnancy. Her pregnancy with the twins did not reach full term and she had a polyhydramnios condition confirmed by Dr Tambisari which was not discovered during her pregnancy.

6.47 Successive re-instatements of Yves Niowenmal by former Prime Minister Maxime Carlot Korman, even though he was suspended repeatedly by different successive Ministers of Health for his misconduct and incompetence. This matter is the subject of another enquiry.

## 7 *REVIEW OF THE REPLIES TO THE PRELIMINARY REPORT*

7.1 In his reply to my preliminary report, Dr Sala made the following comments (see Appendix "E"):

> ***I was never assigned by Mr Tarivonda to head the Maternity Ward and the Antenatal Clinic.***
> *I stated in the interview that I am only doing first on-call.* ***This was made official in the memorandum by Dr Garae on 20.03.96.*** *The second on-call were to be Drs Leveque, Fei, Garae, and Mcnamara*
>
> *I have three clinics every week, Monday afternoons for antenatal high risk cases, Wednesday afternoons is for gynaecology and follow-up clinic and Tuesdays is antenatal booking clinic which I help out when I am not busy.* ***High risk cases are referred to me by the antenatal nurses.*** *It is impossible for me to see every single pregnant women who visit Vila Central Hospital.*

7.2 **Comments of the Ombudsman**

Dr Sala argued that he was not appointed to be in-charge of the maternity and antenatal wards. But this statement contradicts the duties he was fulfilling in the two wards as mentioned by him above in the second paragraph. It, in fact, appears that the duties he has been performing in the maternity and antenatal wards belong to a G/O in-charge of these two wards.

7.3 **Mr Tarivonda** made the following comments to the Preliminary Report (see Appendix "F"):

> ***I appoint Dr Sala on a temporary basis*** *and on the advice of Dr Garae his supervisor. In 1995 Dr Sala was doing his internship and he was required to do Obs and Gynae for 3 months under supervision. Since there was no G/O at VCH, Dr Garae advised me to do a memo and inform the relevant sections of the hospital that Dr Sala would look after Maternity and Antenatal for 3 months and that he would be first on call for those wards.*
>
> *Dr Sala did not understand his limitations in the field of Obs and Gynae.* ***Many occasions he failed to call for help when he should****; these culminated in the problem you're investigating.*
>
> *I was only in the medical superintendent's office for 3 months when all this problem happened. The hospital was without a G/O for a long time and even I submitted requests for a G/O to the Department of Health. The civil servants strike also took its toll on the VCH workforce and you know that.* ***There is never enough nurses at VCH. Also the business of nurses is the matron's responsibility, not mine as the Med Sup.***

7.4 **Comments of the Ombudsman**

Mr Tarivonda confirmed above that he appointed Dr Sala only on temporary basis for 3 months in 1995. It would now probably appear that Dr Sala remained on the job upon receiving the above appointment which was only to last on a temporary basis for 3 months as from August 1995.

Mr Tarivonda claimed that Dr Sala did not understand his limitations and did not seek advice when supervising the two wards. This might explain why he did not attend Ms Batick's case on 07.02.96, when he was phoned and given the details of the case (see Annex "B").

It is quite astonishing to learn from Mr Tarivonda that as Chief Administrator of the hospital, he did not concern himself with the problem of shortage of nurses for the hospital but left it as the matron's responsibility.

7.5 In **Dr Bador's** response to my preliminary report (see Appendix "G"), the following information was stated:

*" Concerning Thomas Sala, there was a letter stating that* ***provisional*** *registration* ***for 6 months*** *was given, dated 10/1/95, signed Tiro Fanua."*

*"As usual in these matters, this decision was taken solely by the Minister of Health".*

*"At this meeting, 6/6/95, we were only 3, for reasons I can't remember, apart of the short notice given to us. ...* ***The question of the quorum was not raised,*** *as far as I can remember, or was not deemed important enough to prevent us to screen the files,..."*

*" The meeting endorsed the decision taken by the minister<<Provisional registration >> for Dr Thomas Sala. ...* ***But it refused to grant registration under the HPB Act****, until internship would have been completed, end of 1995."*

7.6 **Comments of the Ombudsman:**

According to the above comments by Dr Bador, Dr Sala was granted provisional certificate on 10/01/95 by the Minister of Health and he stated that this is a usual practise. However, their is no provision in Section 7 of the HPB Act for Minister to grant such provincial certificate without the Board's decision.

I also would like to repeat that the provisional certificate being issued to Dr Sala on 10.01.95 and full certificate of registration on 20/04/95 prior to any decision by the Board, the Act was breached.

## 8 *FINDINGS OF WRONGFUL CONDUCT AND DEFECTIVE ADMINISTRATIVE PRACTICES*

**MALADMINISTRATION OF FORMER DIRECTOR OF HEALTH MR YVES NIOWENMAL**

FINDING NO.1 : FAILURE TO PREPARE AND FORMALISE DOCUMENTS FOR THE RECRUITMENT OF A GYNAECOLOGIST/OBSTETRICIAN FOR VCH WHEN FUNDS WERE AVAILABLE

8.1 The Ombudsman finds through this inquiry and other complaints that Mr Niowenmal was incompetent to be Director of Health. He failed to ensure that a specialised G/O was appointed to work in the Hospital, and therefore deprived half of the adult population of proper maternity ward services from the end of 1993 till the end of his appointment in 1996. He failed to honour the official document agreed upon between the British and Vanuatu Governments to submit a formal request, as required, to proceed with recruitment for the G/O position at the Hospital. He is directly responsible of the absence of a G/O in the maternity and prenatal wards, and

for the increase of the percentage of babies dead at birth from 4.2% to 6.2% between 1992 to 1994. The British Government left the offer of G/O open for more than one year, but Mr Niowenmal was not interested and never answered.

FINDING NO.2 : FAILURE TO ORGANISE A SELECTION PANEL TO SELECT INTERESTED APPLICANTS.

8.2 Apparently two applicants who knew about the British offer applied for the job but Mr Niowenmal was also found to have neglected to organise a selection panel to select the successful candidate for recruitment and when funds were already made available. His improper actions then led to the withdrawal of the funds on 01.11.95 by the British Government after the deadline was extended. It was a terrible waste and loss for all the women in Vanuatu. The premature birth and death of the twins can be seen as the indirect result of the poor management and decisions taken by Mr Niowenmal. The increase of deaths at births can only been seen as a result of this maladministration.

FINDING NO.3 : FAILURE TO ASSESS THE IMPORTANCE OF HAVING A G/O IN VANUATU

8.3 It also appears that Mr Niowenmal was unaware of the importance of having a G/O in the Hospital, and thus failed to regard the recruitment of a G/O as an urgent matter. He failed to follow up on the earlier request to recruit Dr Tulimanu temporarily during the lengthy vacancy of this specialist position.

Mr Niowenmal failed to assess that the absense of a G/O at the Hospital might be responsible for the increase of deaths at birth (within 24 hours of birth) from an average of 27 deaths per year (1988 - 1991) to an average of 67 deaths per year (1992 - 1996) at the Vila Hospital.

FINDING NO.4 : FALSE EXCUSE GIVEN FOR FUNDS NOT AVAILABLE LOCALLY

8.4 The response that funds were not available locally for a G/O does not appear to be a proper justification by the Department of Health or the Ministry of Health. It looks more like Mr Niowenmal did not have his priorities straight, considering that in 1995, he ordered and paid for two panel signs for the hospital for a cost of 2.2 million vatu. According to Mr Niowenmal, the reason for this was that it would be "flash". This is the subject of another enquiry.

**MALADMINISTRATION OF THE FORMER ACTING MEDICAL SUPERINTENDENT MR LEN TARIVONDA**

FINDING NO.5 : APPOINTMENT OF A NEWLY QUALIFIED GENERAL DOCTOR, DR SALA, WITH ONLY A TRAINING OF G/P TO BE IN-CHARGE OF THE MATERNITY AND ANTENATAL WARDS.

8.5 The Ombudsman finds that Mr Tarivonda was also incompetent to have held the position of Acting Medical Superintendent of VCH. He failed to ensure that the medical staffing (nurses & doctors) of the Hospital were properly organised so that health services were delivered readily to the general public,

in this case, the antenatal and maternity wards. He overlooked more experienced doctors at the Hospital and assigned responsibility of a G/O to a young and inexperienced doctor, still in internship training. His choice was unfair to Dr Sala as it deprived him of the proper and appropriate evolution of his career by putting him in a position he was not prepared to hold yet.

FINDING NO.6 : IMPROPER MANAGEMENT OF THE HOSPITAL SERVICES

8.6 Mr Tarivonda's management of the Hospital was called into question on certain occasions by some doctors at the Hospital and is the subject of another enquiry. Also, Mr Tarivonda did not ensure that there were enough nurses on duty in the wards, after so many qualified nurses were dismissed by the Government when they took part in the public servants' strike in November 1993. It is quite astonishing to find that Mr Tarivonda regards the shortage of nurses at VCH as not his responsibility when acting medical superintendent of the hospital.

**IMPROPER ACCEPTANCE OF RESPONSIBILITY DOCTOR IN-CHARGE OF THE MATERNITY & ANTENATAL WARDS DR THOMAS SALA**

FINDING NO.7: ADMINISTRATIVE AND PROFESSIONAL ERROR IN ACCEPTING A POSITION WITHOUT QUALIFICATION AND EXPERIENCE.

8.7 The Ombudsman finds that Dr Sala made an administrative and professional error in accepting the responsibility of a G/O at the Hospital while he was still doing his internship training. It appears that his lack of knowledge in Gynaecology and Obstetrics may have contributed directly to the poor organisation of the prenatal and maternity wards. This therefore may have created a situation whereby Nurses BJ and BA did not have a better chance to make a proper examination and diagnosis of Ms Batick during her visits to the Hospital.

FINDING NO.8 : POOR ORGANISATION DUE TO INEXPERIENCE

8.8 It also appears that professionally, Dr Sala was not qualified and experienced enough to be doctor-in-charge of the maternity ward and prenatal clinic. He failed to properly organise weekly and daily clinics so that high risk cases like Ms Batick could receive proper health care for their unborn babies. His non qualification in this field of medicine led to polyhydramnios in Ms Batick going undiagnosed and unsuspected as early as 20 weeks during her pregnancy.

FINDING NO.9 : PROFESSIONAL ERROR AND INSTRUCTION

8.9 The Ombudsman also finds that Dr Sala made a professional error in instructing the nurses by telephone to try to stop labour even though he was aware that, medically, the process of labour could not be stopped when the cervix has dilated beyond 3 cm. He also failed in his duty to attend to Ms Batick when he knew that she and the babies were in danger.

**POOR SUPERVISION GIVEN TO NURSES BJ, BA, TJ AND SM**

FINDING NO.10 : THE ADMINISTRATIVE ERRORS MADE BY THEIR SUPERIORS DO NOT ALLOW THEM TO PROPERLY PERFORM THEIR DUTIES

8.10 The Ombudsman finds that Nurses BJ, BA, TJ and SM were placed in a situation in which the administrative errors made by Mr Niowenmal, Mr Tarivonda and Dr Sala did not allow them to fully provide the proper medical care and advice to Ms Batick in her prenatal months of pregnancy and on 07.02.96 at the maternity ward.

FINDING NO.11 : FAILURE TO INSIST FOR THE DOCTOR TO COME DUE TO SEVERITY OF THE CASE

8.11 The investigations also found that Nurses TJ and SM failed to insist on Dr Sala to come to the ward, as they were well aware that the mother and the infants were in danger. They should have also called Dr Garae to come earlier to the maternity ward.

**THE MEMBERS OF THE HEALTH PRACTITIONERS BOARD DR TAMBISARI MR FANUA & DR BADOR**

FINDING NO.12 : ILLEGAL GRANTING OF PROVISIONAL CERTIFICATE TO DR SALA

8.12 It appears that **Mr Fanua**, the 1st Secretary, breached s3(3) of the HPB Act in granting provisional certificate to Dr Sala under s7. There is no provision under the above section which permits this certificate to be granted without the decision of the Board as specifies in s 3 (3) of the said Act.

FINDING NO.13 : ILLEGAL GRANTING OF FULL REGISTRATION CERTIFICATE TO DR SALA

8.13 The Ombudsman finds that **Dr Tambisari** and **Mr Fanua** misconducted themselves in exercising their powers under the Health Practitioners Act. They acted contrary to s3 (3) of the Act in issuing full registration certificate to Dr Sala to practise medicine and surgery prior to any Health Practitioners Board meeting. The s3 (3) provides that decisions of Health Practitioners Board shall be made by a majority of votes of members. As more experienced leaders, they carry a heavier responsibility. They could have prevented Dr Sala's posting in a job he was not qualified enough and experienced enough to occupy. By appointing and registering Dr Sala, they treated him unfairly, and gave Dr Sala responsibilities he was not experienced and qualified to handle, therefore jeopardising the evolution of his career.

FINDING NO.14 : UNLAWFUL GRANTING OF REGISTRATION CERTIFICATE DURING PERIOD OF INTERNSHIP TRAINING AND BEING SUPERVISED BY UNAUTHORISED SUPERVISION

8.14 **Dr Tambisari** and **Mr Fanua** should not have awarded a full certificate of registration to Dr Sala without having him completed his internship training.

They failed to require him to undergo a proper internship under the recommended supervisor from FSM. Apparently, Dr Garae was supposed to supervise Dr Sala, but he was not able to carry out this extra task for three reasons: (1) Dr Garae was only recommended by FSM to supervise primary care practitioners and not medical students; (2) he had his own responsibilities as a paediatrician at the Hospital and (3) he is not a specialised G/O.

FINDING NO.15 : BREACH OF SECTION 3 (1) OF THE HEALTH PRACTITIONERS BOARD ACT BY **DR TAMBISARI, MR FANUA** AND **DR BADOR**

8.15 The investigation also revealed that Dr Tambisari, Mr Fanua, and Dr Bador acted contrary to section 3(1) of the Health Practitioners Act. They held a meeting of the Health Practitioners Board on 06.06.95 without a quorum. The Act specifies that the Minister (Chairman) and four appointed members shall constitute a quorum. However, on 06.06.95 only three members were present. This therefore appears that all decisions made on 06.06.95 by the 3 board members at the HPB meeting were invalid and void, therefore Dr Sala was unlawfully registered to practise as a doctor in Vanuatu.

FINDING NO.16 : BREACH OF THE LEADERSHIP CODE BY **DR TAMBISARI** AND **MR FANUA**

8.16 It also appears that Dr Tambisari and Mr Fanua abused their office by ignoring the Health Practitioners Board Act in illegally registering Dr Sala to practise and holding a HPB meeting without a quorum. They have disregarded Article 66 (1) of the Constitution in that, they have placed themselves in the "position in which fair exercise of their public or official duties has been compromised". They have also demeaned their position, allowed their integrity to be called into question and endangered the health services of the hospital. In doing so, they have diminished respect and confidence in the integrity of the Government of the Republic of Vanuatu and therefore were in breach of the Leadership Code.

**THE PAEDIATRICIAN AT VCH DR GARAE**

FINDING NO.17 : HE WAS NOT RECOMMENDED BY FIJI SCHOOL OF MEDECINE TO BE SUPERVISOR OF MEDICAL STUDENTS DOING INTERNSHIP IN VANUATU.

8.17 Dr Garae was found not to have been recommended by FSM to officially supervised medical students for internship training in Vanuatu. His recognition as supervisor of Dr Sala at VCH was not proper. He should have refused this responsibility for the reasons mentioned in paragraph 7.13 above.

## 9 *RECOMMENDATIONS*

### 9.1 Urgent need for the recruitment of Gynaecologists/ Obstetricians

It is very unusual and almost uncredible for the Department of Health and the Government to let Vila Central Hospital, the main referral centre in the country operate without a specialised Gynaecologist/Obstetrician for a 4 year period. I therefore call on the Government to take all necessary steps to recruit someone fully qualified for this essential position at the Vila Central Hospital, and for the rest of the country (Santo and the outer islands), and to contact the aid donors to apply for such specialists as a most urgent matter as it appeared that Vanuatu has not yet fully produced a qualified G/O. We understand that there is no qualified ni-Vanuatu for these positions.

### 9.2 Former Director of Health Mr Yves Niowenmal not to be re-appointed to the Director's position again

Because of this case and others still the subject of other enquiries, I recommend that the former Director of Health, Mr Yves Niowenmal not be appointed again to the position of the Director of Health, or any position of public responsibility, as he has shown himself incapable of holding such a post, and such responsibilities for the good of the public.

### 9.3 Former Minister of Health Dr Edward Tambisari and Former Secretary to the Minister of Health Mr Tiro Fanua not to hold position of public responsibility again

Due to the facts and evidence found of the breaches of the law, I recommend that Dr Edward Tambisari and Mr Tiro Fanua are not appointed again to hold any position of public administrative responsibility, as they were shown not to respect the existing laws of Vanuatu and to take decisions that have endangered the lives of their people by appointing a student doctor to be the only gynaecologist obstetrician in the whole country.

### 9.4 Further training for Dr Sala

With Dr Sala being involved in this maladministration case, I therefore recommend that he seeks further training if he wants to be specialised in obstetrics and gynaecology, but that he ceases to accept being put in-charge of the maternity and antenatal wards.

### 9.5 Urgent need to review the Health Practitioners Board Act

With the recent breaches of the Health Practitioners Board Act, I recommend that the Department of Health and the Ministry of Health review certain Sections of this Act and forward to Parliament to make amendments to cater for the increasing numbers of Ni Vanuatu students returning with medical and paramedical qualifications to work in different health professions in Vanuatu.

### 9.6 Decisions by the Board Meeting of 06.06.95 to be considered null and void

I recommend that all decisions of the Health Practitioners Board that convened on 06.06.95 without a quorum be considered null and void.

### 9.7 Recruitment of dismissed qualified and experienced nurses, and especially midwifes

From facts and evidence revealed in this report about the shortage of nurses at Vila Central Hospital since the civil servants' strike, and the fact that effective health services can only be provided by qualified and experienced nurses, I urgently call on the Department and Ministry of Health and the Government to review their recruitment and appoint qualified personnel and reinstate if necessary, many of the dismissed technical health officers for the betterment of health services in this country.

The personnel available in the Maternity Wards should be increased as our report shows that there is insufficient staff to handle the growing numbers of pregnant women and deliveries. This should be considered urgently as lives of mothers and babies are at stake.

### 9.8 Cancellation of care fund for top leaders

We recommend that the Vt 25 million budget for the care of the Ministers, President and family be cancelled and reduced to a minimum and instead invest in the overall improvement of the hospital including the hiring of overseas specialists.

## 10 *CONCLUSION*

In accordance with S23 of the Ombudsman Act No.14 of 1995 and S63(4) of the Constitution, I am forwarding a copy of this report to the President, the Prime Minister, and the relevant public authorities. According to the Constitution their duty is to "decide upon the findings of the Ombudsman within a reasonable time and the decisions, with reasons, shall be given to the complainant forthwith".

I therefore request all the appropriate authorities to decide upon these findings within 21 days upon the date of receipt of this report:

- President of the Republic of Vanuatu
- The Minister of the Ministry of Health
- The Director of the Department of Health
- Public Service Commission.

Dated this 28th day of May 1997.

MARIE-NOËLLE FERRIEUX PATTERSON
**OMBUDSMAN OF THE REPUBLIC OF VANUATU**