Case Studies

Kendrapara - Baijanti Das

Date of Death : 07.08.2008

Excessive travel following birth contributes to mother's death

Baijanti Das, a 29 year old mother of two young girls and wife to Ajaya Das, from Kendrapara, succumbed to death just one week after giving birth to twins. Throughout her 8 month pregnancy she had three check-ups, one of which was with the Obstetrics and Gynaecology Specialist, yet this was, worryingly, only the day before labour began.

She **delivered the twins at home and on account of their low weight**, the family took them firstly to the Homeopath, then to the District Headquarter Hospital in Kendrapara and finally to a Nursing home nearly 140 kilometres away in Cuttack. Baijanti, becoming very exhausted and disoriented, was brought to the Patkura Community Health Centre where **she died due to anaemia and heart failure.**

Had Baijanti had the three Ante Natal Care checks required in order to deal with the anaemia she may be alive today. Furthermore, the presence of a New Born care unit in the Kendrapara DHH would have prevented the long journey to Cuttack, which was highly detrimental to her health as **complete bed rest and hospitalisation was what she needed.**

The **O&G specialist did not explicitly explain this** which may have led the family to believe that the twins' health concerns were more pressing than the mother's. One cannot know whether Baijanti would have survived had all these circumstances been different but it certainly would have increased her chances of seeing her four children grow up.

Sonepur – Basanti Badamali

Date of Death: 18.05.2008

Lack of understanding about the effects of travel on a mother after complicated labour contributes to her death

Basanti Badamali was 19 and married to Bibhuti Bhusan Badamali for one year, living in the district of Sonepur. **She had received sufficient Ante Natal Care** provided by both an Auxiliary Nurse Midwife and a private gynaecologist. Basanti was healthy and no complications were noticed during her pregnancy.

Just over **a month before her due date**, Basanti's labour pains started and within half an hour **her child was born at home followed by the placenta 15 minutes later** with no sign of complication noted by the Traditional Birth Attendant. Sadly, **half an hour later, convulsions began and the child died.**

As Basanti's condition deteriorated she was brought to the Binika Community Health Centre where **she was treated with saline, however with no improvement noticed, she was referred on** to

Sonepur District Headquarter Hospital where she was treated.

Basanti's brothers then arrived and wished to transfer her to the Burla Medical College and Hospital, 110 kilometers away, where they hoped that care would be more efficient. Just under 5 hours after being admitted, Basanti died. It was argued that as she was **experiencing post partum eclampsia** she could have been kept at Sonepur's DHH and even minimum care would have been enough to save her life, rather than losing vital hours and care by transporting and transferring.

Boud – Bhargabi Kudei

Date of Death: 08.05.2008

Insufficient medical preparations led to the death of mother and baby

Bhargabi Kudei and Balmiki Kudei belonged to a scheduled caste family. They lived below the poverty line in the district of Boud, India. They had **three unsuccessful pregnancies**, the first two ended in miscarriage, the final one in death.

Bhargabi had sickle cell anaemia. As such, **she was advised to have a monthly check-up.** Three months into the pregnancy, the couple moved to Bhargabi's parents' house just to be closer to health facilities.

Approximately a month before her due date, Bhargabi awoke in the middle of the night in terrible pain. At 3am she was taken to the District Headquarter Hospital in Sonepur and admitted.

The following afternoon Bhargabi died. She was **unable to deliver her child**. The **cause of death was eclampsia**, complicated by sickle cell anaemia. She was **27 years old.**

Bhargabi's **doctors were aware of her condition and the subsequent potential complications that could arise during her pregnancy.** Yet they took insufficient medical preparations to protect her from the complications which arose and eventually led to her painful death.

Deogarh – Bilasini Pradham

Date of Death: 09.04.2008

Consistent support and counselling essential to avoid unnecessary deaths during childbirth

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Malakanagiri – Bina Mandal

Date of Death : 24.03.2008

Lack of means to transport claims another mother's life

Bina Mandal was a 25 year old woman married to Ajaya Das living in the village of Malakanagiri in the district of Kendrapara. She was **seven months into her second pregnancy when she felt sudden lower abdominal pain**

A short 15 minutes later, **both the foetus and placenta were delivered prematurely at home**. Bina then felt severely weak and **abdominal distension** eventually developed. With Bina's condition deteriorating rapidly, the Traditional Birth Attendant advised the family to take Bina to the Upgraded Primary Health Centre at Kalimela. As **no transport was available that night**, the family took Bina the following day. After eventually making it to the Health Centre, unfortunately, just 45 minutes later, **Bina died, approximately 21 hours after delivery**.

The cause of Bina's death was attributed to puerperal sepsis and complicated malaria. Though Ante Natal Care was adequate, even further ANC would not go amiss as **further information on risk and potential complications** for the family is always beneficial and potentially life-saving. Issues with transport have also been fatally deficient for many mothers and their families and Bina's was no different.

Gajapati – Damani Sabar

Date of Death: 29.05.2008

Lack of preparation in specialist hospital led to a mother's death

Damani Sabar was **20 years old**, married to Khamana Sabar with a 1 year old child, and **7 months pregnant with her second child**. She belonged to a Scheduled Tribe community known as Sabar and lived in the district of Gajapati.

Her first child was delivered at home with no complications. Throughout her second pregnancy **she was severely anaemic and exhibited signs of oedema** on her hands, feet and face.

Due to her poor health, on the 27th of May, she was admitted to the Paralakhemundi District Hospital and given **two units worth of a blood transfusion**. Two days **after returning home following the transfusion, she was found unconscious by her family** who took her to the Paralakhemundi Hospital where she was transferred to the MKCG in Berhmapur for specialised care.

She **needed another transfusion**, but the hospital was not adequately prepared for this and Damani died hours later due to Pre Eclampsia Toxaemia. Though medical factors contributed to Damani's death, **counselling at the family and community level** would have given Damani more of a

fighting chance.

Rayagada – Elari Sabar

Date of Death: 01.04.2008

Lack of communication between medical staff and family members contributed to mother's death.

Elari Sabar was married to Surya Sabar and came from a **poor illiterate tribal household** where she would engage in housework, cultivation as well as forest works. This was to be **her fourteenth and last pregnancy**. Eight of her children are still alive today, three of them died before reaching the age of 5 and two were still-born.

This **pregnancy was only registered during her 5th month so limited Ante Natal Care was provided.** Her labour pains began during her 7th month of pregnancy and with the help of ASHA (Accredited Social Health Activist) and the family, Elari was taken to the Primary Health Centre.

She **delivered her child through the normal process although complications occurred when the placenta could not be removed** and heavy bleeding ensued which the doctor tried to control by administering an injection.

The doctors then referred her on to the Sub Divisional hospital in Gunupur and **recommended she get there within an hour but the family did not take her for another three hours and Elari died due to Post Partum Haemorrhage on her way there**.

The family was **not made fully aware of the extent of the complications** after the birth and had they known, precious time may have not been wasted on contacting local doctors and Traditional Birth Attendants between the time of birth and her subsequent death.

Jharsuguda – Gurubari Kalo

Date of Death: 21.07.2008

Power cuts prevented potentially life saving Caesarean Section from being performed

Gurubari Kalo was married to Gelamani Kalo and belonged to a poor Scheduled Tribe family living in the district of Jharsuguda. **Though Gurubari appeared healthy** during this, her first and last pregnancy, **she was anaemic**.

Approximately three weeks before she was due, she began to **experience blurred vision and a heavy head** and so she was taken to the District Headquarter Hospital which was 2km from her home. During her journey however, **Gurubari fell unconscious and upon reaching the hospital she began to convulse and vomit.**

The doctor wanted to sacrifice either Gurubari or her unborn child by **performing a Caesarean but was unable to due to frequent power cuts at the hospital.** Consequently Gurubari was referred on to the Burla Medical College after 10 hours at the DHH.

Gurubari then had to wait a further 2 hours for transport to be arranged. At Burla Medical College

she was provided with saline but **after 2 hours, Gurubari died due to pre-eclampsia.**

Nowrangipur – Hemalata Bhatra

Date of Death : 18.04.2008

Advice not taken: baby and mother die as a result

Hemalata Bhatra, was a 23 year old mother of two and married to Dhanurjov Bharea. They lived in Nowarangpur when she was going through her third pregnancy. Her labour pains began during the evening of the 17th of April 2008 and 2 hours later **she began to bleed profusely**. Upon seeing this, the Traditional Birth Attendant advised the family to take her to the nearest Primary Health Centre, which was in Sanmosigam.

The **TBA's advice was not heeded until the next morning** and Hemalata arrived at the PHC at 7.15am. Here the doctor treated her as best he could. Despite his best efforts, **the baby was stillborn and Hemalata's bleeding continued leading ultimately to her falling unconscious**. She was referred onto the District Headquarters Hospital in Nowrangipur, however she was not taken and Hemalata died at Sanmosigam PHC a short hour and 15 minutes after getting there.

Semalata's sad passing should serve as a pertinent reminder of the importance of the Accredited Social Health Activist (ASHA) and the Auxiliary Nurse Midwife in enhancing awareness of complication readiness.

Nayagarh – Jahna Dutta

Date of Death : 27.01.2008

Lack of confidence in nearest hospital leads to fatal delay in care

Jahna Dutta was a 31 year old mother with two children, one boy and one girl, the youngest being 7 years old. She was married to Laxmidhar Dutta and the family lived in the district of Nayagarh.

Her **two previous pregnancies and births presented no complications**, unlike her third unfortunately. **During her third trimester she frequently felt breathless despite her rest and nutrition being normal**. After labour pain began, 5 and a half hours lapsed until reaching the District Headquarters Hospital, at which point she died despite making it to the delivery room 15 minutes after arriving.

The family chose not to take Jahna to the Sub District Hospital which was closer, presumably due to a lack of confidence in the facility, a view which needs to be rectified. The role of the Auxiliary Nurse Midwife was questioned as **recordings of blood pressure, weight and haemoglobin count were not completed**, nor was there sufficient birth planning or a readiness to deal with complications. ASHA could also have played a larger role in identifying risk and what potential actions could be taken in order to avoid another loss to a family like Jahna Dutta's.

Bhadrak – Jhuna Jena

Date of Death: 04.08.2008

Mother and baby die as a result of dehydration

Jhuna Jena and her husband Balmiki Jena lived in Rajapur Tihidim, a small village in the district of Bhadrak, India. They were classified as a 'Scheduled Caste' household. **Jhuna was 21 when she became pregnant and 22 when she died giving birth**.

During her pregnancy, Jhuna underwent three check-ups. She **was prescribed medicine to help combat the extreme dehydration** from which she was suffering, but for unknown reasons, **only consumed half.**

One night, towards the end of her pregnancy, Jhuna began to experience intense pain in her abdomen. The following morning ASHA (Accredited Social Health Activist) accompanied her and her family to the District Headquarters Hospital. The Obstetrics and Gynaecology specialist performed a sonograph to determine her due-date (hitherto unknown). The sonongraph revealed that the baby was not due for another month. It also showed that **although the baby was alive although the womb water levels were low**. She was **prescribed medication for the dehydration (which the family never bought)** and discharged.

Jhuna was in pain for the rest of the night. The following morning ASHA took her to the DHH but no one looked at her. At her family's behest, **she was taken to a nursing home for an induced delivery.**

Jhuna gave birth to a **still-born baby.**

Jhuna then **went into shock as a result of the premature contractions**. The home tried to transfer her back to the DHH, but she died on the way.

Incompetence and ignorance - at every level - led to the death of Jhuna and her baby.

Kandhamal – Jostna Dandia

Date of Death: 19.02.2008

Sickling test overlooked, contributing to the death of a young mother

Jostna Dandia was **22 years old, literate**, and married to Ajit Dandia. They lived below the poverty line in the district of Kandhamal.

Jostna's **health was weak and she was anaemic**. She was provided with full Ante Natal Care and was experiencing **oedema of the hands, feet and face** during her third month of pregnancy.

After her 27th week, her **vision began to fail and she became dizzy and disoriented** so she was taken to the Primary Health Centre within an hour. **Being unconscious upon arrival**, she was referred on to the District Headquarter Hospital in Kandhamal where she arrived two hours later.

After reaching the hospital her **blood pressure was very high** and she was treated for three days. At this point **a sickling test was conducted which proved to be positive** so the **doctor recommended**

an abortion through tablets.

The following morning, appearing normal yet experiencing some bleeding, the doctor **advised her to stay under supervision**. Two days later she was in great pain with a fever and an embolism.

Though the doctors began a blood transfusion, **due to the development of dyspnea combined with the sickle cell crisis, Jostna passed away just before midnight**. With sickling being so prevalent in the area, a test during Jostna's ANC would have been highly important and potentially life saving.

Baragarh - Kalpana Barik

Date of Death: 16.05.2008

One simple test could have averted Kalpana's death

Kalpana Barik, and her husband Kasta Barik lived in the Indian district of Baragarh, Orissa. They lived below the poverty line. In terms of the Indian caste system, they were in the category of 'Other Backward Class'.

When Kalpana fell pregnant she received full ante-natal care. On 8 May 2008, Kalpana gave birth to a baby girl at the District Headquarters Hospital. There were **no noticeable complications**. However, due to Kalpana's **anaemic state**, she was kept in hospital for three days, over which she was given three bags of blood.

Two days after she was discharged from hospital, Kalpana began to **experience a lot of pain and became dizzy and disorientated.** She was re-admitted to the DHH, who referred her on to the Burla Medical College. There, Kalpana tested positive for sickling. A blood transfusion could not save her. She died 8 days after giving birth.

A simple test during the ANC period could have potentially saved Kalpana. It was widely known that **sickle cell anaemia (pre and post natal) was endemic in tribal areas of Orissa**: the test should have been done. Kalpana Barik was only 24 years old when she died.

Koraput – Kamala Jani

Date of Death : 13.07.2008

Duty of care neglected following referral compounds in death of mother of three

Kamala Jani was a **25 year old mother of three** married to Subash Jani from Koraput. Her labour pains began the day before she gave birth and were consistently increasing in severity as labour progressed.

She was transferred to the Primary Health Center in Kundura and **upon examination it was discovered that the birth was to be a breech presentation.** For more specialised care, she was then referred to the Sub Divisional Hospital in Jeypore.

Sadly, due to a lack of transport to get to the SDH, as well as **receiving no further care after being referred on, she died approximately 7 hours after doctors made the referral**. There was also a

lack of Ante Natal Care as **Kamala's expected due date was not even passed on from the Auxiliary Nurse Midwife to her doctor.** Furthermore, there was **no attempt made by the Center to request an ambulance from the SDH,** despite the poor family of Kamala having no means to do so.

Cuttack – Kuni Jena

Date of Death : 03.08.2008

Lack of attentiveness in various facilities combined with excessive transferrals led to the death of a mother of three

In the district of Cuttack in Orissa on the 3rd of August 2008, Kuni Jena was being mourned by her husband Chabi Jena and two young girls after giving birth to a baby boy in their home. The **family is extremely poor** and their main source of income for the family was from her husband's work as a daily labourer.

30 year old Kuni Jena began suffering from labour pains approximately 10 hours before giving birth. Due to **her severe anaemia** and her general health condition she was transferred between the Community Health Center, the Athagarh Sub-Divisional Hospital and the SCB Medical College and Hospital in order to gain access to proper care.

Having not been admitted at the final hospital for two hours, the family, hopeless and concerned, **brought her home to deliver the boy** only for her to **become restless and pass away in the early hours of the next morning.**

Had the various facilities involved not lost time in **passing Kuni Jena from facility to facility without monitoring her critical condition properly** or having her prepared for delivery, and **the Auxiliary Nurse Midwife been more attentive towards anaemia prevention amongst other parts of maternal care**, this sad loss for the Juna family could most certainly have been avoided.

Balangir – Kunti Pasayata

Date of Death: 05.02.2008

Insufficient Ante Natal Care left three young girls motherless

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Jagatsinghpur – Latika Rout

Date of Death : 24.02.2008

Mother and child died after leaving Primary Healthcare Centre where the ambulance has been defunct for 9 years

Latika Rout was 25 years old and married to Basant Rout. They lived their lives below the poverty line in Jagatsinghpur and had already felt the pain of losing a child.

They had one child who died only 24 hours after coming into the world. Latika's second pregnancy would prove to be even more heartbreaking as neither child nor mother would survive.

During Ante Natal Care, she was checked by an Obstetrics and Gynaecology (O&G) specialist and went home after the check up. Just under a week later, **experiencing mild pain** before midnight she was admitted to the hospital, seen 2 hours later and again in the early hours of the morning. **Labour at this point was expected to progress normally.**

Eight hours later, the doctor diagnosed a case of obstructed labour and she was finally transferred to the District Headquarters Hospital in a rented vehicle as the ambulance at the Primary Health Centre has been out of service for 9 years. Latika died shortly after.

Medically, **her death was caused by a ruptured uterus**, though **negligence and insufficient resources contributed** significantly to Latika's untimely death. The O&G Specialist's arrival was delayed by three hours, while further **referral was not conducted in a timely manner** despite her arriving in the early stages of labour and her **previous history of complications during labour**.

Mayurbhanji – Laxmi Hansda

Date of Death: 15.07.2008

Lack of faith in Hospital contributed to the death of a mother en route to Medical College

Laxmi Hansda was **22 years old** and married to Rupaye Hansda who was college educated and has a small business. They lived in the district of Mayurbhanji.

Laxmi received Ante Natal Care although **she was very weak and anaemic**. Her **labour pains began three weeks before her expected due date** and she was taken to the Community Health Centre in Betanti where she was checked and treated. She returned home, yet experiencing pains in her abdomen that evening, the family called the AWW (Angonwaadi Worker) and she was taken back to the CHC late at night.

The following morning, noticing complications, she was referred on to the District Headquarter

Hospiral where **Laxmi delivered her baby boy with a low birth weight by Caesarean.**

Laxmi and her son stayed in the hospital under supervision for a further week until the stitches could be removed. Laxmi then began to **experience pains in her heart as well as breathlessness,** at which point **she was given a transfusion but she began to convulse during the night.**

With the family believing the quality of service of emergency obstetric cases in the DHH to be questionable, the family insisted Laxmi be transferred to the SCB Medical College and Hospital in Cuttack, but unfortunately **within half an hour on the road Laxmi died**, being survived by her young son and husband.

Sundargarh – Munia Tirkey

Date of Death: 29.07.2008

Mother of four dies due to lack of attention paid to medical history and appropriate preparation

Munia Tirkey was a 35 year old mother of four and married to Ranjan Tirkey, living in Sundargarh. Munia was mildly anaemic during her pregnancy but her nutrition was fair.

She experienced **an ante partum haemorrhage during the last week of her pregnancy and was hospitalized for four days**. Following this, on the 27th of July, her labour pains started and the following morning she was admitted and attended by the Obstetrics and Gynaecology specialist. **With increasing pains that evening she was brought to the labour room and delivered a baby boy.**

However **the bleeding did not cease**, so the doctor stitched the tears and **requested a blood transfusion at 1.30am, however the blood bank was closed and within an hour Munia had died.**

Unfortunately there was a clear lack of preparation for Munia's delivery as she had a **history of ante partum haemorrhage,** meaning that there could have been a supply of blood in case the worst case scenario materialized. Munia's death was one that could have been avoided were there sufficient staff and provisions made for the highly potential outcome of experiencing haemorrhaging after giving birth to her son.

Kalahandi – Namis Sabar

Date of Death: 03.05.2008

Combination of lack of preparedness and access to transport led to mother's death

Namis Sabar was **24 years old** and married to Nidra Sabar, they belonged to an indigenous tribal family of the Sabar community and **lived in a remote area of the district of Kalahandi where the only accessible healthcare is the Sub Centre**.

Namis had fallen pregnant once before but this resulted in a miscarriage for reasons unknown. Her pains began 38 weeks into her pregnancy when she was taken to the Sub Centre in the morning where the Auxiliary Nurse Midwife provided care but **waited a number of hours to see if the**

birth would progress normally.

However this would not be the case and later that evening, Namis was experiencing **severe convulsions and bleeding**. She was referred on to the District Headquarter Hospital, yet **due to the late hour, transport could not be arranged**.

The following morning when transport was available, Namis was taken to the DHH but **died while she was in transit**.

Unfortunately, the role of the ANM, ASHA (Acredited Social Health Activist) and the AWW (Angonwaadi Worker) left much to be desired due to **poor birth planning** as well as a **lack of preparedness to deal with complications**. Namis' long stay at the Sub Centre was unnecessary, leading to **further complications that could have been avoided had Namis been admitted to the DHH earlier.**

Sambalpur – Rajani Khati

Date of Death: 19.05.2008

Lack of training leads to fatal mistake

Rajani Khati was 24 years old and married to Hiralal Biskarma from Chhartisgarh state. They were **living below the poverty line but she was of good health and exhibited no signs of anaemia during her pregnancy**. She was living with her parents in Sambalpur during this, her first pregnancy.

Rajani's labour pains started in the early morning two days before her expected due date and she was admitted into the Maternity Hospital immediately. As the **doctor was not available,** the **nurse checked Rajani's condition and administered an injection** (symptocinon) for the labour pains directly into her vein. However this medication is meant to be administered through a drip.

This mistake **in medication lead to Rajani having a ruptured uterus** which was confirmed hours later upon the arrival of the doctor who conducted an ultra sound confirming blood accumulation due to said ruptured uterus. **Rajani died shortly thereafter.** This very sad loss for the family could have been avoided had the nurses been properly equipped and trained to deal with complications during labour.

Khurda – Rashmita Sahoo

Date of Death : 04.06.2008

Medical history tragically overlooked

Rashmita Sahoo was a 24 year old mother of one and wife to Shivaram Sahoo living below the poverty line in Khurda where she gave birth to another baby in a delivery that led to her death. Leading up to the birth, **her nutrition was normal though she had moderate anaemia and was not resting sufficiently**.

As labor started in the morning, Rashmita became restless. She was taken to the Community Health Centre in Tangi and just over 6 hours later gave birth. Shortly thereafter **congestive cardiac failure**

was diagnosed and Rashmita had to be transferred to the Tertiary Care Hospital, 60 kilometres away, where she died upon reaching the doctor.

Rashimita's medical history could be considered to have been somewhat overlooked as **complications in her first birth could have provided a warning for potential problems and risks in a second birth.** Had this been heeded, she would have been admitted prior to the labour pains starting in order to monitor her condition appropriately. Furthermore the role of the Auxiliary Nurse Midwife may not have been performed fully as **guidance regarding birth planning and complication readiness was inadequate** and she did not attend the delivery. In essence, more personal and scrutinous attention should have been paid to Rashmita.

Balasore- Rekharani Behera

Date of Death: 03.05.2008

Quality and timely care could have saved a mother's life

Rekharani Behera was **30 years old** when she died. Rekharani already had one child with her husband, Basant Behera, the birth of whom resulted in post-partum haemorrhaging. This excessive bleeding was stopped by prompt and excellent care from her doctor. Rekharani also had a cardiac problem - of which the Obstetrics and Gynaecology Specialist were aware. Thus, when she discovered she was pregnant again, Rekharani expected a similar high level of care from the district of Balasore.

Rekharani's second child, a baby girl, was **born naturally** without any problems. However, **complications began after her birth**. It took the doctors two hours to remove the placenta, which was worsened and slowed by heavy bleeding. The **doctor assigned to Rekharani's birth was absent throughout the complications**.

After the removal, the attendants present decided to **perform a blood transfusion**. But by then **it was too late** and Rekharani died within 20 minutes.

Quality and timely obstetric emergency care could have saved Rekharani's life.