Case Summary: Maternal Death

Presented by Dr. Uy Kyna

34-year-old, G5P3, full term pregnancy

Normal delivery → PPH → Referred with ongoing bleeding → Arrived in shock → Died

Timeline of Events

- 01:00 Admission (stable) for full term pregnancy
- 01:50 Delivery at CPA2
- 02:00–02:20 PPH started
- 02:40 Referral to CPA3
- 03:00 Arrival in shock
- 03:50 Blood started (late), insufficient
- 05:40 Surgery(subtotal hysterectomy)
- 12:30 Death

Cause of Death

- Hemorrhagic shock
- Due to PPH
- Due to uterine atony
- Rapid blood loss → death

Delay 1: ANC / Community

- Was risk identified?
- Was birth plan prepared?
- Were danger signs explained?
- Link: ANC gaps lead to poor preparation

Delay 2: Referral

- Was patient stabilized before transfer?
- Was bleeding controlled?
- Was transport equipped?
- Finding: bleeding continued during transport

Delay 3: Facility Care

- Was response immediate?
- Was blood available on time?
- Was surgery decision timely?
- Finding: delays in transfusion and surgery

Key Problems Identified

- Delayed recognition of severity
- Inadequate stabilization before referral
- Delayed blood transfusion
- Delayed surgical intervention
- Poor teamwork

Clinical Lessons (PPH)

- PPH is emergency(gold hour)
- Act within minutes
- Use uterotonics, TXA, fluids
- Start blood early
- Do not delay surgery

System Lessons

- Strengthen ANC risk screening
- Ensure birth preparedness
- Improve referral system
- Ensure blood availability
- Strengthen teamwork

Group Discussion

- Where was the biggest delay?
- What would you do differently?
- How to prevent this death?
- What action at your facility?

Key Message

- This death was preventable
- Every delay contributes to death
- PPH kills fast – response must be faster