

The Death of Savita Halappanavar

October 2012:

Savita Halappanavar was 31 years old and 17 weeks pregnant with her first pregnancy when she was admitted to University Hospital Galway on 21st October 2012. She was miscarrying and already had bulging membranes. Her waters subsequently broke and the miscarriage was deemed “inevitable” although the baby’s heart was still beating. The treating medical team deemed (incorrectly) that it was not necessary to induce delivery and waited for the miscarriage to complete without intervention.

The doctors failed to recognize that Ms Halappanavar had chorioamnionitis (infection of the gestational sac and membranes) with septicaemia (infection of the blood stream). Nothing in Irish law prevents obstetricians intervening to deliver the baby in the situation of miscarriage with clinical or biochemical signs of infection. The Medical Council Guidelines to doctors clearly outlines that it may be medically necessary to end the pregnancy in order to protect the life of the mother even if there is little or no hope of the baby surviving.

However, the medical and nursing staff treating Ms Halappanavar failed to monitor her condition and did not recognize the signs and symptoms of infection until she was in severe sepsis and already gravely ill. They were preparing to induce delivery when the baby girl was stillborn on 24th October 2012. Ms Halappanavar’s condition continued to deteriorate and she died of

cardiac arrest from septic shock in ICU on 28th October 2012.

Obstetric sepsis:

The bacteria which caused Ms Halappanavar’s infection was identified as a rare and virulent form of E.Coli ESBL Extended Spectrum Beta-Lactamase; a multi-antibiotic resistant organism. This infection was previously unprecedented in Irish maternity units. Unfortunately, death due to obstetric sepsis is on the increase in many developed countries. The overuse of antibiotics and the emergence of superbugs is one factor. In addition, investigations in other countries have identified failure to observe and respond promptly to simple clinical signs such as fever, headache and changes in pulse rate and blood pressure as common factors in maternal deaths from sepsis.

Subsequent investigations:

There were three separate investigations into the death of Savita Halappanavar: The Coroner, The HSE and HIQA . All the reports concluded that her tragic death was caused by medical mismanagement of a virulent form of sepsis. The **coroner’s inquest** found that she died of medical misadventure.

The **HSE report** identified three key causal factors into the death of Ms Halappanavar as inadequate assessment and monitoring, failure to adhere to clinical guidelines on the management of sepsis and failure to consider all appropriate management options.

HIQA’s investigating team consisted of 7 medical and nursing specialists and a patient advocate. The team produced a detailed 253 page report and identified a catalogue of system failures with multiple deficiencies in medical care including

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failure to monitor basic clinical observations, failure to recognise that Ms Halappanavar was developing an infection and then a failure to act on the signs of her clinical deterioration in a timely and appropriate manner. HIQA identified 13 missed opportunities to intervene in her care that could have saved her life and made 34 recommendations to improve maternity services in Galway and other maternity units. None of these missed opportunities or recommendations referred to the 8th Amendment. HIQA was critical of Galway and other maternity units for failures of clinical governance to implement the recommendations of the report into the death of Tania McCabe and her son Zach in 2007, which bore disturbing resemblance to the case of Savita Halappanavar.

Improvements to Maternity care:

It is hoped that since the death of Savita Halappanavar that lessons have been learned to prevent the occurrence of another similar tragedy. The HSE has implemented new national clinical guidelines on management of sepsis, clinical handover, miscarriage and the treatment of critically ill women in pregnancy. A new national early warning score system for patients has been introduced. The National maternity strategy was published in 2016 to provide a framework to deliver and improve maternal and neonatal care to ensure adherence to best international practice.

Conclusion:

The death of Savita Halappanavar was a devastating tragedy for her, her baby, her husband, parents and friends. Thorough investigations conducted by

multidisciplinary cross specialist teams concluded that she died as a result of the medical mismanagement of an aggressive sepsis caused by a multidrug resistant bacterium. Ireland's prolife laws did not contribute to her death and it is disrespectful to use her death to advocate for the introduction of abortion in Ireland. May she rest in peace.

References:

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