

**MAHARASHTRA STATE HUMAN RIGHTS COMMISSION, MUMBAI**

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MSHRC/SK/6/2026/ 10844

Date: 04/06/2026

Case No. 3725/13/16/2024

Name of Complainant : Dr. Sumir Dembla

**Respondent : 1. Superintendent of Police,
Nandurbar.**

**2. Civil Surgeon,
Nandurbar.**

**3. Chief Executive Officer,
Zilla Parishad, Nandurbar.**

**4. Additional Chief Secretary,
Public Health Department,
Maharashtra State, Mumbai.**

**5. Dr. Ashok Gaikwad,
Nandurbar.**

**6. Mrs. Sunanda Valvi,
Nandurbar.**

7. Mrs. Seema Nagare,
Nandurbar.

8. Medical Officer,
Rural Hospital, Molgi.

9. Magan Goma Raut
Nandurbar.

Date : 1st June 2026

Coram : Sanjay Kumar, Member

ORDER

1. The complaint is based on a news item published in the Marathi Newspaper, "Loksatta", on 01.03.2024, under the heading, "व्यवस्थेतील व्यथा सांगणारी कविताची कथा". The news article is about maternal death of a pregnant lady, Mrs. Kavita Raut, age 23 years (as per her Aadhar card) a resident of Bardi pada, Post Pimplakhuta of Akkalkuwa Taluka, District Nandurbar, on 15.02.2024 during delivery. Besides, news article mentions about the non-functional ambulance, due to lack of maintenance, for last six months, which was provided to Primary Health Centre by the Government.
2. The case is about apathy, negligence, presence of unqualified and untrained medical staff, absence of doctors in the night and

poor medical infrastructure at Primary health centers (PHC) and Rural hospitals (RH) in the rural areas of Maharashtra. Medical staff of Primary Health Centre and Rural hospital, instead of taking responsibility and conducting delivery, preferred the practice of referral to upper hospitals in the name of complications. In this case, Mrs. Kavita Raut is the poor victim of negligence, apathy, untrained medical staff and poor medical infrastructure at the Primary Health Centre Pimpalkhunta and of Rural Hospital, Molgi. In critical condition she was referred from PHC Pimpalkhunta to Rural Hospital Molgi, ambulance broke down in the way, delivered a boy in the way in ambulance without any medical support, reached rural hospital Molgi, referred again to District Hospital Nandurbar, brought dead to District Hospital Nandurbar, early morning.

3. The pregnant lady from the time of giving birth was profusely bleeding in the ambulance without any medical support and care and being referred from one to another hospital, by medical staff in order to escape responsibility and accountability, completely violating the medical ethics and finally breathing her last.
4. Pursuant to the application, reports were called for, from the respondents. During the proceedings, the following submissions were made by the respondents, which are enumerated below:



- a. The report dated 28.02.2025 submitted by SP, Nandurbar, Ashit Kamble.
 - b. The report dated 22.11.2024 submitted by Dr. Ravindra Sonawane.
 - c. The report dated 20.05.2025 submitted by the Civil Surgeon, District Hospital Nandurbar.
 - d. The report dated 14.08.2025 submitted by the Chief Executive Officer, Zilla Parishad Nandurbar, Shri. Naman Goyal.
 - e. The final submission and compilation of clarifications submitted by Dr. Akash Mohan Gaikwad, Sunanda Valvi, and Seema Nagare.
 - f. The details regarding the victim and her family members submitted by SP, Nandurbar.
5. The conspectus which emerges from the above submissions is as follows:
- a. This case is related with maternal death of Mrs. Kavita Raut. The deceased pregnant woman, Mrs. Kavita Raut, age 23 years, was a resident of Bardi, Taluka Akkalkuwa. Her antenatal registration was completed within 12 weeks of pregnancy at Sub-Centre Bardi under the Primary Health Centre (PHC) Pimpalkhuta. Her Last Menstrual Period (LMP) was dated 27-05-2023, and the Expected Date of Delivery (EDD) was 03-03-2024. During her

pregnancy, she underwent two sonography examinations, and her hemoglobin checkups, tetanus vaccinations, and other routine health assessments were duly completed during the regular immunization sessions.

- b. At the Human Development Camp, the pregnant lady was examined by a gynecologist. Further, her registration under the Pradhan Mantri Matru Vandana Yojana (PMMVY) and other regular maternal services were provided through PHC Pimpalkhuta and Sub-Centre Bardi. During pregnancy every thing was normal and all the medical parameters were well under control.
- c. On 14.02.2024, at around 7:30 PM, the woman experienced sudden labor pain at her residence in Bardi. Her family members attempted to contact the PHC ambulance but were unsuccessful. Consequently, they transported the woman to PHC Pimpalkhuta using a private vehicle, arriving at approximately 10:00 PM. Upon examination by the on-duty GNM. Mrs. Priyanka Vasave, her blood pressure was found to be critically high at 170/121mm, Hand full cervical dilation (10 cm) was noted, indicating imminent delivery.



- d. This was being her first pregnancy and given the hypertensive condition, posing a high risk to her life, Mrs. Vasave initiated primary treatment and referred her immediately to Rural Hospital, Molgi.
- e. While being transported by the 102 Ambulance services from PHC Pimpalkhunta, the Ambulance broke down about 6 km enroute due to technical issues. During this period, the woman delivered inside the ambulance. As the ambulance could not be restarted, the ambulance's driver contacted the 102 toll-free number, and another ambulance from Rural Hospital Molgi was dispatched. No medical staff was accompanying pregnant women in the ambulance; she delivered a boy in the ambulance among her family members. She was profusely bleeding., in the ambulance, and helpless.
- f. The woman was then urgently transferred to Rural Hospital Molgi, where she was examined and referred to the District General Hospital, Nandurbar.
- g. Unfortunately, while being transported to the District Hospital, Nandurbar, the woman passed away between 3:30 AM and 4:00 AM on 15-02-2024 in the ambulance. Medical officers at the District

Hospital, Nandurbar declared her dead upon arrival.

6. For the death of Mrs. Kavita Raut, on the complaint of Shri. Ashok Raut, an accidental death vide AD No. 00/2024 u/s. 174 Cr.P.C was registered at Nandurbar City Police Station on 15.02.2024 and thereafter, all the documents related with death was sent to Molgi Police Station, where it was registered vide AD No. 3/2024 u/s. 174 Cr.P.C.. Autopsy Surgeon after autopsy assigned the cause of death as "death due to retained placenta".
7. The submission made by the Chief Executive Officer (CEO) Zilla Parishad, Nandurbar, Shri Aman Goyal, informs that following the incident, a District-level inquiry committee was constituted by the District Health Officer Zilla Parishad, Nandurbar, on 28.02.2024. Based on the committee's findings, Dr. Akash Gaikwad, Community Health Officer (CHO) at Sub-Centre Bardi, was immediately transferred on the charge of negligence. Additionally, Mrs. Sunanda Valvi, Health Assistant (LHV) and Mrs. Seema Narayan Nagare, Health Worker (OPD ANM) from PHC Pimplakhuta were issued show-cause notices for dereliction of their duties.
8. In regard with non-operational Ambulance, CEO, Zilla Parishad, in his report mentioned that before the incidence, no communication was received at the district level, regarding nonfunctioning / repairs of ambulance. But after the incidence,



immediate instructions were given to repair the ambulance of PHC Pimpalkhunta and it was repaired and currently fully operational. Until its repairs are done, instructions to hire private vehicle for transfer of patient as per need were issued to the medical officers.

9. About vacancy position at PHC Pimplakhuta, CEO, Zilla Parishad, Nandurbar, mentioned that two posts of Medical Officers were vacant at PHC Pimplakhuta, as the Ad-hoc recruitment procedure requires due course of time, Community Health officer Dr. Akash Gaikwad was working at the PHC, on the day of the incidence. But he left the PHC at 6.30 pm. Disciplinary action has been taken against the responsible Community Health Officer Akash Gaikwad. And he concluded that an enquiry has been conducted, guilty individuals have been held accountable, and necessary systematic improvements are being implemented to avoid such incidents in future.

10. Maternal Death Review Committee meeting was held under chairperson Dr. Naresh Padavi, Civil Surgeon, Nandurbar, on 27/02/2024 at 11 am along with other doctors as members. One of the findings of the committee says "if mother is fully dilated try to deliver her or stabiles and then transfer, and if not, so health worker should accompany her during transfer"

11. Annexure 2: verbal autopsy questionnaire for investigation of Maternal Death, attached with Review Committee Report at col. 11 under head Open Narrative format, says

1. PHC Pimpalkhuta to R.H. Molgi – 10 minutes spent for deciding for referral to R.H. Molgi (10.10 pm) and make arrangement
2. Refer to higher center for high blood Pressure, then delivery done at 10.45. After delivery having heavy bleeding so that call to 102 Ambulance because of Facility Ambulance Broke down, further 102 Ambulance take time to reach R.H. Molgi around 1 hour(11.45pm). From R.H. Molgi referral to civil hospital Nandurbar around 12.42am.
3. On the way (Akkalkuan to Nandurbar) died on 15.02.2024 at 03.55 am.

The Review Committee report is silent about the, presence of medical staffs at that time at R.H. Molgi and doctor who extended treatment to Patient Mrs. Kavita Raut at R.H. Molgi. It accepted the delay in arrival of ambulance from R.H. Molgi which is at distance of only 9 Km from the place of breakdown of the vehicle. The distance between PHC Pimpalkhuta and R.H. Molgi is 15 km and Ambulance carrying Mrs. Kavita Raut broke down enroute after 6 km. Review Committee observed that PHC Pimpalkhuta should have stabilized the patient and accompanied the patient.



12. However, The Civil Surgeon, in his report dated 06.05.2025, has given a clean chit to the hospital administration and stated that deceased pregnant woman Kavita Raut was provided proper and appropriate treatment at PHC Pimpalkhuta and Rural Hospital Molgi. The staff of Primary Health Centre Molgi and the ambulance driver were not responsible for the death of pregnant woman Mrs. Kavita Raut.
13. District Health Officer, Zilla Parishad, Nandurbar in his final submission dated 24.04.2026 explained problems due to inaccessible terrain and unwillingness of medical staff to serve in this area, in providing health services. He submitted that approximately 65% of Health Workers (ANM) posts are vacant in the district.
14. Considering all the submissions made by the respondents and after perusal of documents supplied along with reports, the Commission is of the view that the death of Mrs. Kavita Raut has occurred due to the negligence, apathy and dereliction of the duty of Medical Staff of PHC Pimpalkhuta and R.H Molgi. The poor medical infrastructure and poorly maintained ambulance had played a contributory role in the incident. The Medical staff both at PHC and rural Hospital in order to shirk their responsibilities used the referral excuse. The observation of the Commission are as follows:
- a. The enquiry reports both by District Health Officer, Nandurbar and Civil Surgeon, Nandurbar are more

in order to save the delinquent medical officers and staff rather than to give a clear picture of the situation.

- b. Statements recorded during the enquiry and submissions made by the Doctor and staffs of PHC Pimplakhuta before the commission is different in facts and content. During the Enquiry, Seema Nagre, health worker, submitted that she was not present on duty on 14.02.2024. Besides, it was established during the enquiry that CHO, Dr Akash Gaikwad, was absent, as he left PHC in the evening. However, all the three; Dr Gaikwad, Seema Nagre and Sunanda Valvi, in their submission before the commission they submitted that they were present at PHC. Unfortunately, no clarification was extended in any of the submission made by the District Medical Officer or Civil surgeon.
- c. In spite of deployment of the Ambulance at PHC Pimplakhuta, it was not available to pregnant lady even after call and family members have to carry the Pregnant lady in a private vehicle. No explanation was submitted by the respondent in this regard.
- d. Going through the submissions and statements of the staff of PHC Pimplakhuta, it was clear that at



the time of arrival of the pregnant lady to PHC Pimplakhuta, only one medical staff, Priyanka Vasave GNM was available at the PHC.

- e. Health assistant, instead of taking any effort to stabilize the patient, preferred to refer the Patient to R.H. Molgi immediately, knowing very well the medical condition of the pregnant lady. As per record there was full dilation, a situation of imminent delivery. She was referred to a medical Centre at the distance of 15 km in a poorly maintained ambulance that also without any medical support and staff.
- f. There was a breakdown of the ambulance enroute to R.H. Molgi after 6 km, where the pregnant lady gave birth to a boy, without any medical support and care.
- g. It was enquired fact that there was unexplained delay in the arrival of Ambulance from R.H. Molgi to reach at breakdown point.
- h. No effort before referring the patient to R.H. Molgi, to enquire about the availability of doctor or staff was made by the Health Assistant, Sunanda Valvi. Health Assistant should have indicated the R.H. about referral made by her and the Condition of the Patient.

- i. None of the reports says, why the treatment of “intact placenta”, could not be done at Rural Hospital Molgi? Whether it was absence of Gynecologist/Doctor, Anesthesiologist or some other reason. A Rural Hospital is supposed to be equipped and manned to handle such cases.
 - j. All the reports and submissions made before the commission is silent about the presence of doctors at the RH Molgi. It is not clear who exactly extended the treatment?
 - k. Even in critical medical condition of intact Placenta, profuse bleeding no medical staff accompanied the Pregnant lady to Civil Hospital, Nandurbar.
15. The commission on the basis of above observations and after considering various submissions intended to award the compensation to the kin of the victim as relief to the violation of her human right of right to life which encompasses right to proper medical treatment.
16. The State commission in pursuant to sec 16 of The Protection of Human Rights Act, 1993 issued summons to all concerns including Additional Chief Secretary (ACS), Public Health Department, (PHD) Maharashtra State. All remained present and submitted their defense, except, ACS, PHD.



17. The State Commission after considering submissions made by the concerned medical staffs, District Civil surgeon and District Health officer, is of the view that the maternal death of Mrs. Kavita Raut has occurred due to negligence, apathy, poor training, lack of proper infrastructure and absence of medical officers and staff.
18. In a welfare State the primary duty of the Government is to secure the welfare of the people. Providing adequate medical facilities for the people is an essential part of the obligations undertaken by the Government in a welfare State. The Government discharges this obligation by running hospitals and Health Center which provide medical care to the person seeking to avail those facilities. Article 21 of the Constitution of India imposes obligations on the State to safeguard the right to life of every person. Preservation of Human Life is of paramount importance. The Government Hospitals run by the State and the medical officers employed therein are duties bound to extend medical assistance for preserving human life. Failure on the part of the Government Hospital to provide timely medical treatment to a person in need of such treatment results in violation of his right to life guaranteed under article 21.
19. It is now a well-accepted proposition in most of the jurisdictions that monetary or pecuniary compensation is appropriate and indeed an effective and sometimes perhaps the only suitable remedy for redressal of the established infringement of the fundamental right to life of a citizen by the public servants and the State is vicariously liable for their acts. The claim of the citizens is based on the principle of

strict liability to which the defense of sovereign immunity is not available, and the citizen must receive the amount of compensation from the State.

20. In the report submitted by the SP, Nandurbar, it was revealed that the victim of this case, Mrs. Kavita Raut, was of 23 years of age, at the time of her death (as per UID), 12th pass, a housewife survived of one son (delivered at the time of death) and her husband, Magan Gama Raut, R/o Rautpada Bardi, Akkalkua, Nandurbar. She used to reside with her husband and Mother-in-Law, before delivering a boy and her death.

21. The compensation in the present case is computed on the basis of guidelines provided by various judgments in case of death of housewife in motor vehicle accidents and otherwise due to negligence. As per guidelines notional income of housewife is considered above minimum wage of an unskilled labour. Here, while computing compensation, notional income of Mrs. Kavita Raut is taken as minimum wage at Agriculture employment in Zone III, prescribed as Minimum wages in Maharashtra from 1.1.2026 to 30.06.2026, which is Rs. 8315 /month. The computation is as follow:

- a) Notional monthly income of deceased: Rs.8315/-
- b) Future prospects (age below 40) 40%:
 $\text{Rs.8315} + \text{Rs.3326} = \text{Rs.11,641/-}$
- c) Annual Income: $\text{Rs. 11,641} \times 12 = \text{Rs. 1,39,692/-}$
- d) Personal expenses deducted, 3 dependent 1/3:
 $\text{Rs.1,39,692} - 46,564 = \text{Rs. 93,128/-}$



e) Multiplier of 17 for age 21-25: Rs.93,128 X 17= Rs.

15,83,176/-

f) Funeral expenses: Rs. 15000/-

g) Total compensation: Rs.15,83,176 + 15,000/- =

15,98,176/-(rounded to Rs. 16,00,000/-)

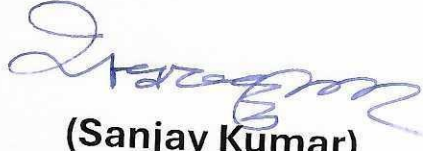
22. The State Human Rights Commission by invoking its power given in section 18(a)(i) gives following recommendations:

- a) The State is recommended to pay compensation of Rs. 16,00,000 (sixteen lakhs) to, the husband of deceased Mrs. Kavita Raut, Shri Magan Goma Raut, for the violation of Human Right to Life of his wife, leading to her death.
- b) Half of the compensation amount Rs. 8,00,000/- (Eight Lakhs) should be given as fixed deposit for 10 years in the name of newly born child, Crise, after confirming his name. It will help in education and other needs of future of newly born child.
- c) The payment should be made within 90 days from the date of order, otherwise the state will pay an interest of 6% on the compensation amount till date of actual realization.
- d) The hon'ble secretary of the State Commission is directed to communicate the recommendation as per procedure to the Additional Chief Secretary, Public Health Department and Nodal Officer of

State of Maharashtra, as per the Government order of Home Department, dated 04 February 2026, to Joint Secretary, POL – 14, Home Department, for the compliance as per sec. 18 (e) of the Protection of Human Rights Act, 1993, in stipulated time.

- e) The office is directed to intimate all the respondents of this case of the order by sending copy of the order.
- f) With this recommendation, Case No 3725/13/16/2024 stands closed and disposed.




(Sanjay Kumar)
Member, MSHRC



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