Office of the West Bengal Clinical Establishment Regulatory Commission
3rd Floor, Standard Assurance Building 32 B.B.D. Bag, Kolkata – 700001.
Phone:- (033) 2262-8447, Email: wbcerc@wb.gov.in Website: www.wbcerc.gov.in

1. Shri Abhijit Chakraborty
2. Smt. Shalu Chakraborty,
   Wife of Shri Abhijit Chakraborty of
   38/10, Nabapalli Ranjan Nagar, P.O. Joka,
   P.S. Haridevpur, Kolkata -700 104

Versus

Apollo Gleneagles Hospital Limited, Kolkata
58, Canal Circular Road, Kolkata – 700 054

BEFORE :

The West Bengal Clinical Establishment Regulatory Commission

Judgement in Complaint ID KOL/2017/000005

Date: 23/06/2017

This is a case arising out of the complaint against the Apollo Gleneagles Hospitals for negligence in treatment of a four month old baby Kuheli Chakraborty filed with the Commission by the parents Mr. Abhijit Chakraborty and Mrs. Shalu Chakraborty resident of 38/10, Nabapalli Ranjan Nagar, P.O. Joka, P.S. Haridevpur, Kolkata -700 104 under Complaint ID KOL/2017/000005.

(2) The complaint in brief is that baby Kuheli Chakraborty was admitted to the Apollo Gleneagles Hospitals on 15.04.17 at about 4.00 p.m. by first approaching emergency of the said hospital and thereafter was admitted as inpatient in the paediatric ward under Dr. V R Srivastava. The parents had approached the Apollo Hospital on a reference from ESI Hospital, Joka for an endoscopic procedure due to passage of blood in stool since last 4 days. The parents complained that as it was the Bengali New Year on 15th April, no doctors were available in the paediatric department and the next day also being the Sunday the baby was not attended to. It was informed to the parents that a sigmoidoscopy was planned for 17.04.17 at 4.00 p.m. and the baby to be kept NBM on IV Fluid from 7 a.m. The parents were informed in late afternoon that the operating Dr. Mahesh Kumar Goenka was unavailable for his personal reasons on the day and therefore the sigmoidoscopy had to be cancelled and were further informed that a colonoscopy would be carried out next day i.e., 18.04.2017 around 5 p.m. by the same doctor. The parents complained that due to NBM on consecutive two days the baby had become weak and was getting unconscious before the scheduled procedure at around 4.30 p.m. on 18.04.17. However, the doctors did not listen to the parents and carried on the procedure for which the baby got cardiac arrest after the colonoscopy leading to the baby being put on ventilator from 6.30 p.m. on 18.04.17 till death of the baby on 19.04.17 at 7.45 a.m. It is further alleged that the doctors gave a dose of anaesthetic (Ketamine) which led to the cardiac arrest of the baby.

(3) The complaint by the parents was filed on 23.04.17 and the Apollo Hospitals were served the complaint and asked to submit their response to the Commission. The hospital filed their reply on 25.04.17 by Dr. Sujay Kar. Director, Medical Services denying the alleged negligence by the hospital or its doctors as stated in the complaint.

(4) On receipt of response from the hospital as stated above, the Commission decided to issue notice to the complainant and the respondent Hospital Apollo Gleneagles for hearing on 05.06.2017 including the connected doctors i.e., Dr. V R Srivastava (Consultant, Paediatric Surgeon), Dr. Mahesh Kumar Goenka (Consultant, Gastroenterology) and Dr. Sanjay Mahawar (Consultant, Anaesthetist).

(5) Parties were present during the hearing on 05.06.17.

(6) The Commission heard the complainant wherein it was submitted that on the admission day i.e., 15.04.17 a doctor on duty advised admission under Dr. V R Srivastava who first examined the baby on 16.04.17 and said that the case will be handled by the Gastroenterology

Department of the hospital and further procedure carried out by them. The baby was assessed by Dr. S C Tiwary, Consultant from the Gastroenterology Department in the late afternoon on 16.04.17 following which it was advised that the baby to be kept NBM from morning of 17.04.17 till the procedure scheduled at around 4 p.m. Accordingly, the baby was kept NBM on IV fluid since morning but around 3 p.m. they were informed by Dr. Srivastava that the sigmoidoscopy will not be done as Dr. Mahesh Kumar Goenka was unavailable. The parents were additionally informed that the procedure would take place around 4 p.m. next day and it will be for colonoscopy rather than sigmoidoscopy. It was also advised the baby will have to be kept NBM and on IV fluid from next day morning. Parents submit that from the morning of 18.04.17 the baby started showing uneasiness and vomiting several times and which was reported the nurses on duty but no doctor was available. This continued through the day and the parents apprehended that given the physical condition of the baby it may not be appropriate for her to undergo surgery which they wished to communicate to the doctors. Dr. V R Srivastava had taken a round in the ward in the afternoon but had not advised anything in particular. At round 4 p.m. the baby was taken by the nurses to another building along with mother of the baby in a wheel chair. The mother submits that she wished to speak to the doctors before the baby was being taken in the procedure room. However, she claims no such opportunity was given to her. The parents further submit that as soon as the baby was brought out of the procedure room, there was a melee of some doctors around the baby and they were taking the baby to ITU. Parents were not allowed access to the baby, as they later came to know, was put on ventilation and thereafter passed away in the morning of 19.04.17.

(7) The Apollo Gleneagles Hospitals represented by its CEO Dr. Rana Dasgupta, submitted that he had nothing further to submit except what has been filed as a reply on behalf of the hospital. The response is as follows:-

On 15.04.17, baby of Mrs. Shalu Chakraborty was referred from ESI Hospital, Joka as a case of passage of blood in stool since last four days for endoscopic procedure. The patient was seen by the on duty pediatric doctor at 4 pm in the ER and advised admission under Dr. V. R. Srivastava (Consultant, Paediatric Surgeon). She was admitted at 4:38 pm on 15.04.17 in Bed no. P-20 (Paediatric General Ward).

On 15.04.17 (Evening), in the Ward the baby was assessed by the on duty pediatric doctor. The baby on examination was haemodynamically stable. The case was discussed with Dr. V. R. Srivstava and her advice was followed. Gastro referral was given on admission. The child was stable overnight.

On 16.4.17, the baby was seen by Dr. V. R. Srivastava and a per rectal examination was done (no definite polyp was felt) and lower GI endoscopy was advised. The baby was haemodynamically stable and was on demand oral (Zerolac) diet. At around 2 pm the baby was assessed by Dr.S.C.Tiwary Consultant from Gastroenterology Dept. and his advice was followed. At around 8pm Dr. V. R. Srivastava was informed that sigmoidoscopy was planned for 17.04.17 at around 4 pm and baby to be kept NBM (Nil By Mouth) from 12 noon and simultaneously to be started on IV fluids.

On 17.04.17, at 9 a.m. the baby was seen by Dr. V.R. Srivastava - planned for sigmoidoscopy to be kept NBM from 11am and to receive enema. IV Fluid was started at 11am as planned. At around 2:30pm Dr. Subash Tiwary informed over phone that in view of no definite polyp in rectum on finger examination, no active ongoing bleed and need for two times anesthesia for two repeat procedures (sigmoidoscopy and then colonoscopy), a decision was taken to cancel sigmoidoscopy and perform full length colonoscopy next day after proper preparation. These reasons were explained to the admitting consultant also (Dr. V.R. Srivastava). Colonoscopy was scheduled for around 4 pm on the following day (18.04.17) and the child could be restarted on feeds. She was started on feed immediately and IV fluids was stopped at around 5pm. The same was conveyed to the parents by Dr. Subash Tiwary. The child was stable overnight.

18.04.17 the baby was kept NBM from 10 am for the endoscopic procedure and maintenance IV fluid was started. Dr. V. R. Srivastava had seen the baby at 11 am. Bowel preparation was also started in the Paediatric Ward. The child was sent to Gastro Department at around 4:15 pm. The colonoscopy was done by Dr. Mahesh Kumar Goenka (from 4:49 pm - 4:54 pm) under moderate sedation with injection Ketamine under close anesthetic monitoring by Dr Sanjay Mahawar, Consultant Anesthetist. The child was shifted to the observation room at around 10 minutes later, where the child suddenly developed cardiac arrest and CPR was started immediately. The child was intubated and put on manual bag and tube ventilation and appropriate medicines were given. The PICU team headed by Dr. P. S. Bhattacharya (Consultant Paediatric Intensivist) were also informed, who arrived immediately. They were joined by

Consultant Cardiologist Dr D Ghosh. Initially, the heart rate was low, but gradually improved to 180 per minute with wide complexes. She was shifted to PICU at 6:10 pm. The parents were counselled and updated about the entire course of events which occurred during that time.

In PICU, the child was put on mechanical ventilation. The heart rate was 156 per minute (broad complex tachycardia), BP 74/46 mmHg on inotropes. Injection Calcium Gluconate (in view of low calcium on the blood gas) was started. The child was assessed continuously by the PICU team and also seen by Dr. Mahesh Kumar Goenka and Dr. V. R. Srivastava. The family was continuously counselled and updated on hourly basis. A 2D echo was done at 2:50 am on 19.04.17 and it showed generalized wall motion abnormality with ejection fraction of 40%. In spite of best efforts, the child again developed cardiac arrest around 7 am on 19.04.17 and had persistent acidosis and hypocalcemia. Despite all resuscitative measures which lasted for more than one and half hours, the child could not be revived.

She was clinically declared dead at 8:50 am on 19.04.17.

An Enquiry Committee was constituted with the following members:

Dr Pradip Mukherjee, Senior Consultant Paediatric Surgeon , NRS Medical College and Hospital, Dr Biswanath Mukhopadhyay, Senior Consultant Paediatric Surgeon , Apollo Gleneagles Hospitals, Kolkata, Dr Partho Bhattacharya, Medical Superintendent, Apollo Gleneagles Hospitals, Kolkata, Dr Tanmoy Das : Senior Consultant Anaesthetist, Apollo Gleneagles Hospitals, Kolkata.

A meeting of the Committee was convened on 20.04.17 at the Board Room of Apollo Gleneagles Hospitals, Kolkata at 11 am. The Committee deliberated on the case, went through all documents and submitted the report. We are also detailing below a point to point reply to issues raised in the complaint letter.

(i) **No doctor was available on 15th and 16th April.**

Patient was seen on 15th April by the pediatric doctor on duty and on 16th April by the Consultants from Pediatric surgery (Dr. V.R. Srivastava) and Gastroenterology (Dr. S. Tiwary) as well as residents.

(ii) **Colonoscopy was fixed for 17th April and then cancelled after keeping fasting for long hours.**

Sigmoidoscopy and not colonoscopy was fixed for 17th April. Patient had be NBM for the same for about 3-4hrs, but was on regular IV fluids. Sigmoidsocopy was not cancelled for nonavailability of doctors but in view (a) no definite polyp felt in rectum, (b) no urgency to do a limited study (sigmoidoscopy) since bleeding had stopped, (c) avoid risk of anesthesia twice if two procedures were to be done-sigmoidoscopy and colonoscopy.

(iii) **Patient was kept on empty stomach again on 18th since morning and became weak and unconscious and the same was conveyed to the doctors.**

Patient was kept NBM but was given IV fluids while in the Paediatric Ward. Dr. Sanjay Mahawar did assess the patient before the procedure and she was hemodynamically stable before and during procedure. Colonoscopy procedure lasted for 5 minutes and there was no direct procedure related complication. On both 17th and 18th of April, the child received optimal nutrition by way of oral and IV fluids. At no time in our knowledge the child was left to fast as when the child is kept by NBM as part of procedural preparation, even then IV fluids offer enough calories.

(iv) **High dose sleeping medicines was given during ventilation in PICU**

The resuscitation and subsequent management was done by a team of doctors led by Dr. P.S. Bhattacharya. Appropriate dose of sedation was administered to the child for post arrest stabilization as per protocol. The aforesaid allegations are incorrect and hence refuted.

(v) The Committee concludes that there was

a. No delay in doctors in seeing and evaluating the child on 15th and 16th April, 2017. The team of Pediatric Consultants, Residents and Gastroenterology doctors saw the patients promptly and regularly.

b. The plan of changing from sigmoidoscopy to colonoscopy was justifiable to avoid multiple anaesthesia. Though the child had to fast for 3-4 hours in view of this change of plan, but IV fluids were continuing.

c. The child had cardiac arrest in the recovery, the same was managed judiciously

d. The dose of Ketamine was appropriate.

e. Patient had persistent and resistant hypocalcemia and high PTH levels which could only be corrected partially.

f. The Committee feels that there is no negligence from Medical Aspect."

(8) In his oral submission, Dr. Mahesh Kumar Goenka submitted that he was first informed of carrying out a sigmoidoscopy on the baby at 2 p.m. on 17.04.17 and since he was unavailable for doing such a procedure by 4 p.m. he advised it to postpone it to next day around same time. It is further submitted by him that he advised for carrying out a full colonoscopy rather than a sigmoidoscopy. Next, he saw the baby only in the procedure room at around 4.30 p.m. on 18.04.17. He carried out the procedure which lasted for about 5 minutes and was uneventful. He further submitted that a follow up x-ray on the baby was done on 18.04.17 at 6.49 p.m. and later on 2.46 a.m. on 19.04.17 which showed no perforation or bleeding to confirm that the colonoscopy procedure was appropriate and not mishandled. He had left the procedure room but came back again on call after 10 minutes when the baby developed cardiac problems and was present when the baby was being examined by a cardiologist post-operation.

(9) Dr. Sanjay Mahawar submits that he first saw the baby only in the procedure room 20 minutes prior to the procedure and he administered anaesthesia in keeping with the established protocol for the procedure. On being asked he further submitted that he had no consultation with the parents or any other doctors prior to the procedure. He also could not draw any light in particular about the baby developing cardiac complications immediately post-procedure.

(10) In her submission, Dr. V R Srivastava said that when she first examined the baby on 16.04.17, she immediately advised that this case would be of the gastroenterology department and consequently Dr. S C Tiwary examined the baby on the same day. Thereafter the baby was managed on the advice of doctors from gastroenterology department through nurses. She did take a round of the ward and saw the baby on 17.04.17 but did not advice in particular.

(11) In view of the above submissions, the following points emerge for determination:

(i) Whether there is any medical negligence on the part of OPs as alleged ?

(ii) Whether there is any mismanagement or deficiency in service on part of the hospital ?

(iii) Whether the complainant is entitled to any relief ?

(12) Decisions with reasons:

(i) The West Bengal Clinical Establishment Regulatory Commission constituted under the West Bengal Clinical Establishments (Registration, Regulation and Transparency) Act, 2017 is entrusted with the powers and functions under Section 38 of the said Act which empowers it to examine and consider complaints, filed manually or electronically through an online system in matters related to patient care service, deviations from declared fees and charges, refusal of supply of copy of medical records and allied matters, alleged irrational and unethical trade practice alleged before the Commission by the aggrieved patient parties against clinical establishments and after issue of notice and hearing both parties, adjudicate, compensate and pass such other orders, as deemed appropriate. It also has powers to award such compensation as deemed appropriate not exceeding fifty lakh rupees, including interim compensation.

(ii) In the particular case the Commission has given adequate opportunity to the OP to file its response on the complaint and served notice of hearing giving due opportunity of being heard to all parties. The overall case which emerges is as follows :

(iii) The baby, Kuheli Chakraborty was admitted at around 4 p.m. on 15.04.17 and advised admission by the Duty Medical Officer to admit under Dr. V R Srivastava. Next day i.e., 16.04.17 Dr. Srivastava advised colonoscopy and referred the case to gastroenterology department though no written advice of such transfer of patient is available. On being examined by Dr. S C Tiwary of the gastroenterology department on 16.04.17 it was decided to have a sigmoidoscopy procedure even though Dr. Srivastava had advised for colonoscopy in keeping with referral from ESI Hospital, Joka. Nothing is on record to show as to how a decision was taken to do sigmoidoscopy in place of colonoscopy. It is also a fact that Dr. Mahesh Kumar Goenka who was supposed to carry out the sigmoidoscopy procedure was unavailable on 16.04.17 and as per his own admission he came to know about undertaking such a procedure on 17.04.17 only at 2 p.m. He advised a colonoscopy in place of sigmoidoscopy. However, no reasons for his change of opinion without even examining the patient is available in the records. It further emerges that when the parents were concerned about the baby indicating weakness and continuous vomiting since the morning of 18.04.17 there was no check up from the gastroenterology department as to the evaluation of the baby regarding her condition to be fit enough to undertake the procedure. As per records it is evident that when the baby was admitted to Apollo Hospital her condition was haemodynamically stable and passing of blood

from the stool had stopped since morning of 15.04.17 and continued to be stable until the morning of 18.04.17 when she started showing symptoms of weakness and vomiting, possibly arising out of the fatigue she may have faced during the previous day of having been kept NBM and on IV fluid. The baby was put off IV fluid from the evening of 17.04.17 when it was decided to cancel the procedure. Dr. Mahesh Kumar Goenka and Dr. Sanjay Mahawar have both submitted that they saw the baby first time only in the procedure room which is about 20-30 minutes before the procedure though each one has stated that the actual procedure carried out was in keeping with the standard medical protocol. We are aware that the baby developed cardiac problems immediately after the procedure and resuscitation procedure failed till the baby was declared dead in the morning of 19.04.17.

(iv) Some obvious questions arise as to whether the hospital was delivering the optimum level of service by keeping the baby for a simple 5 minutes colonoscopic procedure for over three days and whether it could be considered as the standard protocol treatment for the colonoscopy ? The answer is a definite "No" as the records clearly point that the services of doctors were not available on Sunday (16.04.17) and on Monday (17.04.17) and thus the baby had to be put twice on NBM and IV fluid and at least on one occasion for no medical reason which is on 17.04.17. The deterioration in condition of the baby can be attributed to her being subjected to unnecessary NBM and ignoring her physical condition on 18.04.17 while once again putting her under NBM. Colonoscopy/sigmoidoscopy is a simple procedure which can be done in less than 24 hours and in this case too it could have been done so as no medical reasons are available for not doing so. The baby was haemodynamically stable since the time of admission. If the hospital was aware that it does not have services of sufficient doctors to attend on two consecutive days, it could have advised the parents to come at a later day as this procedure was not of such critical nature to need the baby to remain inpatient for three days. Thus the hospital is in complete wrong to have kept the baby inpatient for over three days to carry out the colonoscopy.

(v) We now revert back to the conduct of doctors involved in management of the patient. From the record of events it is simply clear that the baby required almost no medical assistance since the time of admission and uptill morning of 17.04.17 when it was first kept on NBM and IV fluid. The fact that the baby was transferred under the care of gastroenterology ward in place of paediatric ward has not been recorded and submissions made by doctors clearly point to a role which is unfocused and confusing in terms of patient management. It may not be

farfetched to presume that once Dr. Srivastava opined about doing a colonoscopy and the patient put under the management of gastroenterology department, her responsibilities ceded. However, there is also nothing on record to show that apart from a single examination by Dr. S C Tiwary, the gastroenterology department was efficient enough to timely coordinate with the operating Dr. Mahesh Kumar Goenka or the anaesthetist. Had it been so, when the condition of the baby deteriorated on 18.04.17, her hydration levels and other parameters could have been re-assessed, and it could have been possible that the baby would not have been put under anaesthesia on that day. As to the assessment of hydration level, there is no record of urine output having been taken and electrolyte levels assessed. There is also no records as to why advice of colonoscopy was changed to sigmoidoscopy and thereafter again to colonoscopy without a doctor examining the patient. Even though Dr. Srivastava claims that the patient was transferred under the care of gastroenterology department, the death certificate has been signed by her.

(vi) The hospital suo moto constituted an internal enquiry committee with Dr. Pradip Mukherjee, Dr. Biswanath Mukhopadhyay, Dr. Partha Bhattacharya and Dr. Tanmoy Das who have conveniently overlooked glaring lacune as we see from the records and submission of the hospital and the connected doctors. Dr. Pradip Mukherjee has been stated to be a Senior Consultant Paediatric Surgeon at NRS Medical College & Hospital. On verification it appears that there is none serving at the NRS Medical College & Hospital as Senior Consultant Paediatric Surgeon, which is a Government hospital. Thus, it is extremely unethical and inappropriate by the Apollo Hospital to incorrectly designate someone and place him as a member of enquiry committee, which has failed to impartially evaluate the case.

(vii) It may be so that doctors have a set of activities in carrying out a procedure. However, in this particular case it is clear that none of the two important doctors in the act i.e., Dr. Goenka and Dr. Mahawar ever saw the patient physically to assess whether she is capable of undergoing such a procedure. Moreover, none of his team doctors evaluated critical parameters of the baby. The Commission is surprised to note that if a doctor does not evaluate a patient properly before carrying out a procedure it clearly falls under the domain of negligence. We can safely conclude that neither Dr. Goenka nor Dr. Mahawar were aware of the baby's condition prior to the procedure and they went ahead mechanically in carrying out the colonoscopy. Even though on records it is satisfying that the colonoscopy itself was uneventful as also revealed from the x-rays, the same could not be said regarding condition of

baby to undergo anaesthesia and recover back. In view of the foregoing discussions it is amply clear that the hospital did not manage the baby in an appropriate manner, there was lack of communication between the duty doctors, consultant doctors and nurses, the baby was kept for over three days in the hospital for no apparent medical reason and therefore the hospital, the three attending doctors, viz., Dr. V R Srivastava, Dr. Mahesh Kumar Goenka and Dr. Sanjay Mahawar seem to be negligent in treatment and the hospital is additionally guilty of deficiency in services which it is required to professionally provide for, lack of coordination, mismanagement, misrepresentation of facts and making the patient to over stay.

(13) Ordered:

The Commission under the West Bengal Clinical Establishment (Registration, Regulation and Transparency) Act, 2017 is empowered that if any clinical establishment whether by itself or by any other person on its behalf, while providing services causes injury to the service recipient or his death, due to negligence or any deficiency in providing service, it shall be lawful for the Commission, on substantiation of charges, to direct it to pay compensation to the victim or the legal representative of the victim, a sum which shall not be less than ten lakh rupees in case of death; provided further that in case of death, an interim relief shall be paid to the next of the kin within 30 days of the incident.

The Commission having concluded that the clinical establishment i.e., Apollo Gleneagles Hospitals is guilty of mismanagement and misrepresentation of facts, deficiency in services, negligent and also having come to the conclusion the three doctors viz., Dr. V R Srivastava, Dr. Mahesh Kumar Goenka and Dr. Sanjay Mahawar seemed to be negligent in carrying out the treatment as expected, the Commission awards a compensation of Rs.30.00 lakh to be paid by the Apollo Gleneagles Hospitals. Of the said Rs.30.00 lakh, an amount of Rs.10.00 lakh to be paid to the complainant parents, on providing the name for receiving such compensation, within a week and the balance Rs.20.00 lakh in next 3 weeks. Failure to give compensation in due time by the hospital would make it liable to pay an interest of 9% p.a. till the payment is fully made.

The matter of prima facie negligent treatment by the said doctors is hereby also referred to the West Bengal Medical Council in terms of the provisions of section 38(1)(iii) of the West Bengal Clinical Establishments (Registration, Regulation and Transparency) Act, 2017 for taking necessary and appropriate action and inform the Commission about the action taken.

Parties be informed. Copy of the order be placed on website of the Commission.

Sd/-
Anil Verma
Acting Chairperson

Sd/-
Dr. Sukumar Mukherjee
Member

Sd/-
Prof.(Dr.) Gopal Krishna Dhali
Member

Sd/-
Prof (Dr.) Abhijit Chowdhury
Member

Sd/-
Prof (Dr.) Makhanlal Saha
Member

Sd/-
Dr. Madhusudan Banerjee
Member

Sd/-
Dr. Maitreyi Banerjee
Member

Sd/-
Smt. Sanghamitra Ghosh
Member

Sd/-
Dr. Debashis Bhattacharya
Member

Sd/-
Shri Anuj Sharma
Member

Sd/-
Shri Pravin Kumar Tripathi
Member

Certified authenticated.

West Bengal Clinical Establishment Regulatory Commission
सत्यमेव जयते

Secretary
W.B.C.E.R.C.
Kolkata-1