THE WEST BENGAL CLINICAL ESTABLISHMENT REGULATORY COMMISSION.

Present: Justice Ashim Kumar Roy, Chairperson.

Dr. Madhusudan Banerjee, Member

Dr. Makhan Lal Saha, Member.

Dr. Gopal Krishna Dhali, Member.

Prof.(Dr.) Debashis Bhattacharya, Member.

Dr. Maitrayee Banerjee, Member.

Smt. Madhabi Das, Member.

COMPLAINT ID: HOW/2017/000190.

Mr. Krishna Kumar Verma.....Complainant.

-versus-

Bhagirathi Neotia Woman & Child Care Centre & others.....Respondents.

Date of judgment: 22nd December, 2017.

J U D G M E N T.

The complainant Krishna Kumar Verma filed his complaint against Bhagirathi Neotia Woman & Child Care Centre (In short Neotia Hospital) and against Dr Sujata Dutta alleging inter alia as follows:

2. His daughter Anjali Shaw, while carrying a baby for 37 weeks and a few days on July 21, 2017 at around 5.30 am was admitted at Neotia Hospital with gestational diabetes melitus and

hypothyroidism for delivery. On the same day she delivered a still born baby by caesarean section. According to the complainant, on the same day (21st July, 2017) around 7 am USG was done and nothing adverse was reported and both the mother and the baby were well. At around 8 am Dr Sujata Dutta, a gynaecologist arrived at the hospital for performing the delivery of the patient. Within half an hour, at around 9.30 am Dr Sujata Dutta informed the patient party, showing them a USG report that the baby in the womb is not alive and is dead. When the dead body of the baby was made over to them, it was found to be bluish. It was their further case that the colour of the body clearly indicates that the death was either due to wrong medication or poison as a result of negligent treatment.

3. The allegation made by the complainant was contested both by the clinical establishment and the doctor and they filed their reply in the form of affidavit stating as follows:-

On 21st July, 2017, the patient was admitted in Bhagirathi Neotia Woman and Child Care Centre at 05:39:06am for caesarian operation under Dr. Sujata Dutta. As a normal protocol at the time of admission all previous treatment related papers, including OPD papers of the patient were taken for the purpose of further procedure and treatment by the inpatient department. Immediately after admission, the on duty in house Medical Officer,Dr Deborjyoti Pal, in consultation with the consultant Dr. Sujata Dutta had prescribed the patient, "injection SUPACEF/SOCEF 1.5gm, IV (AST), AT 7:30AM, and injection RANTAC, 1 such I.V. at 7:30am." In accordance with the aforesaid prescription, injections were given to the patient by the on-duty sister. The medicine was administered and injections were given as per normal protocol and as

per the advice of the consultant. After admission, Doppler Test was done at around 6:05 am when the foetal heart sound was found 152 beats/minute by the in house Medical Officer and when was repeated at 06:40 am, the foetal heart sound was found 148 beats/minute. The patient was shifted to the operation theatre at around 8:30am for caesarian operation scheduled to be held at around 9am. However, at around 8.40am in OT complex foetal heart sound was found absent by the in house Medical Officer and by the consultant Dr. Sujata Dutta and instantly a further USG was conducted at 9.07am and that did not demonstrate any foetal cardiac pulsation and accordingly patient party was informed. The patient party was immediately apprised to minimize the risk of infection for immediate induction of labour for normal vaginal delivery and to prevent uterine scarring for benefit of future pregnancy but the patient relatives insisted for caesarian section and in writing both the complainant and the husband of the patient gave their consent. The operation was performed and a still born baby was taken out and the baby was "fresh still born". The allegation of negligence was categorically denied. The still born baby was taken out fresh with no sign of life including flat oxymetertrace and the question of turning of the colour of the skin to blue cannot arise at all. The relative of the patient declined post mortem of the still born baby when asked by the hospital authority.

As per norms of the hospital all original OPD papers submitted by the patient at the time of admission was usually returned to the patient party within 1 or 2 days. On 22nd July, 2017 similarly original OPD papers were photo copied for returning the same to the service recipient Anjali Shaw. On the previous day (21-07-2017 at around 9.27am) another patient Akaansha Garg was admitted at Neotia Hospital and was accommodated in the same floor where Anjali

Shaw was undergoing treatment. While in the process of returning the original papers to the patient Akaansha Garg and Anjali Shaw their OPD paper were intermingled and the original admission advice and heamatology report of Akaansha Garg were handed over to Anjali Shaw by the on duty sister. The fatal heart sound of patient Anjali Shaw could not be felt from 8.45am and patient Akaansha Garg was admitted at around 9.27am. Therefore, no negligence in the treatment of Anjali Shaw prior to her delivery and thereafter, could have occurred by confusing with the medical papers of patient Akaansha Garg. It was categorically denied that on July 24, 2017 no hot water was flashed from the hand shower of the commode and as soon as complaint was received immediate inspection was done and the allegation were found baseless.

4. Heard the parties. Considered their respective submissions and perused the medical file of the patient Anjali Shaw.

5. We find the patient was a regular patient under Dr. Sujata Dutta, who after passing MBBS obtained a certificate of specialist training (CTT) in England from Royal College and was registered for seven years. She also worked as a consultant at East Surrey Hospital, London for a period of one year.

Now, after careful perusal of the medical file of the patient, we do not find any lack of prenatal care or fault either by the doctor in the patient management or on the part of Neotia Hospital.

It be noted when we find that primarily the allegation is one of medical negligence against a doctor, we restrained ourselves from proceeding any further in view of statutory

restriction contained in first proviso to clause (iii) of section 38 of the West Bengal Clinical Establishments (Registration, Regulation and Transparency) Act, 2017 but on being insisted by the complainant and the husband of the patient, we looked into the same for their satisfaction. We therefore, make it absolutely clear that any observation touching the issue of medical negligence shall have no bearing if such issue arises for consideration before any other appropriate forum.

6. We do not find any merit in this case and stands dismissed.

Sd/-
Justice Ashim Kumar Roy
Chairperson

Sd/-
Dr. Madhusudan Banerjee, Member.

Sd/-
Dr. Makhan Lal Saha, Member.

Sd/-
Dr. Gopal Krishna Dhali, Member.

Sd/-
Prof.(Dr.) Debashis Bhattacharya, Member

Sd/-
Dr. Maitrayee Banerjee, Member.

Sd/-
Smt. Madhabi Das, Member.

West Bengal Clinical Establishment Regulatory Commission ★ Kolkata-1

Authenticated

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