

Office of the West Bengal Clinical Establishment Regulatory Commission

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Case Reference: WBCERC/SPG/228/2025-2026

Present: Justice Ashim Kumar Banerjee (Retired), Chairman

Dr. Sukumar Mukherjee,

Dr. Makhan Lal Saha

Dr. Maitrayee Banerjee,

Sri. Sutirtha Bhattacharya, IAS (Retd)

Smt Madhabi Das – Member

Mr. Sourav Mishra.....Complainant

- Versus-

Bhagirathi Neotia Woman & Child Clinic and CMRI

.....Respondent

Heard on: January 05, 2026 and March 18, 2026.

Judgment on : April 13, 2026.

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BACKDROP

Ms. Ankita Sultania, wife of Sri Sourav Mishra, the complainant above named was in the family way. On November 23, 2025 suddenly she developed profused bleeding and severe pain abdomen. She attended the Emergency at Bhaghirathi Neotia, Park street at about 11.22 pm. She was examined by the Emergency Medical Officer Dr. Roshni (RMO) in the urgent critical care unit. Doctor Roshni advised for immediate admission. The patient was admitted under Dr. Joyita Biswas. She was also advised for USG for foetal viability. After the admission it transpired that the USG advised could not be done in absence of a sonoloigst.

According to the CE, Dr. Prem Kamani the concerned sonoloigst was on call. She was contacted when she informed that at least 45 minutes would be required to attend the patient. Although she stays nearby she cannot derive. She

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would have to call her driver who stays at Tollygunge and after the driver would come she would be able to proceed to the hospital.

As she was having profused bleeding per vagina her husband contacted CMRI whether USG TVS could be done at that time. CMRI hospital replied in the affirmative. The patient accompanied by her husband, left Neotia at 12.10 am and reached Emergency of CMRI. The patient was admitted at about 1.35 am when the same problem arose as they could not immediately arrange for USG TVS probably, in absence of sonologist. In the process, the golden hour was lost. Ultimately, the patient left CMRI and got admitted at Woodlands when the procedure was done. However, she was compelled to abort.

Being aggrieved, the complainant the husband of Ankita, filed this complaint as against both the CEs.

RESPONSE

The CEs gave their response which are as under:-

BHAGHIRATHI NEOTIA

Ankita came to the hospital on November 23, 2025 at about 11.22 pm with the complaint of per vaginal bleeding as Ankita was pregnant for six weeks and six days. Dr. Roshni, Residential Medical Officer (RMO) attended the patient and advised for immediate admission, medications and USG for foetal viability. The patient was admitted under Dr. Joyita Biswas. Dr Biswas was contacted. She advised for USG foetal viability and to continue medication that the patient had been already taking. USG facility was available at the said hospital "on call" basis at night as there was no regular Radiologist / Sonologist available at the hospital at night. The patient was counselled and informed that maximum 40-45 minutes would be required for doing the USG. The patient

and her husband refused to get the patient admitted and left the hospital at 12.10 am on November 24, 2025. The CE would assert that test could have been arranged however, it might take 40-45 minutes for that the patient did not wait and left the premises.

CMRI

The patient was brought to the Emergency when she was examined. She had continuous bleeding per vagina since 7.30 pm. On PV examination, the Cervical OS was found to be closed with no cervical motion or tenderness. The Emergency Medical Officer advised USG WA FPP in line with standard emergency medical protocol to evaluate the cause of bleeding and assess the status of the pregnancy. Upon admission, the patient was advised to keep her bladder full for USG, however, by the time the radiologist met the patient for USG, it was found that her bladder was not full, as she might have

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passed urine in the meantime. It is pertinent to mention that owing to the urgency of the said case, even the radiologist was summoned from home for doing the USG of the patient. The radiologist did the ultrasound of lower abdomen (on empty urinary bladder) for which no gestational Sac could be seen in the endometrial cavity.

Since the USG did not yield conclusive or desirable diagnostic findings, the patient was advised to undergo re-scan after full bladder and TVS for better imaging results. The on duty Gynae Resident doctor advised for TVS to look for foetal localisation and viability. Since TVS was an invasive procedure they proceeded for abdominal scan FPP which is a non-invasive procedure.

Facts remains the TVS was not done. The allegations of mis-behaviour and non-cooperation at CMRI was not specifically dealt with.

REJOINDER

The complainant gave rejoinder to the response. According to him, the patient was under regular check up of Dr. Sarbani Ghosh, who was out of station on the fateful day. At 10.16 pm the complainant called the hospital help line and informed about the Emergency. The hospital should have arranged for appropriate preparation that was not done.

The patient reached at 11.25pm. The Emergency Medical Officer observed “advised TVS for foetal viability **URGENT**”. However, the hospital could not do TVS, as advised. The hospital also did not provide any Emergency treatment to the patient and treatment was refused in absence of authorisation letter from Dr. Sarbani Ghosh who was admittedly out of station. The hospital ultimately advised to wait till 12 noon on the next day for TVS test. As a result, the complainant could not wait and contacted CMRI who assured

they would do the TVS procedure. The patient was taken to CMRI. At 12.15 am the patient was admitted. However, no Emergency treatment was given for about 4 hours. No TVS was conducted. No treatment was given to control bleeding. No senior or junior doctor examined the patient. When they asked for discharge that was also denied. When the complainant called up Lalbazar Control Room and Alipore Police Station the Police force came and in presence of police force the patient was taken out from the CE at 4.25 am. At that time no wheel chair was provided, no nurse or attendant assisted the patient. The patient had to walk all the way to portico having continued the bleeding.

HEARING

We heard this matter initially on January 5, 2026. In course of hearing Bhaghirathi Neotia would explain in detail about their inability to do the TVS test at the time when the

patient was at the Emergency. According to Neotia, Dr. Prem Kamani, the concerned Sonologist was residing at 35, Aheri Pukur Road Kolkata 700019 that would be close to the hospital. When Dr. Kamani was contacted she informed that she would take “**maximum**” 40-45 minutes to reach hospital as she did not know driving and her driver would come from a distance of 15 minutes. She would have to call her driver over phone and on arrival of her driver she would reach the hospital at the earliest.

Her assertion was strenuously disputed by the patient herself who was present online. According to her, “**maximum**” word was an afterthought. The doctor clearly told over phone that she would need **at least** 40-45 minutes time to come to the CE.

So far the CMRI is concerned the complainant contended, he had audio- visual recordings at CMRI.

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According to CMRI, the patient was examined at the Emergency when she was advised admission. She got admitted. The doctor examined her. USG was done. However, FPP, USG did not have required result hence, she was advised to go for TVS. However, she forcibly left the premises without having any DAMA or LAMA.

On the prayer of Neotia, we permitted them to share information about the concerned Sonologist. We also permitted the complainant to share Audio-Visual recordings that he was having.

We placed this matter for further hearing on March 18, 2026 when we considered the written communication dated February 26, 2026 from Neotia giving detailed address of the concerned sonologist and the interaction they had with the sonologist on that day. We also examined the Audio-Visual

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clippings pertaining to stay at CMRI. We concluded the hearing and reserved our judgment.

OUR VIEW

We have examined the complaint, response, rejoinder and further rejoinder by the Neotia as well as the Audio- Visual clippings that the complainant shared with us.

NEOTIA

As per Neotia, the patient had bleeding and pain abdomen from 7.30 pm hence, it was an acute Emergency. The complainant already informed the hospital about the problem at about 10.25 pm. Hence, Neotia should have made arrangement for TVS scan at the earliest. From the records it appears that such prior information to the hospital did not help the patient at all. The concerned Sonologist was staying close to the CE. The hospital should have sent their transport to bring the sonologist at the earliest that was not done. The

word "maximum" is nothing but an afterthought as we find from the strenuous dispute raised by the patient herself.

We find flaw with Neotia on that score.

CMRI

The CMRI also advised admission of the patient. The patient was admitted, as per their record, at about 1.35 am and she left the hospital at 4.50 am. For three hours she was there. She needed TVS scan that was admittedly not done at CMRI. From the video recordings we find, there was no senior executive present at the relevant time. From the video clipping, we have seen the patient walking down through the corridor for getting in the car. No wheel chair support was given till the patient reached the portico to board the car when the wheel chair support was not at all needed.

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The Audio and video recordings have been shared by the complainant with CMRI. CMRI could not confront such recordings.

There was one more salient feature which we cannot overlook.

We have patiently heard audio recording of the conversation that the complainant had with Dr. Gourabdeep Bhattacharjee, Deputy Medical Superintendent of CMRI over phone. From the conversation, it appears that after the incident CMRI conducted an in-house enquiry. We received the complaint on December 4, 2025. We immediately forwarded the complaint for necessary response to CMRI. CMRI gave their response on December 29, 2025. We heard the matter on January 5, 2026 and thereafter March 18, 2026. For the entire period the CMRI did not inform us about the result of their in-house enquiry and the steps taken by them against the erring

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officials that would show how casual they are in the process of redressal of grievance in the present case.

In course of hearing we enquired about the result of such in-house enquiry. In purported compliance of such enquiry, by a letter dated March 25, 2026 CMRI has only communicated inter-alia the following:-

“The organization has seriously taken into consideration such lack administration and has thus appointed a specific and experienced administrative personnel as night administrator to mitigate such situation.”

No copy of the minutes and / or report of the said enquiry committee has been shared with us.

We also do not know whether any step was taken by the CE against those erring officials for such unpleasant and unfortunate incident.

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CONCLUSION

Ankita had to abort. We do not know whether the foetus was alive when Ankita reached Neotia or CMRI. However, the trauma that she faced throughout the fateful night at Neotia as well as CMRI, would definitely deserve appropriate dealing at our end.

Neotia claims to be a well reputed unispeciality hospital in the city. They would admit, they do not have any in-house Emergency facility at night for radiological investigation that is obviously an issue that they must address. Had there been a proper "on call" arrangement the problem could have been taken care of.

We impose a penalty of Rs. 1,00,000/- as against Neotia.

Compared to Neotia, CMRI is a Higher set-up having multispeciality service. They must have regular Radiologist / Sonologist available to do the procedure at the earliest. The

patient was there for more than three hours. We find from the records maintained by CMRI, they could not do the required procedure up to 4.50 am when the patient left the CE. Moreover, when the patient left in presence of the police force she was not given any wheel chair support which is quite inhumane.

We impose a penalty of Rs. 2,00,000/- on CMRI.

We direct Neotia and CMRI to pass on the compensation to Ms. Ankita Sultania at the earliest with the intimation to the Commission.

The complaint is disposed of accordingly.

BEFORE WE PART WITH

We received complaint, response as well as rejoinder prior to the hearing. We heard the matter on January 5, 2026 when we granted liberty to the parties to share further information and /or documents. Parties shared information and / or records



that we considered at the final hearing on March 18, 2026 when after conclusion of the hearing we reserved it for judgment. During pendency of the judgment the complainant sent two more written arguments dated April 2, 2026 and April 4, 2026. We consciously did not deal with the same as the hearing had already been closed.

Sd/-

(ASHIM KUMAR BANERJEE)

We agree,

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Dr. Sukumar Mukherjee,

Sd/-

Dr. Makhan Lal Saha

Sd/-

Dr. Maitrayee Banerjee,

Sd/-

Sri. Sutirtha Bhattacharya, IAS (Retd)

Sd/-

Smt Madhabi Das – Member

Aulhesh Chakrabarti

[Signature]
Secretary
West Bengal Clinical Establishment
Regulatory Commission