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Case Reference:WBCERC/NPG/253/2025-26

Present: Justice Ashim Kumar Banerjee (Retired), Chairman

Dr. Sukumar Mukherjee,

Dr. Makhan Lal Saha,

Dr.Maitrayee Banerjee,

Smt Madhabi Das – Member,

Mr.Ramiz Raja Mullick……...….Complainant

- Versus-

GNRC MEDICAL, Taki Road ……Respondent

Heard on: February 11, 2026.

Judgment on : March 27 , 2026.

BACKDROP

On October 29, 2025 Wasim Raja Mullick aged about 43 years old attended the Emergency of GNRC MEDICAL, Barasat at 9.43 am with the history of pain abdomen. The CECT, whole abdomen mentioned acute appendicitis with impending perforation. Yet, the patient was admitted under a physician and not under a surgeon. Throughout the first day of admission no surgeon attended the patient although the patient was referred to surgeon by the attending doctor on the day of admission as we find from the record.

The concerned surgeon had seen the patient on the second day at 3 pm and planned for appendectomy as would appear from his note dated October 30, 2025. On the third day i.e; October 31, 2025 the surgery was done at the later part of the day.

There had been post operative complication. The family was not satisfied with the treatment. They got the patient discharged on LAMA on November 2, 2025 and admitted the patient at Charnock

Hospital where the USG revealed, a part of the appendix was yet to be removed and the patient would need curative surgery.

In course of hearing, we come to know, the patient is recovering and is under follow up by the team of doctors at Charnock Hospital.

COMPLAINT

Being aggrieved, the complainant approached us with his complaint for hospital negligence. On examination of the complaint we find, the main issue would be keeping the patient untreated for over 48 hours without doing any surgical intervention that perhaps resulted in post operative complication. During surgery the appendix was found raptured luckily, the patient could be saved after being transferred to another establishment.

RESPONSE

On receipt of the complaint we asked for a response from GNRC. GNRC filed their response along with the medical records on February 9, 2026. Perusal of the entire medical records would support the grievance of delay raised by the complainant.

HEARING

We heard the parties at length.

The hearing was concluded and we reserved our judgment.

EXPERT OPINION

In course of hearing, our esteemed medical member Dr. M.L. Saha has evaluated the entire medical records. He also interacted with the parties concerned. Dr. Saha has given his opinion as under :-

Mr Wasim Raja Mallick 43 years male patient attended GNRC Hospital on 29.10.25. morning with right sided lower abdominal pain for 1 day. He was seen at ER and was advised admission under a physician Dr Arghya Roy.

After admission underwent blood investigations and USG abdomen. Other preoperative workup done on 29.10.25 after admission.

Blood investigations done on 29.10.25 (sample sent at 12.18pm and report time 1.46pm on 29.10.25.) Total leucocyte count was 14670 with polymorph 84% suggesting acute infection. Vural serology on 29.10.25. was also negative.

USG done on 29.10.25-probe tenderness in right iliac fossa with fat strandling- suggested CECT scan to rule out acute appendicitis.

After admission on 29.10.25. at 12.45 a referral to general surgery was done. And at 5 pm it was noted in BHT as general surgery transfer and diagnosed as acute appendicitis.Pateint was referred to Dr S Halder

Patient was seen by a surgeon and advised for escalation of antibiotics and also advised for CECT scan of abdomen. At 6pm on 29.10.25. the note recorded as transfer to general surgery from general medicine.

There was no record of transfer to surgery side on 29.10.25 and was not reviewed by surgeon on 29.10.25 night.

CT scan advised on 29.10.25. at 6pm

CECT scan done on 30.10.25 revealed acute appendicitis with impending perforation.

PAC was done by ? name not clear on 30.10.25 at 3pm and advised for ECHO. Anesthetist also noted that if emergency may be taken up for surgery with high risk consent.

ECHO study done on 30.10.25. and noted in BHT as normal study with EF 65%

Patient was seen by surgeon Dr A Mukherjee on 30.10.25.(time not mentioned). Noted CT finding of acute appendicitis with impending perforation and advised IV fluid, Nil by mouth, PAC, Consent for surgery and planned for Lap/Open appendectomy. Dr Mukherjee did not mention about the date and timing of the operation

Another note on 30.10.25 noted serum bilirubin of 5.2(Direct 0.3 and indirect 4.9)Patient was advised Tab Udiliv, Repeat CBC and LFT and advised to take a high risk consent.

Patient also seen by Dr Pranab Kr Bhattacharya MD (Medicine)- But no specific advise given by him.

Repeat CBC revealed normal leucocyte count and further increase in serum bilirubin level to 6.6mg%.

2D Echocardiography done on 30.10.25. revealed trivial TR,trivial MR and mild AR. However EF was 65%. Normal cardiac chambers. No significant wall motion abnormality seen. No PAH, No pericardial effusion.

Preop advice in BHT- Plan Lap/Open appendicectomy(No date and time in this advice)

There is no record in BHT regarding operation plan on 30.10.25

One preop advise is recorded ion BHT but there are no date and time in that advise.

Consent for the operation including high risk consent from relatives taken on 31.10.25 at 10am.

High risk consent signed by the wife of patient Mrs Piyalee Chakraborty.

Patient was operated by Dr A Mukherjee on 31.10.25. at 2pm. Under spinal anesthesia- Open appendectomy + peritoneal lavage + repair of enteral defect. Appendix was inflamed with perforation at base, abdominal collection with a fecolith.

Postoperative note written on 341.10,25 at 3 pm. Patient was aadvised for shifting to ICU.

Postoperative note in BHT on 31/10.25 at 3.15 pm revealed hypotension and patient was started on Inj Noradrenaline. And also advised for FFP transfusion.

Seen on 1.11.25. at time not mentioned BP 100/60mmHg and was on Inj Noradrenaline..On 1.11.25. at 2.25pm patient was shifted to emergency ICU as per advise of Dr Anirban Mukherjee.

Seen at 4.30pm on 1.11.25. and vital parameter improved to some extent but still on Inj Noradrenaline drip.

BHT note on 1.11.25. at 6pm- details of patient condition not noted. Case discussed with Dr A Mukherjee advised for Inj Pot Chlor and Inj Lasix 4 amp IV stat. SPO2 96% on 6 litres of Oxygen.

Notes in BHT on 2.11.25. by RMO suggestive of respiratory distress. Advised ABG, Chest Xray and medicine refer.

Patient relatives was not happy with the condition of the patient and wanted to shift him to a higher centre. In view of condition the on duty

doctor noted patient unfit for transfer. Pateint realtives persisted and took transfer to higher centre.

However in discharge note of GNRC on 2.11.25. mentioned patient as hemodynamically stable.

Patient was seen at ER at Charnock Hospital on 2.11.25. at 3.05pm. Vitals were stable and patient was afebrile

Admitted at Charnock hospital on 2.11.25 at 4.25 pm under Dr Nirmalya Bagchi.

On 2.11.25 at 9pm patient condition deteriorated and patient was intubated due to discomfort and fall of SPO2. Patient was treated conservatively at Charnock Hospital and was later extubated and recovered well and was discharged on 13.11.25. A CECT scan abdomen done at Charnock revealed a long stump of appendix , suggesting that the primary surgery done at GNRC might be incomplete and patient may require further treatment for the retained stump of appendix afterwards.

Patient relatives complained that although the patient was diagnosed with acute appendicitis on admission on 29.10.25., the surgery was

unnecessarily delayed and was done after 48 hours of admission. Also complained that inspite of the deteriorating condition the treating doctor failed to communicate them the deteriorating status of the patient. They opted for transferring the patient to a higher centre. Wanted a thorough enquiry into the incident and prayed for compensation.

The reply submitted by the CE denied all the allegations. Patient was attended at ER on arrival and was referred to surgeon without any delay. USG reveled probe tenderness in right iliac fossa.CT scamn was done on 30.10.25 revealed acute appendicitis with impending perforation. The patient was taken up for surgery on the very next day on 31.10.25 and claimed there was no delay on the part of the CE. Patient relatives were counseled regularly on the condition of the patient .

Observation and comments:-

- *43 years old gentleman presented with lower abdominal pain and vomiting for one day duration and was assessed by EMO at GNRC on 29.10.25. The clinical presentation was suggestive of*

acute appendicitis. USG done on same day revealed probe tenderness in right iliac fossa and high leucocyte count was strongly suggestive of acute appendicitis. However patient was seen by a surgeon on 29.10.25 evening and advised for a CECT scan to confirm the diagnosis. GNRC hospital has their own CT scan unit. However the CECT scan was not done on 29.10.25. ***So there was delay in getting the CECT scan done at GNRC by one day.***

- *CECT scan done on 30.10.25 and reported as acute appendicitis with impending perforation, This should have raised an alarm for quick referral to surgeon on 30.10.25. and urgent execution of surgery. Surprisingly the surgeon sho has seen the patient earlier was not available on 30.10.25 and patient was referred to another surgeon Dr A Muklherjee on 30.10.25. Dr Mukherjee saw the patient on 30.10.25 and given preoperative and advise and asked for PAC. PAC was done on the same day 30.10.2025.* ***Surprisingly no step was taken to get the surgery done on 30.10.25 itself in view of impending appendicular perforation which is a critical emergency. The statement by CE that***

surgery was done on the very next day is not acceptable. There has been undue delay in execution of this emergency surgery.

- *Operation note revealed appendicular perforation with collection in peritoneal cavity for which peritoneal lavage has been done. Postoperatively patient was having hypotension and required noradrenaline support and patient was also requiring high oxygen therapy.* ***There is no record of proper postoperative counseling regarding the status of the patient. Patient relatives sensing the deteriorating condition of the patient opted for transfer to a higher centre. Although patient was on Noradrenaline support and high oxygen therapy in discharge it was mentioned that patient was hemodynamically stable.***

- *At Charnock Hospital patient was critically ill with ARDS and infective complications, and required ventilator support and supportive support. Patient responded to treatment at Charnock Hospital and discharged home in stable condition. The CT scan done at Charnock hospital revealed retention of segment of the*

appendix. ***The intensive treatment at Charnock Hospital has saved the patient 's life.***

- ***This is true that patient was suffering from complicated appendicitis and deterioration of the patient was due to the underlying disease. However the CE should have been mnore proactive in management of such critical emergency. There has been definite delay in providing optimal surgical care for this patient. Also the postoperative deterioration was also not properly managed.***
- ***This is a fit case for award of compensation to the complainant. Patient may require treatment subsequently for incomplete primary surgery done at GNRC.***

OUR VIEW

We have perused the expert opinion given by Dr. M.L. Saha as quoted supra. On a combined reading of the medical records as evaluated by Dr. Saha, the following issues reveal:-

I) The patient was suffering from acute appendicitis that could be clear from the symptoms as detected by the Emergency Medical Officer on October 29, 2025. Hence, the patient should have been admitted directly from Emergency under a surgeon that was not done.

II) After admission, the patient was seen by a surgeon in the evening who advised CT scan to confirm the diagnosis. The CE had CT scan unit. However, it was not done on October 29, 2025 for reasons best known to the CE.

III) On October 30, 2025 another surgeon examined the patient and advised for PAC. Surprisingly no attempt was made to do the surgery on October 30, 2025 although the CT scan done on the second day, clearly revealed that there had been acute appendicitis with impending perforation which was critical Emergency. Ultimately, the surgery was done on October 31, 2025 at 2 pm after obtaining High Risk Consent from the wife of the patient that was obtained at 10 am. Soon after the surgery the patient had hypotension. On November 1, 2025 his BP was 100/60. At 4.30 pm vital parameters improved to some extent. However, there had been respiratory distress. On November

2, 2025 the relatives were not happy and transferred him to another establishment where it was found that the original surgery was incomplete as a long stump of appendix still remained that would require curative surgery.

IV) The patient is now stable and is under treatment by the other establishment.

V) The patient had acute appendix with perforation and the condition was too critical. There could be serious complication during or after surgery. The CE However, did not arrange for immediate surgery.

Considering the backdrop as highlighted supra, we are of unanimous view that delay in surgical intervention must have expedited the process of deterioration. Fortunately, the patient's life could be saved at the other establishment after transfer.

The patient was admitted on October 29, 2025. He was seen by a surgeon at the evening on the same day. Even then the patient was admitted not under a surgeon. Another surgeon visited the patient on the second day of admission who did not specifically plan surgery.

Surgery was actually done on the third day of admission and that too, at a later part of the day.

The CE was duty bound to explain such delay that they miserably failed.

Fortunately,by the grace of God, the patient could be saved. However, the trauma that the patient and the patient relatives had undergone in the mean time, would certainly justify appropriate compensation.

We award Rs. 5,00,000/- as compensation payable by the CE (GNRC) to the complainant at once.

The complaint is disposed of accordingly.

Sd/-

(ASHIM KUMAR BANERJEE)

We agree,

Sd/-

Dr. Sukumar Mukherjee,

Sd/-

Dr. Makhan Lal Saha,

Sd/-

Dr. Maitrayee Banerjee,

Sd/-

Smt Madhabi Das,

Authenticated

Secretary
West Bengal Clinical Establishment
Regulatory Commission