THE WEST BENGAL CLINICAL ESTABLISHMENT REGULATORY COMMISSION.

Present: Justice Ashim Kumar Roy, Chairperson.

Dr. Sukumar Mukherjee, Member.

Dr. Makhan Lal Saha, Member.

COMPLAINT ID: KOL/2017/000227.

Jayanta Dey .....Complainant.

-versus-

KPC Medical College and Hospital.....Respondents.

Date of judgment: 27th Nov, 2018.

J U D G M E N T.

The case of the complainant Mr. Jayanta Dey, as it transpires from his letter of complaint runs as follows,

On August 25, 2017, at around 4.30 pm, the son of the complainant, aged about 14 years, a student of class XII, after returning from school at around 4.30 p, complained of acute pain in lower abdomen. As no local doctor was available, he was immediately taken to emergency department of KPC Medical College and Hospital. The complainant with his son reached the hospital at around 6.30 pm, when the doctors at emergency attended him and in injections and other oral medicines were administered. After medication, the complainant's son was looking better. Then the hospital authority asked the complainant whether they have any medical insurance or not and after communication that they have the medical insurance, the complainant was told that his son be kept admitted at their nursing home for some days for

observation. The complainant was also told that it was suspected that his son might have appendicitis and that can be confirmed by ultrasonography. As advised by the doctors, the complainant got his son admitted under Dr. A.K. Sarkar. On the next day, when they came to the hospital around 9.30 am in the morning, they found USG was still not done and his son reported that he has no pain but feeling very hungry. Ultimately the USG was done around 12.30 pm after 18 hours of admission of the son of the complainant also the same was advised to be done immediately at the emergency. The complainant requested Dr. A.K. Sarkar for giving some food to his son but Dr. Sarkar told him no food can be given as he was under drip. On that day, at around 2 pm, the complainant's wife Ruchita Dey was at the hospital and according to her, till that time condition of her son was stable. At around 4 pm they received a phone call from the hospital that condition of his son is quite critical and he has been transferred to ICU. Around 4.10 pm when they reached the hospital, they were told that his son had a cardiac attack and at 4.40 pm, he was declared dead.

It is also alleged that when the doctor advised for immediate USG test why there was a delay of 18 hours in doing such procedures. They are unable to understand what caused death due to cardiac attack within 2 hours after his wife left the hospital finding his condition quite stable.

2. Following the above letter of complaint, the complainant addressed another letter to the Commission in which it is pointed out that his son was admitted with acute lower abdominal pain and was primarily diagnosed that he was suffering appendicitis but the reason of death, as per the hospital authority, was due to cardiac attack, whereas according to the post-mortem report, death was due to lung infection in a case of pneumonia. He had contacted Dr. Jatish Sohay, HOD at Jabbalpur Medical College and he opined a patient admitted with acute appendicitis cannot die with pneumonia within 24 hours of admission. I was prayed that a medical board be constituted for a transparent viscera report and formation of a medical board. He suspected there was an uncanny link between the KPC Medical College and Hospital and the post-mortem doctor.

3. The clinical establishment in their reply submitted through Dr. Ashis Kumar Sarkar, under whom the patient was admitted, denied the allegations made in the complaint and submitted as follows,

Master Sayandeep Dey, 14 years, was admitted through the emergency of KPC Medical College & Hospital on 25/08/2017 at about 06.30PM with pain in the right lower abdomen and anorexia for 2-3 hours. There was no vomiting.

On examination, general survey was unremarkable and the chest was clear. He developed fever (101^0 F) at about 10PM. There was tenderness over the RIF (Right Iliac Fossa) but no rebound tenderness, psoas test, Rovsing's Sign were negative. Bowel sounds were present. Senior Residents examined the patient repeatedly - on admission, at 8PM and at 11PM. The intensity of the pain lessened and became mild by 11PMA provisional diagnosis of appendicitis was made

Initial plan was to treat on conservative lines till reports of investigations were available and the patient was put on IV fluid, broad spectrum antibiotics. Analgesics and PPI. Oral intake was stopped as a possibility of surgical intervention was there. Complete blood count, Blood sugar, urea, creatinine, Urine for R/E and whole abdomen USG was advised. Abdominal USG is recommended as first line imaging for confirmation of diagnosis of suspected appendicitis specially in children as accompanying radiation with CT is a concern. USG costs less and has a specificity of around 80%. When the patient was examined, he was conscious cooperative and oriented.

There was no abdominal pain and the patient was afebrile. On general survey there was tachycardia (98/min). Chest was clear. Abdomen was soft and bowel sounds were normal. There was mild tenderness over the right iliac fossa. The hernia sites and scortum were normal. Blood count shows TLC=13,100/cumm, Neutrophils 86% and platelet count was 2 lacs/cumm. Blood glucose, urea. Creatinine and electrolytes were normal. The condition of the patient was communicated to his father but he was anxious because no food was given to him. Since, no USG was done, he was explained that it was not advisable to feed him and then USG department was spoken.

The sonologist commented that there was no abnormality except for bilateral increased renal cortical echogenicity. Retrocaecal Appendix could not be evaluated.

The patient remained comfortable after returning to the ward, but at 2.45PM he complained of pain in the umbilical region. A resident doctor attended to the patient immediately and found the vitals to be stable, chest to be clear, abdomen soft without any muscle guard. After consultation with S.R. injections of Diclofenac and antispasmodics were given and the pain subsided about an hour later the patient suddenly developed acute respiratory distress along with frothing from mouth and nostrils. The on call residents attended immediately. They found the patient unconscious, pulse and B.P. were not recordable, SpO2 was 55% with oxygen. Airway was inspected and oropharyngeal suction done. Bag mask ventilation with oxygen was started. Injections Hydrocortisone, Adrenaline, antiemetic and H2 inhibiters were administered. After consultation with him over phone, the patient was shifted to the ICU immediately.

In the ICU the patient was found to be unconscious, all pulses were absent, BP was not recordable. Patient was intubated and CPR started. Unfortunately, asystole persisted and patient could not be revived in spite of their best effort.

4. As regards the specific allegation made against the Clinical Establishment, the same was dealt with separately:

a. According to the doctor under whom the patient was admitted, there was actually no delay since there was no emergency. However, he contacted the radiology department and requested them for an early appointment for USG of the patient. Subsequently, the USG was done and nothing revealed there from which needed urgent attention or change in treatment plan.

b. Since on careful consideration of details of clinical history, findings and investigation, no explanation was found for causing death, the autopsy was recommended to determine the cause of death but till date no report was received.

c. A provisional diagnosis of appendicitis was made and surgical intervention may have been necessary. In that case any food in the stomach would have been a problem. On the next

day, the patient was waiting for USG of whole abdomen which required 4-6 hours fasting. Water was given to wet the mouth.

Fasting for eighteen hours with continuous IV fluid infusion does no serious damage to the patient. Following surgery, patients young and old are treated with IV infusion without food sometimes for many more hours. Feeling hungry may be a good sign but after the USG the patient had to be given injections for another bout of abdominal pain so we considered it safe not to start oral feeds, If the patient becomes drowsy it may cause aspiration.

d. The patient was treated as per standard medical practice and procedure. He was repeatedly assessed for his pain at regular intervals. He was examined on each occasion and medicines administered accordingly.

On initial assessment it was decided to wait for further investigation reports and treat on conservative lines till reports were made available.

e. Antibiotics were given as he was having abdominal pain, fever and leukocytosis. Analgesics, antipyretics and antispasmodics were given for pain and fever. IV fluid was given for hydration. Relevant investigations were done regarding blood, urine and imaging.

On sudden respiratory distress treatment was initiated immediately and resuscitatory measures were carried out in the ICU as per standard protocol.

5. The parties were heard at length. Their respective submissions were considered. Before the Commission, the attending resident medical officer and two staff nurses were examined on oath and their statement were recorded. The medical documents were very carefully perused.

6. The members of the Commission have also played an active role in the decision making process and gave their views.

7. We find that on 25.08.2017, the service recipient, a child aged about 14 years, with acute pain in lower abdomen and anorexia, had been to the emergency of KPC Medical College and Hospital. At the emergency, he was attended by the doctor and beside above no other medical abnormality was found. The patient was provisionally diagnosed to have been suffering from appendicitis. On the next day, USG was done and there also nothing abnormality was detected except bilateral increased renal cortical echogenicity. The patient was found otherwise stable

and normal. However, on the next day, the patient complained of pain in the umbilical region. Immediately, the resident doctor, Dr. Sumedha Bhattacharjee, attended him although the vitals were found to be normal still the boy was complaining of pain in abdomen and the doctor advised for Inj. Buscopan and Dynapar. Such injection was advised and administered on 26.08.2017 at around 2.45pm. It is now found from the medical records that around 3.45pm. about one hour after the administration of injection, the patient was examined by Dr. Swarnali Mukherjee and as the boy was found unconscious, pulse not recordable, BP not recordable and froth was coming out from mouth and nostril and oxygen saturation fell abnormally (SpO2 55%), he was immediately shifted to ICU and finally expired.

8. This is a case where admittedly, since the treating doctors were unable to ascertain the cause of death, the case was referred for post-mortem. The post-mortem report was produced before the commission and the same was taken into consideration. It appears according to the opinion,..... *death was due to diseased process of both lungs, ante mortem in nature. A mode of natural death.*

However, till date viscera report is not available before the commission.

9. (a) As noted above the doctor on duty in the ward was examined before this commission. According to her at around 2.45p.m she examined the patient and noted her observation in the bed head ticket. At that time she discussed the matter with Dr. Debasish Kundu and advise injection Buscopan and Dynapar. After about 15/20 minutes she reviewed the patient and found that his condition was better. But her observation was not noted in the bed head ticket.

(b) Ms. Arpita Bera, a staff nurse, attached to KPC Medical College and Hospital and registered with the West Bengal Nursing Council, administered injection on the patient. According to her statement recorded on oath as per the advice of doctor, she administered injection Buscopan and Dynapar A. Q. intra muscular, 1 in each buttock. However, in the treatment sheet, the same was noted by a student nurse Susmita Adak.

10. Therefore the facts remain according to the opinion of the post-mortem doctor the death was due to diseased process of both lungs and a natural death. However, it is all through the case of the clinical establishment that the patient attended emergency with acute pain in lower abdomen and was provisionally diagnosed a case of appendicitis and there is no remote

indication in the clinical note that there was any sign of pneumonia either on admission or during his stay in the hospital. Only other thing we find there is no record in the treatment sheet as to what happened between 2.45p.m and 3.45 p.m. on 26.08.2017. However, according to the attending doctor (Resident Medical Officer) Dr. Sumedha Bhattacharjee she examined the patient about 15 minutes after the administration of those two injections and found the patient was stable. In fact from the material on record we do not find any case deficiency in patient care service has been made out, except the findings of the treating doctors and autopsy surgeon are patently contradictory. Till date viscera report is not available. If the opinion of the autopsy surgeon is finally accepted a case for medical negligence may tend to make out. It may also be a case of error in judgment. However, those are the matters to be adjudicated by the West Bengal state medical council not by this commission.

We, therefore, with the above observation close and dispose of this case. If so advised the complainant may approach the appropriate forum in accordance with law.

Sd/-
Justice Ashim Kumar Roy
Chairperson.

Sd/-
Dr. Sukumar Mukherjee, Member.

Sd/-
Dr. Madhusudan Banerjee, Member

Sd/-
Dr. Makhan Lal Saha, Member.

Authenticated

27/11/2018
ARSHAD HASAN WARSI
WBCS (Ex)
Secretary
W. B. C. E. R. C.