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Case Reference: ID-NPG/2018/000457

Present: Justice Ashim Kumar Banerjee (Retired), Chairman
Smt. Sanghamitra Ghosh, IAS, Vice – Chairperson
Dr. Sukumar Mukherjee,
Dr. Gopal Krishna Dhali,
Dr. Makhanlal Saha,
Dr. Madhusudan Banerjee.
Dr. Pradip Kumar Mitra
Dr. Maitrayee Banerjee

Mrs. Mala Pal.....Complainant
- Versus-
ILS Hospitals, Salt Lake (Prof. GPT Health Care Pvt. Ltd.) and Colombia Asia Hospital (A Unit of Navketan Nursing Home)
.....Respondent

Heard on: February 15, 2019, April 16 2019
Finally Heard on: May 16, 2019.

Judgment on: September 19 **, 2019**

APOLOGY

The hearing was concluded on May 16, 2019. However, the post-mortem report duly certified by the Inspector-in-Charge of the South Bidhannagar Police Station, was available on August 2, 2019. Hence, there was considerable delay in delivery of the judgment. Even after receipt of the post

mortem report, we have taken little time to deliver this judgment. I, on behalf of the commission, tender unqualified apology to the parties to the above proceedings.

FACTS

Gour Sundar Pal aged about 64 years was hit by a private motor car in Salt Lake on July 11, 2018 at about 5 to 6 p.m. He was immediately rushed to ILS Hospital, Salt Lake, Calcutta where he was given first aid. The external wounds were dressed. He was referred to a higher set up. From the medical records, it would appear, he was brought at 6 p.m. and discharged at 6.41 p.m. He was admitted in Colombia Asia Hospital, Salt Lake at 7 p.m. He unfortunately passed away at 11.45 p.m. on the same day. His widow Mrs. Mala Pal lodged a complaint of medical negligence as well as hospital negligence against both the clinical establishments referred to above.

COMPLAINT IN BRIEF

Mrs. Pal lodged a written complaint dated August 9, 2018 as against both the clinical establishments. The relevant extract is quoted below: -

> *I, hereby, would like to bring your attention to some matters that not only include the immediate misfortune of my family but also the concern of those that might face the same situation as mine. My husband, Late Gour Sundar Pal, had a road traffic accident (RTA) on 11th July, 2018, around 5:15pm, near Mishra Hotel, DJ Block, Sector-11, Salt Lake, Kolkata-91. He was riding a cycle and following the correct side of the road when a WAGON-R with the number plate- WB083677, came from behind and hit my husband, which caused him immediate severe internal injuries. Due to the pressure of the public that witnessed the accident, the woman who was driving the*

vehicle, took my husband to ILS Hospitals at 6:00pm. But instead of providing him with the emergency treatment that he desperately needed, they only checked his vitals and dressed his minor external wounds. Despite mentioning in their report that the patient's CNS was drowsy, they did not take any necessary action to relive the problem. The ILS Hospitals did not register the details of the person who admitted the patient to their facility, nor did they record IPC and PC, which they were legally bound to do in case of RTA. However, when I was informed of the accident I requested them to begin the treatment as soon as possible and rushed to the hospital. After reaching there, I noticed that the woman that had caused the accident had fled from the scene and there was no doctor attending my husband; he was being treated by a nurse and a midwife. Then I was told by the ILS authority that they had no facility to treat an emergency patient as my husband and we should move him to another facility. The patient was discharged from there at 6:42pm and when asked, the ILS Hospitals did not provide us with an ambulance or any other transport that was equipped with medical support needed for an RTA patient. I hired a general car by ourselves and took him to Columbia Asia but the process took a considerable amount of time which deteriorated the patient's condition.

My husband was admitted to Columbia Asia at 8:24pm and was rushed to the ICU. However, they, too, did not record the IPC and PC, thus violating the law. After their initial assessment they informed us of my husband's injury, that included- (RIB CAGE BROKE, PELVIC BONE DISLOCATED, RIGHT LEG FRACTURED, HEAD INJURY, OXYGEN CONSUMPTION DETORIATING, HAEMMORAGE)' Also, we were informed that my husband was admitted under the neuro surgeon but he was the last to check on the patient, hours after his treatment was started. ***According to the doctors, the patient has suffered alarming level of internal bleeding and was in immediate need of a blood transfusion that would have stabilized his condition****. But the hospital did not have their own blood bank and arranged to get it from outside. When we offered to donate the blood, they refused by stating that it would require more time. However, it took almost*

two hours to get the blood. Already, it was too late by then as my husband had stopped responding to the outside stimuli. If the blood was provided in time, my husband would have a higher chance to survive. After that, the patient was given the ventilation support. And at 11:45pm, he was declared dead.

In the billing provided by Columbia Asia, it was stated that the patient was given medical and medicinal support on 12th, July, 2018, whereas it was clearly stated that that time of death was on 11th July, 2018.

According to the RTA rule, the medical facilities are required to file a police report which Columbia Asia violated by not doing so. And it resulted into keeping the body in their private mortuary and I had to pay for it for their negligence.

The commission asked for comments from both the clinical establishments. The ILS Hospital offered their comments through letter dated February 14, 2019. The relevant extract is quoted below:

Gour Sundar Pal, a 62 years old male (hereinafter referred to as patient) was brought to the Emergency Department of ILS Hospitals, Salt Lake at 6:00 pm on 11/07/2018 who had suffered a road traffic accident (RTA) after he was hit by a car from behind while he was riding on a cycle. Accordingly, he was immediately attended by the concerned Emergency Medical Officer at our Emergency Department and from the medical records it would transpire that on clinical examination, it was found that the patient had swelling in right thigh although all distal pulse was palpable and he could move all digits of right foot. The patient also had wound + in scalp. His heart rate was 64/min, blood pressure was 120/80 mm/Hg, SPO2 was 85% after 8 litre of Oxygen, CBS 144 mg/dl and CNS drowsy.

Accordingly, thereafter ECG was done and IV fluid initiated. Wound dressing were also done along with splinting of right thigh. The patient was given Inj. Drotin and Inj. T-vac and pelvic binder was applied. Kindly appreciate that appropriate first aid was duly given to the patient at the

Emergency Department of our hospital. In fact, an information report was also sent the Police Station on 11/07/2018. However, unfortunately, despite the necessary treatment being given, the patient could not be taken for admission at our hospital because we could not have immediate attendance of an Orthopedic and Neuro Surgeon, which the patient otherwise required immediately post-admission. Accordingly, in the best interest of the patient, we had referred the patient to a higher centre for further treatment management after providing complete first aid without any delay. As such, the question of any negligence in treatment of the patient does not arise as would be evident from the medical documents /treatment records of the patient duly furnished from our end.

They also sent relevant medical records pertaining to the treatment given to Sri Pal, since deceased.

Colombia Asia gave their response through letter dated September 26, 2018. The relevant extract is quoted below:-

Mr Gour Sundar Pal aged about 64 years had presented to the emergency department of Columbia Asia Hospital Salt Lake at 7 ***PM****, 11th July, 2018. His attendants gave a history of an alleged road traffic accident at approximately 5-6 pm (5:30 PM as declared by patient's surrogate in MLC) on 11th July 2018, and stated that he was hit by a car from behind and immediately shifted by bystanders to ILS hospital, Salt Lake, Kolkata where basic resuscitation was done. Patient was conscious at that time as per relatives. From there the patient was shifted to Columbia Asia Hospital at 7 PM, 11th July, 2018, where he was immediately attended.*

At the time of admission, his condition was critical and he was ***hemodynamically unstable*** *with BP of 60/40 mm of Hg and pulse of 70/min. He was immediately resuscitated with IV fluids, colloids and Bipap, followed by ventilation with inotropic support. He was given initial life-saving treatment in ER, where he was attended by registrar's of all specialties like orthopedics, surgery and ICU (intensivists) and then rushed*

to ICU for continuous monitoring and treatment. ***The admission formalities were completed at 8.26 pm but treatment was started on arrival.*** *All registrar's are adequately qualified and are available round the clock.*

The patient had polytrauma with left sided scalp hematoma, with oozing of blood, right femoral? shaft /intertrochanteric fracture +- right tibia fracture, left sided rib fracture, with surgical emphysema, right sided surgical emphysema, left lower limb externally rotated, right lower limb - swelling in thigh, ? hematoma, small penetrating injury over the occipital region, cut injuries over dorsal surface of left arm. A diagnosis of polytrauma was made.

The family was explained about the critical condition of the patient due to internal and external injuries including head injury with ***severe blood loss*** *at periodic intervals. As blood transfusion was required, arrangement for blood was made and till the cross matched blood arrived, colloids were given.*

Planned for CT scan of brain, chest and abdomen, but not done as the patient was hemodynamically unstable. Emergency USG abdomen was done.

Patient had a cardiac arrest at 10 pm and resuscitated within 10 mins. But he continued to be unstable. Subsequently, at 11.10 pm BP was not recordable, pulse not palpable.

Second cardiac arrest at 11:15pm on 11th July 2018. CPR started as per ACLS protocol. but even after 30mins of resuscitation patient could not be revivied. He was declared as dead at 11:45pm on 11th July 2018.

An MLC was filed with Bidhannagar South police station vide no: MLC 6128 and received by the said PS on 11th July, 2018. The body was initially kept in the hospital mortuary and then handed over to the police for post mortem.

The Neurosurgeon Dr. Harish Chandra Gupta saw the patient just before 10 pm but his notes were transcribed at 10.40 pm, as all the doctors were busy with the patient who despite all treatment was hemodynamically unstable. All related specialists like Orthopaedician, CTVS consultant,

General Surgeon, Critical care specialist and others were involved in treatment, but notes are entered late for reason cited above.
Regarding the bill, some charges were levied and dated 12th July 2018, after patient died. This was because of delayed order entry by to 1 hour as the health care personnel were busy with death formalities.

Colombia Asia enclosed medical records pertaining to the treatment.

The matter appeared before us on April 16, 2019 when we gave directions to the parties to exchange affidavits. Accordingly, the complainant filed affidavit dated February 27, 2019. The relevant extract is quoted below:-

I, hereby, would like to bring your attention to some matters that not only include the immediate misfortune of my family but also the concern of those that might face the same situation as mine. My husband, Late Gour Sundar Pal, had a road traffic accident (RTA) on 11th July, 2018, around 5:15pm, near Mishra Hotel, DJ Block, Sector-II, Salt Lake, Kolkata-91. He was riding a cycle and following the correct side of the road when a WAGON-R with the number plate- WB083677, came from behind and hit my husband, which caused him immediate severe internal injuries. Due to the pressure of the public that witnessed the accident, the woman who was driving the vehicle, took my husband to ILS Hospitals at 6:00pm. Instead of doing a personalized evaluation by giving him a thorough and detailed check up required by his condition, they treated his injuries based on layman's assumption, thus denying him the proper care which his severe internal injuries needed at that time. Instead of providing him with the emergency treatment that he desperately needed, they only checked his vitals and dressed his minor external wounds. Despite mentioning in their report that the patient's CNS was deteriorating, they did not take any necessary action to relieve the problem. The ILS Hospitals claimed that they had recorded the IPC/PC but there was no spot visitation by the Police, nor was I contacted by them for starting the MCR (which I had to personally lodge on 13.7.2018). Also, there remains the question, if they had done the IPC/PC,

why could not they provide me with the details of the person that admitted my husband because as per law, the details of the person should be given in the IPC/PC. However, when I was informed of the accident I requested them to begin the treatment as soon as possible and rushed to the hospital. After reaching there, I noticed that the woman that had caused the accident had fled from the scene and there was no doctor attending my husband; he was being treated by a nurse and a midwife. Then I was told by the ILS authority that they had no facility to treat an emergency patient as my husband and we should move him to another facility. The patient was discharged from there at 6:42pm and when asked, the ILS Hospitals did not provide us with an ambulance or any other transportation that was equipped with medical support needed for a severe RTA patient. I had to hire a general car (a private ambulance, which was not a property of the ILS Hospitals, nor it was issued by them) by ourselves and took him to Columbia Asia but the process took a considerable amount of time which deteriorated the patient's condition even further. Without having the proper facility or to treat such serious trauma patients they admitted my husband, gave him a basic aid which led his condition to worsen.

My husband was admitted to Columbia Asia at 8:24pm and was rushed to the ICU. Here, it should be noted that against my claim that they did not register the IPC/PC, the hospital authority said that they indeed registered it. But in this case also there was no spot visitation by the Police, nor was I or my family contacted by them. However, after their initial assessment they informed us of my husband's injury, that included- (RIB CAGE BROKE, PELVIC BONE DISLOCATED, RIGHT LEG FRACTURED, HEAD INJURY, OXYGEN CONSUMPTION DETORIATING,) Also, we were informed that my husband was admitted under neuro-Surgeon but he was the last to check on the patient, hours after his treatment was started during which he already had a cardiac attack. While my husband, a severe trauma patient, needed every kind of medical support that was required at that time for him, they delayed the procedures, thus neglecting the care. According to the doctors, the patient had suffered an alarming level of internal bleeding

and was in immediate need of a blood transfusion that would have stabilized. According to them, the blood would have given him a better chance to resuscitate. But the hospital did not have their own blood bank and arranged to get it from outside. When we offered to donate the blood in order to hurry the resuscitation process, they refused our offer by stating that it would require more time. It took them almost two hours to bring the blood to the hospital from outside. Already, it was too late by then as during that time my husband had other two cardiac attacks and therefore, had stopped responding to the outside stimuli. If the blood was provided in time, my husband would have a higher chance to resuscitate. After that, the patient was given the ventilation support. And at 11:45pm, he was declared dead. However, later, in court, the hospital authority had claimed to provide the blood within half an hour. I refute this claim to be false and demand a visual proof to back their claim.

In the billing provided by Columbia Asia, it was stated that the patient was given medical and medicinal support on 12th, July, 2018, whereas it was clearly stated that that time of death was on 11th July, 2018.

According to the RTA rule, the medical facilities are required to file a police report which Columbia Asia violated by not doing so. And it resulted into keeping the body in their private mortuary and I had to pay for it for their negligence.

Dr. Pramod Sureka, the authorized signatory of ILS Hospital filed affidavit almost reiterating what they had already communicated through their letter dated April 14, 2019. The relevant extract is quoted below:-

a. Gour Sundar Pal, a 62 years male (hereinafter referred to as patient), husband of the complainant herein, met with a road traffic accident (RTA) on 11/07/2018 and accordingly, the patient was brought to the Emergency Department of our hospital at round 6:00 P.M. on the same day with a complaint of hit by a car, while the patient was riding a cycle.

b. That thereafter the patient, since deceased, was immediately attended/ examined by the concerned Emergency Medical Officer (EMO) at the Emergency Department of our hospital. Upon clinical examination, it transpired that the patient had swelling in right thigh although all distal pulse was palpable and he could move all digits of right foot. It further transpired that the patient also had wound + in scalp. His heart rate was 64/min, blood pressure was 120/80 mm/Hg, and SPO2 was 85% after 8 litres of Oxygen, CBS 144 mg/dl and CNS drowsy.

c. Accordingly, thereafter ECG was done and IV Fluid initiated. Kindly appreciate that wound dressing was also done along with splinting of right thigh. The patient was given Inj. Drotin and Inj. Tetanus Toxoid and pelvic binder was applied. Kindly appreciate that appropriate first aid was duly given to the patient at the Emergency Department of our Hospital. Infact, an Information Report was also sent to the Police Station on 11/07/2018. However, unfortunately, despite the necessary treatment being given, the patient could not be taken for admission at our hospital because we could not have immediate attendance of an Orthopedic and Neuro Surgeon, which the patient otherwise required immediately post-admission and this was duly explained by the Emergency Medical Officer on duty.

d. Thereafter, the patient was referred to a higher centre for further treatment management after providing complete first aid without delay. It is imperative to note that after the Emergency Medical officer had advised for shifting the patient to the higher tertiary centre, the hospital manager on duty (M.O.D) by that time came to the emergency and he immediately arranged for an ambulance. The said ambulance had arrived at around 6:40 PM. Be it noted that when the said MOD had contacted for such ambulance, the complainant had not yet arrived and she was nowhere in the scene.

e. That the patient was immediately shifted onto a stretcher along with the pelvic binder, the IV fluid (normal saline) and oxygen was maintained via oxygen cylinder present in our stretcher (which is the norm in every patient with low oxygen) and then the patient was taken inside the ambulance with

the pelvic binder, IV fluid, with oxygen being maintained at 8 litre/min. Kindly appreciate that the patient, since deceased, was treated absolutely as per accepted medical protocol and there is adequate evidence in support thereof. As such the question of medical negligence does not arise at all.

f. That it is imperative to note that notwithstanding our inability to take the patient for admission for further treatment management, it may be said that till the time the patient was in our Emergency Department, proper medical service was rendered which was absolutely as per standard medical protocol and as such there cannot exist any reason to think otherwise. In fact, nowhere in the four corners of the complaint did the complainant ever mention that what was done ought not to have been done and what was not done, ought to have been done.

The complainant dealt with the counter filed by ILS in her letter dated May 2, 2019.

Dr. Sureka in reply filed another affidavit dated May 13, 2019 almost reiterating what he had said in his earlier affidavit. In addition, he enclosed a Vodafone bill of one Rupak Halder that would, in my view, reveal hardly anything to support their contention. Dr. Sureka, however, clarified that the midwife referred by Mrs. Pal in her complaint was Dr. Debangana Adhikary, who attended the patient along with Dr. Anirban Kundu. Dr. Sureka also reiterated, they referred the patient to higher set up in absence of orthopedic and neuro surgeon in their establishment.

The Colombia Asia filed affidavit on March 8, 2019 giving in detail the treatment that was extended to the patient. The relevant extract is quoted below:-

a. Mr Gour Sundar Pal (hereinafter called as "Patient") aged about 64 years had presented to the emergency department of Columbia Asia Hospital Salt Lake on 11th July 2018 at around 7 PM with the history of having met with a Road Traffic Accident. Before seeking any treatment from Columbia Asia Hospital Salt Lake, the Patient has already availed treatment at a third-party hospital which being 'ILS hospitals' as per the admissions made by the complainant Mrs. Mala Pal in her complaint.

b. The patient was presented by his relatives at Columbia Asia Hospital Salt Lake with a history of patient meeting with a road traffic accident on 11th July 2018 between at around 5-6 pm (5:30 PM approximately as per MLC registered and 5:15 pm as per the complaint) on 11th July 2018. It is stated that , The complainant appraised the respondent hospital that, the patient met with this road traffic accident when he was hit by a car from behind and looking at the grievous injuries which were critical to life of the patient and seeing the critical condition of the patient he then was immediately shifted & admitted by bystanders to ILS hospital , Salt Lake, Kolkata in the same car (WAGON R bearing number WB083677) where basic treatment was provided and resuscitation was done. The complainant and her relatives have stated that the Patient was allegedly conscious at that time of accident and considering the facts that the ILS hospital did not have facilities to handle trauma and did not follow proper protocols and have provided treatment in a allegedly negligent manner the patient was discharged at around 6:42 pm of 11th July 2018 then by the complainant against medical advice from ILS Hospital to shift him a higher center knowing all the risk as to consequences involved in getting discharge against medical advice and got the patient shifted to Columbia Asia Hospital at 7 PM, 11th July 2018, where he was immediately attended.

c. On admission to Columbia Asia Salt Lake at around 7pm 11th July 2018 Patient's condition was critical, and he was hemodynamically unstable with BP of 60/40 mm of Hg and pulse of 70/min. Patient then was immediately resuscitated with IV fluids, colloids and Bipap, followed by ventilation with inotropic support. Further, patient was given initial life-saving treatment in

emergency room, where he was attended by registrars of all specialties like orthopedics, surgery and ICU intensivists) and was then rushed to ICU for continuous monitoring and treatment. The admission formalities and documentations related including registering the MLC were completed at 8.26 pm but treatment was started on arrival.

d. During the course of treatment it was observed that the patient polytrauma with left sided scalp hematoma, with oozing of blood, right femoral? shaft /intertrochanteric fracture +- right tibia fracture, left sided rib fracture, with surgical emphysema, right sided surgical emphysema, left lower limb externally rotated, right lower limb - swelling in thigh with hematoma, small penetrating injury over the occipital region, cut injuries over dorsal surface of left arm. A diagnosis of polytrauma was then made.

e. Considering the patient's prognosis was polytrauma the family members of the patient were explained about the critical condition of the patient due to internal and external injuries including head injury with high blood loss at periodic intervals. After initial attempts to secure the airways and breathing could be achieved successfully in the Emergency room , failing which the patient's erstwhile morbid clinical condition might not have even given the chance of minimum success in initial revival/ rescue efforts, the process for arrangement for blood was initiated following mandatory protocol and process of Blood Grouping and Cross-matching and further procurement of Blood, which, in itself requires optimum time to achieve, and till the cross matched blood arrived, colloids, which acts like a fluid/ volume replacement and was given intravenously (into a vein) to replace lost blood and was used to maintain blood pressure and all efforts to reduce the risk of death of the patient was also made.

f. The patient was planned for CT scan of brain, chest and abdomen, but due to the hemodynamically unstable condition the same could not done however only emergency USG abdomen was done.

g. An MLC as per the protocols and the law was filed with Bidhannagar South Police Station vide no: MLC 6128 at around 8:26 pm on 11th July 2018 and the same received by the said police station on 11th July 2018

with necessary enquiries were done copy of the same is attached herewith as ANNEXURE C.

h. All related specialists like Orthopedician, CTVS consultant, General Surgeon, Critical care specialist and others were involved in treatment including Neurosurgeon Dr. Harish Chandra Gupta examined the patient who was hemodynamically unstable.

i. It is submitted that Patient had a cardiac arrest at 10 pm on 11th July 2018 and resuscitated. But he (patient) continued to be unstable. Subsequently, at 11.10 pm BP was not recordable, pulse not palpable.

j. Patient had a second cardiac arrest at 11:15pm on 11th July 2018 and Cardiopulmonary Resuscitation (CPR) started as per ACLS protocol (Advanced Cardiac Life Support/ Advanced Cardiovascular Life Support) but even after 30mins of resuscitation patient could not be revived. He was declared as dead at 11:45pm on 11th July 2018.

k. The police station was timely intimated and necessary enquires were conducted the body of the Patient was initially kept in the hospital mortuary and then handed over to the police for post mortem on 12/07/2018 at around 03:02 PM. The post mortem report is still awaited.

In addition, they challenged the locus standi of the complainant and prayed for dismissal of the complaint on the ground of non-joinder of parties as also the complaint being devoid of cause of action. According to the clinical establishment, the real cause for filing the complaint was to achieve "monetary gain".

In the said letter dated May 2, 2019, she denied each and every allegation including, the allegation of making "monetary gain and being opportunist". Mrs. Pal also offered separate comment on the said affidavit vide her letter

dated May 2, 2019 to which Colombia Asia filed their rejoinder by an affidavit dated May 15, 2019. The relevant extract is quoted below:-

a. *Mr Gour Sundar Pal ("Patient") aged about 64 years had presented to the emergency department of Columbia Asia Hospital Salt Lake on 11th July 2018 at around 7 PM with the history of having met with a Road Traffic Accident. Before seeking any treatment from Columbia Asia Hospital Salt Lake, the Patient has already availed treatment at a third-party hospital which being 'ILS hospitals' as per the admissions made by the complainant Mrs. Mala Pal in her complaint. It is submitted that on admission to Columbia Asia Salt Lake at around 7pm 11th July 2018 Patient's condition was critical, and he was hemodynamically unstable with BP of 60/40 mm of Hg and pulse of 70/min. Patient then was immediately resuscitated with IV fluids, colloids and Bipap, followed by ventilation with inotropic support. Further, patient was given initial life saving treatment in emergency room, where he was attended by registrars of all specialties like orthopedics, surgery and ICU (intensivists) and was then rushed to ICU for continuous monitoring and treatment. The admission formalities and documentations related including registering the MLC were completed at 8.26 pm but treatment was started on arrival.*

b. During the course of treatment it was observed that the patient had polytrauma with left sided scalp hematoma, with oozing of blood, right femoral? shaft /intertrochanteric fracture +- right tibia fracture, left sided rib fracture, with surgical emphysema, right sided surgical emphysema, left lower limb externally rotated, right lower limb - swelling in thigh with hematoma, small penetrating injury over the occipital region, cut injuries over dorsal surface of left arm. A diagnosis of polytrauma was then made.

c. Considering the patient's prognosis was polytrauma the family members of the patient were explained about the critical condition of the patient due to internal and external injuries including head injury with high blood loss at periodic intervals. After initial attempts to secure the airways and breathing could be achieved successfully in the Emergency room , failing which the patient's erstwhile morbid clinical condition might not have even

given the chance of minimum success in initial revival/ rescue efforts, the process for arrangement for blood was initiated following mandatory protocol and process of Blood Grouping and Cross-matching and further procurement of Blood, which, in itself requires optimum time to achieve, and till the cross matched blood arrived, colloids, which acts like a fluid/ volume replacement and was given intravenously into a vein) to replace lost blood and was used to maintain blood pressure and all efforts to reduce the risk of death of the patient was also made.

d. The patient was planned for CT scan of brain, chest and abdomen, but due to the hemodynamically unstable condition the same could not done however only emergency USG abdomen was done.

e. All related specialists like Orthopedician, CTVS consultant, General Surgeon, Critical care specialist and others were involved in treatment including Neurosurgeon Dr. Harish Chandra Gupta examined the patient who was hemodynamically unstable.

f. It is submitted that Patient had a cardiac arrest at 10 pm on 11th July 2018 and resuscitated. But he (patient) continued to be unstable. Subsequently, at 11.10 pm BP was not recordable, pulse not palpable.

g. Patient had a second cardiac arrest at 11:15pm on 11th July 2018 and Cardiopulmonary Resuscitation (CPR) started as per ACLS protocol (Advanced Cardiac Life Support/ Advanced Cardiovascular Life Support] but even after 30mins of resuscitation patient could not be revived. He was declared as dead at 11:45pm on 11th July 2018.

HEARING

We heard the matter on February 15, 2019 when we gave directions for filing affidavits. We extended the period for filing affidavits vide our order dated April 16, 2019. We finally heard the matter on May 16, 2019 when we reserved our judgment.

EXPERT OPINION

Amongst the members of the commission, Dr. Makhan Lal Saha gave his expert opinion on the issue. His opinion is quoted below:-

Events at ILS hospital

Gour Sundar Pal suffered a RTA and brought to ILS salt Lake hospital on 11.7.2018 at 6pm. The patient was seen by MO on duty. Patient Blood pressure 120/80mmHg,Pulse 64/min and SPO2 85% with 8Litres of oxygen, Blood sugar was 144mg%. MO on duty provided primary treatment – IV fluid, Inj TT, Dressing ,splinting, pelvic binder , done ECG etc. and the patient was referred to higher centre. The police intimation done to Bidhannagar North P.S. which was duly received by the police station.

The complainant alleged that the patient was not properly evaluated and no information to the police was made. Also alleged that the person who has brought the patient was not identified.

Patient was seen by MO on duty and provided primary treatment. Any person who brought a patient to emergency need not be identified all the time and he/she may not be questioned by the police. The police intimation was also done by the MO on duty at ILS. That the patient arrived at Columbia Asia Hospital at 7 pm indicates that there was no inordinate delay in this referral process. There is an issue with ambulance. The complainant submitted that she has to search for an ambulance and get one to shift the patient to Columbia Asia hospital. The CE submitted that they arranged an ambulance and that ambulance shifted the patient to Columbia Asia Hospital. The ambulance driver was presented before the commission and he submitted that he shifted the patient to Columbia Asia hospital. In support he could not produce the Log book of the ambulance but produced a bill book where a bill was shown for Rs.500 for shifting the patient to Columbia. But the bill was seen to be not genuine. The complainant agreed that the ILS has made a phone call arranging an ambulance. In view of delay of that ambulance she arranged an ambulance by herself.

The complaint against the ILS hospital is not well substantiated.

Course of Events at Columbia Asia Hospital.

Patient received at Columbia Asia Hospital emergency at 7pm. The initial evaluation revealed Blood pressure of 60/40mmHg,Pulse 70/min,SPO2- . The treatment provided was IV fluid NS 2.5 litres in jet. Inj Midazolam 4mg IV and Inj Atracurium 50mg IV. Inj Atropine and Inj Adrenaline to be given ***No record of treatment is available from 7pm to 8.56pm. on 11.7.2018. However subsequently received ADENDUM FROM Columbia Asia Hospital regarding treatment record during this period.***

The first note in BHT is seen at 9.18pm by RMO Dr Sukanta Majumder at ICU. The primary evaluation done in details and patient was clinically unstable. Given IV fluid , analgesics and referral made to Surgery, CTVS, Neurosurgery. ***Advised for blood transfusion as per massive transfusion protocol****. Advised for all trauma series CT scan and X rays as per plan. Again note by RMO Dr Sukanta Majumder at 9.19pm. and noted advice for CT scan brain, chest and abdomen, urgent surgical decompression if there is any pneumothorax. In page 3 of BHT note by Dr Rashmi Chakraborty at 9.02 pm and 8.56pm. Evaluation done, Patient intubated at 8.56pm. Patient advised admission at ICU under Dr Harish Ch Gupta at 8.56 pm. Another note by Dr Rashmi Chakraborty at ICU at 9.18 pm revealed some findings are different as entered by Dr Sukanta Majumder at same time.*

Note by Dr Sohini Chakraborty at ICU at 8.56 pm. The notes are at variance with the note entered by Dr Rashmi Chakraborty.

Note by Dr Shanatnau Chaudhuri at 10.02pm. Patient with unstable vital parameters. Hb 5.9gm%. Advised for transfusion of 4 units of blood immediately. Note by Dr Shantanu Chaudhuri at 10.11 pm – discussed with patient relatives that there is minimal chance of survival .

Seen by Dr Sabyasachi Goswami at 10.25pm.Parameters noted SPO2 70%, BP 80/60mmHg GCS – no response. Advised for urgent blood transfusion. Advised CT scan and USG abdomen.

Note by Dr Soumyajit Mondal at 10.15pm. Almost copy paste note of Dr Soumyajit Majumder at 9.18pm. Again advised for urgent blood transfusion.

Note by Dr Santanu Chaudhuri at 10.21pm one liner Chest X ray- multiple fracture ribs with no obvious pneumothorax. No advice.

Seen By Dr Harish Chandra Gupta at 10.40pm. ***His notes revealed that the imaging studies reports were not available****. He only referred the patient to number of specialist and asked for optimization of hemoglobin. Note again by Dr Harish Ch Gutpa at 10.41 pm – very very poor prognosis to be explained to patient party.*

Seen by Dr Saumitra Mishra at 10.45pm noted the vitals and noted X ray report and advised for resuscitation to cont.

Seen by Dr Dipankar Sarkar at 10.42pm. He advised IV fluid, Blood requisition and advised for ventilator adjustment. He first time advised for inotropic support with Inj Noradrenaline. He referred to number of consultant. ***GM and CMS and MOD informed to arrange for blood and the consultant who is to see the patient.Dr Sarkar referred the patient to Cardiology/Pulmonology/Cardiothoracic/Orthopedics surgeon****.*

Note by Dr Shyam Sundar Roy at 11.02pm. Seen by Dr A.N.Ghosh, CTVS surgeon- Blood pressure not recordable. No pleural collection. No surgical intervention.

Note by Dr Shyam Sundar Roy at 11.05 pm. Direction for blood transfusion A +ve , to run at 60drops /min. Another note at at 11.14pm for 2nd unit of blood transfusion at the rate of 60drops/min.

Note by Dr Rana Sarabjeet at 11.10pm- noted patient has cardiac arrest now .BP not recordable, Pulse not palpable, No self rhythm, on multiple inotropes. Adv ECHO screen for pericardial effusion. No other active CV intervention.

Note by Dr Shyam Sundar Roy at 11.53pm. At 10pm patient has cardiac arrest. Patient is on IPPV and on inj Noradrenaline. CPR started as per ACLS protocol. ROSC achieved after 10 minutes of resuscitation.

Note by Dr Shyam Sundar Roy at 12am on 12.7.2018. at 11.15 again cardiac arrest. Started CPR . at 11.45pm ROSC not achieved after 30 minutes of resuscitation. Declared dead at 11.45pm. Death summary gave the details . No X ray report is detailed in the death summary,

1st blood report available at 9.40pm Hb 6.4gm%(Page 29). Other reports not depicted in the progress notes written by different doctors.

X rays done at bedside at 9.06pm ,9.04pm,9.41pm,9.43pm,9.44pmon 11.7.18 but reported on 12.7.18 at 5.35pm.USG done at 10.46pm on 11.7.18 and reported on 12.7.18 at 2.14pm USG report not reflected in doctors note.

The postmortem report is now available. The PM report large number of injuries which were not recorded during treatment at ICCU. Patient has fracture shaft femur with posterior dislocation of femur and fracture pelvis. Patient has multiple rib fracture with pleural and lung laceration. The BHT note revealed surgical emphysema but there was no observation about underlying pleural and lung injury. The diminished air entry on left side was noted .

Observation and Comments: -

A polytrauma patient with unstable vitals, low hemoglobin is not being treated as per standard guidelines. ***Although necessity for massive transfusion protocol was advised, this was not followed.*** *In view of multiple injuries there was severe hypotension and severe drop of Hb level.* ***This patient required massive transfusion protocol which was not done in proper time****. The timings of different notes are haphazard. That patient has cardiac arrest at 10pm which was retrospectively entered. This event of cardiac arrest is not even reflected in the notes provided by Dr Dipankar Sarkar which was written at 10.42pm. Dr Dipankar Sarkar asked for referral to number of consultants and informed GM to arrange blood and to arrange for consultant visits.*

Dr Harish Gupta neurosurgeon under whom the patient was admitted saw the patient after about 4 hours *and he noted that imaging reports were not available.* ***Although Patient has major fractures in the lower limb this was not evaluated by an orthopedics surgeon till his death****.*

CTVS surgeon could see the patient at 11.02 almost at the time of ultimate cardiac arrest. In spite of gross chest injury he was not evaluated by CTVS surgeon for long 4hours

Billing issues.

Blood sugar testing- Patient underwent blood sugar testing by glucometer and charged Rs 141.57 for each test. In addition, patient is billed for glucostrip and lancet. This issue was pointed earlier to GM of Columbia Asia Hospital who gave an undertaking that this will be corrected. Unfortunately, this unfair billing for glucostrip and lancet is still continuing.

4 units of packed RBC is being billed for Rs 4800/. Another charge levied for blood transfusion for 1 unit for Rs 1887.

The Echocardiography charge for bedside was Rs.5945. ***The charges for bedside Ultrasonography have been billed for Rs.9044. These appears to be astronomical charges and that too the reports were issued on the next day after the death of the patient.***

There has been gross deficiency in service from the part of clinical establishment in management of this patient. This is a fit case for award of compensation to the complainant

MY VIEW

We have examined the pleadings as well as the medical records produced before us by the aforesaid two clinical establishments. I am in full agreement with Dr. Saha about his comment on ILS Hospital. The patient was in the establishment for 41 minutes. It is not clear who informed the complainant and when she arrived at the clinical establishment. However, the initial dressing and treatment that was given to the patient as it appears from the medical records, was appropriate. The clinical establishment was candid enough to say, they did not have appropriate orthopedic and neuro set up and thus referred the patient to a higher set up. The complainant was categoric in pointing out the

deficiency at the said clinical establishment. The medical records would, however, do not support her contention. Mrs. Pal observed, ILS did not record the identity of the person who brought the patient. The Hon'ble Apex Court categorically made it clear, it was not required. Even the Central Government issued relevant circular to the said effect. It is only to encourage people to extend support to the accidental victim who generally avoid the same fearing harassment by the police. Mrs. Pal would also contend, ILS only checked the vitals and dressed the minor external wounds. It was only upon her request, ILS started treatment. The medical records would speak otherwise. She was also critical about the ambulance support. The clinical establishment would contend, they arranged for ambulance. Mrs. Pal would, however, contend, without getting an ambulance she did not wait for a single moment and got a private car hired for taking the patient to the higher set up. The clinical establishment produced records to show, they did call for an ambulance and the ambulance driver produced bill for the same when Mrs. Pal categorically denied having paid for the ambulance. Be that as it may, the patient was immediately shifted by her and was admitted at Colombia Asia. We do not wish to enter into such controversy in absence of appropriate evidence from either side.

According to ILS Hospital, after arrival of the patient at about 6. p.m., the emergency medical officer attended, the ECG was done, IV fluid was initiated. Wound dressing was done, injection was given. However, he was not admitted as an indoor patient in absence of orthopedic and neuro surgeon set up. ILS informed the local police station and produced a receipt thereof. They also

denied, any midwife attended the patient. According to them, Dr. Debangana Chakraborty, ITU, RMO examined the patient.

The little what ILS could do, had been done. We wish to give them the benefit of doubt in case of deficiency on account of ambulance, if any.

COLOMBIA ASIA

The patient was received by Colombia Asia at 7 p.m. that was admitted by the treating doctors as well as the establishment although the medical records would show, the admission was done at 8.24 p.m there was no medical record pertaining to the treatment for the period from 7 p.m. to 8.58 p.m. Mrs. Pal would contend, they did not inform the police authorities following the requirement of law in a road accident case. The neuro surgeon under whom the patient was admitted examined the patient long after his arrival. The establishment did not have any blood bank and as a result there was delayed transfusion of blood. In fact, records would show, the blood transfusion started at about 11.14 p.m. when the patient stopped responding to the treatment. Mrs. Pal would also point out, even after declaration of death at 11.45 p.m., the clinical establishment did not hand over the body to the police for autopsy that was kept in mortuary throughout the night for which she had to pay.

Dr. Sukanta Mazumdar and Dr. Reshmi Chakraborty separately gave their views. According to Dr. Mazumder, he attended the patient at ICU being called by the emergency doctor. The patient was initially shows "**hameo dynamically**

very unstable". After his shift was over, he handed over the patient to Dr. Shyam Sundar Roy.

Dr. Reshmi Chakraborty in her note stated, she was handed over patient at 8 p.m. when she called for Code Blue.

Dr. Shyam Sundar Roy did not offer any explanation, at least not found by me in the record.

The Colombia Asia in their note observed, the patient came with DAMA that Mrs. Pal categorically denied. We are in full agreement on that score. ILS Hospital categorically stated, they referred the patient to higher set up in absence of appropriate facility at their hospital in Orthopadic and neuro.

The post mortem report would, inter alia, observe "**death was due to the effects of anti mortem injuries**" as noted by Dr. Partha Bhattacharya, Associate Professor, Department of Forensic Medicines and Toxicology, R. G. Kar Medical College, Calcutta.

Dr. Saha, in his report did not specifically throw further light on the issue. He was rather critical about the deficiency of treatment at the clinical establishment. According to Dr. Saha, ***"although necessity for massive transfusion protocol was advised, this was not followed"***. He also observed, ***"this patient required massive transfusion protocol which was not done at proper time"***. Dr. Saha also observed, although patient had major fractures in the lower limb, the same was not evaluated by any orthopedic surgeon till his death. Dr. Saha, however, did not specifically make any comment on the post mortem report.

I have gone through the treatment record of Colombia Asia. Dr. Saha is correct to say, there was no record pertaining to the treatment during the period from 7 p.m. to 8.58 pm. being an important part of the golden hour. The clinical establishment would explain, the doctors were busy in treating the patient. We fail to appreciate, how there could be such an omission for about two hours which was most important for the patient of the like nature. We are deprived of the treatment details, if any, extended to the patient during said period of two hours. Even if the available records are examined in detail, we would find, there were repeated advice for blood transfusion. I have already prepared a table to have a ready picture of blood transfusion advice that is quoted below:-

Sl no	**Date Time Person Role**	**Notes Given**
1.	**Jul 11 2018 9:18PM SUKANTA MAJUMDER ROLE : Resident Medical Officer/Registrar**	GOT A CALL FROM ER ABOUT ARRIVING ROAD TRAFFIC ACCIDENT PT. PT WAS IN ALTERED SENSORIUM WITH DESATURATION, INFORMANT - WIFE AND DAUGHTER OF THE PT. TIME OF INJURY APPROXIMATE 5-6 PM TODAY, NOT EXACTLY NOTED BY THE RELATIVES, MODE OF INJURY HIT BY A CAR FROM BACK ? IMMEDIATELY LOCAL PEOPLE SHIFTED HIM TO ILS SALTLAKE, WHERE BASIC RESUSCITATION DONE, PT WAS CONSCIOUS, ALERT AT THAT TIME AS PER PTS RELATIVE,

		THEN SHIFTED HERE FOR FURTHER MANAGEMENT. PAST H/O RT TIBIAL FRACTURE AND ORIF? GASTRIC ULCER NO OTHER SIGNIFICANT HISTORY NOTED, O/E PT WAS CONSCIOUS BUT DROWSY E2M5V1 PUPIL 2MM B/L+ HR 56/MIN BP 60/44 MM HG, HEMODYNAMICALLY UNSTABLE, PREOXYGENATION DONE WITH 100 % FIO2, CONDITION CRITICAL EXPLAINED TO RELATIVES IN DETAILS , NEED FOR AIRWAY PROTECTION NEEDED, PERSISTED DESATURATION AND HYPOTENSION INSPITE OF ADEQUATE FLUID RESUSCITATION AND OXYGENATION. NO FLAIL SEGMENT NOTED, BUT LEFT SIDED SURGICAL EMPHYSEMA ABOVE AND BELOW CLAVICLE NOTED, PT WAS INTUBATED WITH 7.5 MM ET TUBE WITH SEDATION AND PARALYSIS UNDER DIRECT LARYNGOSCOPY. POSITION CHECKED AND PUT ON 100 % FIOZ VETILATION, AFTER PRIMARY SURVEY , SECONDARY SURVEY, INJURY NOTED - LEFT SIDED SCALP HEMATOMA , WITH WOOZING OF BLOOD RT FEMORAL 7SHAFT /INTERTROCHANTERIC FRACTURE +- RT TIBILA FRACTURE, LEFT SIDED RIB FRACTURE, WITH SURGICAL EMPHYSEMA, RT SIDED SURGICAL EMPHYSEMA ALSO NOTED. CHEST AIR ENTRY DIMINISHED LEFT SIDE, ABD SOFT, IPS + CNS AS DESCRIBE ABOVE, PLAN FIX CERVICAL SPINE IV FLUID BOLUS 1 L THEN 150 ML/HR WITH NS INJ PAN 40 MG IV OD IN) PCM 1 GM IV TDS INJ TRAMADOL 100 MG IV TDS

		'URGENT SURGICAL, CARDIOVASCULAR , NEURO SURGICAL OPINION BLOOD TRANSFUSION AS PER MASSIVE TRANSFUSION PROTOCOL. MONITOR VITALS, INTAKE OUTPOUT REGULARLY GURADED PROGNOISIS EXPLAINED TO RELATIVES IN DEATILS. ALL TRAUMA SERIES CT AND X RAY AS PER PLAN
2.	**Jul 11 2018 9:19PM – SUKANTA MAJUMDER :** **ROLE:** **Resident Medical Officer/Registrar**	CT SCAN BRAIN, PLAIN, CT CHEST,CT ABDOMEN ONCE PT STABILISES HEMODYNAMICALLY URGENT SURGICAL DECOMPRESSION OF PNEUMOTHORAX IF ANY.
3.	**Jul 11 2018 9:02PM - RASHMI CHAKRABORTY ROLE: doctor**	PATIENT HAD PRESENTED IN ER FOLLOWING A ROAD TRAFFIC ACCIDENT AT 5:30 PM .HE WAS RIDING HIS CYCLE WHEN A CAR HIT HIM FROM BEHIND. AFTER THE IMPACT PATIENT WAS CONSCIOUS AND ORIENTED. HE WAS ADMITTED IN ELSEWHERE; WHERE AFTER INITIAL ASSESSMENT THEY REFERRED THE PATIENT TO HIGHER CENTRE. ON EXAMINATION: GCS= 8/15 BP=50/40 MM OF HG PULSE= 58 / MIN SPO2= 70% CHEST= REDUCED AIR ENTRY ON LEFT SIDE ABDOMEN SOFT PUPILS = B/L CONSTRICTED, NOT REACTING TO LIGHT S1S2 AUDIBLE LEFT LOWER LIMB EXTERNALLY ROTATED, RIGHT LOWER LIMB - SWELLING IN THIGH ? HEMATOMA SMALL PENETRATING INJURY OVER THE OCCIPITAL REGION CUT INJURIES OVER

		DOORSAL SURFACE OF LEFT ARM
4.	**Jul 11 2018** **8:56 PM –** **RASHMI CHAKRABORTY** **ROLE: doctor**	ICU, ORTHO, SURGERY, MEDICINE REGISTRAR CALLED FOR WIDE BORE CHANNELS MADE FOLLOWED BY FLUID IN JET AFTER 5 MINS BP= 70/60 MM OF HG PULSE= 102 / MIN CGS= 11/15 AFTER 5 MINS BP= 60/40 PULSE= 112/MIN CGS= 7/15 PATIENT IMMOBILISED INJ MIDAZOLAM 4 ML GIVEN I.V STAT INJ ATRACURIUM (50)- GIVEN IV STAT PATIENT INTUBATED POST INTUBATION PATIENT STARTED DEVELOPING SURGICAL EMPHYSEMA WHICH OVER THE UPPER PART OF CHEST AND NECK URGENT ADMISSION IN ICU UNDER DR. HARISH CHANDRA GUPTA BEDSIDE XRAY CHEST, CERVICAL SPINE, PELVIS INCLUDING BOTH HIPS, B/L LONG BONES LOWER LIMBS.
5.	**Jul 11 2018** **9:18PM –** **RASHMI CHAKRABORTY:** **Doctor : ROLE**	PATIENT HAD PRESENTED IN ER FOLLOWING A ROAD TRAFFIC ACCIDENT AT 5:30 PM . HE WAS RIDING HIS CYCLE WHEN A CAR HIT HIM FROM BEHIND. AFTER THE IMPACT PATIENT WAS CONSCIOUS AND ORIENTED. HE WAS ADMITTED ELSEWHERE, WHERE AFTER INITIAL ASSESSMENT THEY REFERRED THE PATIENT TO HIGHER CENTRE. ON EXAMINATION:

		GCS= 8/15 BP=50/40 MM OF HG PULSE= 58 / MIN SPO2= 70% CHEST= REDUCED AIR ENTRY ON LEFT SIDE ABDOMEN SOFT PUPILS = B/L CONSTRICTED, NOT REACTING TO LIGHT SIS2 AUDIBLE LEFT LOWER LIMB EXTERNALLY ROTATED, RIGHT LOWER LIMB - SWELLING IN THIGH ? HEMATOMA SMALL PENETRATING INJURY OVER THE OCCIPITAL REGION CUT INJURIES OVER DOORSAL SURFACE OF LEFT ARM PATIENT HAD PRESENTED IN ER FOLLOWING A ROAD TRAFFIC ACCIDENT AT 5:30 PM .HE WAS RIDING HIS CYCLE WHEN A CAR HIT HIM FROM BEHIND. AFTER THE IMPACT PATIENT WAS CONSCIOUS AND ORIENTED. HE WAS ADMITTED IN ELSEWHERE; WHERE AFTER INITIAL ASSESSMENT THEY REFERRED THE PATIENT TO HIGHER CENTRE. ON EXAMINATION: GCS= 8/15 BP=50/40 MM OF HG PULSE= 58 / MIN SPO2= 70% CHEST= REDUCED AIR ENTRY ON LEFT SIDE ABDOMEN SOFT PUPILS = B/L CONSTRICTED, NOT REACTING TO LIGHT S1S2 AUDIBLE LEFT LOWER LIMB EXTERNALLY ROTATED, RIGHT LOWER LIMB - SWELLING IN THIGH ? HEMATOMA SMALL PENETRATING INJURY OVER THE OCCIPITAL REGION CUT INJURIES OVER DOORSAL SURFACE OF LEFT ARM PATIENT HAD PRESENTED IN ER FOLLOWING A ROAD TRAFFIC ACCIDENT AT 5:30 PM HE WAS RIDING HIS CYCLE WHEN A CAR HIT HIM FROM BEHIND. AFTER THE IMPACT PATIENT WAS CONSCIOUS AND ORIENTED. HE WAS ADMITTED IN ELSEWHERE; WHERE AFTER INITIAL ASSESSMENT THEY REFERRED THE PATIENT TO HIGHER CENTRE. ON EXAMINATION:

		GCS= 8/15 BP=50/40 MM OF HG PULSE= 58 / MIN SPO2= 70% CHEST= REDUCED AIR ENTRY ON LEFT SIDE ABDOMEN SOFT PUPILS = B/L CONSTRICTED, NOT REACTING TO LIGHT BRE E A S1S2 AUDIBLE LEFT LOWER LIMB EXTERNALLY ROTATED, RIGHT LOWER LIMB - SWELLING IN THIGH ? HEMATOMA SMALL PENETRATING INJURY OVER THE OCCIPITAL REGION CUT INJURIES OVER DOORSAL SURFACE OF LEFT ARM ICU, ORTHO, SURGERY, MEDICINE REGISTRAR CALLED FOR WIDE BORE CHANNELS MADE FOLLOWED BY FLUID IN JET AFTER 5 MINS BP= 70/60 MM OF HG PULSE= 102 / MIN CGS= 11/15 AFTER 5 MINS BP= 60/40 PULSE= 112/MIN CGS= 7/15 PATIENT IMMOBILISED INJ MIDAZOLAM 4 ML GIVEN I.V STAT INJ ATRACURIUM (50)- GIVEN I.V STAT PATIENT INTUBATED POST INTUBATION PATIENT STARTED DEVELOPING SURGICAL EMPHYSEMA WHICH WAS OVER THE UPPER PART OF CHEST AND OVER NECK URGENT ADMISSION IN ICU UNDER DR. HARISH CHANDRA GUPTA BEDSIDE XRAY CHEST, CERVICAL SPINE, PELVIS INCLUDING BOTH HIPS, B/L LONG BONES LOWER LIMBS.
6.	**Jul 11 2018 8:56PM – SOHINI CHAKRABORTI** **Doctor ROLE**	PATIENT PRESENTED TO ER WITH H/O- RTA AT AROUND 5:30PM TODAY, HE WAS HIT BY A CAR WHILE RIDING A CYCLE FOLLOWING WHICH HE WAS TAKEN ADMITTED ELSEWHERE AND WAS REFERRED TO HIGHER CENTRE.

		ACC. TO THE PARTY, HE WAS CONSCIOUS INITIALLY, BUT DETORIATED GRADUALLY O/E GC-7/15 BP- 50/40 MM OF HG PR-56/MIN SPO2- 68% CBG- 115MG% S1 S2 + CHEST REDUCED BREATHE SOUND ON LEFT SIDE, SUBCUTANEOUS CREPS+ ABDOMEN SOFT, BS+ PUPIL-CONSTRICTED B/L, NOT REACTING TO LIGHT L/E RIGHT HIP EXTERNALLY ROTATED SWELLING OVER LEFT THIGH ? HEMATOMA MULTIPLE ABRASIONS OVER THE BODY SMALL PENETRATING WOUND OVER THE LEFT SIDE OF THE OCCIPITAL AREA
7.	**Jul 11 2018 10:02PM - SANTANU CHAUDHURI** **ROLE : Doctor**	SEEN AT 21-15 Hx NOTED PT VENTILLATED PALLOR ++ BP 80/60 ON NORADRENALINE SUPPORT GCS - 7/15 ON ADMISSION, NOW NO RESPONSE TO PAINFUL STIMULI SURGICAL EMPHYSEMA ++ CHEST - AE RT = LT ABD-SOFT, NO DISTENSION IPS + SLUGGISH URINE OUTPUT - 40 MLS IN 1 HR NO OBVIOUS HAEMATURIA CXR - B/L MULTIPLE RIB #S ? RT PNEUMOTHORAX # SHAFT FEMUR (RIGHT)

		Hb - 5.9GM % ON ABG, WITH MARKED ACIDOSIS ADV - NEEDS IMMEDIATE BLOOD TRANSFUSION X 4 UNITS TRANSFUSE COLLOIDS TILL BLOOD IS AVAILABLE URGENT USG AS PT NOT FIT TO GO TO CT IMMEDIATE ASSESSMENT BY CARDIO-THORACIC, NEUROSURGEON, ORTHOPAEDIC SURGEON
8.	**Jul 11 2018 10:11PM - SANTANU CHAUDHURI :** **ROLE Doctor**	DISCUSSED WITH PATIENTS DAUGHTER REGARDING GRAVENESS OF THE SITUATION AND THAT CHANCE OF SURVIVAL IS SLIM
9.	**Jul 11 2018 10:25PM - SABYASACHI GOSWAMI** **ROLE : Doctor**	A CASE OF POLYTRAUMA FOLLOWING RTA - PATIENT WAS REFERED TO COLUMBIA ASIA HOSPITAL - ON ARRIVAL - GCS 7/17 WITH BP=50/40 MM OF HG PULSE= 58 / MIN SPO2= 70% PATIENT WAS INTUBATED IN EMERGENCY AND SHIFTED TO ITU IMMEDIATELY PATIENT SEEN IN ITU ALONG WITH DR. SANTANU CHAUDHURI PT VENTILLATED PALLOR ++ BP 80/60 ON NORADRENALINE SUPPORT GCS - 7/15 ON ADMISSION, NOW NO RESPONSE TO PAINFUL STIMULI SURGICAL EMPHYSEMA ++ CHEST - ? BILATERALY EQUAL ABD-SOFT, NO DISTENSION IPS + SLUGGISH URINE OUTPUT - 40 MLS IN 1 HR SMAL PUNCTURED WOUND HEMATOMA NOTED IN SCALP

		CXR - MULTIPLE RIB FRACTURES XRAY # SHAFT FEMUR (RIGHT) X RAY-=? PELVIC FRACTURE (REPORTS PENDING) PATIENT COMAPANION EXPLAINED ABOUT POOR PROGNOSIS OF PATIENT URGENT BLOOD TRANSFUSION CT BRAIN, CT SPINE, USG WHOLE ABDOMEN - URGENT IV FLUID TO CONTINUE AS PER ICU DOCTOR TILL PRBC AVAILABLE FOR TRANSFUSION OTHER AS ADVISED BY DR. SANTANU CHAUDHURI
10.	**Jul 11 2018 10:15PM - SOUMYAJIT MONDAL** **ROLE : Doctor**	A CASE OF POLYTRAUMA FOLLOWING RTA INFORMANT - WIFE AND DAUGHTER OF THE PT. TIME OF INJURY APPROXIMATE 5-6 PM TODAY, NOT EXACTLY NOTED BY THE RELATIVES, MODE OF INJURY HIT BY A CAR FROM BACK ? IMMEDIATELY LOCAL PEOPLE SHIFTED HIM TO ILS SALTLAKE, WHERE BASIC RESUSCITATION DONE, PT WAS CONSCIOUS , ALERT AT THAT TIME AS PER PTS RELATIVE, THEN SHIFTED HERE FOR FURTHER MANAGEMENT. PAST H/O RT TIBIAL FRACTURE AND ORIF GASTRIC ULCER NO OTHER SIGNIFICANT HISTORY NOTED, O/E PT DROWSY HR 56/MIN BP 68/48 MM HG, HEMODYNAMICALLY UNSTABLE PREOXYGENATION DONE WITH 100 % FIO2 CONDITION CRITICAL EXPLAINED TO RELATIVES IN DETAILS , NEED FOR AIRWAY PROTECTION NEEDED PERSISTED DESATURATION AND HYPOTENSION INSPITE OF ADEQUATE FLUID RESUSCITATION AND OXYGENATION.

		SURGICAL EMPHYSEMA NOTED , PT WAS INTUBATED IN ER POSITION CHECKED AND PUT ON 100 % FIO2 VETILATION, AFTER PRIMARY SURVEY , SECONDARY SURVEY INJURY NOTED – LEFT SIDED SCALP HEMATOMA, WITH WOOZING OF BLOOD, RT FEMORAL SHAFT /SUBTROCHANTERIC FRACTURE +, ? RT TIBILA FRACTURE, ? RIBS FRACTURE, WITH SURGICAL EMPHYSEMA, CHEST AIR ENTRY DIMINISHED, ABD SOFT, IPS + CNS AS DESCRIBE ABOVE, PALLOR + + SHIFTED TO ICU ADV: HARD CERVICAL COLLER IV FLUID AS DIRECTED INJ PAN 40 MG IV OD INJ PCM 1 GM IV TDS IV LINE B/L CENTRAL LINE HB: 5.9 BLOOD REQ; 4 U PRBC BLOOD TRANSFUSION AS SOON AS ITS AVAILABILITY MONITOR VITALS, INTAKE OUTPOUT REGULARLY URINE OUT - 40 ML IN UROBAG USG WHOLE ABDOMEN ALL TRAUMA SERIES X RAY CT PELVIS CT SCAN BRAIN URGENT SURGICAL, CARDIOVASCULAR, NEURO SURGICAL OPINION GURADED PROGNOISIS EXPLAINED TO RELATIVES IN DEATILS.
11.	**Jul 11 2018 10:21PM - SANTANU CHAUDHURI Doctor ROLE**	CXR - MULTIPLE RIB # WITH NO OBVIOUS PNEUMOTHORAX
12.	**Jul 11 2018 10:40PM - HARISH CHANDRA GUPTA : Doctor ROLE**	patient on ventilator vc mode being resuscitated after cardiac arrest once blood pressure not recordabgcs e1vt m1 pupil b/l mid dilated non reacting no imaging studies available ?rt femur shaft fracture ? multiple rib fracture ? pelvic rami fracture

		Continue resuscitation as per icu protocol advice ctys referal General surgery referal orthopaedics referal Critical care referral noct brain once patient condition permissible optimization of haemoglobin%(Hb6.4%)
13.	**Jul 11 2018 10:41PM - HARISH CHANDRA GUPTA : Doctor ROLE**	Very very poor prognosis to be explained to patient party.
14.	**Jul 11 2018 10:45PM - SAUMITRA MISRA ROLE : Doctor**	HISTORY NOTED RTA - PRESENTED WITH HAEMORRHAGIC SHOCK BP LOW PULSE RAPID UNRESPONSIVE VENTELATED X-RAY - FRACTURE PUBIC RAMI, FRACTURE SHAFT FEMUR ADVICE RESUSCITATION TO CONT
15.	**Jul 11 2018 10:42PM - DIPANKAR SARKAR : ROLE Doctor**	PATIENT A ACASE OF RTA FRACTURE PELVIS AND FRACTURE LONG BONES BP LOW INTUBATED AND PUT ON VENTILATION ADVICE INJ NS 500 ML IN JET BLOOD REQUISITION INJ PAN 40 IV BD TO CONT VENTILATION PARAMETERR AC /RATE 18 TV 400 I:E 1:3 FLOW 40L/MIN HOS PEEP 4 FIO2 100% SENSITIVITY 2 TARGET SATURATION 96-99 TARGET ETCO2 32-36 NORADREANLINE @20 ML /HOUR INJ AUGMENTIN 1.2 GM IV TDS TO CONT

		CARDIOLOGICA,L OIONION PULMONOLOGICAL OPINION CARDIOTHORASIC OPINION ORTHOPAEDIC OPINION SURGICAL OPINION NEUROSURGICAL OPINION USG ABDOMEN OVERALL PROGNOSIS IS EXTREMELY GRAVE EXPLAINED TO THE RELATIVES CMS AND GM INFORMED ALONG WITH THE MOD TO DO THE NEEDFUL AND ARRANGE FOR BLOOD AND THE CONSULTANT
16.	**Jul 11 2018 11:02PM – SHYAM SUNDAR ROY : Doctor ROLE**	C/S/B DR. A. N. GHOSH(CTVS SURGEON) CASE OF A POLYTRAUMA PATIENT ON EXAMINATION NO RECORDABLE BLOOD PRESSURE CARDIO-RESPIRATORY RESUSCITATION DONE EARLIER/ ON VENTILATOR CHEST X-RAY= MULTIPLE RIBS FRACTURE B/L WITH EVIDENCE OF SUBCUTANEOUS EMPHYSEMA B/L NO APPARENT PLEURAL COLLECTION AT THIS MOMENT NO SURGICAL INTERVENTION REQUIRED.
17.	**Jul 11 2018 11:05PM – SHYAM SUNDAR ROY Doctor ROLE**	DIRECTION FOR BLOOD TRANSFUSION B.B.NO: ANJ/18-19/295/92 BLOOD GROUP: A POSITIVE DOC: 8/7/18 DOE: 11/8/18 ABOVE MENTIONED ONE UNIT OF PRBO TO BE TRANSFUSED AT THE RATE OF 60 DROPS/MIN.
18.	**Jul 11 2018 11:14PM – SHYAM SUNDAR ROY**	DIRECTION FOR BLOOD TRANSFUSION B.B.NO: ANJ/18-19/295/97 BLOOD GROUP: A POSITIVE

	ROLE **: Doctor**	DOC: 8/7/18 DOE: 11/8/18 ABOVE MENTIONED ONE UNIT OF PRBC TO BE TRANSFUSED AT THE RATE OF 60 DROPS/MIN.
19.	**Jul 11 2018 11:10PM – RANA SERBJEET SINGH :** **ROLE : Doctor**	ADMITTED POLYTRAUMA WITH # AT MULTIPLE SITES HAD CARDIAC ARREST NOW BP NOT RECORDABLE P NOT APLPABLE ECG OUTSIDE OLD CHANGES HERE ON TRANSDERMA;L PACING NO SELF RHYTHM PLAE ON MULTIPLE IONOTROPES PUPILS MID DILATED NOT REACTING TO LIGHT ADV ABG REPEAT FATER BICARB CORRECTION ECHO SCREEN FOR PERICARDIAL EFFUSION EXTREMELY GRACE PROGNOSIS NO OTHER ACTIVE CV INTERVENTION AT PRESENT--CONTINUE IONOTROPES ?PRC TRANSFUSION
20.	**Jul 11 2018 11:53PM – SHYAM SUNDAR ROY : Doctor ROLE**	0/E= SUDDEN CARDIAC ARREST PATIENT IS ON IPPV SUPPORT AND ON NORAD INFUSION CPR STARTED AS PER ACLS PROTOCOL INJ. ADRENALINE 1 AMP IV GIVEN R.OS.C. ACHIEVED AFTER 10 MINS OF RESUSCITATION
21.	**Jul 12 2018 12:00AM - SHYAM SUNDAR ROY Doctor ROLE**	AT 11:15PM O/E= *A*GAIN CARDIAC ARREST PATIENT IS ON ADRENALINE INFUSION AND NORAD INFUSION AND ON IPPV SUPPORT CPR STARTED AS PER ACLS PROTOCOL. OS*PITA* INJ. ADRENALINE 1MG IV GIVEN REPEATEDLY ON EVERY 3 MINS INF. AUXISODA 100ML GIVEN AT JET;

22.	**Jul 12 2018 12:08AM - SHYAM SUNDAR ROY : Doctor ROLE**	AT 11:45PM ROSC NOT ACHIEVED EVEN AFTER 30 MINS OF RESUSCITATION. I HAVE EXAMINED THE PATIENT THOROUGHLY AND GOT THE FOLLOWINGS: PUPILS FIXED AND DILATED BILATERALLY; NO PUPILLARY LIGHT REFLEX B/L; NO CORNEAL REFLEX B/L; BP= NOT MEASURABLE; NO PERIPHERAL PULSE; NO FEMORAL PULSE; CAROTID PULSE NOT PALPABLE; H/R= NO RHYTHM IN ECG MONITOR; CVS= NO HEART SOUND; NO RESPIRATION WITHOUT VENTILATOR; NO ANY REFLEX OR JERKS; IMPRESSION: SO I AM NOW DECLARING THAT PATIENT IS EXPIRED CLINICALLY AT 11:45PM ON 11/7/18.

From the above, it would be clear, the patient would need blood transfusion and the doctors were all unanimous on that score. Even though the clinical establishment would claim to have super speciality treatment logistics they could not arrange for blood transfusion at the appropriate time. Pertinent to note, patient died at 11.45 p.m. after about five hours of hospital stay in the said establishment. Even being a non-medical person, it is clear to me, the nature of

the injuries that are highlighted in the post mortem report are mostly related to ortho and would hardly be fatal. It is unfortunate, the autopsy surgeon did not consider such aspect. From a layman's point of view, I feel, the death was due to the massive bleeding that could not be stopped or taken care of through massive blood transfusion protocol. On that score, the deficiency is apparent and the clinical establishment is guilty of such deficiency.

I hold Colombia Asia being guilty of hospital negligence and the complainant in my view, is entitled to compensation as a consequential relief.

If we consider Section 33 of the WEST BENGAL CLINICAL ESTABLISHMENTS (REGISTRATION, REGULATION AND TRANSPARENCY) ACT, 2017 unless and until the direct cause of the death does not have any established nexus with the deficiency, the minimum amount of compensation of Rs.10 lakh cannot be awarded. Neither the post mortem report nor the opinion of the expert would help me on that score. I feel, we should hear the matter further on the amount of compensation after having proper expertised opinion on this limited issue.

RESULT

We hold ILS Hospital not guilty of negligence giving them the benefit of doubt as referred to above.

We hold Colombia Asia guilty of negligence.

COMPENSATION

We keep this matter for further hearing on the issue of compensation. I would request the following experts to give their valued opinion on the limited issue as

to whether the deficiency found by us and highlighted above, would have a direct nexus to the death of the patient, i.e. absence of blood transfusion. We would request the following doctors to assist us by giving their valued opinion and if possible, being present at the further hearing.

1. Dr. Krishnendu Mukherjee, General Surgeon.
2. Prof Dr. Ranadeb Bandopadhyay, Head of the Department, Orthopadic, Bankura Sammelani Medical College, Bankura.
3. Dr Durga Prasad Chakraborty, Associate Professor (Neuro Medicine), North Bengal Medical College,

We would be glad if the experts could give valued opinion before the date of hearing so that we could circulate such opinion to the complainant as well as the respondent/ clinical establishment so that they could offer their explanation on the said issue.

The office is directed to send a copy of the foregoing judgment along with relevant medical records to the above experts.

Place this matter for hearing one week after receipt of the valued opinion of the experts.

Sd/-

ASHIM KUMAR BANERJEE

We agree,

Sd/-

Smt. Sanghamitra Ghosh

Sd/-

Dr. Sukumar Mukherjee

Sd/-

Dr. Gopal Krishna Dhali

Sd/-

Dr. Makhan Lal Saha

Sd/-

Dr. Madhusudan Banerjee

Sd/-

Dr. Pradip Kumar Mitra

Sd/-

Dr. Maitrayee Banerjee

ARSHAD HASAN WARSI
WBCS (Ex)
Secretary
West Bengal Clinical Establishment
Regulatory Commission
&
Joint Secretary
Health & F.W. Department