Office of the West Bengal Clinical Establishment Regulatory Commission
1st Floor, 32 B.B.D Bag, West Bengal, Kolkata – 700001.
Phone:- (033) 2262-8447 , Email: wbcerc@wb.gov.in Website: www.wbcerc.gov.in

**Case Reference: INT/NPG/2022/080**

**Present: Justice Ashim Kumar Banerjee (Retired), Chairman**

**Dr. Sukumar Mukherjee,**

**Dr. Madhusudan Banerjee,**

**Dr. Maitrayee Banerjee,**

Mr. Ratan Debnath.....**Complainant**

**- Versus-**

AMRI Hospital, Salt Lake and AMRI Hospital, Mukundapur.....**Respondent**

**Heard on: April 13, 2022.**

**Judgment on : May 06, 2022.**

## BACKDROP

Aliva Debnath a 13 years young girl was suffering from high fever for about a week at her residence at Barrackpore. Her father Ratan Debnath, the complainant above named, could contact Dr. Sanghrabroto Sur, consultant pulmonologist of AMRI Salt Lake. Dr. Sur advised him to bring the child at AMRI Salt Lake. Accordingly, the complainant took Aliva to the hospital on February 26, 2022 at about 12 noon. The patient reported at AMRI Emergency. The Emergency Medical Officer took charge of the patient. She was advised to visit OPD ENT that is situated at a nearby building. Although the distance was very short, condition of Aliva did not permit her to go by walking. The ambulance that brought her from Barrackpore, was waiting. Aliva visited the OPD with the help of the ambulance. Dr. Chandan Chakraborty examined her and advised admission. The patient was having rashes on the skin that according to doctors, was the resultant effect of use of Augmentin that was prescribed by Dr. Chakraborty. According to the complainant, Aliva reached

Emergency with the history of high fever and problem in the throat. Although Dr. Chakraborty advised urgent admission under Dr. Emily Mukherjee, paediatrician the patient was admitted after a long wait at 3 PM. According to him, the patient was practically without any treatment waiting for admission, in the lobby of the hospital. She was, however given IV fluids after 6 PM after repeated requests made by the parents. At night, the complainant received a call that the oxygen level of the patient was falling down and she was shifted to HDU and then to ICU. He was advised to find out a higher set up having PICU. According to the doctors, the patient was under septic shock and the condition might deteriorate. All thorough the night, the complainant, although present at the CE, could not get any proper feedback till 8 AM on the next day when he was told that the patient was stable. At 11 AM Dr. Chakraborty and Dr. Mukherjee briefed her and assured that the patient was absolutely stable. However, she would need PICU support for taking care of the exigency, if any, arises.

The complainant was assured by AMRI Salt Lake that PICU would be arranged at AMRI, Mukundapur unit and she would be transferred by AMRI, Salt Lake ambulance.

The patient was having Mediclaim Policy. Since admission was less than 24 hours, the CE declined to give cashless support and the complainant had to pay in cash. He was assured, the patient was "perfectly fine". She would be transferred to AMRI, Mukundapur after intubation that would be done by Dr. Gautam Banerjee who could not be found. After a long wait, at about 4 pm, the complainant saw that the IV channel of the patient was removed. On being pointed out, hurriedly another channel was created. According to him, the patient was without any medication. AMRI ambulance was not provided. A private ambulance was ultimately arranged and the patient was shifted. There had been inordinate delay in shifting the patient.

On reaching AMRI, Mukundapur unit the treating doctors asked him why the patient did not come in AMRI, Salt Lake ambulance and why there was so

much delay although the PICU bed had been reserved since morning. The patient was found to be very critical as the pulse could not be traced. Despite, best efforts of the treating team at AMRI, Mukundapur the patient breathed her last at 1.10 am on February 28, 2022.

**COMPLAINT**

Being aggrieved, the complainant filed the instant complaint before us on March 15, 2022 raising various issues including treatment protocol that would be outside our domain. The issues that were raised, are quoted below:-

*"1. As Dr. Chandan Chakraborty mentioned urgent admission why the IV medicines were started after 6 PM.*

*2. The patient was diagnosed with Septic Shock at 12.38 AM of 27th Feb 2022, as per the Discharge report the rashes were due to intake of Augmentin, but it is clearly understood that the patient was not given emergency treatment after reaching and the Doctor misdiagnosed the rashes which were probably due to*

*sepsis of the patient and was kept without proper emergency care which lead to septic shock.*

*3. the child was 13 yrs old with body weight of around 60 kgs, why AMRI Salt Lake took admission and did not refer to AMRI Mukundapur which had PICU beforehand before taking admission.*

*4. The patient was admitted at 15.13 PM and was discharged at 15.56 PM then why Mediclaim was not adjusted and I was forced to pay cash payment where the patient was admitted for more than 24 hrs.*

*5. I was forced to sign for check out before 12 noon as I have to pay by cash but ultimately the patient was discharged at 15.56 PM.*

*6. After promising a safe transfer from AMRI Salt Lake to AMRI Mukundpur by AMRI ambulance at least we were cheated and forced to take private ambulance for the transfer.*

*7. As I was forced to sign for check out before 12 noon for final bill preparation, the patient was kept completely without medication.*

*8. why the channel was removed from the hand of the patient when she was supposed to be transferred within the different unit of the same hospital.*

*9. How can the condition of a stable patient worsen so much within 45 min of transfer and ultimately die because of negligence on the part of AMRI, Salt Lake. "*

He has prayed for justice as against AMRI, Salt Lake and would also raise grievance as against the treating doctors being Dr. Chandan Chakraborty and Dr. Emily Mukherjee.

**RESPONSE**

Dr. Namita Mittal, Medical Superintendent, submitted her response vide letter dated March 31, 2022. In the response, she gave a brief history of the treatment that was meted out to the unfortunate girl after she had been admitted therein.

According to Dr. Mittal, the patient reached Emergency at 1.30 PM with a complaint of sore throat and fever preceding seven days. The patient was stable and exhibited symptoms requiring ENT consultation. Dr. Chakraborty attended the patient at OPD and advised hospitalisation jointly under paediatrician Dr. Emily Mukherjee. The doctors had prescribed two medication before she was brought to the CE. She developed rashes. At about 4.15 PM, the ward RMO, examined the patient and necessary medications and treatment were given. The paediatrician also examined her late at night at about 10 PM. The patient developed shortness of breath having low oxygen saturation. She was shifted to HDU. She was given fluids, antibiotics were stepped up. Ultimately, she was shifted to ICU and was given NIV support. Her conditions stabilised a bit, hypotension was corrected and respiratory rate was somewhat controlled with NIV. The patient party was informed accordingly and was suggested shifting of patient to any higher setup having PICU facilities.

Dr. Saumen Meur of AMRI, Mukundapur unit could be contacted and Dr. Meur was briefed about the patient's condition. At 9.30 AM on the next day further tests were advised. However, the complainant wanted to have those tests performed after her transfer. The patient was intubated, ventilated at about 2 PM and transferred to AMRI Mukundapur unit. The patient ultimately left the CE at about **5.25 PM owing to many procedures involved before discharge.**

She would defend the CE by contending, at the time when the patient reported at the emergency she did not require any ICU or HDU support and the condition was not as such wanting PICU facilities. At the same time, she required to be urgently hospitalised and shifting her to another hospital could have caused delay in starting the treatment, for all these reasons they admitted the patient. AMRI, Mukundapur unit also submitted relevant records pertaining to the treatment. Dr. Meur signed the response. According to him, the patient was transferred at 18.05 hours. She was diagnosed of septic shock. She was

transferred, intubated and ventilated. **Her condition was extremely poor on arrival.** The relevant extract is quoted below:-

*"It is to be noted here that her condition was extremely poor on arrival. Despite being ventilated she had a gasping type respiration and there was no palpable peripheral pulse. Her perfusion was very poor and SpO2 reading couldn't be obtained. There was visible blood in the endotracheal tube. On monitor there was sinus rhythm with a heart rate of 154/min.*

*In view of frank bleeding in the ET tube suctioning was done and ventilation was supported by bag tube ventilation in 100% oxygen. She was also given a 500 m/s fluid bolus and started on Adrenaline infusion by peripheral cannula.*

*Furthermore there was continued bleeding through ET tube needing frequent suctioning. The Adrenaline infusion was gradually increased to 0.5 microgram/kg/min and by this stage good volume central pulses were palpable. SpO2 was also readable at this stage and was only 37 % despite high pressure bagging with 100% oxygen. A venous blood gas done at this stage showed profound mixed acidosis with pH < 6.8. A bicarbonate correction was given in view of this. In view of continuous ET bleeding she was put on ventilation with high PEEP and 100% oxygen. A chest x-ray done at this stage showed extensive bilateral opacities. Her overall respiratory status was consistent with a diagnosis of Acute Respiratory Distress Syndrome (ARDS). Even on ventilator*

*the patient (since deceased) had SpO2 in 40s. Soon afterwards the child had a profound bradycardia down to 20s and CPR started as per PALS protocol. ROSC was achieved after 3 cycles of CPR with Adrenaline.*

*Femoral central venous line and femoral arterial lines were established for safer delivery of vasoactive and accurate measurement of blood pressure and sampling. Invasive blood pressure was 130/90 mm of Hg initially.*

*Adrenaline infusion was titrated targeting a MAP of around 80 mm of Hg. Pupils at this stage were midsized and very sluggishly reactive. There was no spontaneous movements. Ventilataion support continued as before and SpO2 gradually improved to 60s. A repeat ABGA at this stage still showed profound mixed acidosis with pH 6.78, pCO2 101 mm of Hg and Lactate 11.0 mol/L.*

*The peripheral perfusion was still very poor with difficult to feel pulses. Pulse pressure was narrow. In view of this she was started on Milrinone infusion @ 0.5 microgram/kg/min. A screening Echocardiography showed moderate to severe left ventricular systolic dysfunction.*

*Oxygenation improved a bit after this with SpO2 in 80s but still needing PEEP 20-22. She also needed very high peak pressure ( around 36 cm of water) for a TV of 4 mls/kg. Altered blood was seen from the nasogastric tube and she was already on intravenous PPI. Her urine output was also falling by this stage.*

*Please be enlightened that Her blood investigations revealed a very high CRP (> 450). Very high D-DIMER (>46) and very high NT-proBNP (>25000). A*

repeat ABG done at 21:30 hrs still showed profound mixed acidosis with pH <6.8, PCO2 122 mm of Hg and Lactate 8.4 mmol/ L. Another bicarbonate correction was given. Tidal volume was increased accepting a higher peak pressure as the pH was <6.8.

In view of falling urine output a dose of Frusemide was given without any significant urine output. Her blood pressure started falling again soon afterwards and the Adrenaline dose was increased again. The Pulse pressure became wide this time and Noradrenaline was also started and gradually increased to 0.5 microgram/kg/min. The MAP was maintained around 80 for a little while with these support.

However her ventilation became worse again. Tidal volume had to be reduced again as the peak pressure was crossing 45 with worsening. Haemodynamics. Despite reducing tidal volume haemodynamics continued to deteriorate. Despite increasing both Adrenaline and Noradrenaline to 0.7 microgram/kg/min the MAP remained in low 40s.

She went into asystole again at around 23:45 hrs and was given 1 cycle of CPR with Adrenaline. She had become completely anuric by this stage. Despite increasing Adrenaline and Noradrenaline to 1 microgram/kg/min her blood pressure remained low. She had multiple episodes of cardiac arrest needing CPR this point onwards. She had another cardiac arrest at around 01:00 hrs on 28.02.2022 and despite 3 cycles of CPR with Adrenaline, spontaneous

*circulation couldn't be established. She was declared dead at 01:10 hrs on 28.02.2022.*

*According to the condition of the patient as per my treating hypotheses I catered that the cause of death was Acute Respiratory Distress Syndrome (ARDS), Disseminated Intravascular Coagulation (DIC) and Septic Shock and I have documented the same in my findings in the BHT."*

**HEARING**

We fixed this matter for hearing on April 13, 2022 when the entire treating team and the officials belonging to AMRI, Salt Lake Branch were present online. So was the AMRI, Mukundapur unit.

Mr. Ratan Debnath, the ill-fated father narrated his ordeal. He would reiterate his grievance that he had already made through his complaint. According to Mr. Debnath, on being advised, he took Aliva by ambulance and reached there at about 12 noon. He was made to wait. He was asked to visit the OPD with the patient. The condition was so critical that she had to be taken to the OPD which was very near to the main building through ambulance. Dr. Chakraborty saw

the patient and advised admission. According to Mr. Debnath, approach of Dr. Chakraborty was very casual. Although Dr. Chakraborty advised admission that was inordinately delayed. Throughout the day the patient was without any medication, no proper care was taken at the CE. The patient was shifted to bed after a long wait. Dr. Mukherjee examined the patient at about 3 PM . At night, when the patient's condition became critical they asked Mr. Debnath to find out a better setup having PICU. Despite, best efforts he could not make such arrangement. Ultimately, AMRI, Mukundapur unit could arrange a bed and confirmed it next day morning. The AMRI, Salt Lake branch, however, inordinately delayed transfer. He was assured that the patient would be shifted by the AMRI, Salt Lake ambulance being escorted by a doctor. However, at the time of discharge, the hospital did not extend such support and the patient party arranged a private ambulance without any doctor. He would reiterate, that channel was removed. On being pointed out, it was again created in the other

hand. One of the causes of delay was non availability of Dr. Gautam Banerjee, who was supposed to do the intubation.

Mr. Debnath was very much satisfied with the treatment at AMRI, Mukundapur unit. He has no grievance against the AMRI, Mukundapur unit or its treating team who attended the patient there. According to Mr. Debnath, it was for sheer negligence and delay at AMRI, Salt Lake that the patient life could not be saved. Despite, best efforts of the treating team of AMRI, Mukundapur she breathed her last within a short span of time. He would pray for justice and stringent punishment against the AMRI, Salt Lake branch and the persons involved therein in the process of treatment.

**EVIDENCE**

Mr. Debnath deposed on his behalf.

**RATAN DEBNATH**

My 13 years old daughter had some ENT problem. I contacted an ENT

specialist at Barrackpore. He examined the patient and prescribed Augmentin and other medicines to be used thrice a day. Even after medication the condition did not improve. She had rashes on her skin. We contacted another doctor Dr. Indranil Kundu who changed the medicine. On February 23, 2022 I contacted the ENT specialist. On February 25, 2022 I got my daughter examined by Dr. Indranil Kundu. The pain did not reduce and the fever was also not remitting and was coming with regular interval. Her oxygen level was falling down. She was not taking any food. I contacted an ambulance and took her to AMRI, Salt Lake's Emergency. I met Dr. Sur who examined the patient for about 15 minutes. The patient was very weak. The patient was not able to walk without any support. She was taken to Emergency through wheel chair. AMRI, Salt Lake did not give any treatment at Emergency and advised her to see an ENT specialist Dr. Chandan Chakraborty at OPD. She was not able to walk. I again put her in ambulance and took her to the next building where OPD was situated. AMRI, Salt Lake did not even start any IVfluid. Dr. Chakraborty

advised admission. I took her again to Emergency through ambulance. She was made to wait for long. No treatment was given at the emergency. The admission process was delayed. Dr. Chakraborty examined her. He also asked her to walk, she was not able to do so. I told him about the past events. Dr. Chakraborty would, however, ignore her weakness and asked me that we should not pamper the child. He advised admission. I again approached reception desk with all my medi-claim documents. I requested them to start emergency medication because, from the very morning she was without having any food or medication. Even the prescribed IV saline was not given. She was made to wait for about one and a half hours. Although I booked a cabin she was belatedly transferred to a general bed. I requested the nurse to start IV fluid and other treatment. They brought the portable machine and got the X-ray done. While I enquired they assured me that everything was fine. At about 6 PM Dr. Emily Mukherjee came. She examined the patient. She also got skin test done. She also prescribed medicine and left the premises. At about 10.30 PM I received a call that the

patient was serious and was being transferred to HDU. Shortly thereafter, another phone call came and informed me that the patient had been shifted to ICU. At about 12.30 AM in the night the doctor present therein, informed me that the patient was in septic shock and he asked me to arrange for a PICU bed somewhere else as AMRI, Salt Lake did not have such facility. He also assured that they would be also trying for a PICU bed at their Mukundapur unit. I tried my best to get a PICU bed but in vain. At about 8AM in the morning I could get opportunity to see the patient and doctor assured me that the patient was absolutely stable and nothing to worry. At about 10.30 AM I was called at upstairs then I was made to wait for 30 minutes. Dr. Chakraborty was there. Dr. Chakraborty reiterated the samething which he had said on the earlier date and again asked me not to pamper the child. He would also inform that all parameters are ok. Dr. Emily Mukherjee was, however, of the opinion, that patient must be shifted at a proper setup having PICU facility. Dr. Mukherjee, also informed that she could arrange a bed at AMRI, Mukundapur and she had

already talked to Dr. Meur. Dr. Meur had already been briefed. There would be no difficulty. We must proceed to AMRI, Mukundapur unit along with the patient. At that time Dr. Chakraborty, Dr. Sur, Dr. Mukherjee all were present. So was the hospital staff in-Charge of ambulance. He assured that the AMRI would provide their own ambulance along with a doctor support at the time of transportation and the patient would be safely shifted at AMRI, Mukundapur.

AMRI, Salt Lake branch insisted that we must clear the bill immediately. The billing department would insist for cash payment as the Insurance Policy would not be applicable since the discharge would be before expiry of 24 hours period. I had Medi-claim Policy for Rs.6,00,000/-. I could arrange cash payment from my colleague and clear the same. I am working in West Bengal Tourism Department. Even, after payment the patient was not shifted. I was told, there might be jerking at the ambulance, so the patient would require intubation and that would be done by Dr. Gautam, who was absent at that time. Every time I was assured that AMRI, Salt Lake will provide their ambulance

along with the doctor. We frantically searched for Dr. Gautam but in vain. Ultimately, the patient was intubated. The patient was kept only on oxygen support without any other treatment.

They could not arrange AMRI, ambulance. They gave a phone number of a private ambulance I contacted the said ambulance who said that he would not be in a position to come before 45 minutes. We had to wait for such ambulance. At about 5.25 PM the patient was shifted

At that time the ambulance staff pointed out that cannula had already been removed. On being pointed out, they hurriedly created another channel in the other hand. When we reached AMRI, Mukundapur we faced the question as to why we had delayed arrival and why the patient had not come through AMRI ambulance. They said, at about 11 AM the bed was arranged but the patient was not transferred. We could not give any satisfactory answer to either of the said questions.

AMRI, Mukundapur did their best. They tried their level best to save her. Her pulse could not be found. The doctors had shown X-ray plate. Time to time update was given by them. The AMRI, Mukundapur doctors had shown us the condition of the patient. Patient was bleeding.

My first question is when I took the patient at AMRI, Salt Lake they were apprised that the patient was having fever for last seven days. They did not treat the patient at Emergency instead, advised us to go to OPD to see ENT specialist. Even after coming from OPD the entire process of admission were delayed. Preliminary basic treatment was not given. She was made to wait outside the Emergency.

The AMRI, Salt Lake, in their response, stated, I refused test at AMRI, Salt Lake. It was not so. I refused test when the patient had already been directed to be shifted. They got consent papers signed by my wife for costly medications to be used. Medication was not given. Even, the privacy document had also been signed while she was being transferred to HDU. I never asked them not

to do the test. Even, at 8 AM I knew that the patient would be shifted I cleared the bill in cash when they declined to access the Medi-claim Policy. In their response, they claimed, at about 4.55 PM they started IV fluid. However, the BHT did have any stamp or signature of the treating doctors. The date and time was subsequently put. They also stated, rashes were due to Augmentin. They failed to diagnose that this rashes could be because of sepsis and as such they could not give proper treatment on that score.

Their statement on shifting is inconsistent. In the one hand they would say, they got the patient admitted because of her critical condition and at the same time they would contend, they referred her to different setup due to non-availability of PICU bed. On the one hand, they would say that shifting patient at the threshold could have delayed the process of treatment although the facts would reveal that there had been inordinate delay in getting the patient admitted. Had it been told at the threshold that the patient should be taken to

AMRI, Mukundapur at the earliest, it would have been logical. It appears, the contrary was done only to fork out money and nothing else.

It is ridiculous to suggest that would agree to pay in cash or medi-claim. Once medi-claim, would certainly insist on medi-claim policy to be used instead of cash.

Her discharge Summary would denote, that she was having saturation at 92% whereas at the time of discharge the recording would reveal that she was having saturation at 72%. While being pointed out, they would blame their machine as according to them, the machine might have been wrongly displaying the actual saturation. Even, at the time of shifting they assured, the patient was absolutely fine and she would be ok within two to three days. The bill was ready by 12 noon. I paid at about 1.PM. If they would contend, even thereafter they were continuing medication there should have been another supplementary bill for the said purpose.

In reality, it was not so. My assertion that the patient was not having any medication, would be corroborated by the fact that the bill was finalised by 12 noon and no further bill was made thereafter. The patient did not have any medication after 11 AM except oxygen support.

If they would contend, the patient was absolutely stable at the time of shifting how the AMRI, Mukundapur unit after 45 minutes would observe just contrary to it.

There was no doctor in the ambulance. Ambulance was not arranged by them. They provided the phone number. I called the ambulance.

Lungs was completely shadowed. It was full of blood. Pulse could not be found.

I lost my child within one day. AMRI, Mukundapur did their best. AMRI Salt Lake was thoroughly guilty of medical negligence. I pray for stringent action as against the AMRI, Salt Lake. They can not bring back my child, so they must

be imposed appropriate penalty by way of compensation so that in future they would not do so with any other patient. I also seek justice as against the treating team. I have not yet made any formal complaint against them.

Dr. Mittal produced all concerned one by one when they made their statements that we recorded through our audio device.

**DR. NOMITA MITTAL**

Dr. Mittal would express condolence for the unfortunate demise of the 13 years old girl. Dr. Mittal was not there at the relevant time. She was not involved in the process of treatment. After the complaint was raised she enquired and was apprised of the incident through her emergency team. All points have been enquired into. The patient party was known to Dr. Sur and Dr. Sur was guiding them. He came to the emergency and coordinated the entire process. Dr. Sur took her to ENT specialist and such decision was taken by Dr. Sur on behalf of the complainant and the patient was taken to Dr. Chakraborty, the ENT specialist.

**DR. SANGHABRATO SUR**

The patient came with a social reference to me. The patient was seen by an Apollo doctor. They wanted to have a second opinion. Since I was not ENT

specialist I took them to Dr. Chakraborty. I had no information prior about her condition of health and the patient was coming via ambulance. She had some problems with the throat so I took her to Dr. Chakraborty. I came to the emergency. I saw the patient.

At this stage, Dr. Mittal interrupted and said that child was having medication. She was quite stable. When the child was in OPD the child was absolutely normal. I had only social reference. They did not come to see me. I wanted to help them due to my social reference. Dr. Chakraborty advised her for admission and I coordinated so that she could get admission. She was absolutely normal at the point of time. I did not find any criticality in the patient.

Dr. Mittal again interrupted. There was no earlier report having severe illness at that time. The patient had seven days fever and she was having medication.

**DR. CHANDAN CHAKRABORTY**

The patient came to OPD along with Dr. Sur and her father Mr. Debnath. I saw the patient. She was having seven days fever and pain in the throat. Weakness was there. I advised detailed examination to be done. There was a gross dehydration. I was not sure whether she was being properly treated at home or not. I thus advised the institutional treatment and as such advised her admission. I suggested fever and dehydration related investigation to be immediately done. I also prescribed IV fluid and antibiotic. I had consultation

with Dr. Emily Mukherjee, the pediatrician and the investigation started. It took time to get the report. The patient was on oral feeding. When Dr. Mukherjee saw the patient she was brushing her teeth. The treatment started on urgent basis. No question of delay from my end, would arise. We have given dehydration correction and got the fever down. So long we could not get the investigation report we could not proceed further. We did not have any previous medical records to get a rough and ready idea about the illness.

At that time, Mr. Debnath confronted Dr. Chakraborty and categorically asserted that all medical records that he was in his position, were shown to him.

We also decided to have a neurological consultation that would appear from my prescription. To find out whether there was any sepsis or not, I prescribed ABG CRP, IL-6, potassium, sodium and other related examination. However, we had to wait for the report to proceed further in the treatment. It was a case of joint admission with Dr. Emily Mukherjee and we treated the patient jointly. The patient party came with the intention to get institutional treatment and I accordingly advised them to do so after examining the patient. When the patient came at the OPD she came by walking. She was quite stable and question of PICU admission at that stage, did not arise.

**DR. EMILY MUKHERJEE**

I got a call from the hospital at about 5.15 PM and I saw the patient at 5.30 PM. By that time 1.50 ML urine she passed. She was feverish. She had throat pain. I saw the rashes. I enquired whether there was any covid in the house. The parents admitted that her grandfather had covid but it was one and a half years ago. I found her vital ok. She had dehydration for which antibiotic had already been prescribed. Thinking it to be sepsis broad spectrum antibiotic was prescribed. IV fluid was given. The patient party did not refuse investigation. I saw her brushing and there was a soup kept. She wanted take soup after brushing the teeth. I felt it ok. At night, I got a call that the patient had shortness of breath. The patient was ultimately transferred to ICU. The ICU expert Dr. Susrut Bondhyapadhya examined the patient CRP was 440 which was extremely high. I saw the CRP report at 10 PM. I was convinced that the child could not be managed in the Salt Lake setup and as such advised shifting at a PICU setup. I made a summary and shared it with the parents however, the parents could not make any arrangement. We also tried from 10 PM in all hospitals having PICU facility bed but could not succeed. Woodlands was having a bed. We also shared the contact number with the patient party. She was given Bipap. Next day early morning, I contacted the concerned RMO who was managing Salt Lake and Mukundapur and came to know, a bed could be arranged at Mukundapur. I contacted Dr. Meur and apprised him about

the condition of the patient. She was conscious. She improved a lot in the morning. AMRI Mukundapur agreed to take her. This was at 9 AM in the morning on the next day. By 11.30 AM I consulted the patient family and confirmed the bed at Mukundapur. Inflammatory marker was very very high that I came to know from other two reports I got in the next day morning. I cautioned the complainant about the criticality of the patient. Again I enquired whether there was any covid patient in the house or not. Then, the patient family modified their statement and said that the covid was there one and a half month ago in the family. It was possibly post covid symptom.

The earlier cannulation might have been blocked for movement hence, the second channel was done.

**MR. MANISH**

Channel was blocked. New channel was later initiated. There was no delay in between.

**DAY DUTY MANAGER**

In the morning around 10 AM when I joined duty I came to know, the patient was planned for shifting. At around 12 O'clock we got the final confirmation from AMRI, Mukundapur about the bed. Then we started transfer procedure. At around 2O'clock when there was a need of emergency ambulance my ICCU care ambulance was not there and I assured that I would be arranging a private ambulance.

We also contacted AMRI, Mukundapur for ambulance. They could not also provide any ambulance. So we called our vender ambulance. We have tieup with a private ambulance set up. We talked to the ambulance driver as well as doctor what they would need during transportation. Ambulance came at 4 PM.

Dr. Saumodeep Mukherjee was there in the ICU. The Ambulance people apprised him what they would require for transportation of the patient. Accordingly, the patient was made ready for shifting. Intubatation was done at around 2 PM . Dr. Bondhyopadhya did it.

**FLOOR MANAGER.**

As the patient party was trying to expedite the process I helped them to complete the bill at the earliest. Since it was less than 24 hours they paid in cash. Payment was made at 3.56 PM. He modifies, as soon as bill was made ready payment was made. We prepared the bill as per Insurance agreement. We did so to give benefit to the patient as Insurance rate is less than cash rate. Had it been cash patient the bed charges would be Rs.14,000/- instead of Rs. 11,000/- We had two types of bill; cash bill and Insurance bill. Rs. 2,182/- discount was given as per TPA agreeement. Had it been cash bill the CRP rate which was charged Rs.1,940/- would have been much higher. The Manager now changes his statement, the cash patient would be charged as per the advisory given by the Commission. In case of a cash patient the bed charges and the doctors charges would be much more. However, the investigation

would be the same at par with the TPA agreement. The person again modifies his statement by saying, he is not aware of the investigation rate and he would be able to say so after gathering such information. It is done by the paramedical staff.

**AMRI, MUKUNDAPUR TEAM**

Dr. Meur spoke on behalf of the AMRI, Mukundapur team. Child arraived at 6.05 PM. She was very critically ill. She was gasping. There had been bleeding from endrotraqutial tube. D-DIMER was very high and child developed ARDS. She had four cardiac arrest at AMRI, Mukundapur, where blood pressure was very low, saturation was not at per normal level. Despite, our efforts, she was there for seven hours when she breathed her last.

**HEARING**

We recorded the statements of the persons involved in the process of treatment that we set out as above.

At the hearing Dr. Sukumar Mukherjee, our esteemed member interacted with treating doctors team. Dr. Madhusudan Banerjee, another esteemed Member would support the observations made by Dr. Mukherjee.

Dr. Maitree Banerjee, another esteemed member, was also in doubt whether the patient had post covid symptom.

Dr. Mukherjee gave his opinion in writing.

**Dr. SUKUMAR MUKHERJEE**

*"Observation:*
*Phase I:- AMRI Salt Lake*

*Aliva Debnath, 13 years girl was taken to AMRI, Salt Lake on February 26, 2022 at around 1.30 PM with high grade fever, cough and throat discomfort. The patient was admitted after long wait at 3 PM. After admission she was seen by RMO at around 4.15 PM and treatment given with Injection Piperacillin and Tazobactam after skin test and IV fluids at around 6 PM. In between she was examined by ENT surgeon Dr. Chandan Chakraborty who advised urgent admission under care of Dr. Emily Mukherjee, pediatrician ICU and himself. On 26/02/2022 at 10 PM the girl developed shortness of breath with desaturation and fever. Incidentally, she was observed to have widespread body rash assumed to be related to Augmention received at home. In view of the progressive worsening with hypotension and desaturation a provisional diagnosis of septic shock or anaphylactic shock was made. And IV fluids 1M epinephrine and change of antibiotics were made. More so NIV support was given for extreme tachypnoea, ABG showed metabolic acidosis with hypoxia. There was partial improvement but still unstable, few additional test were done at 9.30 AM on 27 February 2022 while she was in HDU/ICU. However, elective intubation was done at 2 PM prior to planned transfer to PICU in another set-up AMRI, Mukundapur. (PICU not available in AMRI Salt Lake)*

*Ultimately, the patient reached AMRI, Mukundapur at around 6 PM in a private ambulance leaving Salt Lake AMRI at around 5.25 PM.*

*Phase-II AMRI, Mukundapur.*

*Patient reached PICU at 18.05 hrs in a private ambulance in a very critical stage with acute haemodynamic and respiratory crisis with mixed respiratory and metabolic acidosis. The multiorgan failure consisting of ARDS, myocardial decompensation, disseminated intravascular coagulation are the hard end-points culminating to cardiac arrest at around 01.10 hours on 28.02.2022. Within a span of seven hours since arrival repetitive resuscitative measures were proven ineffective. No post mortem examination was done.*

***Comments**: The patient 13 years girl stayed in AMRI, Salt Lake for about 26 hours from 3 PM on 26 February 2022 till 5.25 PM on 27 February 2022 before transfer to AMRI, Mukundapur where she stayed for about seven hours. Patient deteriorated at around 10 PM on 26 February 2022. Blood test done at 9.30 AM on 27 February 2022 and intubation done at 2 PM on 27 February 2022 prior to transfer to PICU at around 5.25 PM. It appears to have some internal delay on 27 February 2022 . No pre-hospital progression of the patients illness are available except intake of Augmentin.*

*Patient was transferred by private ambulance and not on AMRI salt lake ambulance.*

*Very rapid progressive and deterioration were observed after admission. Here "Time is life" is not strictly adhered.*

*It was a clear picture of systemic sepsis with multiorgan failure suggested by elevated procalcitonin but negative blood culture, very high CRP, altered N/L ratio, high IL-6, high D-DIMER. Subsequently very high nt Pro BNP was observed at AMRI Mukundapur.*

*Peritonsillitis is unlikely to be a primary culprit. Covid Swab test has not been done. No post mortem examination has been done to elucidate the exact cause of the severe sepsis."*

**OUR VIEW**

After the hearing is concluded we had interactions amongst us. The panel is unanimous of the view that there had been total mis-handling of the patient by AMRI, Saltl Lake. No doubt, the patient was too critical possibly, it was a post covid syndrome or an acute viral infection that the initial treating doctors could not diagnose. The rashes on the skin might be because of sepsis. This is our prima-facie findings. Pertinent to note, no post mortem examination was done to know the actual cause of sepsis that ultimately led to death. We are not

competent to deliberate on the treatment protocol that would, however, not absolve the responsibility of AMRI, Salt Lake branch.

The patient was introduced by Dr. Sur. The patient reached the CE at 12 noon as per the complainant and 1 PM as per Dr. Mittal. From the records it would show, the patient was ultimately admitted at 4 PM after long three hours wait without any treatment that cannot be justified. Dr. Emily Mukherjee examined the patient soon after her admission. Her initial observation about the patient was in a right direction. She initially tried to manage the patient. However, at 10 PM when the patient became critical and shifted to ICU, she apprised the patient party about her condition and asked them to find out a PICU bed for her. She also prepared a case summary to facilitate transfer of the patient. She on her own, tried to contact other hospitals having PICU but in vain. Ultimately, she could arrange a bed at AMRI, Mukundapur next day morning. By 11 AM the bed was confirmed. Dr. Mukherjee did her best what she could do in the circumstances. We, however, refrain from making comment about Dr.

Chakraborty. From 11 AM to 5.45 PM, long seven hours wait, was really crucial for the patient. Our observation in this regard is corroborated by Dr. Meur. Even, the complainant, the ill-fated father, would praise the AMRI, Mukundapur team led by Dr. Meur. However, it was too late for them and despite best efforts they could not save the young girl. We are not sure, whether the patient could be saved if the initial delay in admission and subsequent delay in shifting could be avoided that does not absolve the CE from their negligence.

CE tried to explain the first delay. Dr. Sur, received the patient who was introduced to him by a social connection. Since the patient had a throat problem he took her to Dr. Chakraborty. Dr. Chakraborty advised admission. Hence, there could be no reason for a long wait to get the patient admitted. It is not the case of the Salt Lake branch, the bed was not available, in fact, no one from the CE tried to explain the long wait after the OPD episode.

The second delay is more crucial. Dr. Mukherjee categorically stated, she confirmed the PICU bed at 11 AM, it might be at best 11.30 AM. The treating

team decided to have the patient intubated. According to the CE, it was done at 2 PM. The complainant contended, Dr. Gautam Banerjee could not be found. Such definite assertion was never reverted. From 2 PM to 5.45 PM, no plausible explanation was given. The Ambulance In-Charge gave the phone number of the driver to the complainant. The driver said, he would be coming after 45 minutes. When the driver came with the ambulance, Cannulla was found to be missing. It was refixed on being pointed out. These facts, taken together, would clearly show lackadaisicall approach of the AMRI, Salt Lake.

**CONCLUSION**

We hold the CE being AMRI, Salt Lake responsible for the negligence. We cannot convincingly say that such delay had a direct nexus with the death of the patient. At the same time we are confident to say, it is one of the main causes for which the patient did not get proper treatment at the crucial hours.

We impose a compensation of Rs. 9,00,000/- as against AMRI, Salt Lake. We appreciate the sincere effort of Dr. Mukherjee of the Salt Lake branch and the entire treating team of the AMRI, Mukundapur branch. Despite their sincere efforts, they could not save the young girl.

**ORDER**

We direct AMRI, Salt Lake to pay the said sum of Rs. 9,00,000/- to the complainant. In case the complainant is not desirous of accepting the said sum the CE would deposit the money with Commission and Commission would, in turn, donate the said amount to any philanthropic institution of the parents' choice in the memory of the ill-fated child who lost her life at her very young age.

The complaint is disposed of accordingly.

Sd/-

*( ASHIM KUMAR BANERJEE )*

We agree,

Sd/-

**Dr. Sukumar Mukherjee,**

Sd/-

**Dr. Madhusudan Banerjee,**

Sd/-

**Dr. Maitrayee Banerjee**

Authenticated

ARSHAD HASAN WARSI
WBCS (E
Secretary
W. B. C. E. R. C.