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: MUR/2020/000856

Present: Justice Ashim Kumar Banerjee (Retired), Chairman

Dr. Sukumar Mukherjee,

Dr. Makhan Lal Saha,

Dr. Maitrayee Banerjee,

Smt. Madhabi Das.

Mr. Bikash Mondal.....Complainant

- Versus-

Lila Hospital.....Respondent

Heard on: August 8, 2022.

Judgment on : August 31, 2022.

BACKDROP

Smt. Bipasha Mondal, aged about 23 years old was admitted at Lila Hospital under Dr. Pushpal Goswami for delivery of her child on August 11, 2020. She was earlier under regular check-up of Dr. Goswami. Dr. Goswami performed Caesarean C Section at 8.15 am on October 5, 2020. The patient was shifted to ward after the surgery at 9 am as we find from the medical records. The patient became critical late at night. Dr. Goswami was informed at about 12.30 am on the next day. The patient was shifted to ICU at 1.30 am. The patient was intubated and given ventilation support. She expired at 7.15 am.

COMPLAINT

On October 10, 2020, the father of the ill- fated patient Mr. Bikash Mondal, resident of Dangapara, District- Murshidabad lodged a complaint. According to the complainant, the CE as well as Dr. Goswami did not take proper step despite request. Doctor did not visit for atleast once after delivery and did not disclose the proper cause of death to the patient family that the office received after the first hearing.

RESPONSE

The Commission asked for response from the CE and placed it for hearing on December 3, 2020. On December 1, 2020 the CE gave their response. According to the response, the LUCS was done by Dr. Goswami at 8.15 am. The procedure was uneventful. The vitals were normal. The patient was seen by Dr. U.K. Roy,

the Anaesthetist at 1 pm as well as 5 pm. The patient was under constant care of the on duty medical officer. Time to time, the consultant was apprised of the condition of the patient. At about 1 am on October 6, 2020 there had been drastic deterioration of the condition of the patient. She was shifted to ICU, intubated and put on mechanical ventilation. The consultant gynaecologist was present at the ICU till the patient expired at 7.15 am on the said date.

HEARING

The Commission placed the matter for hearing on December 3, 2020 when the Commission granted liberty to the complainant to file his detailed complaint through an affidavit coupled with a direction upon the Clinical Establishment to give their version within three weeks thereafter and rejoinder, if any, by three weeks thereafter. The Commission also requested the concerned Gynaecologist, Anaesthetist and the OT sisters to be present at the hearing.

The order dated December 3, 2020 was duly communicated to the parties.Despite such communication, no affidavit was filed by any of the parties.

The Commission placed it for final hearing on February 19, 2021. The parties were duly represented. The Commission heard the complaint at length and finally passed an Order of penalty to the tune of Rs. 3,00,000/-payable by the CE to the complainant. There had been a sum of Rs. 28,000/- outstanding on account of unpaid bill. The Commission permitted the CE to deduct the said amount from the amount of penalty while making the payment.

POST HEARING EVENT

The CE by a mail dated March 3, 2021 asked for a copy of the Order so that they could make payment of the said sum. The mail was sent by Shri Himadri Ray on behalf of Lila Hospital. The relevant extract is quoted below:-

"I would like to communicate with you by stating that in connection with the complaint ID No. MUR/2020/000856, you were pleased to fix a date on 19-02-2021 for hearing by issuing an order vide Memo no. 2735/WBCERC/2020 on 03-02-2021. As per the order we were present on the date and time via video conference. After hearing both the parties you were pleased to direct us to pay a sum of three lacs as compensation and upon our submission of non- payment of patient bill by the party you further directed us to pay the amount by deducting the patient bill within two weeks. But this is only for your information that till date we have not received such order nor via mail or post. Hence its my humble submission before you to please guide us that as we are a law abiding organisation, ***we are ready to pay the amount directed by you****. But till date no order has been received. So what should we do if the two weeks from the date of hearing past or should we pay the amount prior to receiving any documented order".*

WRIT PROCEEDING

The CE filed a writ petition being WPA15668 of 2022 on July 13, 2022 upon service of a copy of the same on the Commission on July 15, 2022. The matter came up for hearing before the Hon'ble Court on July 20, 2022 when upon hearing the rival contentions, the Hon'ble Judge passed the following order:-

"The impugnedorder is set aside for the above reasons. ***The Commission shall be at liberty to call for affidavits or other corroborative evidence from the petitioner and the complainant.*** *The Commission is directed to pass a fresh order upon hearing the parties. The Commission* ***shall endeavour to complete the hearing and pass the order within six weeks from the date of communication of this order. The petitioner and the concerned respondents shall file their respective affidavits within two weeks from date".***

The Office downloaded the order from the internet on the said date i.e July 20, 2022.On perusal of the said order dated July 20, 2022 the Office immediately issued notice of hearing to the parties concerned coupled with a request to file affidavit as directed by the Hon'ble High Court. No affidavit was filed by any of the parties.

HEARING ON REMAND

The matter came up for hearing afresh on August 8, 2022 when Mr. Kallol Ghosh represented the CE. He was present online.

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Secretary
Regulatory Commissior

The complainant was absent. The Office contacted him over phone. He would express his inability to join the virtual meeting as he did not have such facility. The Commission permitted him to be present through his mobile phone. The Commission put him on speaker mode so that he could be audible not only to the Commission but also to Mr. Ghosh who was present online on behalf of the CE. By such process, the hearing was given to both the parties.

RIVAL CONTENTIONS

Mr Mondal reiterated what he had stated in his complaint. He was consistently contending that the consultant Gynaecologist never saw the patient till she became critical. The CE also did not take due care. As a result, his daughter breathed her last at a very young age of 23 years. He would pray for justice before the Commission.

Mr. Kallol Ghosh, representing the CE, would contend that they would leave the entire issue to the Commission for proper adjudication and whatever they would feel best they should do justice. No specific issue was raised by Mr. Ghosh. The Commission concluded the hearing and kept judgement reserved.

EVALUATION OF MEDICAL RECORDS

The CE did not submit any formal Bed Head Ticket. The relevant papers that came up for our consideration are as follows:

- Prescription of Dr. Pushpal Goswami, dated September 15, 2020 hearing subsequent noting dated September 25, 2020 and October 5, 2020.
- Form filled up by Biplab Kumar Mondal giving detailed address of the patient.
- Admission form dated October 5, 2020 that would have detailed record of medication given to the patient on October 5, & 6, 2020.
- Admission cum consent form signed by Biplab Kumar Mondal recording birth of a girl child at 8.19 a.m. on October 5, 2020 through LUCS done by Dr. Pushpal Goswami and Dr. U. Ray.
- Consent form in Bengali duly signed by Biplab Kumar Mondal.
- Estimate of billing amount and patient charges card
- Consultancy bill
- OT note
- Anaesthetic note dated October 5, 2020 coupled with a Bengali consent form duly signed by Biplab Kumar Mondal for Caesarean C Section.
- Medicine Chart dated October 5, 2020 recording that the patient expired on October 6, 2020 at 7.15 a.m.
- Daily intake output chart
- Monitor recording of ICU 8 dated October 6, 2020 and investigation requisition form.
- Investigation requisition form from ICU
- TPR/BP Chart

- History Sheet containing five pages.
- BILL

ANALYSIS

Five vital records would be relevant herein. Let us deal one by one.

I) ADMISSION FORM

The back side of the admission form would have details of the injections. It appears that the injection'H.CORT' was administered at 12.10 pm and the next one 'NACPHIN' was given at 12.30 am. This was possibly a mistake on the part of the nurse who administered the injection. Either it was given at 12.30 pm on October 5, 2020 or it was at 12.30 am on the next day i.e. October 6, 2020.

Keeping two blank lines the injections were recorded being given on the next day i.e. October 6, 2020. The 'NORAD' & 'ADRENALINE' were given IV whereas'ATROPINE' was given at 1.30 am and twenty five percent D was administered at 5.30 am on October 6, 2020.

So, on a combined readings of the recordings, it would appear that no medicine was administered in between 12.30 pm on October 5, 2020 and 12.30 am or 1.30 am on October 6, 2020. So it would be a clear indication that no injection was given for about 12 hours in between October 5 and October 6, 2020 at last not recorded.

II) MEDICINE CARD

Medicine Card would record 'JONAC SUPPOSITORY' was given at 10 hours on October 5, 2020 and 22 hours on the same day. 'NEBUDUOLIN' was given on October 5 at six hours, 12 hours, 18 hours and 24 hours. 'CETZINE' was given at 22 hours. Injection 'ZOSTUM' was given at 10 hours and 22 hours. Injection 'MIKACIN' was given at 10 hours and 22 hours. Injection 'METROGYL' was given at 6 hours and 18 hours. Injection 'PAN 40' was given at 6 hours and 18 hours. Injection 'TRAMAZAC' was given at 10 hours and 22 hours.

On a combined reading of the medicine card as detailed above, it was clear that there was a wide gap between the medicines and /or injections given in the Morning on October 5, 2020 and night on the same day.

III) DAILY INPUT OUTPUT CHART

There was no recording of output. The input chart would show recording at 9 am, 1 pm and 7 pm. After 7 p.m. there was no such recording of intake. ICCU monitor and ventilator monitor would, however, record vitals from 1 am onwards on the next day.

IV) TPR AND BP CHART (PLAIN)

The TPR CHART would record vitals on October 5, 2020 and such recording

was done at 6.43 a.m. and thereafter from 9.25 a.m. till 12 p.m. **There was no recording from 12 pm onwards on October 5, 2020.**

V) HISTORY SHEET

We find History sheet recording of BP at 12 am, 5 pm and 8.30 pm. The first recording at 12 am was also a mistake. It should be 12 pm because the immediate next two recordings were done at 5 pm (undated) and at 8.30 pm on October 5, 2020. On the next page, at 12.30 am the consultant was referred.The date was originally given October 5 that was penned through and made it as October 6, 2020. There were subsequent recordings at 1.30 am, 1.47 am, 1.50 am and 3 am. The patient died at 7.15 am.

Maintaining the chronology as discussed above, from the medical records referred to above, it was clear that there was no recording of vitals for about 10 / 12 hours on October 5, 2020. All recordings on the said date were done on regular basis till 12.30 pm. It was again done when the patient became critical late at night.

Consultant was referred at 12.30 am. He came and treatment was given however, the patient did not survive.

OUR VIEW

The medical experts present at the panel are unanimous of the opinion that it was incumbent upon the CE to keep a close vigil of the patient during post-

operative period. We have found recording of vitals on October 5, 2020. We considered OT note that had recording at 10.30 am., 11.30 am and 5 pm. We do not find recording of vitals after 12 pm.

As per the History sheet, Dr. Goswami advised medicine after checking the vitals at 12 pm (wrongly recorded as 12 am). There were two more recordings at 5 pm and 8.30 pm However, it is very difficult to rely upon the subsequent two recordings as there are ample doubts as to the said recordings. On a close look to the History sheet it would appear that Dr. Goswami used the entire page in its right hand side recording his advice and he signed at the foot of the page after writing such advice. However, the subsequent two recordings at 5 pm and 8.30 pm were squeezed in between. If one would say these were subsequently recorded, such doubt cannot be brushed aside.

In this regard, we would rather place reliance on the consistent assertion of the complainant, the father of the deceased. Dr. Goswami never came to see the patient on that evening. He came late at night when the patient became critical, after being informed. The vitals recorded at 5 pm and 8.30 pm did not have any corroboration from the BP chart maintained by the nursing staff.

The members present at the panel are unanimous of the view that the patient was not monitored for a long time until she became too critical late at night referred to above.

It is true, the patient was taken due care since she became too critical and shifted to ICU. **The medical experts are of the opinion that had the post-operative complications noticed earlier there could have been a chance of survival.**

CONCLUSION

Following Section 33 of the West Bengal Clinical Establishments (Registration, Regulation and Transparency) Act 2017, the Commission is empowered to award compensation at the rate prescribed there for. In terms of the said provision, in case of death, there should be a minimum compensation of Rs. 10 lakhs. However, we are not sure whether the cause of death had a direct nexus with the hospital negligence. We could see the Post Mortem Report. The relevant columns "Cause of death" was kept blank. So we do not get any support therefrom. It would not be proper for us to award such compensation. At the same time we feel that considering the factual scenario and after being convinced that there had been latches on the part of the CE, we must award some compensation.

Under the provisions of Section 38 of the said Act of 2017 the Commission is empowered to pass appropriate order as it thinks fit and proper on examination of the evidence that has surfaced in course of hearing. The Commission is also empowered to award interim compensation.

On a proper perusal of the medical records as discussed hereinbefore, it is amply clear, there had been latches on the part of the CE to the extent that there was deficiency in nursing care particularly recording of the status of the patient, at least, on hourly basis. However, whether the line of treatment was correct or not, would not be available to us for scrutiny as it would amount to scrutiny of the medical protocol that would be clearly outside our domain. At the same time, we cannot brush aside the deficiency that is apparent. Hence, we feel, interest of justice would be sub-served, if we impose an interim compensation and wait for an appropriate decision on the issue by the appropriate authority, being the West Bengal Medical Council, if approached.

RESULT

Considering the above, we impose a compensation of Rs. 3,00,000/-(less Rs. 28,000/- being the unpaid bill) as against the CE.

We grant liberty to the complainant to approach the West Bengal Medical Council to consider medical negligence if any, and if he is successful therein he would be at liberty to approach us afresh for further relief.

The complaint is disposed of accordingly.

Sd/-

(ASHIM KUMAR BANERJEE)

Authenticated

Secretary
West Bengal Clinical Establishment
Regulatory Commission

We agree,

Sd/-

Dr. Sukumar Mukherjee,

Sd/-

Dr. Makhan Lal Saha,

Sd/-

Dr. Maitrayee Banerjee

Sd/-

Smt. Madhabi Das.

Authenticated

Secretary
West Bengal Clinical Establishment
Regulatory Commission