Office of the West Bengal Clinical Establishment Regulatory Commission

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Case Reference: INT/HGY/2022/211

Present: Justice Ashim Kumar Banerjee (Retired), Chairman

Dr. Sukumar Mukherjee,

Dr. Makhan Lal Saha,

Dr. Maitrayee Banerjee,

Sri. Sutirtha Bhattacharya,

Sri. Tanmay Roy Chowdhury,

Smt. Madhabi Das.

Mr. Palash Kuamr Saha **.....Complainant**

- Versus-

ArogyaNiketan Nursing Home, Uttarpara **.....Respondent**

Heard on: December 14, 2022.

Judgment on: April 13, 2023.

BACKDROP

A young lady of 26 years old was admitted at the CE on September 28, 2022 just on the eve of durga puja the annual festive season in Bengal. She was having high fever. She was attended by the CE having detected Dengue NSI Antigen, Serum by ELISA14.35 unit much above the positive mark. 1 gG, Serum by GAC ELISA was 6.76 unit whereas 1gM, Serum by MAC ELISA was 9.42 unit.

Dr. Kausik Munsi was the treating doctor under whom the patient was admitted. Pertinent to note, the patient was married just for seven months and was in her in-laws place where she was attacked with Dengue. Dr. Munsi was known to the in-laws family and they were instrumental in getting her admitted at the CE on the advice of Dr. Munsi.

She was under treatment from September 28, 2022 to October 2, 2022 and all those five days she was having high fever. She was referred to higher set up on the fifth day as her platelet count started falling abruptly. She was taken to Medica Superspeciality Hospital at the late hours of the night. Unfortunately she breathed her last on the very next day at about 9 am.

COMPLAINT

According to the complainant, they had no grievance as against Medica Superspeciality Hospital as they tried their best to save the patient, but in vain.

The complaint would pertain to medical negligence of Dr. Kausik Munsi as well as hospital negligence done by Arogya.

The gist of the complaint are set out hereinunder:-

I) No admission document was available. There had been continuous drop in Platelet, except on September 30, 2022. However, the hospital did not take any step for corrective measure.

II) There had been "**Interpolation of platelet counts**" as would appear from the medical records.

III) October 1, 2022 was her fourth day of admission whereas it was shown as day one. Similarly October 2, 2022 was shown as day two instead of day five.

IV) Top sheet of Monitoring of Dengue was not signed by any doctor except on September 30, 2022.

V) There had been over writing on September 28, September 30, and October 2, 2022.

VI) No day to day treatment protocol was recorded.

VII) No platelet transfusion arrangement was there at the nursing home.

VIII) The patient was admitted under Dr. Kausik Munsi. He was the only doctor treating the patient. However, order of referral was signed by another doctor.

IX) No discharge document was available.

X) On the day of referral, BP was not recorded throughout the day. The recording was done in the evening only.

RESPONSE

The CE submitted their response through its Director Dr. Ratan Lal Saxena.

According to Dr. Saxena, the patient was admitted with Dengue and as per medical norms the treatment was done. The patient was a known case of diabetic and was on insulin during her stay. Dr. Munsi regularly explained the patient status to the patient family. The admission Document / Initial Managemnet was recorded and the treatment records were present in their BHT. **There was no continuous drop**

of platelet, except on October 2, 2022 when the count became 40,000 in the morning and 34,000 in the evening.

The PCV and Platelet were being done twice daily as would be evident from the reports. There had been minor and unintentional errors on the top sheet however, that did not affect the treatment. Platelet was manually rechecked everyday and those figures were hand written. The printed blood reports were available by late evening and patient was transferred at 6.16 pm on October 2, 2022. The patient family was informed that blood transfusion could not be done. They did not have any in-house blood bank and patient was requiring advance medical management hence, she was referred to higher set up.

The complainant gave a rejoinder. According to the complainant, the patient never attended any doctor's chamber before the fateful incident. Hence, there could be no question of taking insulin.

There was no medical document to support the contention of the CE that the

patient was a diabetic. Dr. Munsi was never available during visiting hours, so question of regularly explaining to the patient party did not arise. Medical files were handed over at the time of transfer. The documents now shown to the Commission, were subsequently manufactured. There was a continuous drop of platelet count that would be apparent from the record. The over writings were glaring. It was never told to the patient's family that they did not have any blood bank.

HEARING

We heard the matter on December 14, 2022. The complainant was the ill fated father of the deceased. The patient was admitted by the in-laws. The concerned doctor was known to them. However, the in-laws did not participate at the hearing. The uncle of the patient made submissions on behalf of the complainant. According to him, since death of the patient, the in-laws did not keep in touch with the parents of the patient. According to him, the counselling alleged to have been done by Dr. Munsi, might have been with the in-laws. However, the parents

were never consulted or updated about the condition of the patient. His main emphasis was on manipulation of the platelet record.

In response, the CE would reiterate what they stated in their response. In addition, Dr. Dipsikha Chakraborty, the concerned pathologist, appeared and admitted that those over writings and / or interpolations were done by her. She would try to explain her conduct by contending, since the machine counts were recorded initially on manual count the figure differed and she corrected it by pen. She should have counter signed it that she inadvertently missed. However, in so many words, she admitted her mistake.

On our request, Dr. Tanmay Banerjee, the concerned critical care expert of Medica Superspeciality Hospital, was present. He attended the patient. According to him, the patient came at a very critical stage and platelet was quite on the lower side. Initially, on coming to the hospital platelet shot up to 90,0000 however, there had been drastic fall. He was not very sure about the actual cause of the death. So was our medical experts present at the panel.

We concluded the hearing and kept it for judgment.

OUR VIEW

Dr. Sukumar Mukherjee, and Dr. M. L. Saha, our esteemed members of the panel, were present at the hearing. They had interaction with the complainant, CE as well the doctors. They have submitted their comments which are extracted hereinafter:-

DR. SUKUMAR MUKHERJEE,

"Patient name -Ms. Paramita Saha, 26 years

Daughter of Palash Kumar Saha

The above patient was diagnosed with Dengue on 28/09/2022 and admitted on 28/09/2022 at Arogya Niketan Nursing Home, Uttarpara, Hoogly under care of Dr. Kausik Munsi . She was haemodynamically stable with reported body weight of 92 Kg at the age of 26 years. Her father claimed she was not diabetic. After admission her blood sugar was found high above 200 mg both at Arogya Niketan Nursing Home and subsequent Medica Superspeciality hospital. However, under the circumstances estimation of HbA1c would have solved the problem whether it is stress hyperglycaemia or pre-existent diabetes. But no report of HbA1c is available from Arogya Niketan Nursing Home. In the management of dengue platelet count and PCV or HCT are the markers of progression of dengue with capillary leak syndrome at the specified time of natural history.

The platelet count done on 29/09/2022 , 30/09/2022 and 1/10/2022 at Arogya Niketan Nursing Home are clearly overwritten. Platelet count on 2/10/2022 was 40,000/ cumm when she was referred to Medica Superspeciality Hospital. This is certainly a lapse on the part of laboratory of Arogya Niketan Nursing Home. More so she developed altered Prothrombin time and APTT on 2/10/2022 at Medica Superspeciality Hospital. Patient had excessive menstral bleeding during her stay. I find it intriguing to find bed head ticket which shows normal figures of platelet count on 29/09/2022, 30/09/2022 and 1/10/2022 with different pen marking I cannot confirm that this is the only cause of her premature death. I suggest handwriting expert will clarify the anomalies. No post mortem has been done in this case to make out vital organ haemorrhage like brain, lung. Subsequently, she was found to have severe dengue at Medica Superspeciality hospital and she expired on 03/10/2022."

DR. M. L. SAHA

"Paromita Dey aged 26 years was seen by Dr Kaushik Munshi on 28.9.22,diagnosed as dengue fever and advised admission and prescribed some medicines and some investigations. Patient was admitted at Arogya Niketan

Private limited at Uttarpara on 28.9.22. Details status on admission are noted in admission sheet- Fever of 103 degree F, Pulse 116/min, BP- 120/80mmHg,Blood sugar 226mg. Platelet count on 27.8.22. 2.3 lakhs. IV fluid, Inj Pan and Inj Paracetamol prescribed and advise given for some more investigations in progress note except mentioning Inj Human Actrapid .

On 29.9.22 at 7am patient has fever of 103 degree farenheit. and advised Inj PCM. On same day CBG was recorded at 248mg. On the same day recorded chest with Vesicular breaths... On 29.9. Inj Mikacin was added.

On 30.9.22 at 12.30pm - advised for estimation of blood for PP sugar. Also noted Chest & vesicular breath... On 30.9.22. at 6pm recorded platelet count as 191000 in the morning and 151000 in evening. Advise was to repeat all. 30.9. another note reagrding ,Chest vesicular breath.

On 1.10.22 at 9am noted temperature of 104 degree F and advised cold sponging and Tab P 650mg and Inj Pactine 1gm IV sos. On 1.10.22- same note regarding chest vesicular breath.... On 1.10.22. noted platelet count as 148000 and 134000. And advised repeat all. Again on 1.10.22.same note written as chest vesicular breath.

Progress note on 2.10.22 at 11am- Patient conscious and pulse 82/min. B.P. 110/70mmHg and Temp 98 degree F and advised continue same, Monitor vitals and inform SOS

2.10.22 same note mentioning chest vesicular breath... BP 120/70mm Hg, Pulse 134/min, SPO2 95%.Advised for shift to HDU. In the same note advised for ECG, MP and MPDA. I gM scrub typhus. Malarial parasite thick and thin and ECHO. Advised transfer to higher centre for tertiary care..

Dengue monitoring sheet revealed that the patient was monitored daily with recording of vitals and all investigations parameter. However the top sheet is not signed by doctor or nurse on 28.9.22. On 29.9.22. signed by nurse only on morning shift. Not signed by doctor. On 30.9.22. signed by nurse in all three shift but not signed by doctor. Topsheet on 1.10. and 2.10. not found.

Patient's father has submitted a detailed complain mentioning specific areas of deficiency.

The CE has submitted a reply but all the points are not answered satisfactorily

Observation and comments:-

- This young lady aged 26 years, was seen by Dr Kaushik Munshi on 27.9.22 and was admitted under his care on 28.9.2022 with dengue fever.
- Since admission and afterwards after admission patient had persistent high blood sugar of >200mg and was treated with Inj Insulin. Claim of Mr Palash Saha that she was not diabetic is not tenable.
- There is one sheet mentioning the advise to be followed on admission. The allegation Mr Palsh Kumar Saha that all the records in BHT was done afterwards cannot be substantiated based on the documents submitted to us.

- *There is an important issue regarding the reports of platelet count and its record in the BHT. This is true that the typed report of platelet count was tampered almost daily except 2.10.22 by pen on repeated occasions without any counter signature. The pathologist tried to explain, this manual alteration was done to correct the difference between machine and the manual count. But the way it was tampered is unlikely to explain this difference based on machine count and manual count. But whatever report was issued from the laboratory is reflected in the top sheet except in 4/5 occassions. The PCV report and platelet count report was written in the wrong box. Platelet count written in the column of PCV and vice versa. That the patient had continuous drop of platelet, could not be substantiated by going through the documents supplied ,as the altered value in the report was recorded in the top sheet.*
- *As per records the patient had sudden deterioration on 2.10.22 and accordingly she was transferred Medica Hospital on 2.10.22 night. The patient was critical on transfer and died on the next day morning.*
- *The transfer order was written by the RMO which is the usual practice. The transfer order sheet mentioned about the clinical status of the patient and also the note regarding the treatment done from 28.9.22. to 2.10.23*
- *The top sheet bear no signature of the doctor. The progress note entered in the BHT does not reflect the clinical status of the patient.*

- *There is no sheet in the BHT to substantiate that patient relatives were counselled on regular basis.*
- *Any negligence on the part of treating doctors does not come under the purview of the commission."*

CONCLUSION

The anomalies that are pointed out in the foregoing judgment and the expert opinion given by our esteemed members it is clear, the patient was not properly treated.

The medical negligence is outside our domain. The complainant would be free to approach appropriate authority against Dr. Munsi if he desires so.

The hospital negligence is also apparent. The investigations were done by the hospital treating the patient as in-house patient. Dr. Dipsikha Chakraborty admitted, the interpolations were done by her. Whether such interpolations actually vitiated the treatment protocol or not, would be considered by the appropriate authority. The fact that the interpolations were done would be enough to blame the CE.

The patient needed blood transfusion. The CE could not arrange for the same that became fatal.

Those are salient features of hospital negligence and we cannot be mere on-looker on the issue.

We impose a penalty of Rs. 9,00,000/- (Rupees Nine Lakhs) on the CE. The CE must compensate the complainant being the ill- fated father of the victim patient within a month from the date of receipt of the copy of the foregoing judgment and order.

This order of penalty would not preclude the complainant to approach us afresh as against the CE in case he is successful before the appropriate authority on medical negligence against the treating doctor.

The complaint is disposed of accordingly.

Sd/-

(ASHIM KUMAR BANERJEE)

We agree,

Sd/-

Dr. Sukumar Mukherjee,

Sd/-

Dr. Makhan Lal Saha,

Sd/-

Dr. Maitrayee Banerjee,

Sd/-

Sri. Sutirtha Bhattacharya

Sd/-

Sri. Tanmay Roy Chowdhury

Sd/-

Smt. Madhabi Das.

Secretary
West Bengal Clinical Establishment
Regulatory Commission