WEST BENGAL HUMAN RIGHTS COMMISSION

Purta Bhavan, 2nd Floor, Salt Lake, Kolkata – 700 091.

File No. 1239/WBHRC/COM/2015-16

P r e s e n t

1. Shri Naparajit Mukherjee — Acting Chairperson
2. Shri M. S. Dwivedy — Member

Brief Facts of the Case:

A news item appeared in Bengali daily 'Bartaman' on 15.02.2016 stating that one pregnant lady patient, namely, Moumita Dutta, resident of Purba Putiary Satbigha, PS-Regent Park, Kolkata was admitted to Chittaranjan Seva Sadan hospital for delivery. Allegedly, one Anaesthesist came late to the hospital on account of which the delivery of Smt. Moumita Dutta was delayed and the foetus died in her womb. The matter was raised before Dr(Smt) Sutapa Ganguly, Principal of Chittaranjan Seva Sadan College of Obstetrics, Gynaecology and Child Health (hereinafter referred to as C.S.S. College) who stated that the incident was indeed serious and an enquiry committee would be constituted to look into the matter.

2. **Action Taken by the Commission**:

On the basis of the above mentioned news item the Commission took suo motu cognizance on 15.02.2016 and called for a report from the Principal Secretary, Health and Family Welfare Department and separately from the Director, Chittaranjan Seva Sadan by 20th March, 2016.

An Enquiry Report was received by the Assistant Secretary of West Bengal Human Rights Commission from Dr. Sutapa Ganguly, Principal, C.S.S. College vide her Memo No, CSS/Estt/420/16 dated 19.03.2016 enclosing the enquiry report regarding Smt. Moumita Dutta, wife of Sri Subal Dutta of Purba Putiary Satbigha, PO-Purba Putiary, PS-Regent Park, Kolkata, conducted by the committee consisting of Prof. A.K. Mukhopadhyay as Chairman, Prof. Narayan Jana, Dr. R.P. Dey, Associate Prof, Dr. S. Saha, H.O.D., Paediatric Medicine, Shri Krishna Singh, Member, Rogi Kalyan Samity(RKS),C.S.S., Smt. Lila Mondal, Nursing Superintendent, C.S.S. College and Shri Amit Kumar Hazra, Sr. Assistant Superintendent(Non-Medical) (ASNM), C.S.S. – all members of the Committee.

In the Enquiry Report it was stated that Smt. Moumita Dutta (21 years) was a booked case of Unit-II who was admitted on 12.02.16 from OPD, Reg. No. 1240, as a case of "second gravid, P1+O, with no living issue with previous vaginal delivery. Her expected date of delivery was 21.02.2016 and she had regular antenatal check up". She was admitted 9 days before her expected date of delivery as it was "a case with Bad Obstetric History". As per the report she was monitored by VS, advised daily fetal movement count. She was advised emergency Caesarean Section at 8:10 a.m. on 14.02.2016 because of fetal distress in early labour(FHR-108 per minute). However, at that time no anaesthetist was available at the O.T. and the scheduled duty anesthetic, Dr. Manjula Das was informed

immediately over telephone but she replied her inability to reach the O.T. before 2 hours although her stipulated duty was scheduled at 8 a.m. in the same morning. During the interim period, the patient was monitored with Cardiotocography(CTG) and given moist Oxygen inhalation in left lateral position. The CTG showed base line fetal heart rate 120 bpm, heart rate variability of more than 5. There were deceleration and no acceleration of fetal heart rate. Call book for information of emergency Cesarean Section was sent at 9:15 a.m. and O.T. sister received the call book at 9:25 a.m. The patient's relatives were counseled about the fetal prognosis by Dr, Sukriti Kundu, on duty Senior Medical Officer. Dr. Manjula Das, the Anaesthesist on duty reached O.T. at 10:19 a.m.(as confirmed by CCTV footage) and O.T. commenced around 10:45 a.m. The Cesarean Section was carried out by Dr. Trisha Dutta assisted by the Junior Residents.. "The liquor was thickly meconium stained. A still born male baby, 2.6 Kgs of weight was delivered and the patient party was informed about the condition of the baby. However, the condition of the patient was stable".

The Enquiry Committee came to the following conclusions – (a) There was a significant delay of 2 Hrs and 20 minutes for execution of Cesarean Section because of non-availability of on duty Anaesthetist Dr. Manjula Das. (b) After careful scrutiny it appears that there is a delay of about 15 minutes in O.T.

arrangement apparently because of routine cleaning of O.T. on a Sunday, which could have been avoided had the Anesthetist arrived on time. The Enquiry Committee gave the following recommendations:

(a) On duty Anaesthetist must not leave O.T. till the next Anaesthetist on duty has physically reached the O.T. Proper handover must be ensured and such an instruction has already been issued from the Principal of the hospital vide this office Memo No. CSS/Estt/1404/15 dated 31.07.2015.

(b) The acute crisis of manpower both in the department of Anaesthesiology and the department of O&G has been an unresolved issue for the last several months. The issue should be addressed as early as possible.

On receipt of this report, the Commission on 11.05.16 decided to examine Dr.(Smt) Manjula Das under Section 16 of the Protection of Human Rights Act, 2006 and she was duly examined on 15.06.16 by the Commission and her statement was recorded. In her statement she admitted that she was working as Anaesthetist of C.S.S. College and she was posted at the same place on 14.02.16. She had been examined the report submitted by the enquiry committee and also got copy of the enquiry committee report. On 14.02.16 patient Smt. Moumita Dutta was advised emergency Caesarean Section at 8:10 a.m. She admitted that when she was contacted over telephone she replied her inability to reach O.T. before 2 hours and she reached O.T. around 10:19 a.m.

She admitted her mistake. She also accepted the findings of the enquiry committee.

Following recording her statement the Commission observed that the enquiry report submitted by the Health Department has given some recommendations. In one recommendation it is mentioned that Circular No. CSS/Estt/1404/15 dated 31.07.2015 has been issued by the Principal of C.S.S. College for proper handing over which must be ensured by doctors. In the instant case this circular was violated. Therefore, the Commission directed the ADG&IGP of the Investigating Wing of the Commission to enquire into the matter and (a) obtain a copy of circular No. CSS/Estt/1404/15 dated 31.07.2015, (b) whether there is any record book of handing over/taking over charge and (c) who was the Anesthetic on duty till 8 a.m. on 14.02.16 prior to Dr. Manjula Das and at what time that Anesthetic had left without handing over charge to Dr. Manjula Das.

S.P. Investigating Wing of the Commission conducted this enquiry and submitted his report to the Commission on 19.07.2016. During the course of enquiry they obtained a report from Prof. Sutapa Ganguly, Principal, C.S.S. College vide her Memo No. 1056/16 dated 15.07.16 in which she stated that copy of Circular No. ESS/Estt/1404/15 dated 31.07.2015 could not be recovered. The record book of handing over/taking over was implemented

from 17.02.2016 i.e. three days after the fateful incident. She submitted a copy of duty roster of anesthesiology department from 08.02.16 to 14.02.16 in which it showed that one Dr. R. Khatoon was on duty from 8 p.m. to 8 a.m. However, there is no system of handing over and taking over charge in the duty roster.

The Commission examined the report submitted by the S.P. Investigating Wing of the Commission(on the basis of his enquiry) and came to the conclusion that there is no circular regarding handing over and taking over on 14.02.16 and that it would be pointless to examine Dr. R. Khatoon on the issue regarding handing over charge to Dr. Manjula Das. Also, non-recovery of Circular No. CSS/Estt/1404/15 dated 31.07.2015 raises considerable doubts about its very existence.

3. **Findings of the Commission**:

The Commission considered the enquiry report as well as the statement of Dr.(Smt.) Manjula Das and subsequent report filed by Prof. Sutapa Ganguly on the basis of the enquiry conducted by the S.P. Investigating Wing of the Commission. The Commission is of the opinion that the patient Smt. Moumita Dutta, wife of Sri Subal Dutta of Purba Putiary Satbigha, PS-Regent Park, Kolkata was admitted to hospital on 12.02.16 as a case of second gravid, P1+O with no living issue with previous vaginal delivery. Her expected date of delivery was 21.02.16. She was a case with bad obstetric history and this fact was well known to the concerned doctors on duty attending of the patient. She was

advised daily fetal movement count and monitored by VS. On account of fetal distress on 14.02.16 around 8:10 a.m. she was advised emergency Caesarean Section as heart rate of feotus was decelerating rapidly as mentioned in the enquiry report. However, no anaesthetist was available in the O.T. of C.S.S. Hospital. Anaesthetic on duty Dr. (Smt) Manjula Das was contacted over phone who expressed her inability to reach at the O.T. before 2 hours. This fact has been duly admitted by Dr. (Smt) Manjula Das in her statement before the Commission. The Call Book for information of emergency Cesarean Section was sent at 9:15 a.m. In this case there was a delay of nearly one hour after the first detection of fetal distress, the decision of emergency Cesarean Section taken at 8:10 a.m. Dr.(Smt) Manjula Das, Anaesthesist arrived at 10:19 a.m. at the O.T. and the operation commenced at 10:45 a.m. done by Dr. Trisha Dutta and assisted by others. A still born male baby, weighing 2.6 Kg was delivered but it was very fortunate the condition of the mother was stable.

The Commission felt that the Anaesthesist Dr.(Smt.) Manjula Das was primarily responsible for this unfortunate incident to happen when a still born baby was delivered because of her delayed arrival by over 2 hours. Again, there was some definite mismanagement in the O.T. as the operation could not commence before 10:45 a.m. although Anaesthesist had arrived at 10:19 a.m. Therefore, 26 minutes of precious time was lost in undertaking the Cesarean Section which could perhaps, saved the life of the infant. The Commission takes serious note about the report of Prof. A.K. Mukhopadhyay, Chairman of the Enquiry Committee and others in which it has been mentioned that all

instructions vide Principal Office Memo No. CSS/Estt/1404/15 dated 31.07.2015 has already been issued for proper handing over and taking over. The Commission feels that this has been incorporated deliberately to mislead the Commission as there is no existence of such a circular as well as the handing over and taking over register on 14.02.2016. According to the admission of the Principal, Prof. Sutapa Ganguly, the system was started only on 17.02.2016. The Commission feels that misleading facts should not be incorporated in the enquiry report given from such a high level as Prof. A.K. Mukhopadhyay who is Medical Superintendent-cum-Vice Principal(MSVP) of C.S.S. College.

4. **Recommendations of the Commission**:-

The Commission makes the following recommendations in this respect:

I) Departmental proceedings be commenced immediately against Dr.(Smt) Manjula Das for arriving 2 hours late i.e at 10:19 a.m. on 14.02.2016 whereas she was scheduled for duty at O.T. from 8 a.m. on 14.02.2016. Had she come on time the emergency Caesarean Section could have been undertaken timely and the life of the infant saved.

II) A compensation to the tune of Rs. 1,00,000/=(Rupees One Lac) be paid to Smt. Moumita Dutta, 21 years, wife of Sri Subal Dutta, Purba Putiary Satbigha, PS-Regent Park, Kolkata for the birth of a still born baby during Cesarean Section at C.S.S. Hospital on 14.02.2016 which the Commission considered occurred due to serious negligence on the part of the hospital authorities.

III) The Commission feels that an explanation be called from Prof. A.K. Mukhopadhyay, Medical Superintendent-cum-Vice Principal of C.S.S. Hospital and Chairman of the Enquiry Committee for

submitting a misleading report that **Circular No. CSS/Estt/1404/15 dated 31.07.2015 has been issued for proper handing over and taking over of the duty Anaesthesist while no such circular actually existed and that this process was started from 17.02.2016 as admitted by Principal, Dr. Sutapa Ganguly herself**.

IV) From the report of the Enquiry Committee it is very clear that there was mismanagement at the O.T. itself which caused a delay of about 26 minutes from the arrival of the Anaesthesist(10:19 a.m.) to the commencement of the Cesarean Section (10:45 a.m.)The Commission feels that 26 minutes of precious time was lost which was very vital for saving the life of the infant. Adequate measures be taken to streamline the cleaning process etc of O.T. and Sundays should not be an excuse as mentioned in the enquiry report of Health Department.

Principal Secretary, Health Department may consider issuing a circular to all Govt. hospitals about maintenance of record book of handing over and taking over and call book not only for Cesarean Section but also for the Surgeons of various departments.

5. Principal Secretary, West Bengal Human Rights Commission to communicate the recommendations to the Chief Secretary, Govt. of West Bengal and who is requested to communicate an action taken report on the above recommendations to this Commission within 4(Four) months time.

Sd/-	sd/-
(M. S. Dwivedy)	(Naparajit Mukherjee)
Member	Acting Chairperson

Dated, 21st July, 2016

SDB