ODISHA HUMAN RIGHTS COMMISSION
2nd Floor, Toshali Bhawan, Satyanagar
Bhubaneswar-751007

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OHRC Case No. 2756 of 2014

Students of Human Rights, PG Deptt. of Law, Utkal University ... petitioner

ORDER

Students of Human Rights, P.G. Department of Law, Utkal University, Bhubaneswar under the leadership of Zahid Parwez, DVN Murty, Diptimayee Sahu and Patralekha Pattnaik through a petition dated 23.8.2014 enclosing a press clipping of 'The New Indian Express' dated 14.8.2014 under the caption **"Pregnant woman made to wait for 20 hours, left unattended"** approached the Commission with a prayer to take suo motu action in a case in which the human rights of a pregnant woman namely; Mamata Sahu, wife of Sudhansu Sahu, a resident of village Baghabarahipatna under Balianta Police Station limits in Khordha district, who had come to the Capital Hospital, Bhubaneswar for her delivery was not only violated for not being provided with immediate medical assistance to give birth but also violated the human right of a baby for being deprived of taking its birth.

The petitioner students have, in brief, narrated that when Mamata Sahu was brought to the Capital Hospital, Bhubaneswar at 2.00 AM on 13.8.14 for delivery, she had remained unattended in the Hospital and

at about 5 PM, her attendants were told to get her sonography test conducted in a particular private diagonistic centre located outside the Hospital since such facility is not available in the Capital Hospital. After the Hospital authorities from such a test could come to know that the foetus is already dead, and the condition of the patient is deteriorating sharply they at about 10.30 PM asked the patient's attendant to shift her to Cuttack. But as a matter of fact, the patient was transferred to Cuttack in the next morning.

The petitioner students have raised four questions with regard to the way the authorities of the Capital Hospital have handled the case of Mamata Sahu which ultimately resulted in the death of the foetus, which are reproduced as below;

(i) Why Mamata Sahu was made to wait till 2.00 PM although she was admitted in the early hours of about 2.00 AM?

(ii) Why have they not referred Mamata Sahu to Cuttack immediately when they had accommodation problem at the OT and when they also knew that Mamata is quick with the child and needs a Cesarean?

(iii) When it was evident that Mamata Sahu needed cesarean why have they sent her for ultra sonography and that too in a particular private diagoinistic centre?

(iv) What is the purpose of referring Mamata Sahu to Cuttack after the sonography report revealed about the death of the foetus?, and why have they not operated upon her and taken out the dead foetus in the Hospital itself?

The petitioner students alleged that such lacakadaisical attitude on the part of the concerned doctors of the Capital Hospital have played havoc with the life of both the patient and the foetus and in the long run, the foetus was deprived to see the light of the day. It is further alleged that the carelessness, negligence and inhuman torture shown towards Mamata Sahu by the concerned Hospital authorities have not only violated Article 5 of Universal Declaration of Human Rights but also Article 16 of the said Rights inasmuch as the Hospital authorities denied the rights of Mamata Sahu and her husband to have their baby born to them by not attending her on time which culminated in the death of the foetus. Besides that, it also led to violation of Article 21 of the Constitution of India as the foetus which was awaiting to come out has a Right to Life and the same has also been clearly denied by the doctors and other the staff as a whole due to their combined failure in timely attending Mamata Sahu whose delivery was imminent and the consequent death of the foetus is nothing but a cold-blooded murder.

The petitioner students while praying for a proper enquiry into the matter also prayed for awarding compensation to the victim lady for her sufferance and the loss of the foetus.

The Commission perused the report of the Director, Capital Hospital, Bhubaneswar dated 25.10.14.

The report speaks that Smt. Mamata Sahoo, 24 years HF of village Baghabarahipatna under Balipatna PS, a 3rd .gravida lady with history of two previous LSCS was admitted into the Capital Hospital, Bhubaneswar on 13.8.14 at 3.00 AM vide IPD Regd. No.27317 dated 13.8.14. Her expected date of delivery (EDD) was calculated to be on 01.10.2014. She

was not in labour pain, but had complaint of back-ache. The general condition of the patient was found to be stable and Fetal Heart sounds were present. The patient was managed conservatively and was advised Ultra Sonography. At 3.30 PM on 13.8.14, Fetal Heart sound could not be heard by the examining doctor. USG was done. As per the Ultra Sonography report, I.U. Fetal Death , Amniotic fluid was almost absent and a right adnexal mass was found. As the operation at this stage would have been difficult, the same fact was explained to the attendants of the patient and at 10 PM, it was decided to refer the patient to the SCB Medical College & Hospital, Cuttack for better management of her case. But the attendants refused to agree to such a proposal. Since the patient's condition was stable and emergency LSCS was not indicated, CS was advised next day morning at 7.00 AM. At about 8.30 AM, the patient developed hematuria on putting a Catheter. Since the patient took some biscuits at 8.30 AM, the Anaeesthesist advised to wait for another five hours as there was risk in administering anaesthesia. However, at 9.50 AM, patient's attendants refused to sign the high risk bond for operation. At 10.20 AM, they agreed to take the patient to the SCB Medical College & Hospital, Cuttack and finally the patient was referred to Cuttack at 10.45 AM. Since there was a large fibroid tumour and scanty amniotic fluid with hematuria, it might have led to sudden feotal death, and the condition became grave enough to refer the patient to the SCB Medical College & Hospial, Cuttack. Ther was no deliberate attempt to make the patient wait for 20 hours. Initially, the attendants of the patient showed reluctance to take the patient to the SCB Medical College & Hospital, Cuttack, but when they refused to sign a risk bond in

such a high risk case of their patient, they agreed to the proposal of referring the patient to SCB Medical College & Hospital, Cuttack.

The Commission heard Dr. Biswa Bhusan Patnaik, Director, Dr. Chittaranjan Patra, O & G Specialist, Dr. Ramarani Dei, Specialist attached to PP Centre, Dr. Sandeep Das, Specialist in Anaesthesiology and Dr. Sriram Chandra Das, Anaesthetist of Capital Hospital, Bhubaneswar and the petitioners on 18.11.14. For proper adjudication of the matter, the Commission supplied a copy of the report of the Director, Capital Hospital, Bhubaneswar dated 25.10.14 as well as a copy of the petition of to all the doctors who attended the Commission for their study and response. The Director, Capital Hospital, Bhabaneswar who submitted before the Commission to produce his enquiry report shortly was directed to produce the original bed head ticket of the patient Mamata Sahu forthwith.

Perused the enquiry report of the Director, Capital Hospital, Bhubaneswar which was conducted by him on 21.8.14.

Also perused the statments of Dr. Chittaranjan Patra, O & G Specialist, Dr. Ramamani Dei, O & G Specialist, Dr. Sandeep Das, Anaesthesist and Dr. Sriram Das, Anaesthesist of the Capital Hospital as forwarded by the Director, Capital Hospital, Bhubaneswar in its letter dated 1.12.14.

The copies of the enquiry report of the Director, Capital Hospital, Bhubaneswar as also the statements of the concered doctors were supplied to the petitioners for their response, if any.

Perused the response of the petitioners dated 13.12.14 to the report of the Director, Capital Hospital, Bhubaneswar dated 25.10.14,

and that of the statements of the team of doctors of the Capital Hospital who were involved in the treatment provided to the patient Mamata Sahu.

In the first place, the petitioners have termed the report of the Director, Capital Hospital, Bhubaneswar as fictitious and false in all respects and said that attempts have been made to hush up their culpability.

In the second place, the petitioners said that as admitted in the report, the general condition of the patient along with the feotus was healthy and stable. But, as admitted, the foetus died at 3.30 PM which was noticed by the doctors only after the death of the feotus. Thus, from these facts, it is amply clear that the patient and the feotus were not given any treatment for 12 hours and there was also no report as to what has exactly happened during those 12 hours which ultimately led to the death of the feotus. It is further alleged that hospital staff had awakened only after the death of the foetus. It could be further inferred that the patient was never kept under proper care and vigil continously for first 12 hours of her admission in the Hospital. Thus, it clearly establishes the negligence on the part of the doctors, who have allegedly not provided the patient any proper and timely treatment, for which it led to the death of the feotus.

In the third place, the petitioners submitted that reduction of amniotic fluid is never sudden and it is slow in process. It never increases or decreases suddenly within few hours. The petitioners have contended that had the Ultra Sonography been done much earlier, the feotus could have been saved through appropriate medication. Since

there was a delay of clear 12 hours in this case, it led to the death of the foetus. Thus, it is a clear case of gross negligence by the doctors and the hospital.

In the fourth place, the petitioners raised a pertinent question as to why the Capital Hospital has advised Mamata Sahu to get USG done outside particularly when such a facility is very much available in the Hospital itself. The petitioner have pointed out that the Director of the Capital Hospital through his hand written enquiry report dated 21.8.14 has said that **"Doctor was not efficient enough for Ultra Sound examination at O &G Ward-sent for such an examination from outside."** The petitioners are at a loss to understand that even though all the machineries are available in the Hospital, no efficient staff is available to operate the same. The petitioner have further stated that on perusal of the hand written report of the Director, Capital Hospital, it reveals that the Dirctor has himself contradicted his own statement at a later stage which says that at about 8.30 AM on 14.8.14 USG was again done at the Hospital itself. From this very fact, it is not understood how the Director has himself stated there was no efficient staff to run the USG machine. According to the petitioners, the Director has given a false statement in order to escape themselves from their liability as to why they have referred to the patient for USG outside when such facilties are very much available in the hospital itself. The petitioner urged the Commission to conduct an enquiry to verify the fact whether actually there was dearth of any efficient staff to handle such medical equipments.

In the fifth place, the petitioner contended that if Mamata Sahu being herself an indoor patient could have been given the right kind of advice as to the diet to be taken by her, then it could not have been possible on her part to take the biscuits, for which the anaesthesist advised to wait for five hours as there was risk to administer anaesthesia to her. It is a well-known fact that diet is supplied to all in-door patients by the hospital itself and if she has taken biscuits, then it leaves no manner of doubt that she was supplied biscuits by the hospital staff. This is yet another instance of negligence on the part of the hospital staff who could not know whether the patient has taken biscuits prior to the operation and this fact was alone came to light after the anaesthesist came to know from the patient herself at the OT table, for which all preparation for the operation became infructuous. The petitioner vehemently contended that this fact has laid bare the gross negligence on the part of the hospital as to the procedure to be followed prior to the operation as mandated by the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002 and there is palpably a serious lacuna in properly advising the patient.

In the sixth place, the petitioners have stated that though the hospital authorities claim that there was no deliberate attempt to make the patient wait for 20 hours, but the fact remains that they have made the patient to wait for 20 hours without any fool-proof treatment irrespective of the nature of the attempt. This long delay in providing the required treatment to the patient resulted in the death of the foetus.

In the seventh place, the petitioners said that as per the report, the patient was a high risk, but the high risk was not the matter when

the patient got admitted rather she was simply diagnosed with backache. The high risk factor came to light when the foetal heart sounds were not heard and ultra sonography was conducted at 3.30 PM. It was only then the complications such as low amniotic fluid, fibroid tumor, adnexal mass etc were found with the patient. This high risk can clearly be attributed to the negligence and careless attitude of the hospital authorities which is clearly evident from their statements in the report. Thus, their culpability is in no way pardonable and the liability has to be fixed on them.

In the eighth place, the petitioners claim that when it was known that the feotus is dead at about 3.30 PM then the doctors on duty terming it to be a high risk case referred the patient to the SCB Medical College & Hospital, Cuttack and upon refusal of her attendants, the doctors describing her condition to be stable advised for LSCS on the next morning. Here, a question comes to the mind of the petitioners that if the condition of the patient was stable then where was the need to refer the patient to the SCB Medical College & Hospital, Cuttack and if at all the patient was high risk then why have they postponed the operation to the next day rather than operating immediately on the same day itself. Be that as it may, the doctors were no doubt found to be acting in a vacillating manner and resultantly, the brazen negligence was crystal clear.

In the ninth place, the petitioners made a scathing attack on the issue of missing of the Bed-head ticket of the patient Mamata Sahu. The petitioners held the view that when the report of Dr. Bijaya Panda, HOD of O&G Department dated 20.11.14 dicloses that all the bed-head tickets

of the patients were missing since or prior to 10.11.14, how the Director, Capital Hospital, Bhubaneswar could produce a copy of the bed-head ticket of 18.11.14 of the patient when on such date he was not in possession of the same. The petitioners further held that either the copy of the bed-head ticket submitted before the Commission was fabricated, false or the report was knowingly withheld with an ulterior motive as there are some serious discrepancies in the bed-head ticket of Mamata Sahu which if submitted in original will expose the negligence of the doctors. Thus, it is clearly seen that the Director, Capital Hospital has tried to mislead the Commission in order to hush up the actual state of affairs.

In the tenth place, the petitioners have stated that as per relevant provisions of the Indian Council (PCE&E) Regulation, 2002 **"every physician shall maintain the medical records pertaining to his/her indoor patients for a period of three years from the date of the commencement of the treatment....."** and **"if such records are not maintained for three years then they shall be liable for disciplinary action".** However, the Director, CH, Bhubaneswar in its letter No.7615 dated 22.11.14 simply issued a warning to Smt. Sumitra Kumari Mohanty, Staff Nurse I/C, O&G-I, Capital Hospital, Bhubaneswar which appears to be an afterthought and apparently no action has been taken against Dr. Bijay Panda, HOD, O&G Department, Capital Hospital, Bhubaneswar who can never be absolved of the culpability as because he is more responsible than the Staff Nurse. However, such a thing was done following the personal appearance of the Director, CH, Bhubaneswar before the Commission on 18.11.14.

In the eleventh place, the petitioners have mentioned that filing of an FIR before the IIC, Capital Police Station, Bhubaneswar vide No.7607/CH dated 22.11.14 is also an afterthought which raises a question as to why such an FIR was not filed earlier. However, such a thing was done following the personal appearance of the Director, CH, Bhubaneswar before the Commission on 18.11.14.

The petitioners in their prayer, among other things, prayed for awarding a compensation of Rs.10 lakhs to the victim, who for the sheer negligence and carelessness of the treating doctors had to undergone such a harrowing experience in life.

The petitioners in support of their case have referred to two cases namely; K.Murugesan vrs. Sarala Devi I (1999) CPJ 542 (Chennai) and Union of India vrs. Susheela Mathai and Anr., 2007, W.P. (C) 9676, Delhi High Court. Perused the same.

Considering the prayer of all the three petitioners, who were present in the Court on 2.1.15 notices were issued to Dr. Arati Satpathy, Dr. Pratibha Jena and Dr. Ashok Das, all O & G Specialists of the Capital Hospital, Bhubaneswar, who had attended the patient Mamata Sahu on the night of 12th August, 2014 and at 3 AM of 13.8.14 as is evident from the photocopy of the bed-head ticket so produced by the Director, Capital Hospital, Bbubaneswar to appear before the Commission on 13.8.14 to explain about the kind of treatment given to the patient Mamata Sahu, who was reportedly carrying 8 months and was complaining of back-ache. The Commission also directed Dr. Ramamani Dei, O & G Specialist who also attended the patient to appear along with the aforementioned doctors. Similarly, as prayed for by the petitioners,

the Superintendent, SCB Medical College & Hospital, Cuttack was asked to produce the bed-head ticket of the patient Smt. Mamata Sahu, wife of Shyamsundar Sahu of village Baghabarei Patna under Balipatna PS limits in Khordha district, who was admitted into the Department of O & G of the SCB Medical College & Hospital, Cuttack on 14.8.14 through an authorised person on 19.1.15 in the Court. The Commission acceding to the requests of the petitioners supplied them the bed-head ticket of the patient Mamata Sahu.

In response to the notice issued by the Commission, a group of doctors comprising Dr. Arati Satpathy, Dr. Prativa Jena, Dr. Ramamani Dei, all O & G Specialist of the Capital Hospital, Bhubaneswar and Dr. Ashok Kumar Das, ex-Specialist, O & G of Capital Hospital and presently posted at the Sub Divisional Hospital, Banki attended the Court on 19.1.15. The Commission heard the petitioners as well as the doctors, who had attended the patient Mamata Sahu in the Capital Hospital, Bhubaneswar.

As prayed for by the petitioners, a copy of the Discharge Certificate and the Bed-head ticket of the patient Mamata Sahu as furnished by the Superintendent, SCB Medical College & Hospital, Cuttack were supplied to them and were specifically told to file their written submission, if they so like in a reasonable period of time.

Perused the written response of the petitioners dated 3.2.15 to the submissions made by the doctors before the Commission on 19.1.15.

The petitioners have mentioned that on perusal of the referral slip of Balipatna CHC dated 13.8.14, it appears that the patient Mamata Sahu was in labour pain when she was referred to the Capital Hospital,

Bhubaneswar. The petitioners while dealing with this particular issue have stated that despite a clear-cut mention of the fact that the patient was in labour pain in the said referral slip, the referred hospital authorities have not given her any treatment for nearly twelve hours nor went for any clinical investigation and simply kept her waiting for the entire period of 12 hours till the fact of the death of the foetus was confirmed from the USG done outside the hospital at about 3.30 PM. This clearly manifests the wilful negligence on the part of the doctors attending Mamata Sahu.

The petitioner have further submitted that the original bed-head ticket of the patient Mamata Sahu which would have disclosed the fact mentioned above, the same has been stated to have been lost and submitted a photocopy of the so-called original bed-head ticket with a lot of manipulations and interpolations which is nothing but an afterthought. The petitioners strongly contended that in the absence of original bed-head ticket, a xerox copy does not have any legal significance.

Perused the photocopy of the bed-head ticket and discharge certificate of Mamata Sahoo as received from the Superintendent, SCB Medical College & Hospital, Cuttack dated 16.1.15. The patient who was undergoing treatment in the Department of O & G, SCB Medical College & Hospital, Cuttack was discharged on 24.8.15 after remaining for ten days in the Hospital and her condition was stated to be satisfactory.

On a careful study of the reports and counter submissions of the petitioners, the Commission feels that the patient Smt. Mamata Sahu was left unattended to by the doctors of the Capital, Hospital,

Bhubaneswar for clear 12 hours since her admission although it is a fact that the doctor of the CHC, Balianta referred her to the Capital Hospital, Bhubaneswar with the observation that she was in labour pain. It is an admitted fact that by the time the patient was admitted into the Capital Hospital, Bhubaneswar her condition was found to be stable and feotal heart sounds were present. It is a fact that without any loss of time, the patient could have been advised to do an Ultra Sonography since such a facility could not be admittedly provided to her because of lack of trained manpower to operate it. Hence, the long delay in advising the poor patient to go in for an Utra Sonography at private diagonistic centre in all faireness proved fatal to her foetus. It is crystal clear that even though Ultra Sonography facilities were there in the Capital Hospital itself, nobody perhaps could be prepared to take the burden of doing the said test in the Capital Hospital on the simple plea of non-availbility of the efficient hand which is very much evident from the report of the Director, Capital Hospital, Bhubaneswar that on the next day, i.e. on 14.8.14 USG was of the patient was done at 8.30 AM in the Capital Hospital itself. From this very fact, it is clearly established that although USG facility was very much available in the Capital Hospital and could have been easily provided to the patient, the same was not done apparently due to careless and negligent attitude on the part of the doctors. It is proved beyond doubt that the poor patient who had run all the way to the Capital Hospital with a great expectation to be a proud mother had suffered immensely due to complete apathy and callousness of the doctors. Secondly, even though the doctor of the Capiatal Hospital became sure that operation of the patient would not be advisable and in

their opinion, shifting of the patient to the SCB Medical College & Hospital, Cuttack is inevitable, they should have somehow arranged to send the patient to Cuttack without succumbing to the demands of the relatives of the patient, who were reportedly found unwilling to see the reason, and in fact, such an action would have been a right thing. Had that thing been done, there would have been no problem in the next day, for which the patient was turned away from the OT by the Anaesthesist on the ground that the patient had taken some biscuits. However, as submitted before the Commission by the Aneathesisit, in such a case of grave nature, anethesia could have been administered to the patient without waiting for five hours.

As it appears, from the very moment of the admission of the patient till she was referred to the SCB Medical College & Hospital, Cuttack, her case was not handled without any care and diligence.

On a careful perusal of the counter submission of the petitioners, the Commission is convinced that medical negligence on the part of the Capital Hospital authorities is tell-tale.

Since the patient became an ultimate loser in this case because of the callous attitude of the doctors of the Capital Hospital who are the instruments of the State, the State is vicariously liable for acts of their ommission and commission. she needs to be compensated by the State for the negligence of the doctors of the Capital Hospital, Bhubaneswar.

While analysing the whole gamut of issues, it is an inescapable truth that upon arrival of Mamata Sahu in the Capital Hospital seeking necessary medical care and treatment, it was a mistake on the part of the doctors of the O & G Department of the Capital Hospital,

Bhubaneswar for not attending to the patient for a long period of 12 hours. Therefore, such a mistake which would tantamount to negligence cannot be pardoned as because gross medical mistake will always result in a finding of negligence, and in this case too medical negligence is proved beyond doubt. Had the doctors taken the case of patient Mamata Sahu with all seriousness, then there would have no chance of the death of the foetus, which was very much alive as detected by the doctors soon after arrival of the patient in the Capital Hospital. Negligence was also visible when the doctors took the patient to the OT without having prior consultation with the Anaesthetist, for which, the patient was turned away from the OT as she had taken some biscuits and thereby the operation was postponed to another five hours. Even if the expert opinion of the Anaesthetist says that there is nothing wrong to go ahead with the operation, the operation was postponed at the eleventh hour, apparently due to lack of proper coordination among the doctors and the Anaesthetist. Even though the patient was ultimately referred to the SCB Medical College & Hospital, Cuttack for better treatment, it was only after the death of the foetus. It is an undeniable fact that the agony of the patient would remain so long as she remain alive for the loss of the foetus resulting from the long delay in providing her the requisite treatment., and therefore, the patient deserves to be compensated for mental agony sufffered by her.

Since medical negligence in this case is conclusively proved, the Commission is inclined to recommend a financial assistance of Rs.1 lakh (Rupeees One lakh) to be paid to Smt. Mamata Sahu, the patient, who not only lost the foetus for being deprived of getting timely medical

treatment in the Capital Hospital, Bhubaneswar but also will continue to suffer from untold mental agony for her such loss. In the opinion of the Commission, it is indeed grave violation of the human rights of Mamata Sahu, the patient, and the award of Rs.1 lakh as compensation can only be termed as a token reparation. Accordingly, it is recommended that the State is to pay Rs.1 lakh (Rupees One lakh) to Smt. Mamata Sahu , wife of Shyam Sundar Sahu , a resident of village Baghabarahipatna under Balipatna PS limits in Khordha district within eight weeks and a compliance report be sento the Commission for its record.

This order be communicated to the Commissioner-cum-Secretary to Govt., Health & Family Welfare Department, Bhubaneswar as well as the Director, Capital Hospital, Bhubaneswar for appropriate action in the matter.

JUSTICE B. K. MISRA
ACTING CHAIRPERSON