NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION
NEW DELHI

FIRST APPEAL NO. 172 OF 2012

(Against the Order dated 09/01/2012 in Complaint No. 27/2003 of the State Commission Kerala)

1. M/S. SAMAD HOSPITAL

Represented by Dr. Sathi M. Pillai, Near K.S.R.T.C. Bus Staion, Attingal,

Thruvanathapuram

Kerala

2. Dr. Sathi M. Pillai,

M/s. Samad Hospital, Near K.S.R.T.C. Bus Station, Attingal,

Thiruvananthapuram

Kerala .....Appellant(s)

Versus

1. S. MUHAMMED BASHEER

S/o Sahul Hameed, Jessy Manzil, Mamoodu, Venjaramoodu,

Thrivanathapuram,

Kerala

2. SAINAM BEEVI

W/o Muhammad Basheer, Jessy Manzil, Mamoodu, Venjaramoodu,

Thiruvananthapuram

Kerala

3. SUNITHA BEEVI

D/o. Sainam Beevi, Jessy Manzil, Mamoodu, Venjaramoodu,

Thrivanathapuram

Kerala

4. SHAMEENA BEEVI,

D/o Sainam Beevi, Jessy Manzil, Mamoodu, Venjaramoodu,

Thiruvananthapuram

Kerala

5. JASIM

S/o Muhammed Basheer, Jessy Manzil, Mamoodu, Venjaramoodu,

Thrivananthapuram

Kerala

6. KERALA INSTITUTE OF MEDICAL SCIENCES
Represented by the Managing Dirrector, Kumarapuram,
By Pass Road,
Thiruvananthapuram
Kerala
7. Dr. Sahadulla,
Consultant Physician, KIMS Hospital, Kumarapuram,
Thiruvananthapuram
Kerala .....Respondent(s)

BEFORE:

HON'BLE MR. JUSTICE R.K. AGRAWAL,PRESIDENT
HON'BLE DR. S.M. KANTIKAR,MEMBER

For the Appellant : Appeared at the time of arguments:
For the Appellants : Mr. Gopakumaran Nair, Sr. Advocate
with Ms. Priya Balakrishnan, Advocate

For the Respondent : Appeared at the time of arguments:
For the Respondents: Ms. V. Mohaha, Sr. Advocate
with Ms. Usha Nandini V., Advocate

Dated : 25 May 2022

ORDER

DR. S. M. KANTIKAR, MEMBER

Although most blood transfusions save lives, some people aren't so fortunate and are victims of transfusion errors.

1. The married couple, A. K. Nazeer and his wife Sajeena were undergoing infertility treatment at Samad Hospital, Thiruvananthapuram (hereinafter referred to as the 'Opposite Party No. 1'). The abdominal Ultrasonography (USG) scan revealed fibroid uterus and advised laparoscopic removal of the fibroids. Sajeena (hereinafter referred to as the 'patient') underwent laparoscopic surgery on 01.08.02 and she was shifted to the post-operative ward. In the evening at 7.30 PM, Dr. Sathi M. Pillai (hereinafter referred to as the 'Opposite Party No. 2) asked for blood transfusion. The blood transfusion was started at 8.30 p.m., but immediately she developed blood transfusion reactions and complications. It was alleged to have happened due to mismatched blood by transfusion. It is alleged that one staff of Cosmopolitan Hospital disclosed to the 2 nd Complainant and his brother Ashraf about the mistake committed at Samad Hospital by giving B $^{+ve}$ blood instead of O $^{+ve}$ blood. The Complainants have also averred in Paragraph 8 of their written complaint that mismatched blood was given to the patient Sajeena at the first Opposite Party Hospital. It was confirmed by Dr. Sahadulla, the Consultant Physician (hereinafter referred to as the 'Opposite Party No. 4') at KIMS Hospital, Thiruvananthapuram. Being aggrieved by the

alleged negligence, during blood transfusion and further treatment, the Complainants filed the Consumer Complaint before the State Commission, Kerala and prayed for compensation of Rs. 45 lakh with interest + Rs. 4.5 lakh towards medical expenditure and Rs. 50,000/- as costs.

2. The Opposite Parties Nos. 1 and 2, in their written versions, denied the mismatched blood transfusion to the patient Sajeena. It was submitted that the patient developed complications which were beyond their control and expectation. The complications were promptly treated but the patient developed DIC (Disseminated Intra Vascular Coagulation), a very serious condition. The doctors took expert consultation of Dr. R. K. Prabhu from the Taluk Hospital and the patient was referred to a higher centre immediately for better management.

3. The State Commission partly allowed the Complaint and directed the Opposite Parties Nos. 1 and 2 to pay a total compensation of Rs. 9,33,000/- to the Complainants Nos. 2 to 6 with cost of Rs. 15,000/-.

4. Being aggrieved, the Appellants (Hospital and the Opposite Party No. 2) filed this First Appeal.

5. During arguments, the learned Counsel from both the sides reiterated their evidence adduced before the State Commission. We have perused the Medical Record, *inter alia*, the Order of State Commission. We also took reference from the standard text books on Transfusion Medicine, Hematology and Internal medicine.

6. The State Commission examined few witnesses DW1, DW2, DW3, DW4 and DW5. On careful perusal of record (case sheet), it is evident that on 01.08.2005 the laparoscopic surgery was completed by Dr. Meera / Dr. Sindhu at 5.00 pm and at 7.30 pm, the Opposite Party No. 2, Dr. Sathi M. Pillai ordered blood transfusion. The blood was started at 8.30 pm, but within half an hour, the patient developed shivering and wetting of surgical wound. She became pallor. Dr. Sudheer attended at 11.30 pm and administered injection hydrocortisone, avil and botrospace. The urinary catheter and drainage tube shown blood stained urine. According to DW-1, there was no indication of blood transfusion and also there was no urgency or emergency for ordering blood, when the surgery was uneventful. The deposition of DW-3, Dr. Sindhu that she spent only 15 minutes in the post-operative ward, noted the patient's vitals normal and she was not in shock. The blood transfusion was not necessary. Dr. Sathi M. Pillai ordered the blood transfusion; decision was taken without any basis or without discussing with Dr. Meera or Dr. Sindhu, who performed the surgery and have recorded "no bleeding at 5.30 PM and the vital were normal".

7. The DW5, Dr. K. C. Usha, the Professor and Head of Transfusion Medicine at Medical College Hospital, Thiruvanthapuram, in her evidence submitted that immediately the transfusion must be stopped if blood transfusion reaction occurs and proper resuscitation to save the life of the patient is necessary. The blood sample from vein of the opposite limb shall be sent for further investigation and collect urine to check haemolysis. These samples along with the blood bag (with remained blood) to be sent to the same blood bank to check haemolysis. Urine test for haemoglobinuria is often transient. It was also the bounden duty of the doctors at OP-1 hospital to preserve the balance of blood in the blood bag.

8. The State Commission observed that the Opposite Parties Nos. 1 and 2 have failed to follow the standard procedures after the transfusion reaction. The hospital failed to communicate the blood bank and not investigated the transfusion reaction by sending the remaining blood bag,

patient's blood and urine samples. It is evident from the cross-examination of DW-2, that at about 9 pm, the transfusion reaction was developed and no immediate steps were taken by the Samad Hospital. The case sheet also lacks details of treatment between 9 pm to 11.30 pm.

9. We further note from the evidence of DW-4/OP-4, Dr. M. I. Sahadulla, a physician that the patient was brought to the Opposite Party No. 3 Hospital at 2 a.m. in critical state. She had developed DIC with haemoperitonium, acute respiratory distress and acute renal failure. Thus, the DIC was developed on account of transfusion reaction.

Discussion:

10. The main questions before us are:

i. whether wrong blood was transfused, if yes- then whether hospital or the blood bank is liable?
ii. whether it was a transfusion reaction or DIC ?

11. Answer to (i) that the observations of State Commission on Ex. B6 are more relevant. On the reverse side of page 52 of case sheet (B6) against the date 02.08.2002 the clinical note entered as;

" apparently mismatched Tx Pt - 0 $^{+ve}$ given A $^{+ve}$ blood"** .

It was endorsed by Dr. Valentina and has also recorded in case sheet (B6), the probable cause for the transfusion reaction as mismatched blood transfusion and the resultant DIG + ARF + severe bleeding. It is also noted that the patient continues to be oliguric. Thus, in our view, the afore entry itself is sufficient to prove that mismatched blood was transfused to the patient. It was due to the blood bag which was kept in hospital refrigerator and transfused on the fateful day. Moreover, it was the duty of hospital to prove the wrong blood was issued from the Blood Bank , but the Apellant failed to prove it. Proper medical record has more importance. The finding of State Commission show the glaring lapses of the Opposite Parties Nos. 1 and 2, who have not kept the transfusion register showing the number of bags, its date of receipt or use or disposal. Thus, possibility of error in identification of the blood bags or identifying the patients was more. According to DW - 2 and 3 the blood transfusion was performed under the control of the duty doctor Salini and the duty nurse but there is no documentary evidence to prove their contention. We, further, note that the blood bag was kept in storage of the Hospital premise. It should be borne in mind that the cross-matched blood received from the blood bank shall be transfused within reasonable time preferably within 24 hours. However, in the instant case, there is no record that when the blood was brought from the blood bank. Therefore, we conclude for Q. (i) that wrong blood was transfused to the patient and the hospital staff is liable for the negligence.

12. Answer to (ii) whether **it was a Transfusion Reaction or DIC** .

- Admittedly, the surgery was uneventful, but within half an hour of the initiation of the transfusion, the patient suffered shivering and diagnosed it as a transfusion reaction. It is pertinent to note that the witness Dr. Valentina deposed that the transfusion blood of B $^{+ve}$ group whereas the patient was O $^{+ve}$.
- It is pertinent to note that if the transfusion reaction is suspected, the duty of treating doctor is to immediately send the blood sample from a limb of other side and along with the

blood for cross-matching. The urine to be examined for haemoglobinuria. Even, it was legal duty of the blood bank to keep the pilot samples of the blood bags till the expiry of the blood i.e. 21 days. There was no such evidence that blood and urine sample were collected any efforts made my OP-1 hospital to rule out haemolytic reaction.

- From the details of Anaesthesia notes dated 8.8.2002 maintained by OP-3 KIMS Hospital, recorded that as: - post myomectomy patient - mismatched blood transfusion - DIC Renal failure - pulmonary edema, ARDS. The aforesaid entry would make it abundantly clear that it was transfusion reaction.
- From the evidence of Dr. Valentina and her notes in the case sheet(B6), it was a case of transfusion reaction due to mis-match blood resulting into DIC + ARF + severe bleeding.

13. When red blood cells are destroyed, the process is called hemolysis and the hemolytic transfusion reaction is a serious complication that can occur after a blood transfusion, sometimes due to errors. Because humans are involved in every step of the process from collecting blood to storing the blood and administering the blood into an IV, mistakes can occur that can lead to blood transfusion errors. The errors include mislabeled blood, wrong patient receiving a blood transfusion, the patient receiving the wrong blood type. The most serious reactions are caused by transfusion of ABO-incompatible red cells which react with the patient's anti-A or anti-B antibodies. There is rapid destruction of the transfused red cells in the circulation (intravascular haemolysis) and the release of inflammatory cytokines. The patient often quickly becomes shocked and may develop acute renal failure and disseminated intravascular coagulation (DIC). Transfusion of less than 30 mL of group A red cells to a group O patient has proven fatal

14. In most of the cases the hospital staff failing to respond to the signs and symptoms of a blood transfusion error. Thus the cause can be as simple as a breakdown in safety protocols or poor training. Though most hospitals and surgical centres have strict procedures on blood storage, but sometimes improper or poorly stored blood got issued. Reporting all transfusion-related adverse reactions to the Blood Bank promptly is more vital. Haemovigilance is the 'systematic surveillance of adverse reactions and adverse events related to transfusion' with the aim of improving transfusion safety. Transfusion reactions and adverse events should be investigated by the clinical team and hospital transfusion team and reviewed by the hospital transfusion committee.

15. The Hon'ble Supreme Court in the case of **Postgraduate Institute of Medial Education and Research Chandigarh vs. Jaspal Singh & Others** [4] held that mismatch in transfusion of blood resulting in death of the patient after 40 days, a case of medical negligence. In the instant case wrong blood transfusion to Sajeena was an error which no hospital/doctor exercising ordinary care would have made. Such an error is not an error of professional judgment but in the very nature of things a sure instance of medical negligence and the hospital's breach of duty contributed to her death. Thus, we have no hesitation to hold the Opposite Party No. 1 and 2 liable for deficiency in service and the medical negligence.

Compensation:

16. Before fixing the quantum of compensation we have to look into several issues. The Complaint was filed by 6 complainants. The patient Sajeena and her husband A. K. Nazeer were undergoing treatment for infertility at Samad Hospital, therefore A. K. Nazeer (Complainant No.1) was the most aggrieved party. He unfortunately died in a road accident during the pendency of the complaint before the State Commission. Accordingly, his name was deleted and the parents

of deceased Sajeena are Complainants Nos. 2 and 3 whereas Complainant No. 4 to 6 are the two sisters and brother of Sajeena. The parent's most stressful event in their life and cause for a major emotional crisis was that they lost their 28 years married daughter due to medical negligence and son-in-law in road accident. In our view, the State Commission erred in quantifying the amount Rs. 9,33,000/- as a compensation, but the complainants deserve for enhanced compensation. The Complainants stated that the deceased was earning Rs. 15000/- per month, but nothing is on record to prove her earnings. Therefore, in the ends of justice putting reliance upon the recent judgment of Hon'ble Supreme Court in ***Arun Kumar Manglik v Chirayu Health & Medicare Pvt. Ltd.*** **[5]** and in ***Lata Wadhwa v State of Bihar*** [6] **,** we allow a lump sum compensation of Rs. 20 lakh to the parents of the deceased Sajeena.

17. Based on the foregoing discussion, the Appeal is dismissed with modification to the Order of the State Commission. The Appellants shall jointly and severally pay Rs. 20 lakh as a compensation and Rs. 1 lakh towards the cost of litigation within 6 weeks from today to the parents of deceased Sajeena. Any delay beyond 6 weeks, shall attract interest @ 7% per annum till its realization.

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[1] Clinical Haematology in medical practice by G.C.de Gruchy.

[2] Wintrobe's Clinical Hematology

[3] Rossis Principles of Transfusion Medicine

[4] (2009) 7 SCC 330

[5] (2019) 7 SCC 401

[6] (2001) 8 SCC 197

.....J
R.K. AGRAWAL
PRESIDENT

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DR. S.M. KANTIKAR
MEMBER