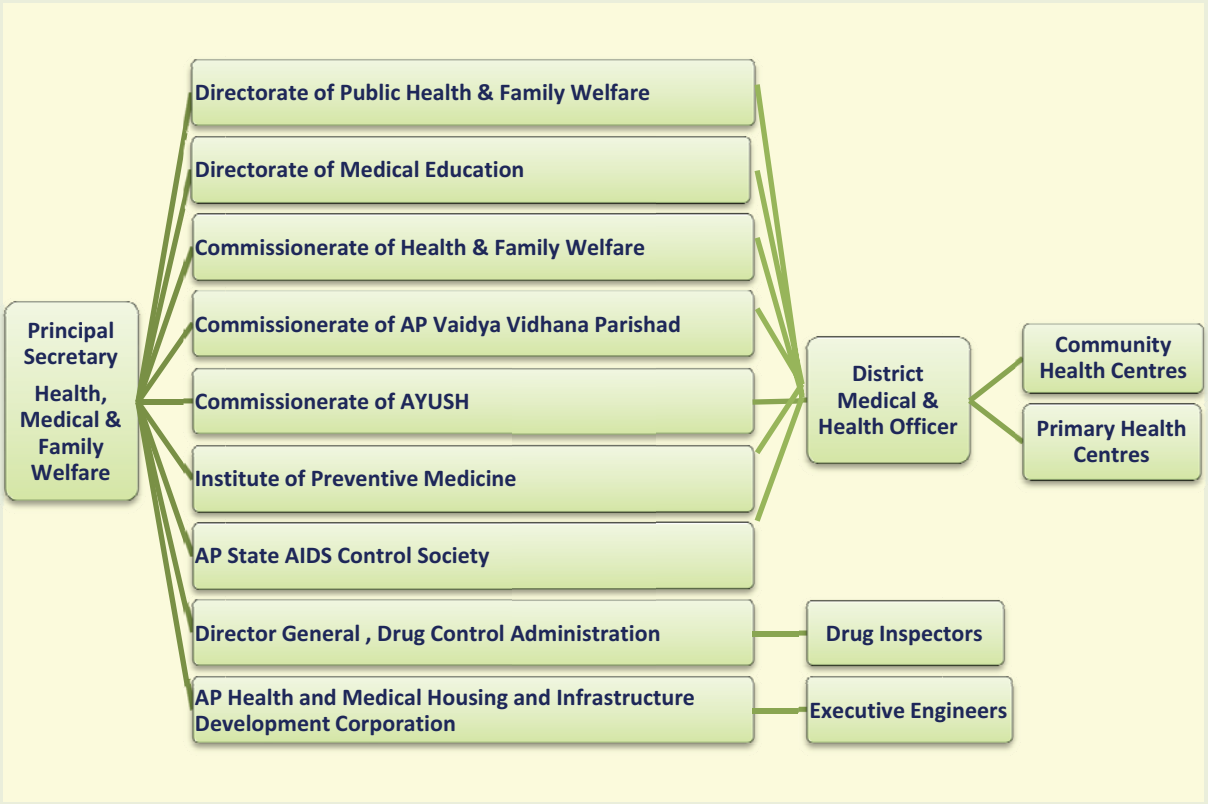
Chapter 5 - Health, Medical and Family Welfare Department

5.1 Department profile

The Department of Health, Medical and Family Welfare is responsible for providing preventive and curative healthcare services to the people of the State. Its main functions include formulation and execution of health related schemes, construction of healthcare centres at various levels/locations, procurement and supply of essential medicines to Government medical institutions, monitoring the functioning of Government run hospitals, medical colleges, etc.

The Department discharges its functions through several agencies/directorates/ commissionerates. The organogram of the Department is given below.



As part of our audit, during the year 2010-11, we have reviewed the functioning of ***(i) Blood banks and (ii) Trauma Care Centres.*** We have also brought out cases of ***(iii) Fraudulent drawal of pay and allowances and advances*** in a few Primary Health Centres and ***(iv) Utilisation of equipment in two Government Medical colleges.*** Our findings are discussed below.

5.2 Functioning of Blood banks

Blood banks[1] are regulated by Drugs and Cosmetics Act, 1940 (Act) and relevant rules made thereunder. Government of India formulated the National Blood Policy (NBP) in April 2002 to bring about a "comprehensive, efficient and a total quality management approach" to functioning of blood banks throughout the country to ensure easy access to adequate and safe blood.

There were 233 blood banks[2] in Andhra Pradesh as of May 2010. We reviewed, during July - December 2010, the functioning of 45 (out of 126) blood banks in eight districts[3] over a period of three years (2007-10). Our findings in this regard are given in the succeeding paragraphs:

5.2.1 Absence of relevant data

The State Level Committee (SLC) constituted in May 2010 for suggesting measures for strengthening the management of blood banks, estimated the demand for blood in the State at eight lakh units per annum. As against this, the existing 233 blood banks[4] are able to collect only seven lakh units per annum. Considering this gap in demand and supply, there is an imperative need to utilise the available resources efficiently. However, the State does not have a centralised online database indicating the availability of various groups of blood at the blood bank level, district level and at the State level.

Blood collected is to be preserved in CPDA[5] solution at temperatures between 4º C and 6º C and utilised within 35 days of its collection. Audit scrutiny revealed that blood units in certain cases collected in all the 45 sampled blood banks had to be discarded due to their non-utilisation within the specified time. The concerned blood banks attributed this to low demand for blood in the neighbouring hospitals. This situation could have been averted had there been a centralised database of blood in the districts and the State as a whole, as the needy hospitals/patients in adjoining areas could have used it to the benefit of their patients.

The SLC had recommended (June 2010) setting up a well knit regionally coordinated blood banking system with structured blood transfusion services and an inbuilt mandatory quality assurance mechanism through the establishment of Mother Blood banks to ensure availability of screened safe blood, by upgrading one Government Blood bank per district to be called Mother Blood banks. However, no such blood banks had been established in the State so far (August 2011).

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[1] Blood bank means a place/organization/unit/institution or other arrangement made by them for carrying out all or any of the operations for collection, apheresis, storage and distribution of blood components or as whole human blood

[2] Adilabad: 6; Anantapur: 6; Chittoor: 10; East Godavari: 13; Guntur: 16; Hyderabad: 62; Karimnagar: 9; Khammam: 7; Krishna: 15; Kurnool: 6; Mahboobnagar:5; Medak: 4; Nalgonda: 5; Nizamabad: 5; Prakasam: 5; Ranga Reddy: 12; SPS Nellore: 4; Srikakulam: 2; Visakhapatnam: 13; Vizianagaram: 5; Warangal: 7; West Godavari: 9 and YSR: 7. Of these, 66 blood banks are under control of Government and 167 private

[3] Anantapur (5), Chittoor (10), Guntur (8), Hyderabad (8), Krishna (4), Kurnool (6), Medak (1) and YSR (3); (Government: 23 and Private: 22)

[4] Government - 66, Red cross - 38, Voluntary/Charitable - 53 and Private hospitals - 76

[5] Citrate-Phosphate-Dextrose-Adenine

Blood banks are required to maintain the details of blood donors in a register, indicating vital details such as date of collection of blood, name of the donor, address, age, weight, percentage of haemoglobin (Hb), blood group, etc. Proper labelling should also be done on the blood packets to ensure that blood was collected from a physically fit and willing donor. This procedure was prescribed to ensure that blood is not collected from ineligible donors and to protect the donor. Further, this will ensure that the blood stock, that does not conform to the prescribed standard is destroyed so that infections don't get carried through blood transfusion. It was noticed that, in 24 out of 45 blood banks test checked, this vital data was not captured/recorded in the blood donors register in respect of as many as 22,995 donors[6]. Further, in the blood bank at Government Hospital, Anantapur, crucial information which was very essential for supply of blood, viz., **blood group,** was not recorded in the donors register in respect of blood collected (2009-10) from 240 donors.

Failure to record such vital details is not only fraught with the risk of transfusion of wrong blood to the patients, but may finally leave the blood unutilised and discarded and would result in wastage of a scarce resource defeating the very objective of the donors to save another precious life.

5.2.2 Donor safety

As per the eligibility criteria fixed for blood donation under the Drugs and Cosmetics Rules, 1945 (Rules), the donor of blood should be in good health, mentally alert and physically fit. We observed the following violations of these standards in the test checked blood banks.

Conditions stipulated for drawal of blood	Audit findings
Age: Donor should be within the age group of 18 to 60 years.	In 23 out of 45 blood banks verified, blood was collected from 291 donors who are below the age of 18 years.
Weight: Weight of donor should not be less than 45 Kg	In 10 out of 45 blood banks verified, blood was collected from 71 donors whose weight was less than that specified.
Haemoglobin content: Haemoglobin content of donor's blood should not be less than 12.5 gm/dl. Persons with haemoglobin less than this prescribed quantity cannot be treated as healthy person for blood donation. Further, blood weak in haemoglobin content does not help in carrying oxygen to cells of the patient.	In 41 out of 45 blood banks checked, blood was collected from 3,617 donors (details given in *Appendix-5.1*) whose haemoglobin content was less than the prescribed rate i.e.12.5 gm/dl, the lowest being 8.5 gm/dl.

As can be seen from the details tabulated above, donor safety was compromised by violating the eligibility criteria for blood donors.

[6] HB percentage not recorded: 22,114; Age, Weight, etc. not recorded: 881

5.2.3 Extract of blood components

World Health Organisation (WHO) had emphasised the need for optimal utilisation of donated blood by use of specifically required components instead of whole blood. In view of the gap between demand and actual collection of blood units, conversion of blood into various components was an inherently effective way of overcoming the shortage of blood. In none of the 45 test checked blood banks, there was any evidence to prove that the blood banks had made any effort to extract blood components from the units collected. Thus, optimal utilisation of the scarce resource was not ensured.

5.2.4 Calibration of Equipment

Rules stipulate that the equipment used in collection, processing, testing, storage and sale/distribution of blood and its components should be observed, standardised and calibrated at regular intervals as described in the Standard Operating Procedures Manual wherein details of frequency of calibration of various equipments are also prescribed. Though the prescribed equipment was available in adequate number in all the test checked blood banks, calibration of 102 equipments in 11 (out of 45) blood banks reviewed in audit had not been done.

In the absence of equipment calibration at regular intervals the risk of the results/ readings (obtained by using these equipments) not being accurate and reliable was ever present. Therefore, there was no assurance about the quality of the blood supplied by these blood banks.

5.2.5 Ineffective monitoring by Drug Inspectors

The Drugs Controller (India), Directorate General of Health Services, New Delhi issues licences to blood banks only after verifying it and carrying out a joint inspection along with the Director General, Drug Control Administration (DG, DCA).

Prior to issue of licence/renewal of licence to any blood bank for carrying out its operations, Drug Inspectors (Inspectors) working under the control of DG, DCA, are required to examine the premises and appliances/equipments, inspect the process of manufacture along with the means for operation of blood bank, processing of whole human blood for components, manufacture of blood products together with their testing facilities and also enquire into the professional qualification of the expert staff and other technical staff employed.

If the licensee fails to comply with any of the conditions of the licence or with any provisions of the Act or Rules thereunder, the licence may be cancelled or suspended. Licence to blood banks is valid for five years from the date of its issue and it has to be renewed thereafter from time to time. Rejected licensee can re-apply within six months after complying with.

We observed that:

- A majority of the Inspectors in the sampled districts have not complied with the above procedures. Monitoring of the blood bank operations/activities by the Inspectors was

also found to be ineffective. Out of 45 blood banks verified, 22 had not been inspected by the licensing authority during 2008 and 2009.

- In case of two blood banks[7], we noticed that their licences had expired in 1999 and 2007. However, joint inspection was conducted belatedly only in January 2010. Thus, the blood banks functioned unauthorisedly during the intervening years. There were no recorded reasons for the inordinate delay in the conduct of joint inspection.

5.2.6 Huge shortages of Drug Inspectors

The jurisdictional area of a Drug Inspector depends on the number of pharmaceutical units in the area and more than one Inspector may be required in a district.

We observed (August 2010) that there was acute shortage of 'Drug Inspectors' in the Department. There were only 24 Drug Inspectors against 558 posts required as per norms. Although, Government had sanctioned 75 additional posts during 2007-09, even these were not deployed as of August 2011. The Department stated (August 2010) that there were no eligible persons in the Department in respect of vacancies to be filled in through promotions and action was underway for direct recruitment.

5.2.7 Conclusion

As brought out in the foregoing paragraphs, the functioning of blood banks in the State is far from satisfactory. Although specific rules were framed for ensuring the safety of blood donors, a majority of the blood banks verified in audit flouted the rules. Non-compliance with the Rules and ineffective monitoring by the Drug Inspectors had resulted in several deficiencies, endangering the safety of both the donor and the needy patients.

5.2.8 Recommendations

- Government should initiate immediate steps for creating a centralised online database indicating the availability of various blood groups to facilitate efficient use of this scarce resource.
- Government should ensure that vital details like name, blood group, age, weight, address, etc. of the donors are captured scrupulously by all the blood banks to eliminate the risk of transfusion of wrong blood to the patients and avoid wastage.
- Measures should be initiated to ensure that equipment used in collection, processing, testing, storage and sale/distribution of blood is calibrated at regular intervals to ensure that the readings are accurate and reliable.
- Government needs to address the problem of huge shortage of Drug Inspectors to ensure effective monitoring of blood banks.

The matter was reported to the Government in June 2011; reply had not been received (December 2011).

[7] District Hospital, Machilipatnam and Area Hospital, Gudiwada

5.3 Functioning of Trauma Care Centres

5.3.1 Introduction

GoI envisaged (November 1999) a scheme for developing a network of Trauma Care Centres (TCCs) along the Golden Quadrilateral, to provide emergency treatment to accident victims. The scheme involved provision of financial assistance for upgradation and strengthening of emergency facilities in State hospitals located on National Highways. The hospitals designated by the State Government and approved by GoI, were to be upgraded to Levels I to IV within a period of twelve months from the date of sanction. The grants covered various components like civil works, equipment, manpower, communication systems, training, legal assistance, etc. depending on the level of upgradation of a particular hospital.

In Andhra Pradesh, 17 hospitals[8] (Level-II: 9; Level-III: 8) were selected (2004-09) for upgradation as TCCs at a cost of ₹ 125.25 crore[9]. As of August 2011, GoI released ₹ 49.08 crore [10] to these hospitals.

GoI sanction had stipulated specific time frame within which the released funds were to be utilised as follows:

- Tendering for equipments should be completed within a period of 10 days of receipt of sanction letter.
- Manpower required should be finalised within 30 days for each of the Trauma Care Centre (TCC), etc.
- The expenditure statement, utilisation certificate should be submitted to GoI within 12 months for considering further release of funds.

Audit scrutiny (April/May and October 2010) of the relevant records of the hospitals concerned revealed that none of the 17 TCCs were fully operational as of August 2011 due to non-completion of civil works or, where the civil works had been completed, equipment had not been procured or, required manpower had not been put in place.

5.3.2 Execution of civil works

The scheme envisaged renovation of existing hospital buildings[11] for Trauma Care. In the hospitals which were to be upgraded to Level-II and Level-III, certain civil works for operationalisation of Trauma Care Centres were to be taken up and completed. As per the scheme guidelines, all the civil works were to be completed within a maximum period of 12 months of the sanction.

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[8] **Level-II:** 2004-05: Government General Hospital, Kurnool; 2005-06: King George Hospital, Visakhapatnam; 2006-07: District Hospital, Srikakulam; 2007-08: District Hospital, Rajahmundry; Government General Hospital, Guntur; District Hospital, SPS Nellore; 2008-09: RIMS, Adilabad; District Hospital, Nizamabad; and Government General Hospital, Anantapur
Level-III: 2006-07: District Hospital, Eluru; 2007-08: Area Hospital, Tuni; Area Hospital, Tekkali; District Hospital, Ongole; CHC, Nayudupeta; 2008-09: Area Hospital, Kamareddy; District Hospital, Mahboobnagar and CHC, Penukonda, Anantapur

[9] ₹ 9.65 crore each for nine Level-II TCCs and ₹ 4.80 crore each for eight Level-III TCCs

[10] construction activities: ₹ 12.04 crore; equipment: ₹ 31.55 crore; manpower: ₹ 4.98 crore; other minor items like training, legal assistance, etc.: ₹ 0.51 crore)

[11] Projected Cost/Sanction accorded: Level II: ₹ 80 lakh; Level III: ₹ 63 lakh/₹ 65 lakh

The hospitals placed the amounts intended for civil works with the Andhra Pradesh Health and Medical Housing and Infrastructure Development Corporation (APHMHIDC), the nodal agency created (May 1987) by the State Government for construction of buildings, procurement and supply of equipment for all the Medical institutions in the State. Hospital-wise details of the amounts released during January 2005 to April 2010 for civil works, amounts deposited with APHMHIDC, stage of completion, etc. are given in *Appendix-5.2.*

We observed that:

- civil works were completed (August 2011) only in seven hospitals[12] (expenditure: ₹ 4.71 crore) and delays in completion of works ranged from three months to as high as three years;
- in seven out of 17 other hospitals[13], civil works had not been completed. In Government General Hospital, Anantapur, even the land required for construction had not been identified; and
- in three other hospitals, viz., Rajiv Institute of Medical Sciences (RIMS), Srikakulam; Government General Hospital, Guntur and RIMS, Adilabad, civil works of TCC building was clubbed with civil works being executed in other buildings of the same hospitals. Since these buildings were at various stages of execution, civil works of TCC buildings was also delayed.

Tardy progress in completion of the buildings to house TCCs resulted in release of further funds amounting to ₹ 76.17 crore by GoI, towards other components like equipment, etc. being put on hold, as discussed in the subsequent paragraphs.

5.3.3 Procurement of equipment

GoI's sanction stipulated that tendering for equipments[14] should be completed within a period of 10 days of receipt of sanction. On finalisation of tenders and after receipt of these documents in the Ministry, the next instalment of 40 *per cent* would be considered for release. The remaining 10 *per cent* would be released after placement of supply order. Thus, there was an inherent need to complete the process of procurement of equipment at the earliest. As most of the basic and essential equipment was already available with the identified institutions, assistance for equipment was restricted (by GoI) to ₹ 5 crore in respect of Level II TCC and ₹ 2 crore in respect of Level III TCC. This would imply that the hospitals were to identify/select only such of the vital equipments which are very critical to trauma care centres. We observed that such an exercise was lacking in all the test checked hospitals.

[12] King George Hospital, Visakhapatnam; District Hospital, Rajahmundry, East Godavari; Government General Hospital, Kurnool; District Hospital, Tekkali, Srikakulam; Area Hospital, Tuni, East Godavari; District Hospital, Eluru, West Godavari and RIMS, Ongole, Prakasam

[13] District Hospital, SPS Nellore, Government General Hospital, Anantapur, District Hospital, Nizamabad, Community Health Centre, Naidupet, SPS Nellore, Area Hospital, Kamareddy, Nizamabad, District Hospital, Mahboobnagar and Community Health Centre, Penukonda, Anantapur

[14] Cost involved: ₹ 12.80 crore for Level II TCC; ₹ 2.53 crore for Level III TCC

As against the release of ₹ 31.55 crore[15] by GoI towards procurement of equipment to nine hospitals, the hospitals had placed ₹ 28.37 crore with APHMHIDC (details are given in *Appendix-5.3*) for supply of equipment. As of August 2011, APHMHIDC had supplied equipment worth only ₹ 13.20 crore leaving ₹ 15.17 crore unutilised with them. In response to an audit enquiry, APHMHIDC stated (September 2011) that tenders in respect of the equipment indented for TCCs were still under process. It was further observed that,

- Except Government General Hospital (GGH), Kurnool, none of the other eight hospitals could fully utilise the funds meant for procurement of equipment. While GGH, Kurnool, utilised the entire amount of ₹ 5.27 crore, five hospitals[16] had received only equipment valuing ₹ 7.93 crore as against ₹ 16.35 crore released for the purpose to APHMHIDC. Some of this equipment thus procured was not as prescribed by GoI for upgradation of TCCs.
- Two hospitals viz., (a) Government General Hospital, Guntur and (b) District Hospital (RIMS) Ongole, were not supplied any equipment by APHMHIDC though necessary funds (₹ 7 crore) were placed at its disposal in December 2010/January 2011. Reasons for delay were not available with the hospitals.
- In Area Hospital, Tuni, ₹ 2.17 crore intended for purchase of equipment, were kept by the hospital in fixed bank deposits instead of transferring it to APHMHIDC. Specific reasons for non-utilisation of the amount were not furnished by the hospital authorities.
- In case of both Level-II and Level-III TCCs, the assistance in respect of General Surgical equipments was restricted to 2 sets (total cost limited to ₹ 4 lakh) only. We observed in King George Hospital, Visakhapatnam that, some of the important equipments such as Ultra Sound Scan, 500 MA X-Ray machine and CT Scan Multi-slice could not be procured by the hospital, where general surgical equipments had been purchased in excess. The Superintendent of the hospital contended (May 2010) that, as the hospital has the potential to emerge as Level-I centre (from existing Level-II), more number of sets of surgical equipment required for a full fledged Level-I centre were procured. The reply is not acceptable as procurement of more sets of general surgical equipment should not be at the cost of vital trauma care equipment viz., Ultra Sound Scan, 500MA X-ray machine and CT Scan Multi-slice required for effective functioning as a Level-II Trauma care centre.

Thus, while APHMHIDC was ineffective in speedy procurement and supply of equipment, the Superintendents of the hospitals also had failed to monitor this aspect vigorously resulting in non-receipt of the indented equipment even after the lapse of considerable time after placing the indents with APHMHIDC and funds remaining unused.

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[15] King George Hospital, Visakhapatnam: ₹ 5.01 crore; RIMS, Srikakulam: ₹ 2.94 crore; District Hospital, Rajahmundry: ₹ 2.85 crore; Government General Hospital, Guntur: ₹ 5.00 crore; District Hospital, SPS Nellore: ₹ 4.95 crore; Government General Hospital, Kurnool: ₹ 5.02 crore; Area Hospital, Tuni, East Godavari: ₹ 2.17 crore; District Hospital, Eluru, West Godavari: ₹ 1.61 crore and RIMS, Ongole, Prakasam: ₹ 2.00 crore

[16] King George Hospital, Visakhapatnam: ₹ 3.80 crore; RIMS, Srikakulam: ₹ 0.41 crore; District Hospital, Rajahmundry, East Godavari: ₹ 0.51 crore; District Hospital, SPS Nellore: ₹ 2.76 crore; District Hospital, Eluru, West Godavari: ₹ 0.45 crore

5.3.4 Manpower

As per the Scheme guidelines, GoI would meet the expenditure on manpower necessary for the Trauma Care Centres during the first five years of their existence. GoI accordingly released (March 2008 – October 2010) ₹ 4.98 crore (for one year) to the State at the rate of ₹ 0.76 crore for six [17] Level-II hospitals and ₹ 0.42 crore to one [18] level-III hospital. Although the State Government was to finalise the required manpower for each TCC within the stipulated period of 30 days of receipt of sanction of the grant, it accorded sanction for recruitment of staff for the TCCs, that too only for 10 (out of 17) hospitals in March 2009.

We observed that,

- the staff sanctioned was not as per the approved norms applicable for Level-II and Level-III TCCs (as detailed in *Appendix 5.4*).
- Even in the hospitals where manpower was sanctioned, as against the prescribed norm of 84 for Level-II hospitals and 75 for Level-III hospitals, staff actually recruited was far lower and ranged between three to seventeen.
- Further, the hospital authorities recruited only Data Entry Operators and staff nurses, that too only partially, while other technical staff like General Surgeon, Orthopaedic Surgeon, Anesthetist, Medical/Para Medical staff critical for TCCs were not recruited.
- In Government General Hospital, Kurnool where the upgradation of the hospital to TCC had been sanctioned way back in the year 2004 and where the required building had already come up and the required equipment had been procured, no staff had been sanctioned by the State Government as of August 2011, despite the lapse of over five years.

Thus, Government's failure in planning and managing the activity of recruitment and deployment of technical manpower to the hospitals resulted in non-execution of the project within the prescribed timelines.

The hospital authorities contended (June 2011) that, the TCCs were extending treatment to accident victims with the existing staff. The contention is not acceptable, because in the absence of specialised staff as envisaged in GoI's sanction the TCCs cannot be considered fully operational.

5.3.5 Utilisation Certificates

We analysed the reasons as to why the funds (₹ 125.25 crore) sanctioned were not released in full by GoI to the hospitals. While releasing funds, GoI stipulated that, Utilisation Certificates (UCs) along with the audited accounts of the funds sanctioned should be submitted to the Ministry within 12 months of release of funds to ensure further releases. We observed that, except King George Hospital, Visakhapatnam, none of the other 16 hospitals had utilised the funds as detailed above, nor furnished as of April 2011 UCs for

[17] District Hospital, SPS Nellore; District Hospital, Rajahmundry; GGH, Guntur; GGH, Kurnool; KGH, Visakhapatnam; and RIMS Srikakulam
[18] District Hospital (RIMS), Ongole

the full amounts received. As against ₹ 49.08 crore released by GoI, UCs for ₹ 31.72 crore were yet to be furnished by the hospitals and non-compliance of this requirement resulted in further release of funds (₹ 76.17 crore) by GoI being withheld, as mentioned in para *supra*.

5.3.6 Conclusion

The 17 Trauma Care Centres (TCCs) sanctioned (2004-09) by GoI have either not been set up or are yet to become fully operational as of August 2011, either due to the civil works not being completed, or where completed, due to delay in procurement of equipment and absence of requisite manpower. Thus, the objective of providing basic life support and emergency care in the golden hour i.e., first hour of injury to accident victims in the Golden Quadrangle within Andhra Pradesh remains unachieved even after the lapse of over two to five years of necessary sanctions having been accorded by GoI.

The matter was reported to Government in July 2011; reply had not been received (December 2011).

5.4 Functioning of equipment in Medical colleges

Scrutiny of the records relating to utilisation of equipment in Government Medical College, Anantapur (November 2010) and Siddhartha Medical College, Vijayawada (June 2010) and the relevant records in the Office of the Director of Medical Education (DME) revealed the following.

5.4.1 Government Medical College, Anantapur

Government Medical College, Anantapur, receives at least 50 cancer patients every month. GoI released (December 2005) ₹ 2 crore as one time grant to the college under National Cancer Control Programme (NCCP) for development of Oncology wing based on the proposals submitted (January 2004) by the College through the State Government.

For commissioning of Oncology wing, the following steps were to be taken:

- Purchase of necessary equipment
- Construction of bunker as per the norms prescribed by BARC[19] for installation of the equipment
- Deployment of technically qualified staff for manning the Oncology wing

Equipment consisting of treatment planning system, Cobalt Unit "60" tele-therapy system and source costing ₹ 2.12 crore[20] was received during July 2006 - December 2007. In order to put the equipment to use and commission the Oncology wing, simultaneous action was to be taken to ensure synchronization of all the above three activities. We however, found that such an exercise was not undertaken by the Medical College. Though requisite funds (₹ 41 lakh) for construction of bunker were placed at the disposal of APHMHIDC[21] in

[19] Bhabha Atomic Research Centre
[20] Treatment planning system (₹ 0.31 crore); Cobalt unit "60" tele-therapy system (₹ 1.24 crore) and Source (₹ 0.42 crore); Custom charges on the above equipment (₹ 0.15 crore) funds over and above ₹ 2 crore met from Hospital Development Society funds
[21] AP Health and Medical Housing and Infrastructure Development Corporation Limited

March 2006 itself, the site was handed over to the contractor belatedly in August 2007. As a result, bunker could be completed and the equipment was installed only by April 2008. Even after installation, calibration of the equipment, which is a pre-requisite for starting the treatment, was done only after a gap of one year i.e., in April 2009 owing to non-availability of technical staff[22]. Further, due to non-availability of technical staff, generation of field radiation survey reports was delayed which ultimately caused delay in obtaining necessary permission from BARC for commissioning the treatment. Further, even after receipt of BARC permission in September 2009 to commence treatment, the DME failed to deploy Oncologist to man the equipment. In the meantime, the warranty period of the equipment[23] and the two year period (after expiry of warranty) of free maintenance service, to be provided by the company, had expired. That apart, the hospital could not confirm the prospect of radio active cobalt unit serving its full life. As of August 2011, in the absence of an oncologist the equipment had not been put to use and no patients were being treated.

Thus, due to lack of synchronization of all the three activities of construction of bunker, installation of the equipment and deployment of technical staff, coupled with failure of the DME to deploy Oncologist to man the equipment, the equipment procured way back in 2006 remained idle even after the lapse of five years. This deprived the cancer patients of Anantapur and neighbouring districts of the benefit of advanced cancer treatment.

5.4.2 Siddhartha Medical College, Vijayawada

The YVC Oncology Wing and Research Centre, Chinakakani (Hospital), attached to Siddhartha Medical College, Vijayawada was provided (October 1998) with Theratron Phoenix Cobalt Unit (Unit) worth ₹ 1 crore for treating cancer patients[24]. As of February 2009, the tele-cobalt source had completed two half lives and the output level neared minimum level[25] beyond which the Unit would not be permitted for usage until the new source is installed. The Unit was closed in October 2009 and no inpatients were admitted thereafter.

Audit scrutiny revealed the following.

For ensuring continued service by the unit for treatment of cancer patients, two activities were to be properly synchronized:

⇒ Periodical review of the availability of source so as to initiate action to seek funds in advance from Government for replacement of source, especially in the context that the GoI supplier firm (BRIT) takes about six months for supplying the source material, after full payment of the cost in advance.

⇒ Ensuring the availability of Medical Physicist and Radiological Safety Officer throughout for operating the Unit.

[22] Professor: 1; Assistant Professor: 2; and Tutor: 1 in the Department of Radio-Therapy
[23] which was 15 months from the date of shipment or one year from the date of installation whichever is earlier had expired
[24] 235 cancer patients in the year 2008 and 127 cancer patients in the year 2009 were treated
[25] Minimum level:50 RMM; output level as of March 2011:53 RMM

It was observed that such an exercise was lacking. Though the Principal of the Medical College took up the matter with the Director of Medical Education (DME) in February 2009 itself and followed it up regularly for replacement of tele-cobalt source with 200 RMM output, DME forwarded the proposals to Government seeking funds only in March 2011, i.e., after the lapse of more than two years. In the meantime, the cost of replacement of the source had escalated (September 2010) to ₹ 1.12 crore. State Government was yet to provide the estimated funds (August 2011) for the purchase of the source material.

Further, the posts of Medical Physicist and Radiological Safety Officer remained vacant since August 2009. Consequently, the Radio Therapy Unit had to be closed in October 2009 as directed by Atomic Energy Regulatory Board. The DME confirmed the audit observation.

Thus, failure of DME in not taking up the matter with the Government immediately after reporting by the Medical college for provision of funds, coupled with non-filling up of the vacancy of Medical Physicist resulted in the Radio Therapy Unit not functioning and lying idle for over one and half years depriving the cancer patients of the benefit of treatment.

The matter was reported to Government in May/June 2011; reply had not been received (December 2011).

5.5 Fraudulent drawal of pay and allowances and advances

Provisions of Treasury Rule 23 read with appendix 18 of AP Treasury Rules stipulate the following:

- **When a Government servant proceeds on transfer from one place to another in the same State or circle of audit, the Government servant should obtain a last pay certificate (LPC) from the officer in charge of the Treasury from which he last drew pay, or, if he is a non-Gazetted Government servant, from the head of the office with whom he was last employed.**

- **A Treasury Officer may not permit any withdrawal in respect of pay or allowances of a Government servant to whom he has granted LPC, unless the certificate is first surrendered.**

- **To ensure that no further payments are made towards pay and allowances in respect of person transferred, the fact of issue of LPC should be communicated by the Drawing and Disbursing Officer to the Treasury Officer. It is also the duty of the Treasury Officer to record the fact of issue of LPC in the flyleaf of the employee maintained by the Treasury.**

Further, as per provisions of the Andhra Pradesh General Provident Fund Rules, subscribers of General Provident Fund may be sanctioned an advance only from the amount standing to their credit in the fund.

Audit scrutiny (November 2010) of records of the Medical Officers[26] of two primary health centres (PHCs), Duppalapalem and Chavitidibbalu in East Godavari district (DDO) and those of Sub-Treasury Officer, Addatheegala (jurisdictional treasury) (STO) revealed that non-compliance with the above codal provisions resulted in fraudulent drawal of pay and allowances and advances aggregating ₹ 17.73 lakh as indicated below.

The DDO had drawn pay and allowances in the names of staff members who were already transferred and in whose cases Last Pay Certificates (LPCs) had already been issued. It was observed in audit that pay and allowances were also drawn by the drawing officers in the stations[27] where the individuals had actually been transferred to.

The DDO had also drawn amounts towards House Building Advance, Motor Cycle Advance, etc. against the individuals already transferred from the PHCs. Further, the DDO withdrew GPF advances from their accounts although the accounts did not have sufficient balances at their credit. The amounts of such fraudulent drawals aggregated ₹ 17.73 lakh as detailed in *Appendix-5.5.*

The DDO failed to produce the relevant records like aquittances, bank statements, etc. called for by Audit team. As a result, the details such as, to whom the amounts were paid and personal bank accounts to which the amounts were finally adjusted, etc. could not be verified in audit. The Sub Treasury Officer also did not produce flyleaves[28] which would have revealed all the month-wise payments made to the individual i.e., pay, special pay, HRA, CCA, GPF and other advances, of the periods subsequent to issue of LPC in respect of the individuals in whose names the money was drawn. Scrutiny of the only flyleaf made available to Audit revealed that the fact of transfer and issue of LPC was not recorded in the flyleaf by the STO, which facilitated the drawal of pay and allowances even after issue of LPC. Thus, it is evident that there was collusion between the DDO and the STO.

On the matter being pointed out (November 2010) in Audit, the Regional Director (RD) of Medical and Health Services, Rajahmundry, confirmed (March 2011) the fraud. RD stated that disciplinary action had been initiated against one of the

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[26] The Medical Officer of PHC, Duppalapalem is also holding charge of PHC, Chavitidibbalu during this period of fraudulent drawal

[27] Sankavaram, Yeleswaram and Kuthukuluru in East Godavari district; University Hospital, Mangalagiri, Guntur district

[28] Flyleaves in respect of (1) Sri M. Gangaraju, APMO for the period from June 2008 to February 2009, (2) Smt Naga Malleswari, Staff Nurse for the period from May 2009 to May 2010 and (3) Smt D. Mariamma, PHN, for the period from September 2009 to October 2010 were not made available to Audit. Flyleaves in respect of (1) Dr N. Rajakumari for the period from March 2009 to June 2010 was only made available to Audit

delinquent officials. Action on the enquiry report[29] duly fixing the responsibility on the treasury personnel concerned for violation of prescribed Rules, was yet to be taken (November 2011). The District Collector, East Godavari, sought (February 2011) permission from Government for initiating criminal cases against the delinquent Treasury officials and Government orders were awaited (November 2011).

The matter was reported to Government in June 2011; reply had not been received (December 2011).

[29] furnished by the Deputy Director, District Treasury Officer, Kakinada , East Godavari district