IN THE COURT OF 2nd ADDL. SENIOR CIVIL JUDGE & JMFC., AT BIDAR

Present : Abdul Khadar, B.A. LL.B.,
2nd Addl. Senior Civil Judge & JMFC.
Bidar.

Dated this the 3rd day of January 2022

Criminal Case No. 140/2016

The State represented by
Police Sub Inspector.
New Town Police Station, Bidar.

... Complainant
(By Asst. Public Prosecutor.)

V/s

1. Dr.Rajashree W/o Shivaraj Biradar,
Age: 32 years, Occu:Doctor,
R/o: Susrut Nursing Home,
J.P.Nagar, Bidar.

2. Dr. Vaijinath S/o Basappa Biradar,
Age: 65 years, Occ: Doctor,
R/o Rampure Bank Colony, Bidar.

3. Dr.Saibanna S/o Mani Ambate,
Age: 52 years, Occ: Compounder,
R/o J.P.Nagar, Bidar.

4. Dr.Rajshekhar S/o Veerabhadrappa Patil,
Age: 52 years, Occ: Doctor,
R/o Near Saipushpanjali Kalyan Mantap,
Bidar.

... Accused

(A-1 by Sri. P.M.R Advocate)
(A-2., by Sri. N.S.C, Advocate)
(A-3 by Sri M.R.G , Advocate)
(A-4 by Sri M.M.Advocate)

- Date of commission of offence : 12-10-2014
- Date of report of offence. : 13-10-2014
- Date of arrest of accused. : ----

Nature of offences : U/sec. 304(a) and 202 R/w 34 of IPC

- Date of opening of evidence. : 18-06-2019
- Date of closing of evidence. : 03-01-2022

Opinion of the judge. :

-:J U D G M E N T:-

This case is registered by New Town Police Station against the accused persons for the alleged offence punishable 304-A, 202 R/w Sec.34 of IPC.

2. **The brief facts of the case of the prosecution is as under :**

On 12-10-2014 at about I.00 p.m within the jurisdiction of the New Town Police Station at J.P Nagar

Shustrut Nursing Home belongs to Sri Biradar, the sister of CW.1 by name Smt.Sampavathi went to the hospital by walk and admitted for leproscopic assisted vaginal histeroctomy operation. The Accused No.1 to 3 have conducted the operation to the deceased Sampavathi without maintaining the ventilator facility in the hospital of accused No.1 and also not followed the pre-operation procedures for a period of 5 hours and they have not given any intimation about her health condition to the CW.1 to 3 and 7 to 13. Thereafter the accused No.1to 3 are shifted the deceased Sampavathi to the hospital of accused No.4 as there is no facility of ventilator support and intensive care unit in the hospital of accused No.1 and the accused No.4 get admitted the deceased Sampavathi in his hospital at about 10.00 p.m, with an intention to screening the accused No.1 to 3 from their negligent act and made disappearance of evidence of offence and declared the death of Sampavathi at 5-00 a.m., to the CW.1 to 3 on 13-10-2014, even though she died before that. Therefore the accused No.1 to 3 have committed gross negligence while conducting the operation and accused No4 intentionally made omission to give

information to the CW1 to 3. In this regard the brother of deceased Sampavvathi lodged complaint on 13-10-2014 at about 8.45.a.m., before the New Town police against the Accused No.1 to 4. CW.24 on receiving the written complaint from the C.W.1 he registered case in their Crime No.315/2014 for the offences punishable U/S 304(A) and 202 R/w 34 of IPC and preferred the FIR sent it to the Court and his superior officers and set the criminal law into motion.

3. On the same day CW.24 visited the Shusrut Nursing Home and Biradar Hospital, at about 10.30.a.m, he shifted the dead-body of Sampavathi to the Government Hospital, Mortuary in ambulance and filed requisition to CMO Sujatha requesting her to keep the dead body in the mortuary. On the same day he conducted inquest panchanama of deceased Sampavathi in the presence of CW. 4 to 6 at about 11-00 a.m., to 1 p.m. at that time he noticed that on the stomach of deceased 2 inches 4 holes are found. Therefore, he send the dead-body to the postmortem through P.C. 1080 and with a requisition and after postmortem, he handed over the dead-body to the relative of the deceased Sampavathi. On the same day at about

4.pm. to 5 p.m. he conducted spot mahazar in the presence of CW 2 and 3 at Biradar Hospital. On 14-10-2014 he recorded the statement of CW.2, 3 and 7 to 13. On the same day he issued notice to Accused No.1 calling her to produce treatment particulars of deceased Sampavathi and accused No.1 furnished the details as sought by along with copy of bail order to him and he received the same and kept in the record. He handed over the case records to CW.25 for further investigation. CW.25 in his investigation received the Postmortem Report and also sent the Vishra which are collected at the time of postmortem to the FSL through CHC 644 and received the acknowledgement from the CHC 644 and received the FSL report and also wrote a letter to the Superintendent of BRIMS to know the cause of death of Sampavathi dated 23-02-2015, 02-03-2015 and received the final opinion of expert on 06-03-2015 for cause of death and kept the same in the file. On the same day he received the case sheet of Shree Hospital again he wrote a letter to District Government Surgeon give opinion where the accused No1 to 4 committed gross negligent to provide treatment to the deceased Sampavathi. On 12-01-2016

Medial Superintendent submitted committee members opinion and received final opinion from the medical Superintendent on 29-04-2016 and after completion of the investigation, he filed the Charge Sheet against the Accused No.1 to 4.

4. After filing of charge sheet, this court was taken cognizance for the offenses punishable under section 304A, 202 r/w 34 of I.P.C. After service of summons the accused have appeared through their counsel, before this court and they are released on bail. Copies of the prosecution papers were furnished to the accused as contemplated under section 207 Cr.P.C and by securing Accused the accusation for the offences punishable under sections 304A, 202 r/w 34 of I.P.C were framed and read over to him, he pleaded not guilty and claims to be tried.

5. In order to establish the alleged guilt of the accused, the prosecution in all has examined 11 witnesses at PW1 to 11 and got marked 34 documents as per Ex.P1 to P34. By confrontation during the course of cross examination marked 5 documents at Ex.D1 to D5. After closure of evidence of the prosecution, the accused were examined as

contemplated u/s.313 Cr.P.C and their statement was recorded. The accused have totally denied the case of the prosecution and in defense Accused No.3 himself examined as DW1 and marked 3 documents at Ex,D1 to D3.

6. Heard on both the sides.

7. The following points would arise for my consideration are:

1. Whether the prosecution proves beyond all reasonable doubts that, on 12-10-2014 at about 1 p.m. the deceased Sampavathi went by walk along with CW 1 to 3, 7 to 13 to the Hospital of Accused No.1 by name Sushruth Nursing Home for leproscopic assisted vaginal histeroctomy operation where the accused No 1 to 3 without maintaining ventilator facility and not following pre-operation procedure by negligently conducted operation for a period of 5 hours, thereafter she has been shifted to accused No.4 hospital without intimating the health condition of deceased to her family members and she died due to complications of Laproscope assisted Vaginal Hysterectomy and thereby the accused No1 to 3 have committed the offence punishable U/S 304-A R/w 34 of IPC ?
2. Whether prosecution further proves beyond all reasonable doubt that on the above said date, time and place, the accused No.4 with an intention to screening the act of accused No1 to 3 made disappearance of

evidence of offence and thereby the accused No.4 has committed the offence punishable U/S 202 R/w 34 of IPC ?

3. What Order ?

8. My findings to the above points are:

Point Nos.1 and 2 :: In the Affirmative.

Point No.3 :: As per final order below for the following,

R E A S O N S

Point No.1 and 2 -

9. As point Nos. 1 and 2 are interlinked each other and discussion of one point has its direct bearing on the discussion of another point. Hence, for the purpose of brevity and convenience and with a view to avoid repetition of discussion of evidence, I discuss these points jointly.

10. In so far as the oral evidence are concerned prosecution has examined as many as 11 witnesses as per PW1 to PW11. PW1 Veershetty is the Spot Mahazar Witness, PW.2 Jagannath is the complainant, P.W.3 Vijaykumar is the Inquest Mahazar Witness, P.W.4 Ghaleppa is the husband of deceased Sampavathi, P.W.5 Dr.Sunil who conducted the postmortem of deceased Sampavathi, P.W.6 Dr. Shivakumar

Shetkar, who given final opinion for the cause of death of deceased Sampavathi, P.W.7 Dr.Madana Vaijinath and P.W.10 Dr.Sangamesh Kunkeri are the member of committee formed by the P.W.6 and they given their individual opinion for the cause of death of deceased Sampavathi. P.w.8 Dr.Uma Deshmukh who given finding regarding the case sheet of Shusrut and Shree Hospital. P.W.9 is the ASI Madappa who registered the case and partly investigated the case. P.W.11 Santhosh L.T. P.S.I, who investigated the case and submitted the charge sheet against the accused persons. The documents Ex.P1 to P34 are given in annexures.

11. Let me analyze how for the prosecution is successful in proving the guilt of the accused to the hilt with the assistance of these oral and documentary evidence.

12. Let me take the evidence of the P.W.1 spot mahazar witness, he deposed that, on 13-01-2014, at about 4 p.m, the New Town police have called him and CW2 and taken them to the Accused No.1's hospital, on account of death of Sampavathi who was the sister of CW.1 as she was died at the time of the operation. The police conducted the

Spot panchanama in their presence and the said spot has been shown by the C.w.1 Jagannath to the police and the spot panchanama conducted inside the operation theater of Shshrut Nursing Home as the said document is marked at Ex.P1 and he know the contents of the Ex.P1. He identified his signature and the same is marked at Ex.P1(a). This witness cross examined by the counsel for the accused in length but nothing worth while elicited from his mouth to show that he is not present at the time of spot mahazar and he signed at police station. In the cross-examination he stated that, he was went to the house of CW7 on he date of incident where police called him to act as pancha to the spot mahazar. He admits that, the C.w.1 is his relative, the deceased Sampavathi died on 12-10-2014 and same day conducted the burial of dead body and he knows the C.w.2. CW7 was the son his elder brother. Hospital consisting one floor and towards east operation theater is exist Further deposed that at the time of mahazar himself CW2 and police were present. The police have drawn the Mahazar, but he do not know the name of police. He denied that, he is not present at the time of drawing of Spot Panchanama and he

signed on the Ex.P1 at Police station. In the cross-examination of the Accused No.2, he admits that, he himself and the C.w.7 were doing tailoring work and at the time of Panchanama, the dead-body was not present in the hospital. He denied that, himself and the C.w.7 in order to grab the money from the accused No1. they blackmailed and filed this false complaint. He is from Aurad. He admits that, the accused No.3 is running medical shop inside the hospital. He denied that, in order to help the C.w.1, he is deposing false evidence. The evidence of PW.1 is sufficient to prove the spot mahazar in accordance with law.

13. Let me take the evidence of the P.W.2 , who is the complainant and brother of deceased Sampavathi, he deposed that, his sister Sampavathi got married about 30 years back with C.w.7 Ghaleppa. They had two children. She had uterus problem for that she was taking treatment in the hospital of 1st Accused. On 12-10-2014 at about 1 p.m, his sister went by walk to the accused No.1 hospital for leproscopic operation along with himself CW 7 to 10 and admitted her. The Doctors told him that they would conduct operation at about 4-00 p.m and they demanded

Rs.25,000/- treatment charges out of Rs.25,000/- Rs.10,000/- was received as advance from him, but they have not given receipt. Further deposed that accused No.1 to 3 taken the deceased Sampavathi to the operation theater at about 4 p.m.. thereafter accused No 1 and 3 came out side the OT at about 7.p.m, and stated that the water is filled inside the lungs of Sampavathi BP also come down and it is not possible to conduct leproscopic operation and they have to conduct open surgery for that they have to call other doctors and you have to pay additional fee of Rs. 5000/-, as he paid Rs.5,000/- and also took the medicines as per the prescriptions given by the doctor. Further deposed that at about 8 p.m. he went to inside the OT and saw that the Accused No.1 sitting and the body of the Sampavathi having blood stained when accused No.3 came and sent them to out side. On enquiry they have not stated the health condition of Sampavathi. and till 9.45 accused No1 not sent other doctors from OT. Thereafter accused have taken the Sampavathi on strutter and shifted body to the accused No4 hospital in a private ambulance saying that Sampavathi health condition is very serious and they have not having

ventilator and ICU facility. When they reached accused No.4 hospital where accused No4 stated him that Sampavathi health condition is very serious as they has to the assistance of expert doctors from Yeshoda Hospital Hyderabad and also called, the doctors of Yashodha Hospital came on 13-10-2014 at about 2 a.m., to Shree Hospital and examined Sampavathi and they told them that Sampavathi is dead many hours back and they collected Rs.12,000/- fees. Further deposed that till 5.00 a.m., he bring the medicines as per the prescriptions of accused No.4. Thereafter the accused No.4 declared death of Sampavathi at about 5 a.m.. He stated that the accused No.4 knowing fully well that the Sampavathi died in the hospital of accused No1 in order to save them and to grab money from the complainant he intentionally declared the death at about 5.a.m. He deposed that the accuse No1 to 3 have made gross negligence during leproscopic operation by making holes on the stomach and not properly sutured due to which blood filled on the lungs as result she died in the hospital. In this regard he lodged complaint against accused No1 to 4. He identified his signature on complaint at Ex.P2. Further deposed that on

the same day, at about 4 p.m, Police came to the hospital, and in the presence of C.w.2 and 3 they have conducted the spot panchanama and he also given the further statement on 14-10-2014 and he identified the Accused No.1 to 4 before the court.

14. This witness has been cross-examined by the counsel for the accused in length, but nothing has been elicited form his mouth to show that his evidence is not trust worthy and not reliable one. He deposed that since two years the deceased Sampavathi having leproscopic problem and she is taking treatment from the 1st Accused and this facts also known to her husband CW7. He pleads ignorance that, since two years, his sister got the leproscopic problem and she was taking treatment from the Accused No.1 once in two months. He denied that Samapavathy became serious as she was taken to the hospital. He admits that, in the complaint, he has not mentioned the name of the Accused No.2, he denied that, by colluding Police have created the medical documents. He admits that, at the time of operation, the doctors have taken the patient inside the operation theater. He admits that, at the time of the

Panchanama, the Police have not seized any articles inside the operation theater. He denied that, the Mallkarjun Kamashetty, Yogesh Kamashetty have conducted the operation and the accused No.1 was not present at the time of operation. He admits that he has not mentioned the name of accused No.2 in his further statement. He admits that CW.2, 7 to 13 are present at the time operation. He denied that, in order to claim compensation before the consumer forum, they have filed a false complaint against the accused persons.

15. He also denied that, he is deposing false since the accused No.1 not did the operation of deceased Sampavathi. He pleads ignorance that, before two years back, his sister suffering from leproscopic disease and his brother -in-law not stated that, he is showing his sister in the hospital of 1st Accused since two years. He admits that, before conducting operation, he has obtained the consent from the husband of the deceased and he also attested the signature on the consent form and he saw the patient in outside the hospital and he has not heard or seen in the operation theater. After complaint, the Police taken the dead-body from the Shree

Hospital. The Biradar Hspital situate at Navadgeri and the house of Saibanna is situate adjacent to the hospital and he admits that his signature is not found on the case sheet maintained by the Shushrut Nursing Home dated: 12-10-2014 and they taken the dead body at about 4 p.m. on 13-10-2014 in the Government Hospital prior to lodging of the complaint and he do not know what are the care taken by the doctors to safeguard the life of the deceased Sampavathi. He denied that, after the death of Sampavathi, he blackmailed the Accused No.1 to 4 and he has filed a false complaint and also he is demanding money from the doctors and he denied that, the Accused No.1 to 4 not shown any negligent act while operating the deceased Sampavathi and they are not responsible for the cause of death. He admits that accused No.1 alone conducted the operation of Sampavathi and she herself shifted the deceased to accused No4 hospital with the assistance of accused No3 saying that there is no facility of ventilator. He pleads ignorance that accused no 4 provided ventilator to deceased Sampavathi. He admits that accused No.4 examined Sampavathi and stated the health condition of

Sampavathi is critical one to him, after that, the death of Sampavathi was declared at about 5 a.m. He denied that accused No.4 has made maximum effort to save the life of Sampavathi. On perusal of the evidence of PW.2 it crystal clear that, the deceased Sampavathi having leproscopic problem since 2 years and she was taking treatment from accused No1 and the deceased was admitted on 12-10-2014 for operation as per the say of accused No1 and she did operation with the assistance of accused No.3 by taking consent from the husband of the deceased. It is not in dispute that accused No.1 conducted surgery with the assistance of accused No,2 and 3 and during the time of surgery she died due to pulmonary oedema. The counsel for the accused taken defense that the CW.1 has with an intention to grab the money form the accused he filed false complaint against them and he had special interest in this case, as the claim petition is pending in the Consumer Forum and hence the evidence of PW2 is not trustworthy. No doubt the doctors have made all efforts to save the life of the Samapavathi after complications and not at the initial stage. Hence, the evidence of PW.2 is avail to the case of the

prosecution to prove the negligent act of the Accused No.1 to 4.

16. Another witness by name Vijaykumar has been examined as PW.3, he deposed that, he know the CW.4 and also the deceased Sampavathi. On 13-10-2014 at about 11 p.m. the New Town Police have conducted the inquest panchanama at mortuary of Government Hospital, Bidar, where he found that, on the stomach of the dead-body of Sampavathy 2inches 4 holes and the Police have told him that, the said holes are made for the purpose conducting operation and in which there is a bleeding and he identified his signature as the same is marked at Ex.P3. In the cross examination, he admits that, he do not knows C.w.1 and he used to stitch the clothes once in a year in the shop of C.w.7. He himself went to the hospital and before Postmortem he has not visited the Biradar or Shree Hospital. As per the say of the police, he signed the Ex.P3. It is suggested that on the stomach of the deceased he found four holes and no other external injuries are found. The Police also seized the clothes and other things from the dead body and the Police have not recorded his statement. He admits in Column

No.13 of Inquest there is a recital that, one Dr.Rajashree Biradar and Kamashetty were operated the deceased Sampavathi and due to their negligent her death was occurred and some issue arises regarding doctors negligence, the deceased Sampavathi was died. The evidence of PW3 is quite clear that in his presence police drawn inquest of deceased Sampavathy and the accused have not sutured the holes after surgery as bleeding on the holes. Hence, the evidence of PW.3 is avail to the prosecution to prove the inquest panchanama.

17. Then the evidence of PW.4 Galeppa who is the husband of deceased Sampavathi, he deposed that, CW.1 is his brother-in-law, Cw.8 is mother-in-law, C.w.9 and 10 are his sister-in-laws. Before 30 years back he married with Sampavathi and through their marital life, they begotten two children. He further deposed that the deceased Sampavathi was having some periods problems as he is showing her in the Accused No.1 hospital and also providing treatment. On 05-09-2014, the Accused No.1 treated his wife after examination she gave some medicines and after that, the said problem was cured. After one month, again she was

taken to the Accused No.1 hospital where, the Accused No.1 opined that, she had uterus problem as she needs leproscopic operation if not done it dangers her life and at that time the accused No.1 was pregnant. He agreed for the operation and on 12-10-2014 he taken his wife by walk at about 1 p.m., to the hospital of accused No.1, later Cw.1, 8 to 10 are came to the hospital. The Accused No.1 agreed to operate the deceased at 4 p.m with the assistance of Vaijinath Biradar and Saibanna. The expenses for the operation she demanded Rs.25,000/- out of that, she has received Rs.10,000/- as advance, but she has not given any receipt. Thereafter, they shifted the deceased Sampavathi to the operation theater. He further deposed that, at about 7 p.m., the Accused No.1 and 3 came inside the O.T. and told that, it is not possible to conduct leproscopic surgery as the water filled inside the lungs and her B.P. was up and down hence they have to conduct open surgery as they has to taken expert doctor and they need Rs.5,000/- fee and obtained the same and also bring the medicines from the outside. She waited till 8 a.m. in front of operation theater but the doctor have not stated the health condition of

Sampavathi. Thereafter, himself and Vidyavathi went inside the operation theater where the Sampavathi body blood stained and on the stomach four holes found in which blood was coming. The Accused No.1 sitting by holding his hand on her head at that time, Accused No.3 came and sent them outside that OT till 9:45 p.m. the Accused No.1 to 3 have not called other doctors then they shifted Sampavathi on stretcher where he found the body of Sampavathi covered by cloth and her body was cold and she was not breathing. When he asked the Accused No.1 to 3 called them there is no ventilator facility in their hospital hence, they shifting to Shree Hospital and in private ambulance they shifted Sampavathi shifted to the hospital of Accused No.4. Where he admitted and on examination, he found the serious condition hence he called the doctors from Yashodha Hospital , Hyderabad. They came at about 2 a.m. on 13-10-2014 and examined the Sampavathi, they told that, the Sampavathi was died before some hours back and he received Rs.12,000/- and paid to the doctors of Yashodha Hospital. Thereafter, the Accused No.1 till 5 a.m. given treatment. When they demanded the health condition of

Sampavathi then they declared she was died and the Accused No.1 to 3 at the time of operation they cut the vain inside the stomach due to the bleeding water filled in the lungs the accused not sutured the holes due to the negligent act, the Sampavathi was died, then they shifted the body to the Accused No.1 hospital at about 7 a.m. on 13-10-2014. Thereafter, C.w.1 lodged complaint against the accused. The Police visited hospital and shifted the dead-body to the District Hospital, Bidar. In this regard, he has given statement before the Police. The prescription, Hematology Lab Report, Serology Lab Report, Chest X-ray Report, Sonographic Report, requisition slip and Sonographic film marked at Ex.P4 to P10.

18. This witness cross-examined by the Counsel for the accused in length , but nothing has been elicited from his mouth to show that, the Accused No.1 to 4 have conducted surgery with his consent and they made all attempts to save the life of Sampavathi. He admits that, the deceased Sampavathi was his second wife and since from one year, deceased having uterus problem. He denied that, at the time of admission to the hospital of 1st Accused, the

Sampavathi health condition was critical. He admits that, Biradar Hospital having good reputation in Bidar. He pleds ignorance that the family members of the accused No.1 are all doctors. He stated that before leproscopic operation the accused No.1 has examined the tests mentioned in Ex.P4 to 10 and he has not shown the said test reports and not taken any advise from the other doctors before conducting the operation of Sampavathi. He denied that, before conducting the operation, the Accused No.1 had obtained his consent for any problem is happened during the surgery, they are not responsible. Further deposed that when he saw inside the O.T, the Accused No.1 was operating the deceased Sampavathi in leproscopic machine. He admits that, the doctors have made all efforts to save the life of the Sampavathi in humanity ground and after that he has not given the complaint against accused before the Police Station. He admits that, he filed claim petition claiming damages of Rs.80,00,000/- against the accused persons before the Consumer Forum. He denied that in order to get compensation from the accused he deposing false evidence. He denied that, his wife not died on the fault of

the accused No.1 to 4 ans she died other complications. He deposed that, the accused No.1 hospital not having ventilator facility, due to which she died at the time of operation. He admits that, before operation, accused have told the health condition of Sampavathi and after obtaining consent and with signatures, they started operation. He stated that he has not accompanied with CW.1 at the time of lodging complaint and Police have not recorded his statement at that time. He admits that, since 1 ½ year his wife having menstrual cycle problem and the accused No.1 herself treating the deceased and at the time of operation, the accused No.1 was 8 months pregnant. On perusal of the evidence of PW.4, it is clear that, his wife was suffering from uterus problem and she was taken treatment for that at the hospital of Accused No.1 since 2 years. As the accused have conducted the leproscopic surgery of deceased Sampavathi by making hoes on the stomach and cut the main nerve not sutured due to which water filled inside the lungs and died complications of laproscope assisted vaginal hysterectomy. The effort to save the life of the deceased Sampavathi after complications is no way helps the accused to prove their

defence and the evidence of the PW4 is avail to the prosecution to prove the guilt of the accused persons.

19. Then comes to the evidence of P.w.5 Dr.Sunil who is the professor and H.O.D of Forensic Medicine, he deposed that, he obtained degree in MD Forensic Medicine. He deposed that, he conducted so many postmortem in his service. On 13-10-2014, at about 1.30 p.m. he received the dead-body of Sampavathi in respect of Crime No.315/2014 to conduct the postmortem examination. Himself and Dr.Sudheer Kumatekar, Dr. Hemalatha, Dr.Sunilkumar C.A. conducted the Postmortem between 1:30 p.m. to 2:30 p.m. On external examination he noticed body of female, well nourished and cold on body yellow printed Saree, green colour hospital gown. Rigor mortis generalized all over the body. Postmortem lividity seen on back except pressure points and fixed. We noticed external injuries they are

1. Surgical suture wound in at peri umbilicus region of size 2cms with one intact suture. On cutting the suture wound is cavity deep.

2. Surgical suture wound on right lumber region of size 2cms with one intact suture on cutting the suture wound is

cavity deep.

3. Surgical suture wound left lumber region of size 2cms with one intact suture on cutting the suture wound is cavity deep.

4. Surgical suture wound 3 cms below injury No.3 in left region of size 2cms with one intact and the other parts are intact.

20. So far as cause of death is concerned opinion is reserved till the chemical analysis and report of histo pathological examination. Accordingly, they have conducted the Postmortem and put their signatures and same was collected by the Police. Due to cut and partial cauterized infundibulo pelvic ligaments which is supplied by so many arteries and veins and also there is cutting of the cervix, in peritoneum area blood clots and fluid blood about 900 ml was collected. He identified his signature on Ex.P11 and the same is marked as Exp11(a). Thereafter he received Histopathology report on 03/03/2015, chemical analysis report on 23/02/2015 and opined that, the cause of death is Complications of Laproscope Assisted Vaginal Hysterectomy. The final report is marked at Ex.P12. He also identified the

case sheet, the same is marked at Ex.P13. As per his opinion, there is a evidence of Laproscope assisted vaginal Hysterectomy and the evidence of cut and partial cauterized infundibulo pelvice ligaments. Encircling sutures then peritoneum cavity shows presence of blood clots & fluid blood about 900ml. and both lungs are grossly congested and edematous because of this complications the patient was died.

21. In the cross examination he admits that he is only expert of forensic medicine and not OBGY and the rigor morties to indicate the determine the times sine death and on his examination he saw that the rigor morties generalized all over the body. 12 hours after the death for full rigor morties. Further he has not observed during postmortem the characteristics of pallar morties, algor morties and liver morties. Further deposed that he has not mentioned in the postmortem report the changes of the colour of the face of dead body and he has not mentioned age of Injury No.1 to 4 in the PME report. One of the complication is Laproscope assisted vaginal procedure. Air gas embolism is possible by air but not by blood clot. There should be source of entry of

the gas in the arteries then this phenomena may be possible and not completely block the blood flow to the lungs and no blood is clotted. He admits that in pulmonary air embolism the patient can be caused death. He denied that in pulmonary air embolism during laproscope procedure it is commonly cut the reproductive organs to purpose of removing the uterus through bleeding may be possible internal organs. He admits that the heart large blood vessels were intact He denied that in pulmonary edema and gas embolism the blood clot in the brain. He admits that while leproscopic surgery saline solutions used or administer through IV drip. He admits that fluid and blood is different and both are liquid forms. He denied that he has not made any effort to detect the carbon dioxide embolism in her heat while conducting PME and not opened the heart and there is no any injury or rapture to heart and large blood vessels. He denied that himself and CW14 to 16 have not conducted the PME. He denied that case sheet is mention in final opinion related to the OBGY witness voluntaries that it is related to the hospital where patient was admitted. He admits that on gone through the document

there is no excess ansthestic agent. Further deposed that rigor morties start to develop after 4 hours of the death and generalized all over the body up to 12 hours. From 12 hours to 24 hours to 36 hours after the death it start to pass off from head to foot with sighs of decomposition. While conducting the PME of Sampavathi rigor morties generalized all over the body. He denied that, it is mandatory sought the opinion from the Karnataka Medical Council Bengaluru and Medical Council of India give the final opinion. He admits that in PME column No.4 he has not exactly mentioned in peritoneum cavity presence of the blood clots and fluid blood and not sent the same to FSL. He admits that during laproscope surgery surgeon is used CO2 and anesthetic is used oxygen. He has not mentioned mesentery and omen tum adhesion and old operation or old injuries in PME. He admits that doctor cannot declare the death of the patient and in medical terminology death is brain death. He denied that, the deceased Sampavathi died due to air/gas embolism and admits that, she died due to acute pulmonary edematous because it is one of the complication and complication means as per medical

terminology the occurrence of two or more diseases in the same patient and one or more diseases concurrent with another diseases. He denied that he has given false report on the pressure of police and relative of deceased Sampavathi and given false evidence. He admits that any nature of injury or serious patient or any patient doctor will made efforts to save the life of patient and doctors will not show enmity towards he patient. He admits that any patient suffered disease of lesion or fibroid on the uterus and untreated for two years such patient condition is very critical and sensitive. Generally 4 holes are made during laproscope surgery and the whole are made with the help of port instrument and the whole size is 10 mm and 3 mm . He denied that due to increase of blood pressure at that time there is possibility of fluid accumulation in the lungs. He admits that to remove the uterus during hysterectomy surgery all ligaments are needed to be cut and as per PME one ligament is cut. In normally during vaginal delivery blood loss is 500 ml and during Cesarean section 1000 ml blood will be loss and during Cesarean hysterectomy surgery 1500 ml blood will be loss and he has

not mentioned specific complication of laproscope assisted vaginal hysterectomy in Ex.P12. This evidence of PW 5 is clear that the deceased Sampavathi was died due to Complications of Laproscope Assisted Vaginal Hysterectomy.

22. Then the evidence of PW.6 Dr. Shivakumar Shetkar, who is Medical Superintendent of BRIMS, he deposed that, on 11-08-2015, the Investigation Officer has given requisition, requesting him to give opinion about the death of deceased Samapavathi was occurred due to complication of laproscope assisted vaginal hysterectomy or not. After receiving the requisition, he endorsed and sent the details in this regard and on 27-08-2015. Again investigation officer has send the requisition along with 8 questions regarding the opinion about the death of Sampavathi along with PME, FSL and Case Sheet of Shushrut Nursing Home and Shree Hospital. After receiving the requisition on 06-01-2016 he formed the experts committee consisting of 5 doctors who are the members of the committee to conduct enquiry on 12-01-2016. After forming the committee he has issued the notice to Accused No.1 and 3 and the husband of deceased Sampavathi to attend before the committee on 12-01-2016.

The proceedings was held and both the parties have attended before the committee and thereafter the case was posted on 19-01-2016. He wrote a letter to the PSI NTP requesting them to grant some time to give opinion. Om 14-03-2016 he submitted the Confidential Report along with the expert committee opinion.

23. On 23-03-2016, against the investigation officer wrote a letter to give the opinion specifically. On 29-04-2016 he issued Final Opinion about the death of deceased Sampavathi and it was occurred due to complication of anesthesia and surgery and also given opinion that, both the anesthetists and surgery have struggled maximum effort to save the life. At the time of giving requisition, the investigation officer also submitted the documents and the same are marked Ex.P11 to 13 and Ex.D3. The opinion of the doctor is marked at Ex.P14. The letter given by the Accused No.4 is marked at Ex.P15. The opinion of the Dr.Kashinath Kamble is marked at Ex.P16. The opinion given by Dr.Uma Deshmukh is marked at Ex.P17. Dr.Madan Vaijinath's opinion is marked at Ex.P18. The Requisition given by the PSI NTPS is marked at Ex.P19. The letter

given by the PSI NTPS is marked at Ex.P20. The official Memorandum Dated: 06-01-2016 s marked at Ex.P21. The letter given by PSI Dated 12-1-2016 is marked at Ex.P22. The Proceedings held by superintendent of BRIMS is marked at Ex.P23. The Office Order is marked at Ex.P24. The confidential Letter Dated 14-03-2016 is marked at Ex.P25. The letter Dated 16-03-2012 is marked at Ex.P26. The official Memorandum Dated 18-04-2016 is marked at Ex.P27. The FSL Report is marked at Ex.P28. The specific opinion given by the Medical Committee members Dated 29-04-2016 is marked at Ex.P29. He has given forwarded documents to the New Town Police Station.

24. In the cross-examination of the counsel for the accused, he deposed that, he is expert in Skin and V.D. Subject. He received intimation from the I.O. on 11-08-2015 and where the I.O.has not mentioned the name of the accused and he has not registered the case. He admitted that, he has not communicate the same to the State Medical Council, Bengaluru or District Medical Council before giving final opinion. After gone through the FSL, P.M.E and Case Sheet of both the hospitals, the doctors have made sincere

effort and struggle to save the life of the deceased Sampavathi. In Ex.P29, the witness has admitted that, both the Anesthetists and Surgeon have struggled maximum to save the life. The same is marked at Ex.D6. He further submits that, adrenaline and dopamine drugs are used when patient is having low B.P. to stabilize the normal condition of B.P. It is further admitted that, there is no excessive anesthetic agent found in the document and before issuing the final opinion himself and the committee members have not visited the hospital of Accused No.1 and 2. The complication means" the occurrence of two or more deceases in the same patient and one more deceased concurrent with the another diseases.

25. Then the evidence of PW7 Dr. Madan Vaijinath, who is the member of the Committee. He deposed that, CW.18 has formed the committee to conduct the proceedings that, one Sampavathi has been operated and in Shushruth Nursing Home and that operation resulted into death due to the complications of surgery and anesthesia. The C.W.18 called him in his chamber orally and he went wherein discussion was held among the committee members with

regards to the death of Sampavathi. After one or two days itself C.w.8 has submitted the some copies to him. Thereafter the chairmen of the committee has again asked to attend the proceedings which will be held on 19-01-2016. On that day, he attended the meeting apart from the committee members, Dr.Tapse and Dr.Rajashree and Dr.V.B Biradar were present. After discussion, they asked the committee members to given opinion in writing. As per the direction of committee, the chairmen he has not given blood report and scanning report and physician opinion. He has gone through the case sheet of Susruta Hospital belonging to Sampavathi, Postmortem Report and V.B Biradars Separate notes and surgeon noted given to him. After gone through the opinion that, the cause of death due to bleeding in the peritoneal cavity and due to complication of laproscope assisted vaginal hysterectomy. He also saw the Ex.P11 Postmortem it shows that, there was injury to artery and vein which were not sutured or arrested bleeding will be there continuously unless the bleeding vessels cot or tied bleeding will be continued in the peritoneal cavity. Further, patient goes for complication thereby other complication

like lungs, kidney, heard and brain will be affected. In the present case, bleeding vessels are not cot bleeding continued some portion of the blood clots were found in peritoneal cavity. He has stated that during the operation surgeon has cut the infundibulo pelvic ligaments and cauterized accordingly to PME Report and then the surgeon was asked to stop the surgery for some time. It is stated that, the Anesthetists struggle later on the surgeon cervicovaginal incision was put and blood clots and blood have been evacuated, which was collected in peritoneal cavity. It means more amount of blood was collected in peritoneal cavity, blood have been evacuated from the peritoneal cavity through this cervicovaginal incision. If the blood was continuously causes, then multiple organs failure B.P. will come down respirition stops. Once, the bleeding starts respirition going to hampered because of that there will be collection of water in the lungs then heart is going to fail slowly and because of that kidney failure, brain will not work because of insufficiency of blood to these vital organs because of this patient is going to die, pulmonary oedema means collection of water and the part of blood contains in

the lungs. Further, he deposed that, before operation he advised to the patient as well as attendants as stated above. If the patient once decide to operate same thing what diagnosis. He further depose that, if they agree for operation then he advice for investigation of blood, ECG, what is required investigation for patient will be done. He take opinion of physician regarding fitness for surgery and also he take opinion of anesthesia and physician they thing blood transfussion is required or not he plan for it, if every thing goes fine, he will go for surgery. Further, in Ex.P5 to 7 Report is normal. Leproscop assisted vaginal hysterectomy except anesthesia and surgeons two minimum staff nurse and two OT attenders are required. In the cross-examination he admits that, he is not a leproscopo surgeon and he has not obtained certificate in laproscope Surgeon. He denies that, the main uterine artery was not cut. He admits that, the same was not mentioned in the PME Report with regards to the main uterine artery cut. He admits that, both the organs functions is different. In this case uterus is not removed it intact, and Dr.Sunil Tapse is not the member of committee, that the seal and signature of P.W.5 is

appeared in Ex.P18. He denied that, in order to help the complainant and say of Dr.Sunil Tapse, they have issued false opinion and he has given his opinion to the Chairmen of the committee in close cover. Ex.P13 to P-17 all are the copy of xerox. The Chemical Analysis Report and FSL Report are comes under the purview of pathology and PME is come under the purview of department for Forensic Science that, auscultation is action listening the sound from the heart and lungs, stethoscope is used to medical diagnosis for heart and lungs specially in auscultation and accumulation of fluid in lungs causes breathing problems. He admits that, crepetation heard on the both lungs it is sign of detoration of patient, under the detoration patient the air embolism or gas embolism occurs only heard and heart will arrest immediately patient will die. He denied that, testing the air embolism is only procedure to remove the heart and emmersion in to the water with care and caution observing the heart if bubbles is appeared, it is sign of air embolism. He admits that, the doctors struggled and made all the efforts to save the life of patient. In further cross-examination, he admits the the hospital in which the

operation will be taken, that hospital must have clean hospital, well equipped operation theater, well trained nurses or staffs and good intensive Care Unit. He has not mentioned any cause of death in his report. In Ex.P7 and 8 witness further stated that Ex.P5 is shown that his report is normal. It is not a serious case. But patient has to undergo operation to avoid the further complications of life and patient disease will be explained and consent will be taken from the patient if the patient is fully conscious if not patient husband or any other close relatives. He has not mentioned the cause of death in the report. He denied he is not competent to issue Final Report in Medico Legal Cases. He admits that the laproscope assisted vaginal hysterectomy will be performed maximum within one and one half hour.

26. Then the evidence of P.W.8 Dr.Uma Deshmukh She is one of the member of the committee she is working as in charge H.O.D OBG in BRIMS Bidar, since from 1996. She deposed that, she examined the case sheets of Shusrut and Shree Hospital in respect of deceased Sampavathi has given finding. The patient was admitted to Shusrut Hospital for fibroid uterus and her B.P was 140 to 19 and E.C.G was

normal. The Patient had developed intra operatively Acute pulmonary edema and then surgeon ask to stop the surgery, others help, patient was stabilized with resusciation but required ventilator for further stabilization and hence, shifted to Shri Hospital , where the patient was put on ventilator for time being patient was table upto 12 midnight , but patient started deteriorating and she was not able to maintain B.P. with all drugs and support the patient was declared dead at 5 a.m. on 13-10-2014. Pulmonary edema was the reason for post mortun finding for water in the lungs. The Accused No.1 who operated doctor and she is a qualified leproscopic surgeon. She has been trained at Akola Laproscopic Centre, Akola Maharashtra State. In this regard she has produced the Certificate as per Ex.P17. In her cross-examination, she admits that, the doctors have sincerely made efforts to save the life of deceased Sampavati and other doctors also they have called. This type of complication will happened during surgery and sudden table death can happen and which is undiagnosed, but the anesthetists tried to save the patient. She admits that, excessive anesthetist not found in the case Sheet. The

accute pulmonary odema two types-1 Cardiogenic and non cordiogenic due to pulmonary embolism obesity and using ocpiles. The laproscopic is a surgical procedure for diagnostic and therapeutic. The operative doctor pregnancy period is not mentioned in the Ex.P17.

27. Then the evidence of PW.9 Madappa, ASI, New Town Police, he deposed that, on 13-10-2014 at about 8:45 a.m. C.w.1 came and given written complaint, on received the same, he registered the Crime in Cr.No.315/2014 and preferred FIR and sent it to the Court and he went to the Susrut Nursing Home and shifted the dead-body to Biradar Hospital to Government Hospital Mortuary at about 10:30 a.m. and requested the CMO Dr.Sujatha to kept the dead body at mortuary and on the same day at about 11a.m. to 1 p.m in the present of C.w.4 to 6 he conducted the Inquest Panchanama and when he found that on the stomach 2' four holes found and then he handed over the dead-body to through PC.1080 for Postmortem. After postmortem, he handed over the dead-body to the relatives of deceased Sampavathi and on the same day, at about 4 p.m. to 5 p.m. he conducted the Spot Mahazar in the presence of C.W.2 and

3 at Shusrut Nursing Home and recorded the statement of C.W.7 to C.W.13 and C.W.2 and C.W.3 and on 14-10-2014 at about 8 p.m., he issued the notice to Dr.Rajashree to provide the treatment documents given to deceased Sampavathi and he received the same on 14-10-2014. The Accused No.1 appeared and given copy of bail order, the same ha been kept in the file and to further investigation he handed over the case records to C.W.25 and the FIR is marked at Ex.P30. The Requisition filed to Shri Sujatha marked at Ex.P31 and Postmortem requisition is marked at Ex.P32 and Requisition marked at Ex.P33 and police notice is marked at Ex.P34. This witness cross-examined by the counsel for the accused in length, wherein he stated that, in the Complaint and FIR, name of the accused No.2 mentioned as Kamashetty and he has not visited the hospital of accused No.4. The deceased Sampavathi died at Shree Hospital and he has not recorded the statement of witnesses at Shree Hospital and not recorded the statement of doctors at Hyderabad, who treated the deceased at the last time and he has not drawn mahazar at the time of receiving the case sheet of deceased Sampavathi. He denied that, at the time of death of

deceased Sampavathi, they registered the UDR as per Ex.P32 and 33 in Cr.No.15 he has not taken the signature of doctors of BRIMS Hospital, at the time of Inquest Panchanama. He denied that, the relative of deceased Sampavathi has taken the body to their home as natural death in order to claim compensation from the Accused No.1, the relative of the deceased kept the dead-body in the Hospital of Accused No.1 and thereafter, he went to the hospital and registered the case. He denied that, in order to help the C.W.1 to 7, he registered a false case and deposing false evidence. He admits in operation theater, he has not found any things at the time of conducting Spot Panchanama.

28. Then the evidence of P.W.10 Sangamesh Kunkeri examined and he deposed that, he has given anesthesia approximately, 40,000 surgery. He know the C.W.14 to 19 and C.W.21 to 23 and C.W.7 and he do not know C.W.1. Dr. Shivakumar Shetkar formed the committee to investigate the death of Smt. Sampavathi, who operated on 12-10-2014. He was the member of the expert committee. Based on case sheet, he has given his opinion. He has mentioned

that, they have examined the patient before the anesthesia but, actual certificate was not found in the case sheet. When anesthesia is given to the patient it is implied that, anesthesiologist has examined the patient and he identified the Ex.P29. This witness cross-examined by the counsel for the accused, wherein, he deposed that, he has not seen the dead-body of deceased Sampavathi and he has not treated the Sampavathi. He has given his opinion based on the documents given by Dr. Shivakumar Shetkar, Committee Chairman. He also mentioned that, the entire surgical team made efforts to save the life of deceased Sampavathi. There is no evidence of overdose of anesthesia in this case and Pre anesthesia evaluation was done before surgery and Dr.Vijaykumar Antappanavor given report stating that, the patient is fit for surgery. The C.V.S, C.N.S R.S and P.A are normal. H.B., platelet, serum creatinine, B.P., E.C.G are normal before conducting surgery. The surgical team followed the mandatory procedure. The gas embolism can occur during the laproscopic surgery. Injection lasix was given for pulmonary edema. Long duration surgery have more chances of gas embolism. The laproscopic surgery

can extent from one hour to four hour in most of the cases. He denied that, based upon false requisition he has given the false report and deposed false evidence.

29. Then the evidence of PW.11 Santosh L.T. by oversight PW.11 is typed as PW.10 in the deposition, who is the Investigation Officer, has deposed that, he has received the case records on 15-10-2014 from C.W.24 and verified the case records and received the PM Report and sent the Vishra to FSL to CHC 644 and received the FSL Report and wrote a letter to C.W.6 for the cause of death on 23-02-2015, 02-03-2015 and 06-03-2015 and also received the case sheet of Shree Hospital and written a letter to District Surgeon to give the report for cause of death, whether the Accused No.1 to 4 have committed any negligent act at the time of conducting operation. On 14-03-2016, he received the committee opinion and also received the Final Report from the Medical Superintendent on 29-04-2016. After completion of the investigation, he has filed the charge sheet. The F.S.L. Report at Ex.P35 , the Case Sheet is marked as Ex.P13. This witness cross-examined the learned counsel for the accused, wherein, he admitted the entire

suggestion posed to him. He admits that, in FIR and Complaint, there is no mention of Accused No.3 name. In his investigation, he has not found the Accused No.3 injected the deceased Sampavathi and the Accused No.3 has not committed any offence and the same was found in the complaint, further statement and eye-witness. He falsely implicated the Accused No.3 has been denied. In complaint and FIR, the Accused No.4 name is not found. The deceased Sampavathi was shifted on 12-10-2014 at about 9:45 p.m. due to there is no ventilation facility in the hospital of Accused No.1. One Dr.Rajashekhar Patil provided the ventilator facility to deceased Sampavathi and the said Dr.Rajshekhar Patil stated that the Complainant and C.W.7 to call the Hyderabad doctor for further treatment. The said doctor came and treated her from 2 a.m. to 2:30 a.m. at Shree Hospital on the same day. After examination, he declared that the patient condition is very serious and he left the patient in Shree Hospital and he has not recorded the statement of said doctor. On 13-10-2014 at about 5 a.m. the said Sampavathi has died as mentioned in the case sheet as per Ex.P13.

The accused No.3 himself examined as DW.1 and he deposed that he is running medical and general store at Shusrut Nursing Home Complex since 20 years. There is no relation to this case. Intentionally he is implicated in this case. He produced License , Registration Certificate and Ownership Certificate at Ex.D-1 to D-3. Perused already by confrontation . Ex.D-1 to D-5 already marked on behalf of the accused at the time of cross-examination. Hence, the Ex.D-1 to 3 have been corrected as Ex.D-6 to 8 instead of Ex.D-1 to D-3. This witness cross-examined, wherein he stated that, he is residing at Ujani village, Aurad Taluk before this case as he do now know C.W.1 and 7 and there is no personal enmity himself and them. He denied that, at the time of operation of deceased Sampavathi, he was present inside the operation theater and assisted the doctors. The evidence of D.W.1 and documents produced, it shows that, he is not a doctor and he is running medical store in the hospital of Accused No.1. But, the evidence of P.W.1 and 4 clearly shows that, he was assisted accused No.1 and 3 at the time of operation of deceased Sampavathi in the operation theater. The said evidence of P.W.1 and 4 not at

all shaken by the Accused No.3 and hence, the evidence of D.W.1 no avail to him to prove his defence.

30. On perusal of the entire evidence of prosecution it appears that P.W.1 to 4 are the husband, brother and relative of deceased. It is not disputed fact that, the deceased Sampavathi admitted to the hospital of accused No.1 for the purpose of laproscope operation and she went to the hospital by walk. It is undisputed fact that before conduct operation the accused No.1 examined all pre-operative tests and the said tests reports were normal. It is undisputed fact that the accused No1 and 3 have operated the deceased and the accused No1 to 3 shifted her to the accused No.4 hospital due to non availability of ventilator and she died due to complication of anesthesia and surgery.

31. The learned A.P.P. vehemently argued that, at the time of surgery, the hospital authority have no I.C.U, ventilator and oxygen facility and before conducting the surgery, the Accused No.1 to 3 should have obtained the certificate of patient by physician and also anesthesia department and got test the blood, X-ray, E.C.G. But in this case, the Accused No.1 to 3 have not followed the

procedures and also not obtained the physician certificate and anesthesia fitness certificate before conducting the surgery. Except Ex.D3, they have not produced any necessary test reports. The evidence of PW.6 clearly discloses that, at the time of conducting the committee proceedings, the committee has issued the notice to the parties. The accused No.1 to 4 are not produced any documents before the committee. Hence, the Accused No.1 to 3 have not followed the pre-operation procedures and hence this act is negligence on the part of the Accused No.1 and 2. As per the Ex.D3, the Accused No.1 to 3 have admitted the deceased Sampavathi to the hospital of Accused No.4 at 9:45 p.m. on 12-10-2014 for ventilator support. This fact clearly goes to show that the Accused No.1's hospital had no ICU and ventilator facility. This is also one of the negligence on the part of the Accused No.1 to 3. The Accused No.1 to 3 have conducted a major surgery hysterectomy under general anesthesia without ensuring that life saving facility and the availability in their hospital and oxygen care facility in their hospital. The evidence PW.7 shows that, the Accused No.1 to 3 have commenced surgery

at 5 p.m and not completed till 9:45 p.m., it shows that, they time passed for four hours in operation theater. If the Accused No.1 to 3 have got no knowledge, then they would have called the other doctors and experts to the hospital of Accused No.1 for assistance. But, they have not done so. The evidence of PW.5 shows that, at the time of Postmortem examination, in Ex.P12, the cause of death is complication of Laproscope Assisted Veginal hysterectomy. After gone through the Postmortem Report, Inquest Report, Case sheets and FSL Report, the deceased Sampavath died due to complication of Laproscope Assisted Vaginal hysterectomy surgery. If the Accused No.1 to 3 by taking all precautions, they conducted the operation, the patient would have not died to the complication. So, it clearly goes to show that, the Accused committed gross negligence towards deceased Sampavathi. As per the evidence of PW.5, he come to the conclusion that, there is evidence of Laproscope Assisted Veginal hysterectomy and the evidence of cut and partial cauterized infundibulo pelvice ligaments, encircling sutures then peritoneum cavity shows the blood clots and fluid blood about 900 m.l. Both the lungs are grossly congested and

edematous because of this complications, the patient was died. This opinion of the PW.5 shows that, there is gross negligence on the part of the Accused No.1 to 3 for that reason, the deceased Sampavathi was died. The P.w.5 evidence also due to cut and partial cauterized infundibulo pelvic ligaments which is supplied by so many arteries and veins and also there is cutting of the cervix. This goes to show that, Accused No.1 to 3 while conducting the surgery negligently cauterized infundibulo pelvic ligaments as the blood of Sampavathi was lost. Further, P.W.5 evidence also discloses that, due to the problem created by the Accused No.1 to 3 in negligent manner while conducting the surgery. This clearly shows that, without taking any care in negligent manner cut of thereby, the deceased Sampavathi caused loss of blood committed. It clearly goes to show that, the Accused No.1 to 3 have committed gross negligence. In the evidence of P.w.7 shows that, he had gone to the case sheet of Accused No.1 hospital, P.M.Report and anesthesia report, he has given opinion of the cause of death due to bleeding in the peritoneum cavity due to the complication of Laproscope Assisted Vaginal hysterectomy. He has also seen

the Ex.P11 P.M Report during the operation are arrested bleeding was and the said portion was not sutured or tied bleeding continued in the peritoneum cavity. there was injury to artery and vein which were not sutured or arrested bleeding will be there continuously unless the bleeding vessels cot or tied bleeding will be continued in the peritoneal cavity. Further, patient goes for complication thereby other complication like lungs , kidney, heard and brain will be affected. There will be collection of water in the lungs then heart is going to fail slowly and because of that, cutting failure, the brain will not work and because of that reasons the patient is going to die.

32. Further argued that in the evidence of P.W.8 also due to the pulmonary oedema by filling the water to the longs, the patient was died. This means there was injury to artery and vein which were not sutured or arrested bleeding will be there continuously unless the bleeding vessels cot or tied bleeding is there continuously. It means due to negligence in cutting and arresting that artery blood was lost, thereby the water was filled in the lungs. It is held that, there is negligence on the part of the Accused No.1 to 3. On

perusal of the Ex.P29, the opinion of the committee goes to shows that, the death of deceased Sampavathi was occurred due to complication of anesthesia and surgery and in the said report also, there is a mentioned that, both anesthesia and surgeons have struggled maximum to save the life of patient. The Accused No.1 and 2 are not absolved from their negligence.

33. Further argued that in respect of Accused No.4 is concerned, he knowing fully well that, the death of Sampavathi occurred before 5:30 a.m. he made drama of because of disappearance of evidence is a negligent to help the Accused No.1 to 3 and thereby, he intentionally done the same and hence the provision of Sec.201 of IPC attracts for the negligence. The prosecution also argues that, the due to complication of laproscopic vaginal hysterectomy and also the death of deceased Sampavathi was occurred due to complication of anesthesia and surgery by contesting evidence of PW.5 to 7 and the Accused No.4 got admitted the deceased Sampavathi to his hospital at 10 a.m. on 12-10-2014. The doctors of Yashodha Hospital, Hyderbad came to the hospital of Accused No.4 and at about 2 a.m. on 13-

10-2014. As per the Postmortem Report at Ex.P11 and evidence of Pw.5, the death of deceased was occurred 12 to 24 hours prior to Postmortem. The Postmortem was conducted by the P.W.5 at 1:30 p.m. to 2:30 p.m. The death of deceased Sampavathi has occurred at about 1:30 a.m. on 13-10-2014 i.e., before arrival of doctors from Yashodha Hospital, Hyderabad. The Accused have taken the defence that, the doctors have conducted the operation carefully and the deceased Sampavathi died due to some other disease. If deceased Sampavathi died due to some other reason, then there is no leproscopic vaginal hysterectomy. P.w.1 to 4 and their evidence is corroborated each other. If the deceased Sampavathi was died due to some other disease, definitely, the accused would have lead cogent evidence as per Sec.106 of Evidence Act. The husband of the deceased was present at the time of operation. He also stated that, the Accused No.1 to 3 have taken the deceased Sampavathi to the operation theater and how much time they took and not calling the other specialists doctor then the accused No.1 to 3 have getting complication while conducting operation and also the Accused No.4 had given treatment to the dead-body

of deceased Sampavathi. Even the doctor helped in order to rescue the Accused No.1 to 3 to cause disappearance and the evidence of Pw.1 to 4 also proves that, the Accused No.2 was present at time of of operation and he was assisting the Accused No.1 and 3 by calling the OT doctor and also arrival of the doctor of Hyderabad in conducting the operation. The P.W.1 and 3 are the pancha witnesses of Spot and Inquest they also support the prosecution case. It is well settled laws that the prosecution should not stick on to the statement recorded, he may elicit some importance through the witness in order proper disposal of the case and to assist the Court to come the conclusion that, it is just and proper decision. On these grounds, he prayed for conviction of Accused No.1 to 4 in accordance with law.

34. The counsel for the accused No.1 argued about the maintenance of the hospital and also argued that, Sec 304-A has to be proved, when it comes to the medical negligence, the prosecution has to prove the gross negligence and the recklessness as mentioned in the land mark judgments and precedents set by the Hon'ble Supreme Court of India. The prosecution is in confusion between the

complications and the alleged negligence that is gross and recklessness, which are the main ingredients. The prosecution has to establish beyond all reasonable doubt, the complication were the result of the alleged gross negligence and recklessness. The accused No.2 is a prosecution calling any anesthesia is seeking help and opinion of the specialists and due to care in the interest of the patient. This goes to how that, the sufficient care and precautions was taken by the Accused No.1 which is corroborated by the opinion of the expert committee report on the cause of death as per Ex.P16 to18. The case sheet of both hospital and the opinion of the expert committee, FSL Report are going to show that, there is no any negligence or where the accused have proved the line of treatment which was not questioned challenged by the prosecution side. As per PW.8 in her cross-examination states that, the Accused No.1 is operated doctor and she is a qualified laproscopic surgeon, she has been trained at Akola Maharashtra State. She has seen the certificate of the same which proves that, she is competent and qualified doctor capable of exercising ordinary skills of Laproscopic assisted

surgery, like hysterectomy PW 8 in her evidence clearly stated above the requisite skill is processed by the accused No. 1 to perform the LAVH and the patient developed int-operatively acute pulmonary oedema and she was asked to stop surgery by accused No. 2 and another anesthetist. The prosecution has failed to prove that complication of pulmonary edema is not likely to occur during the surgery, which is most important fact and ingredient to prove the medical negligence. The evidence PW 5, 7 , 8 shows that there is a possibility of pulmonary embolism not only by partial curter of Infundibulo Pelvic Ligaments causing pulmonary edema, which may leads to heart failure. This could be the main reason of complication, leading death of the patient, not the negligence i.e., gross negligence. The prosecution has failed to prove the case beyond reasonable doubt that pulmonary edema caused by the Accused No. 1 . If at all, the said complication is not possible to occur during the performance of LAVH then the case of prosecution could have been believed. PW 5 admits that PM Report he has not mentioned which ligaments was cut, as per PM report only one ligament is cut and he is not sure of the specific cut

causing bleeding which leads to pulmonary edema complication. PW 5 further admits that in PM Report he has not mentioned which artery and vein supplied to the Infundibulo- Pelvic Ligaments are cut during the surgery, such cutting of ligaments to perform the surgery is so gross and recklessness amounting to gross negligence. The prosecution also failed to prove that the presence of blood about 900 ML Fluid, blood clot and blood (not exactly how much ml. Of blood) leads to the alleged complication and cause of death of patient. The prosecution also failed to prove that the accused No. 1 has caused to increase the risk of the patient while performing the surgery. The accused No.1 taken sufficient care and attention to reduced the risk of the patient on timely basis and stopped the surgery ad shifted for better are and management of the patient. The accused No. 1 hospital is having Manual Ventilator, for better care and attention, was shifted to the higher center for Mechanical Ventilator. The counsil for the accused further argued that to prove the negligence the IO has sought the Final Opinion for the Dist. Surgeon for cause of death. Who constituted an Expert committee of 6 members, the said

committee to commence the enquiry in to the said clarification committee Member submitted their individual opinion. The committee the given final opinion as per PW 29 where it appears there is no negligence on the part of the accused during the performance of the LAVH surgery and also shows how the accused have tried to save the deceased Sampavathi. Even the performance of LAVH and its complications were informed to the concerned and informed-consent was obtained expressly in Ex.D3 in good faith for the benefit of the deceased Sampavati to stop the vaginal bleeding, complication of pulmonary oedema which may be likely to occur/cause during surgery to the deceased Sampavathi who died due to the said complication, is not and offence committed by the accuse No. 1. Even PW.8 in her evidence stated that, the requisite skill is proceeded process by the Accused No.1 to perform LAVH and the decisions relied by the prosecution is not applicable to the facts and circumstances of the present case on hand the are related to civil liability, not criminal Liability. Further argued that for every death during medical treatment in medical in medical man can't be proceeded the against for the

punishment the courts were to impose criminal liability on the the hospital and doctors for everything that goes wrong, the doctors would be more worried about their own safety than giving all the best treatment to their patients. Hence the prosecution has failed to prove beyond reasonable doubt which specific complication was the reason or cause of alleged gross negligence during the LAVH surgery performed by the accused No. 1. Hence prayed to acquit the accused in accordance with law.

35. The counsel for the accused No. 4 argued that as per the request of the CW 1 and CW 7, the Accused 4 over Telephonic message/call informed the doctors of Yashodha Hospital Hyderabad regarding the patient condition and requested on behalf of Cw 7 at 11.00 PM on 12-10-2014. IN response to the Telephonic call of accused No. 4 the doctors team visited the Shree Hospital with Cardiac Ambulance around to 2:30 A.M on 13-10-2014, for shifting the patient to Hyderabad, the examined the patient and found the patient was in critical condition with unstable lacmodynamic parameter and refursed to shift the patient in their cardiac Ambulance to Yashodha Hospital Hyderabad, and advised to

maintained the patient with same treatment. The doctors of Shree Hospital by informing the patient condition to attainders and form and time to time and maintained the case sheet. Inspite of several efforts made by Accused No. 4 in coming out from the critical condition of the patient who was on the ventilation support patient health was not supported and lastly at 5:00 A.M death of Sampavathi was declared on 13-10-2014. And death is 12 to 24 hours prior to Post-Mortem the same as been admitted by the PW 5 the death might have occurred between 4 to 18 hours. PW 8 in his evidence stated that death is declared at 5.00 am on 13-10-2014 and the time shown in PME varies. Under the these circumstances the allegation as against Accused No. 4 regarding suppression of material fact death of Sampavathi much prior to PME 12 to 24 hours is not supported by the document evidence and the evidence adduce by the prosecution nowhere establishes the fact of is accused No. 1 supported the accused No. 1 to 3. Hence prayed to acquit him in accordance with law.

36. The counsel for the accused has relies the decision of Hon'ble Apex Court reported in **(2021) 10 is SCALE 350**

in the case of Dr. Harish Kumar Khurana V/S Joginder Singh and Others wherein held that, where the treatment is not successful or the patient dies during surgery, it cannot be automatically assumed that the medical professional was negligent-Indicate negligence there should be material available on record or else appropriate medical evidence should be tendered – Negligence alleged should be so glaring, in which event the principle of res ipsa loquitur could be made applicable and not based on perception. On bare reading of the cited decision due respect is not applicable to the facts and circumstances of the present case in hand and the same is delivered on different context.

37. On perusal of oral and documentary evidence produced by the prosecution it is clearly establishes the fact that the accused No 1 to 3 conducted laproscopic operation of deceased Sampavathi by making 4 holes on stomach there was injury to artery and vein which were not sutured bleeding will be there continuously in the peritoneal cavity due to which deceased Sampavathi condition goes for other complication like lungs, kidney, heard and brain will be affected. Moreover there will be collection of water in the

lungs then heart is going to fail slowly and because of that, cutting failure, the brain will not work and because of that reasons the Samapavathi was dead. The evidence also discloses that, the accused No1 to 3 conducted the surgery and accused No4 helped the accused No1 to 3 knowingly the accused No 1 to 3 have committed an offence, intentionally omits to give information to the husband and relatives of deceased Sampavathi which he is legally bound to give. To prove the negligence on the part of the accused No.1 to 4 the prosecution has to prove its case through medical evidence and not required the evidence of independent eyewitness in this case the prosecution by examining the PW5 to 8 and 10 proved that the accused No1 to 3 have operated the deceased Sampavathi in the hospital of accused No.1 and the documents at Ex.P11 PM Report corroborates the evidence of PW1 to 4 regrading the surgical suture wound in at peri umbilicus region, on right lamber region, left lamber region and below injury no.3 in left region size 2 cms of deceased Sampavathi and the evidence of PW7 also shows that the accused No.1 to 3 during operation they cut the infundibular pelvic ligaments

and cauterized, due to which blood was continuously bleeding and the water was collected in the lungs of Sampavathi. The accused No1 to 3 conducted surgery without having ventilator facility, due care and caution to ensure the critical life saving equipments as Sampavathi died. Therefore the prosecution has successfully proved the guilt of the accused No 1 to 4 beyond all reasonable doubt hat they have committed the offence punishable u/s.304[A], 202 r/w 34 of IPC. Therefore, prosecution has prove the negligence on the part of the accused No.1 to 3 and has prove the destruction of evidence on the part of the accused No.4 beyond all reasonable doubt and hence the benefit of doubt is not extended to the accused persons. Accordingly, I answer point Nos.1 and 2 are the **affirmative**.

Point No.3 :

38. In view of my above discussion and the reasons stated therein on Point Nos.1 and 2, I proceed to pass the following:

ORDER

Acting U/s. 255(2) of Cr.P.C. accused No.1 to 4 are hereby convicted for the offences punishable under Section 304-A and 202 r/w Se.34 of I.P.C .

The accused No.1 to 3 are hereby sentenced to under go S I for Two years and fine of Rs.10,000/-each for the offence punishable under Sec.304 A r/w 34 of IPC. In default of payment of fine they shall under go S.I. for six month.

The accused No.4 is hereby sentenced to under go S I for Six month and fine of Rs.5,000/-for the offence punishable under Sec.202 r/w 34 of IPC. In default of payment of fine he shall under go S.I. for One month.

Their bail bond and surety bond shall be in force for 6 months in view of amended provision under Sec.437(A) of Cr.P.C.

As required Under Sec. 363(1) of Cr.P.C office shall furnish copy of this judgment to the accused No.1 to 4 free of costs, forthwith.

(Dictated to Stenographer directly on computer, typed and computerized by him, corrected by me and then, pronounced by me in the open Court this the 3rd day of January 2022)**.**

(Abdul Khadar,)
2nd Addl. Senior Civil Judge & JMFC.
Bidar.

:A N N E X U R E:.

List of witnesses examined on behalf of Prosecution:

PW-1 : Veershetty S/o Basappa
PW-2 : Jagannath S/o Madeppa
PW-3 : Vijaykumar S/o Sharanappa
PW-4 : Ghaleppa S/o Veerabhadrappa
PW-5 : Dr.Sunil S/o Parshuram Tapse
PW-6 : Dr.Shivakumar S/o Dr. Gandhar Shetkar
PW-7 : Dr.Madana Vaijinath S/o Prabhanna
PW-8 : Dr.Uma Deshmukh S/o Baswaraj Deshmukh
PW-9 : Madappa S/o Shivappa
PW-10 : Dr.Sangamesh Kunkeri S/o Baburao
PW-11 : Santosh L.T. S/o Lingashetty

List of documents marked on behalf of Prosecution:

Ex.P1 : Spot panchanama.
Ex.P1(a) : Signature of P.w.1
Ex.P2 : Complaint

Ex.P2(a) : Signature of P.w.2
Ex.P-3 : Inquest Panchanama
Ex.P-3(a) : Signature of P.w.3
Ex.P-4 : Doctors Report
Ex.P-5 : Lab Diagnostic Report
Ex.P-6 : Lab Serology Report
Ex.P-7 : Chest X-ray Report
Ex.P-8 : Sonography
Ex.P-9 : Requisition Slip
Ex.P-10 : Ultra Sound Photo
Ex.P-11 : Doctors Report
Ex.P-12 : Final Opinion
Ex.P-13 : Shree Hospital Report
Ex.P-14 : Experts Opinion
Ex.P-15 : Document Dated 27-08-2015
Ex.P-16 : Document in Cr.No.315/2014
Ex.P-17 : Document Caves of due Report
Ex.P-18 : Report of Doctor.
Ex.P-19 : Requisition
Ex.P-19(a) : Signature of P.w.6
Ex.P-20 : Letter
Ex.P-20(a) : Signature of P.w.6
Ex.P-21 : Official Memorandum
Ex.P-21(a) : Signature of P.w.6
Ex.P-22 : Letter
Ex.P-22(a) : Signature of P.w.6
Ex.P-23 : Proceedings
Ex.P-23(a) : Signature of P.w.6
Ex.P-24 : Office Order
Ex.P-24(a) : Signature of P.w.6
Ex.P-25 : Confidential Letter
Ex.P-25(a) : Signature of P.w.6
Ex.P-26 : Letter
Ex.P-27 : Official Memorandum
Ex.P-27(a) & (b) : Signature of P.w.6
Ex.P-28 : FSL Report

Ex.P-29	: Specific Opinion
Ex.P-30	: FIR
Ex.P-30(a)	: Signature of P.w.9
Ex.P-31	: Requisition
Ex.P-32	: Inquest Panchanama
Ex.P-32(a)	: Signature of P.w.9
Ex.P-33	: Requisition
Ex.P-33(a)	: Signature of P.w.9
Ex.P-34	: Copy of Notce
Ex.P-34(a)	: Signature of P.w.9
Ex.P-35	: F.S.L Report

List of witnesses examined on behalf of Accused:

DW-1 : Saibanna S/o Manikappa

List of documents marked on behalf of Accused:

Ex.D-1	: Confronted portion of Complaint
Ex.D-2	: Confronted portion of FIR
Ex.D-3	:Case Sheet of Shushruta Nursing Home
Ex.D-4	: Confronted portion of Inquest (Ex.P-3)
Ex.D-5	: The portion of Excessive Bleeding mentioned in Ex.P-4.
Ex.D-6	: License
Ex.D-7	: Registration Certificate
Ex.D-8	: Ownership Certificate.

List of Material objects marked on behalf of Prosecution :

(**Abdul Khadar,**)
2nd Addl. Senior Civil Judge & JMFC
Bidar.

Judgment pronounced in the open Court,
vide separate order

ORDER

Acting U/s. 255(2) of Cr.P.C. accused No.1 to 4 are hereby convicted for the offences punishable under

Section 304-A and 202 r/w Se.34 of I.P.C .

The accused No.1 to 3 are hereby sentenced to under go S I for Two years and fine of Rs.10,000/-each for the offence punishable under Sec.304 A r/w 34 of IPC. In default of payment of fine they shall under go S.I. for six month.

The accused No.4 is hereby sentenced to under go S I for Six month and fine of Rs.5,000/-for the offence punishable under Sec.202 r/w 34 of IPC. In default of payment of fine he shall under go S.I. for One month.

Their bail bond and surety bond shall be in force for 6 months in view of amended provision under Sec.437(A) of Cr.P.C.

As required Under Sec. 363(1) of Cr.P.C office shall furnish copy of this judgment to the accused No.1 to 4 free of costs, forthwith.

2nd Addl. Senior Civil Judge & JMFC.
Bidar.