IN THE NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION AT NEW DELHI

CONSUMER COMPLAINT NO. 292 OF 2013
WITH
NC/IA/5358/2018
NC/IA/14854/2018
NC/IA/8229/2019
NC/IA/244/2020
(PLACING ADDL. DOCUMENTS, PLACING ADDL. DOCUMENTS, DIRECTIONS, MODIFICATION OF ORDER)

Mrs. Richa Navendu Shrivastava
403, Paradise Palace,
Plot No. 361/375,
Sector 6, Nerul West,
Navi Mumbai 400 706 ... Complainant

Versus

1. Dr. Sangram Karandikar,
Consultant Gastrointestinal and
Laparoscopic Surgeon,
Arihant Hospital at 101-B,
Sai Shraddha, Plot No. 312,
Near Nerul Police Stn., Sector 21,
Nerul, Navi Mumbai PIN 400706

Also having address at:
Hiranandani Fortis Hospital, Vashi,
Mini Seashore Road, Sector 10,
Navi Mumbai 400 703

2. The Medical Director,
Fortis Hiranandani Hospital,
Vashi, Mini Seashore Road, Sector 10,
Navi Mumbai 400 703

3. Dr. Ramesh Tikare,
Consultant Anesthesiologist
Hiranandani Fortis Hospital, Vashi,
Mini Seashore Road, Sector 10,
Navi Mumbai 400 703 ... Opposite Parties

BEFORE:
HON'BLE MR. JUSTICE A.P. SAHI, PRESIDENT
HON'BLE MR. BHARATKUMAR PANDYA, MEMBER

For the Complainant : Mr. K. G. Sharma, Advocate
Mr. Ritesh Khare, Advocate
Ms. Namrata Chandorkar, Advocate
Mr. Rajat Dabas, Advocate
Mr. Nikita Anand, Advocate
Mrs. Richa Navendu Shrivastava (In Person)

For the Opposite Party No. 2 : Mr. Sidharth Agarwal, Senior Advocate
Mr. Malika Chaudhuri, Advocate
Mr. Viswajeet, Advocate

For the Opposite Party No. 3 : Dr. G. N. Shenoy, Advocate

Pronounced on: 1st October, 2025

ORDER

HON'BLE MR. JUSTICE A. P. SAHI, PRESIDENT

1. The complainant has come up alleging medical negligence against the opposite party no. 1 – Gastro Consultant and Surgeon; the hospital, Fortis Hiranandani Hospital, opposite party no. 2 and Dr. Ramesh Tikare, Consultant Anaesthetist of the opposite party no. 2, hospital. The allegation is that late Navendu Srivastava had consulted the surgeon, the opposite party no. 1 herein on 05.12.2012 for a surgery of Piles. The patient was referred to the opposite party no. 2 hospital where the surgery was planned and for that the patient was admitted on 12.12.2012 as per the instructions of the opposite party no. 1. It is alleged by the complainant that even though the opposite party no. 1 was the main surgeon, who had to come to the hospital to attend on the patient yet the patient was attended by the R.M.O. of the opposite party no. 2, named, Sneha.

2. According to the complainant, the patient was admitted on 12.12.2012 at 12.30 p.m. in the afternoon when several documents were got signed and the surgery was scheduled at 3.00 p.m. The opposite party no. 3, Dr. Ramesh Tikare was the Consultant Anaesthetist.

3. The complainant was not taken to the operation theatre and on an inquiry, the complainant and the attendants were informed that due to non-availability of the operation theatre, the surgery would be delayed and would in all probability be performed in the evening. Since the patient had to be operated upon he was placed on absolute restriction of 'no meal by mouth', as a result whereof, the patient had to remain practically on fast.

4. According to the complainant, the non-availability of the operation theatre was because the hospital had lined up surgeries for delivery of children through caesarean as there was a heavy demand for conducting surgeries for delivery of children on that day because of the attractive date, that was 12.12.2012.

5. The contention of the complainant is that because of this choice of a fanciful date, by would be parents, the hospital catered the surgery services on priority to the mothers to be for delivery of their children on the said date, and this was the reason for the postponement of the surgery of the patient neglecting his urgent need while was kept on 'no meals by mouth' which status continued throughout the day. It is urged by the complainant that inspite of the fact that the complainant had been given the option of the surgery at 3.00 p.m., the patient remained on fast, and this aspect was completely neglected possibly for quick earnings through priorities extended to caesarean surgeries that generated revenue for the hospital.

6. The complainant contends that at around 4.15 p.m. the nurse attending on the patient injected a drip of an IV fluid, and securing the flow thereof, the nurse went away. Within 15 to 20 minutes of the administration of the IV

fluid, the patient started shivering, became uneasy and complained of abdomen pain and headache. His eyes turned red and the skin reddened all over and the patient started vomiting. He also passed some loose motion as well.

7. According to the complainant when the alarm was raised, the duty medical officer recorded an ECG and one Dr. Kate was called, who immediately instructed the administration of Avil, Injection Emeset, Inj. Tramadol, Injection Febrinil along with Injection Cort-S.

8. According to the complainant, the patient had vomited literally everything including water whereafter the opposite party no. 1 visited and examined him. The surgery was postponed till the next day but the patient remained critical and did not improve and the shivering and breathlessness continued and the patient was advised the administration of injection Perinorm.

9. According to the complainant, in spite of coordinating with the hospital staff, the consultants were not available and the opposite party no. 1 suggested the patient to be admitted in ICU. According to the complainant, the patient was shifted to the ICU at about 7.15 p.m. where also untrained nurses were managing the patient on telephonic instructions.

The allegation of the complainant is that this condition of the patient, which had become serious, was not appropriately assessed by the opposite party no. 1 and he failed to gauge the gravity of the situation. This lack of diagnosis led to a deteriorating condition but without any further treatment, the patient was continued without any feed and the surgery was postponed for the next morning.

10. The patient's condition, as recorded, indicated that he had fever 103^0 Fahrenheit and his respiratory rate was 36 per minute and inspite of this condition, the opposite party no. 1 did not visit the patient. At about 11.00

a.m. on 13.12.2012, the medical officer informed that the condition of the patient had worsened and he was kept under observations. The relatives of the patient were not allowed inside the ICU and they were informed that the patient was still sleeping and had been put on continuous cardiac monitor. Various pathological tests were conducted and the patient was advised to be put on ventilation. According to the complainant, they wanted to shift the patient to another hospital but the opposite party no. 1 stated that the patient was not in a condition to move. Further examination CT scan was delayed but by this time the fever continued and chest infection and pneumonia had developed. The patient had passed loose motions during the night of 13-14.12.2012 and on 14.12.2012 in the morning, the patient was put on ventilator. On 15.12.2012 a dialysis was planned but around 2.00 a.m. the patient died.

11. The complainant has charted out her allegations contending that the pre-operative evaluation was negligent and there was no indication about the fitness of the surgery that was planned. The surgery had been planned because of the stage of piles from which the complainant had been suffering but no informed consent was taken, as is required under law.

12. The complainant clearly alleged that keeping the patient fasting at the pre-operative level and postponing the surgery might have caused dehydration and hypothermia etc. and therefore, the pre-operative fasting time, according to the complainant, had a heavy toll as it was unnecessarily extended, even though the time for the surgery had been fixed at 3.00 p.m. It is urged that the protocol of keeping a patient fasting for longer duration of hours on the ground of non-availability of the operation theatre was a violation of the protocols and the hospital was involved in money making. In spite of this, the administration of the IV fluid caused the complications that arose out of gross carelessness and willful negligence.

13. On the basis of probabilities, it is also alleged by the complainant that the shivering and rigors in the body started immediately after the administration of the IV fluid and it is therefore, highly probable that the said IV fluid was contaminated that might have caused shivering and further complications.

14. The submission is that if patients are kept on fast far too long, problems of administering anesthesia does arise. Thus, according to the complainant, there was chaos and mismanagement that occurred immediately after the administration of the IV fluids and in the estimation of the complainant any other possibility was ruled out except that there was a serious reaction to the fluids on account of its contents and contaminates.

15. The patient was attended by Dr. Arvind Kate, Dr. V. V. Krishnan, the first one being a Pulmonologist and the second was a Physician in General Medicine. The complainant has come up with a case that neither any appropriate steps were taken nor the opposite parties followed the protocol and consequently, they were negligent. The complainant has relied on the affidavit of one Dr. Rajendra S. Bangal to urge that this opinion establishes in detail that the opposite parties had been careless in following the medical protocol on the following grounds.

> "a. The consent forms of the OP No. 2 hospital are neither patient specific nor procedure specific and as such are severely lacking in the parameters of an informed and intelligent consent, required for it to be valid in law.
>
> b. A thorough study of sequence of events in the entire episode in this case and perusal of the hospital documents clearly reveal complete lack of protocol for preparation of 'Operation Theatre list' and total in-coordination amongst the hospital administration, the

consultants and nursing staff in cases of either postponement or cancellation of scheduled surgeries.

c. The process of examining the patient pre-operatively by a physician for his fitness to undergo the surgery or by an anaesthetist to assess the patient's status was not carried out in a manner commensurate with the standard recommended guidelines in this regard.

d. The medical records reveal that the patient was kept fasting (Nil By Mouth) for almost 20 hours, as his scheduled surgery was postponed for non-availability of operation theatre. During the period, there was no attempt on the part of the hospital staff to make the patient aware of the potential complications associated with the prolonged NBM status including hypoglycaemia, increased protein breakdown, fluid and electrolyte imbalance etc. and their consequences. Even there is no evidence of any internal communication or liaising between the consultants and the nursing staff about:

i. The postponement of surgery

ii. Expected time of surgery.

iii. Revision of the decision to keep the patient NBM and to allow him oral intake.

iv. Orders to assess the patient's parameters for indication of complications of prolonged fasting.

e. A comprehensive view of this case reveals that the decisions that were taken about the postponement of surgery of the patient were not for the benefit of the patient, but to fit in with the operation theatre system. This surely amounts to deficiency in service.

f. The role of the primary surgeon or the consultant under whom the patient is admitted is very crucial in such situations. A well co-ordinated approach amongst various cadres of staff in the hospital, monitored by the primary consultant, would have definitely prevented this tragedy, which was basically triggered by prolonged fasting followed by its deleterious consequences."

16. As stated in the affidavit of Dr. Bangal in paragraph 7 onwards, which also recites that the report of the post mortem indicating infection of Laptospirosis has been found to be incorrect. Thus, the post mortem report cannot be relied upon nor can the story of Laptospirosis as also the cause of death be believed.

17. After issuance of notices in this complaint, the opposite parties appeared and the opposite party no. 1 and 3 have filed their response as well as evidence affidavit, on whose behalf, Dr. G. N. Shenoy has appeared and advanced his submissions.

18. The opposite party no. 2, namely, Forties Hiranandani Hospital could not file their written statement in time. This stands recorded in the ordersheet on 22.07.2014, which is extracted hereinunder:

"Counsel for the parties present.

OP-2 has not yet filed the reply. Counsel for OP-2 admits that they were served in the month of October, 2013. 45 days have already elapsed. **Consequently, we forfeit the right of filing the written statement.**

Opposite parties No. 1 & 3 have filed the written version with a delay of 25 days. The application for condonation of delay in filing the written version is filed.

Reply and arguments on 19.01.2015."

19. Thus, the opposite party no. 1 and 3 have filed their written version with a delay of 25 days, which was accepted by this Commission on imposition of Rs.25,000/- costs that has been recorded in the order dated 19.01.2015. The opposite party no. 2 therefore, lost their right to press any pleadings.

20. On 18.12.2015, review application no. 294 of 2015 filed by the opposite party no. 2 that was rejected holding that the opposite party no. 2 had not filed the reply within the period as prescribed under law and therefore, its right to file written version stood forfeited and the review petition was dismissed.

21. The opposite party no. 2 further made an attempt to file an affidavit of evidence. The said request was granted on 07.09.2016. However, on 06.12.2016, I.A. No. 11950 of 2016 was taken up clarifying that the opposite party no. 2 could not file any affidavit of evidence as their right to file written statement had already been closed. Accordingly, it was held that the affidavit evidence filed by the opposite party no. 2 shall not be read for the purpose of any defence on its behalf. The order dated 06.12.2016 clearly records the same.

22. The position, therefore, is that the opposite parties no. 1 and 3 have filed their reply and evidence but the right of the opposite parties no. 2 stands forfeited in the light of the order passed by this Commission as indicated above.

23. The matter was heard by the Commission on 27.08.2019, when the arguments were noted, and thereafter the Commission found it appropriate to obtain an expert medical opinion for which a reference was made to the All India Institute of Medical Sciences, New Delhi. The order dated 27.08.2019 is extracted hereinunder:

"Heard learned counsel from both sides.

The response of opposite parties no. 1 and no. 3 to the reply of the complainant to the additional documents filed by the opposite parties no. 1 and no. 3 is taken on record.

At this stage we do not deem it necessary that interrogatories to the complainants are required. The interrogatories filed by the opposite parties no.1 and no. 3 are not taken on record at this stage.

The complaint is of alleged medical negligence on the part of the opposite parties.
We deem it appropriate to obtain expert medical opinion on the basis of the entire material on record as on date (i.e. as on 27.08.2019).

We refer this matter to Director, All India Institute of Medical Sciences (AIIMS), New Delhi and request him to form a medical board of experts in the concerned specialties, and to send the board's opinion in sealed cover to this Commission within eight weeks of receipt of the entire material of this case.

Learned counsel for the complainant may kindly prepare a complete compilation of the entire material available on record as on date along with pagination and index within four weeks.

Learned counsel for the opposite parties have no objection.

The Registry is directed to provide the necessary facilitation to learned counsel for the complainant for this purpose.

The Registry is further directed to send the entire compilation to the Director, All India Institute of Medical Sciences (AIIMS), New Delhi by special messenger within one week of its preparation by learned counsel for the complainant, alongwith a copy of this Order.

The compilation so sent to the Director, All India Institute of Medical Sciences (AIIMS) may be attached with the case-file by the Registry.

List on 16.01.2020 at 2.00p.m. for further hearing."

24. The case could not be taken up thereafter and the Covid-19 intervened. Further during this period, All India Institute of Medical Sciences tendered its report on 21.12.2019 that was communicated to the Commission on 24.12.2019. After receipt of the report, learned counsel for the parties were given an opportunity for receiving the copies of the medical report from the All India Institute of Medical Sciences whereafter written arguments were invited. The case was heard after Covid on 13.09.2022 and orders were reserved but on 16.05.2023 it was directed that the matter requires further consideration on the issue of "Leptospirosis". The parties were given opportunity to file relevant literature on the subject in the background that the post mortem report indicated one of the symptoms of death due to 'Leptospirosis'.

25. As noted above, the All India Institute of Medical Sciences had given its report and consequently the matter was heard on 11.01.2024 when the following order was passed:

"**Dated : 11.01.2024**

ORDER

This complaint has been filed by the widow of Late Shri Navendu Shrivastava who was a 42 year old professional employed as a piping design manager in a multinational company in Mumbai. It is stated that he was also promoted as a senior manager and was drawing a comfortable salary. The Complainant has also a son who was studying in the 6th standard at the time of filing of the complaint.

In short, the deceased approached the Opposite Party No.1 for treatment of Piles. On 19.11.2012 the Opposite Party No.1, at Arihant Hospital, diagnosed him with **Grade 4 Prolapsed Haemorrhoids (Piles)**. Tests were advised whereafter he recommended surgery and further planned it for being performed at the Fortis Hiranandani Hospital on 12.12.2012. Accordingly, the deceased was admitted for surgery at 11:40 AM at Hiranandani Hospital with a surgery slot that was planned for 3:00 PM on the same day. According to the Complainant he was admitted with no abnormalities of any major diseases or otherwise and his parameters were found to be normal. However, according to the Complainant, no pre-anaesthesia or pre-operative check-ups as per surgery protocols were carried out and the deceased was shown lined up for surgery at 3:00 PM in the said Hospital.

According to the Complainant, since it was a fanciful date that is 12.12.2012, there was some sort of a rush for Cesarean Delivery Operations and according to the Complainant because of the Hospital trying to accommodate more of these patients, ignored the urgency of the deceased to be sent inside the Operation Theatre who in spite of having been admitted on the plan indicated by the Opposite Party No.1 could not be brought to the Operation Theatre and continued to remain in the ward. This information was being given to the Opposite Party No.1 and since the operation had to be carried out the deceased was not allowed any intake of food or water.

According to the Complainant, the deceased was subjected to intravenous administration of fluids which according to the Complainant was bereft of any medical advice and was

handled only by nurses and at about 3:00 PM as per the case sheet the deceased was found shivering after the infusion of the said fluids.

According to the Complainant, the doctor namely Opposite Party No.1 in spite of being informed did not attend to the patient himself and was conversing telephonically without any steps being taken in order to remedy the said situation which had arisen. Learned Counsel points out that redness on the body of the deceased started appearing and he became restless. The contention is that in spite of this no steps or any treatment was conducted till 5:00 PM whereafter the Complainant raised an alarm and the Resident Medical Officer (RMO) of the Hospital Dr. Kate issued instructions for administering certain injections. The patient had developed vomiting and he was unable to consume anything through his mouth. At this stage the case sheet indicates that the surgery was postponed for the next day.

The patient's condition did not improve and he developed breathlessness and was experiencing loose motions as well. At about 7 o'clock in the evening, the patient was shifted to the ICU when the Opposite Party No.1 came to examine him in the evening. By that time the patient had become critical with high fever. The Opposite Party No.1, however, did not visit him and the Complainant was informed that the condition of the patient had worsened, certain tests were to be carried out and by the next day on that is 13.12.2012 the situation had worsened.

Resultantly, there was no occasion for the surgery to be conducted for which he had been admitted in the hospital and

instead complications arose which according to the Complainant was on account of the drug or fluid infusion reaction for which no proper management or care was taken and ultimately, on 15.12.2012, he was declared dead at about 9:10 PM at night.

Learned Counsel informs that a complaint before the police was also lodged which was later on registered as an FIR in 2016. The post-mortem was conducted on 16.12.2012 and the report thereof recorded that the opinion as probable cause of death is reserved. The Histopathology Report in respect of the said post-mortem was obtained from J.J. Group Hospital, Mumbai dated 24.01.2013 and the Forensic Laboratory Report dated 26.02.2013 also arrived with an indication that the chemical test did not reveal presence of any poison. The final cause of death was opined by the General Hospital Post-Mortem Centre on 26.02.2013 indicating Pulmonary Embolism in a case of Leptospirosis with bleeding piles.

In the proceedings with regard to the complaint against the hospital and the doctor, a Medical Negligence Committee Report was furnished on 14.02.2014 where seven points were indicated and then it was opined that an opinion from an expert committee from J.J. Hospital be obtained. The experts committee of J.J. Hospital submitted a report on 02.04.2014. Pointing towards the said report learned Counsel urged that the said expert committee report has disparities inasmuch as Leptospirosis was again mentioned without there being any confirmatory tests carried out for the same.

Learned Counsel also submitted that the case sheet of the hospital incorrectly mentioned that the relatives had refused

investigations of chest X-Ray and ECG which has been noted at point no.3 but the same stands contradicted at point no.6 which indicates that X-ray and CT tests were done on 12.12.2012 and 13.12.2012. Learned Counsel submits that this endorsement in the case history sheet of the hospital that the relatives of the patient had refused to get the chest X-Ray and CT Scan carried out is incorrect.

Since the criminal complaint could not proceed without there being any expert opinion of the doctors the Directorate Of Medical Education And Research had been entrusted with this task in terms of the Government order dated 03.11.2015 and they submitted the report on 16.01.2016. Learned Counsel pointed out that the issues that prevailed upon the said committee were opined to be point no.2, 3, 9, 11 and 13 of the said report. However, the police Commissioner was not satisfied with the reasons given therein and he therefore wrote a letter to the Director for a clarification on the comments that were made in the report dated 16.07.2016. The said clarification and the reasons were provided through a confidential letter dated 14.06.2017 indicating the deficiencies and the negligence on the point of the hospital and the doctors.

During the pendency of this complaint, a report was also called for from the All India Institute of Medical Sciences which has also been read by the learned Counsel for the Complainant extensively and which records that the patient probably had an adverse reaction to the intravenous fluid which progressed on to septicaemia. However, the AIIMS report also recites that no clear count of deficit in

management can be ascertained against the hospital except administration of intravenous fluid causing adverse reaction. It has also been observed that no significant deviations in management from the current practices have been noted.

Learned Counsel invited the attention of the Bench to the summary of discussions dated 13.12.2012 recorded in the physician counselling form where it has been noted that the patient had severe septic shock. He therefore submits that the transfusion of intravenous fluid and the reaction is therefore to that extent admitted in the report by AIIMS and therefore this was a serious negligence that caused the death of the patient.

He has then invited the attention of the Bench to certain literature with regard to the norms for treating Leptospirosis and he submits that the laboratory report was only a presumptive diagnosis without any confirmatory diagnosis having been carried out. It has been vehemently urged that the contents of the intravenous fluid which was being administered and which came to be stopped as is evident from the case sheet on record was never sent for any examination nor any test carried out and in fact the entire evidence with regard to the indiscriminate administration of the fluid by unqualified paramedical staff without the directions of the concerned doctor resulted in utter chaos and mismanagement at the moment when the patient needed the best of attendance at the hospital. No steps were undertaken to get the contents of the intravenous fluids tested which was obviously not done and the evidence was destroyed. The same would have clearly established as to why the condition of the patient worsened on account of such administration and

he died even without getting the treatment of such surgery for which he had been admitted.

It is also urged that keeping the patient starving for almost 20 hours and no surgery having been performed in this careless atmosphere proves gross negligence on the part of the opposite parties.

Learned Counsel therefore submits that on various counts there is negligence that has already been pleaded on record and hence this complaint should be allowed and the relief prayed for be granted.

The arguments could not conclude today and the learned Senior Counsel for the Opposite party is to advance his submissions.

As agreed between the parties, list on 27.03.2024 at 02:00 PM."

26. The arguments on behalf of the complainant could not conclude on that date and therefore, the matter was again directed to come up on the date fixed and in between an application was moved for correcting certain dates and the arguments that was disposed of 13.03.2024 giving liberty to the learned counsel to reformulate the arguments and advance submissions accordingly. On 17.05.2024, Shri K. G. Sharma advanced his submissions and concluded the same, which is extracted hereinunder:

"**Dated : 17.05.2024**

ORDER

Mr. K.G. Sharma, learned counsel for the complainant, indicated certain facts to be noted, which, according to him, need a rectification in the narrative of the order dated 11.01.2024. He

points out that at internal page-2 of the order, the status of shivering of the deceased which was noticed at 5.00 p.m. was followed by the visit of the opposite party no.1 (Dr. Sangram Karandikar) at 6.00 p.m. and it is thereafter that he was shifted to the ICU at 7.00 p.m. He has also pointed out that the complaint categorically in para-8(c), (d) and (e) recites that the intravenous fluid seems to have been administered between 4.15 pm and 4.30 p.m.

He then submits that at page-3 of the order the sequence of the visit of the opposite party no.1 has to be taken at 6.00 p.m. and his shifting to the ICU at 7.00 p.m.

He has then advanced his submissions contending that the pleadings with regard to an alleged manipulated document endorsing the administration of fluids at 3.00 p.m. has been pleaded in the reply given by the complainant through the affidavit dated 27.06.2019 filed vide diary no.25686. He has invited the attention of the Bench to para-18 of the said affidavit. The contention therefore is that there has been some manipulation in the documents which is apparent according to him in view of the facts narrated above.

The submission further is that the hospital sheets indicate the arrival of the opposite party no.1 (Dr. Sangram Karandikar) at 6.00 p.m. when the surgeon did not attend at all till the next morning and Dr. Karandikar instructed that no meals should be given to the patient after 12.00 midnight as the surgery had been postponed for the next day.

The third submission is that the report dated 21.12.2019 given by the All India Institute of Medical Sciences clearly declares that no credibility can be given to the diagnosis of Leptospirosis, inasmuch

as no confirmatory test was carried out at all and therefore it remained only presumptive. The submission is that this has been clearly pleaded in the complaint itself and further such a conclusion that has been drawn in the post-mortem report is incorrect, inasmuch the concerned doctor who conducted the same could not have arrived at any such conclusive finding without there being any confirmatory report available, hence the conclusion drawn by the All India Institute of Sciences supports the allegation made by the complainant.

Further, Mr. Sharma invited the attention of the Bench to the affidavit of Dr. Rajendra S. Bangal, who, he submits, is an expert of Forensics & Toxicology and who in his affidavit dated 16.08.2013 which is on record categorically opines that the aforesaid diagnosis of Leptospirosis is an afterthought. He further submits that the said affidavit of Dr. Bangal has neither been contradicted nor rebutted by any evidence by the opposite parties.

It was pointed out that an additional document was filed on 21.05.2019 which was contradicted by the affidavit/reply of the complainant on 27.06.2019 as indicated above.

He concluded his arguments by submitting, that the fact that the operation theatre was not available was only an excuse and hence to take a plea that the operation theatre was not available does not seem to be compatible with medical protocols. When the complainant's husband was to be operated upon but due to unnecessary reversal of priorities he was again made to stay on no-meals overnight once again. The contention therefore is that it is on account of these deficiencies that the complainant's husband lost his life.

The arguments on behalf of the other side shall continue on the next date of hearing.

List on 27.08.2024 at 2.00 p.m. "

27. Due to one reason or the other, the case could not be finally heard and then the matter came up before this Bench on 08.11.2024 when Mr. Sidharth Aggarwal, learned counsel for the opposite party no. 2 advanced his submissions that stands recorded in the order, which is extracted hereinunder.

"**Dated : 08.11.2024**

ORDER

The arguments had been advanced on behalf of the complainant on 11.01.2024 and again on 17.05.2024 that have been recorded in the orders of the aforesaid dates.

This is how the matter was posted once again for hearing to commence today.

Mr. Sidharth Aggarwal, learned Senior Counsel for the opposite party no.2/Hospital, has commenced his arguments by pointing out towards the documents that have been compiled in a convenience compilation beginning from the advice given to the patient for being admitted into the hospital in order to conduct the surgery that was planned and was to be conducted on 12.12.2012. He has then proceeded with the nurses' notes and the progress sheets recorded by the attending doctors from the point of admission at 12.30 p.m. onwards. He has also read the consent form and then has also invited the attention of the Bench to the surgeries listed on 12.12.2012 to point out that they were not only Caesarean operations but also comprised of other surgeries that were to be

conducted on that day in the hospital. He urges that the attribution of prioritized services by the Hospital of surgeries to expectant mothers on that date as a special choice because of the date of 12.12.12, was a cause for holding up the patient due to non-availability of the operation theatre is a totally incorrect allegation as there all types of surgeries listed and performed on that day. The deceased had been allocated a slot in the morning and was accordingly advised to get himself admitted at 8.30 a.m. in the morning, but he, as per records, arrived for admission at about 11.39 a.m. The deceased patient after arrival at 11.30 a.m. was examined and admitted by which time it is pointed out that since the patient had not been taking meal by mouth, IV fluids were administered at 3.00 p.m. His contention is that the patient was not left to wait and starving on account of any delay caused by the Hospital as alleged, and accordingly with the IV fluids being administered, adequate steps had been taken in order to keep the patient stable.

He points out from the note sheets of the nurses and the doctors that the patient was stable and there were no other complaints. Accordingly at 4.00 p.m. a slip was sent for full diet because the surgery was postponed as the operation theatre was not available. From the nurses notes and the progress sheets of the doctors, he also points out that at 5.00 p.m. the patient complained of shivering and chest pain and accordingly the patient was immediately attended to with full response by the team of doctors attending on him, with a direction that the IV fluids should be stopped for an hour. The surgery was postponed and certain medicines, including Avil, were administered to the patient. Another team of the Pulmonology Department headed by Dr. Kate attended at 5.30 p.m. who also recorded the state of the patient indicating retrosternal

pain with no history of breathlessness and cough. However history of chills had been recorded. Accordingly certain medicines were advised that were administered and have been recorded in the referral notes of Dr. Kate. This further confirms attendance on the patient by the doctors required to take care of him.

He points out that the vitals of the patient have also been recorded which did not indicate any complications as such but the assessment was made and the response to the treatment found manifestation through the injections that were administered to the patient. He therefore submits that at every stage the patient had been attended to and as such the aforesaid documents do not reflect any negligence, much less a medical negligence.

At this stage, he has pointed out that as would be coming-forth, after he commences his arguments further, that in all probability the patient had suffered from leptospirosis which is a bacterial infection and the symptoms, the treatment and the diagnosis as well as the ultimate medical reports would confirm the same. He contends that the arguments on behalf of the complainant about there being no confirmatory report in this regard is an impossible argument which has been advanced as the test could not be performed keeping in view the fact that the patient passed away on 15.12.2012 itself.

The arguments could not conclude today. He prays for an adjournment.

As even otherwise no time is left to continue with the arguments, let the matter be listed on 23.01.2025 at 2.00 p.m."

28. The case was once again heard on 28.04.2025 when the following order was passed:

"**Dated: 28.04.2025**

ORDER

1. The arguments on behalf of the Complainant commenced on 11.01.2024 that have been recorded. Certain clarifications to conclude the arguments on behalf of the Complainant was allowed on 13.03.2024 and then the arguments on behalf of the Complainant led by Mr. K. G. Sharma were concluded on 17.05.2024, with liberty to the other side to proceed with arguments.

2. Mr. Sidharth Aggarwal, learned Senior Counsel advanced his submissions on 08.11.2024, which could not conclude and as such the matter was taken up today when Mr. Aggarwal concluded his arguments on behalf of the Opposite Party No. 2 Hospital.

3. He submitted that the chain of events needs to be recapitulated for which he invited the attention of the Bench to the recording on 12.12.2012 in the referral notes of the hospital at page no. 75 of the convenience compilation. He urged that it records that there was no history of breathlessness or cough or chills and there was some pain in the abdomen and uneasiness. He submitted that the vitals were noted and it was observed that the patient was tensed. The contention is that it was about 5.30pm, when the aforesaid symptoms were recorded that appropriate steps were taken and medicines were administered that have been noted in the said sheet.

4. At 7.15pm, the critical care assessment was carried out and the patient was shifted to the Intensive Care Unit as there was a sudden onset of pain in the abdomen and headache. He has further emphasized that the patient had passed stool twice since morning to point out that this was not a case where stool was passing very frequently as alleged on behalf of the Complainant. The temperature of the patient was recorded at 103^{o} and accordingly, the patient was recommended ECG, Chest X-ray and other tests including urine test

as well as Ultrasonography of the abdomen. An information was sent to Dr. Karandikar and Dr. V.V. Krishnan. An advice was given by Dr. Karandikar to conduct ECG, Chest X-ray, X-ray abdomen and urine test. Simultaneously, the required medicines were immediately advised and administered including Monocef which is an antibiotic, keeping in view the symptoms that were noted. All this is recorded in the progress sheet at page no. 37-38 of the compilation.

5. He has then invited the attention of the Bench to the recordings at 8.45 pm, indicating that the patient at present was comfortable and certain tests were suggested, whereafter at 11.50pm, fever was recorded at 101° and accordingly, another antibiotic injection Miacin was prescribed and administered. The contention is that continuous attendance and monitoring of the symptoms was being done and tests advised.

6. He has then proceeded to explain the progress notes dated 13.12.2012 at 9:40am, regarding chest heaviness and pain as the steps immediately and promptly taken after noting certain tests results as recorded at page no. 42, immediately thereafter at 10.00 am, it was recorded that a high coloured urine had passed and the skin was blanched giving a toxic look. The patient was anxious and the symptom of sepsis was recorded noting that the present condition of the patient was critical. The relatives and family members were informed and explained about the condition of the patient which stands recorded at page no. 43 of the compilation. This was followed by the examination by the team of doctors at about 10.50am that stands recorded at page no. 137 of the convenience compilation planning the possible line of action, keeping in view the patient's condition which was critical and who was in septic shock. Dr. Krishnan and Dr. Karandikar were also intimated

and advice was given for neck central line and arterial support with an SOS signal for ventilation support.

7. At 11.00am, the pulmonary team consisting of Dr. Ghosh and Dr. Kate reviewed the patient and recorded that he was in a poor condition, but was conscious and suggested the line of treatment as well as for providing mechanical ventilator support. This stands recorded at page no. 78 of the referral notes. At about 12.20 pm, the team of Dr. Krishnan and Dr. Sangram arrived and noted the patient's status of septic shock, advising the interventions that were immediately required with a broad spectrum antibiotic being administered. This stands recorded at page no. 138.

8. Simultaneously, the patient was also seen by Dr. Jugale, who noted the passage of dark urine and chest pain and apprehending any infection also advised a test for leptospirosis. This stands recorded at page no. 80 of the convenience compilation. The tests were therefore advised very promptly on 13.12.2012 itself to tackle any such symptoms. The blood samples were taken and dispatched, the blood report whereof was received on the next date on 14.12.2012. It may be noted that the blood samples for the tests had been taken at 5.00pm in the evening on 13.12.2012. This report is at page no. 13 of the convenience compilation and Mr. Aggarwal has explained the serum reading, indicating that the Leptospyra Igm serum was clearly indicated as high. The submission is that Igm reading reflects a recent first time infection and, therefore, has to be taken care of. There was, however, nothing alarming in the Igg serum count, which relates to any past exposure or old infection. He has then explained as to how antibodies are formed for developing immunity and, therefore, the appropriate tests were carried out. Pointing out towards the readings in the said report, he submits that since the Igg reading was only 3.7 and less than 5, therefore, it was

negative. On the other hand, the Igm count was exceptionally high at 31 which was above 20 and was, therefore, positive. He, therefore, submits that the apprehension about such an infection was promptly confirmed as is evident from the recording at page no. 80 and, therefore, all possible steps were promptly taken for an appropriate treatment according to medical protocols. There is no evidence of negligence at all in extending the appropriate treatment to the patient.

9. To buttress his submissions, he points out that at 11.00 am on 14.12.2012, even before the blood test report regarding leptospyra serum had arrived, treatments for leptospirosis had commenced by administering appropriate medicines at 11am, which stands recorded at page no. 53. He, therefore, submits that this apprehension which stood later on confirmed with the test reports had already been taken care of.

10. Mr. Aggarwal contends, that the contention of the Complainant that this was an unnecessary exercise undertaken, is therefore an argument against evidence on record to prejudice as if the doctors were unnecessarily treating the patient for leptospirosis.

11. Mr. Aggarwal then urged that this entire argument of an infected IV saline having been injected, causing shivering on account of the said administration is an absolutely unwarranted allegation in view of the symptoms having been recorded on 12.12.2012 and 13.12.2012. The shivering was taken care of by administering an injection and there was no evidence to indicate any ailment of infection or a contaminated bottle of saline being administered.

12. Mr. Aggarwal submits that the contention on behalf of the Complainant that there was no sample made available for testing the contents and quality of the saline is an argument in futility as the saline had already been administered inside the human body of the

patient and therefore, to ask for such a material which had already been injected is an unnecessary argument which has been advanced to create some prejudice as if the saline had caused some infection. He submits that there is no such evidence available nor are there any symptoms to administer the same. The entire allegation of the Complainant is as if the patient was unnecessarily being treated for leptospirosis when in fact his condition had deteriorated only after the administration of the IV fluid.

13. Mr. Aggarwal has invited the attention of the Bench and has also read the literature on leptospirosis at page no. 330 of the convenience compilation to urge that death can occur due to such an infection and its symptoms and treatments have also been indicated in the said authority that has been relied on by the Complainant herself. He, therefore, submits that the entire protocol was adopted and the symptoms and the diagnosis stands confirmed in view of the said literature that has been filed by the Complainant herself.

14. He has then urged that it would be appropriate to peruse the reports that have been made the basis of the contentions. He has read the post-mortem report, which is at page no. 286 of the compilation. It refers that the patient expired on 15.12.2012 at 9.10pm. The post mortem was conducted on 16.12.2012. The opinion as to the probable cause of death, the same was reserved. The forensic examination report did not reveal any poison. The final cause of death report was tendered on 26.02.2013, recording that death was caused on account of pulmonary embolism due to new pnenonia in case of leptospirosis with bleeding piles.

15. Next, the matter was examined by the medical negligence Committee on the letter of the Police Inspector and it was opined vide letter dated 14.02.2014 to obtain a report from an Expert

Committee from Sir J.J. Hospital, Mumbai as it was observed that there were contradictions in the post-mortem report and the indoor case papers. He then points out that in pursuance of the said recommendations, the next report is by the expert committee from Sir J.J. Hospital dated 02.04.2014, which is at page no. 299-300 of the compilation. He points out that after going through all the documents, the Committee which consisted of four Professors, opined that there is no act of negligence on the part of the treating doctors.

16. Not being satisfied with the said reports, the Complainant made a complaint before the Government of Maharashtra and a Committee was set up for inquiry into the exact cause of death of the patient. A letter also seems to have sent on 10.07.2014 by the Investigating Agency and the Committee was constituted to investigate into the matter vide Government Order dated 03.11.2015. The said letter is at page 301.

17. The factual report was tendered by the Directorate of Medical Education and Research, intimating that an objection had been taken regarding the appointment of Members by the Complainant and accordingly, the new committee was constituted that conducted the hearings. Mr. Aggarwal submits that 13 pointers were indicated out of which doubt was expressed on the functioning of the hospital regarding point no. 2, 3, 9, 11 and 13. He submits all generalized indications of doubt have been expressed and an abrupt conclusion has been drawn that there was negligence in the primary treatment given to the patient in view of point no. 2, 3, 9, 11 and 13. Mr. Aggarwal submits that it was not understood as to on what logic and basis had the said conclusion been drawn. The report was bereft of either any support from medical protocol or literature nor was it in any way a report worth the name, so as to conclude negligence.

This report dated 16.01.2016 is at page no. 305 of the convenience compilation.

18. He then submits that an addendum was sent on 14.06.2017, which is at page no. 321 of the paperbook which once again, formulates points and while answering point no. 2, it was indicated that the trouble was caused due to a normal saline drug infusion which may be treated as a medical accident and, therefore, the hospital administration is responsible on this count. He submits that all the opinions that have been expressed either at sr. no. 2 or at sr. no. 1 of the said addendum are bereft of any consideration or empirical assessment on the basis of medical protocols or literature and therefore, the addendum is equally without any substance.

19. This Commission, therefore, doubted the contents of these subsequent reports and then passed an Order on 27.08.2019 calling for an expert medical opinion from the All India Institute of Medical Sciences. In response thereto, the AIIMS has tendered a report dated 21.12.2019 that has been dispatched to this Commission vide a letter dated 24.12.2019 and is on record. He submits that the report of AIIMS clearly records that a multi-disciplinary approach for the management of the patient was undertaken. It has also been indicated that the patient was fasting and intravenous fluid was introduced that probably developed adverse fluid reaction that was managed accordingly. While recording investigations, it has observed that these symptoms had appeared after the starting of intravenous fluid and the investigation reports were suggestive of some infective process. It has, however, been categorically recorded that blood and urine culture and investigations for malaria and dengue were all negative.

20. Mr. Aggarwal has, however, countered the observations made regarding the process of infection of leptospyra and has urged that

this conclusion drawn by the AIIMS team is contrary to the literature and to the standard period of detection. Hence, to that extent, the report of AIIMS is medically incorrect. He further submits that the symptoms indicated in the post-mortem report having not been given credit are for reasons which were otherwise incorrect as indicated above. The conclusion with regard to a probability of adverse reaction to the infusion of intravenous fluid or any adverse reaction thereto is incorrect and against all pathological reports and other reports or the hospital records that are available. He, therefore, submits that post-mortem report and the report from the expert from the team of Sir J.J. Hospital reflects the correct status, whereas the report of the committee set up by the Government subsequently is bereft of the reasoning and is based on surmises. The report of AIIMS has been contested to the extent indicated above and it is urged that there is no evidence to indicate any infection through the administration of intravenous fluid or any contamination therein and in such circumstances, where there is no scientific or medical evidence to establish the cause of death due to administration of intravenous fluid, the entire contentions raised on behalf of the Complainant is without any basis.

21. To the contrary, the fact of leptospirosis infection having developed, leading to the death of the patient has been established from the record of the hospital, which deserves to be accepted as neither any deficiency in treatment nor any shortcoming in the taking of steps has been established, as such there is no reason to conclude much less any medical negligence against the Opposite Parties.

22. After the conclusion of the arguments by Mr. Aggarwal, Dr. G.N. Shenoy for the Opposite Parties Nos. 1 and 3 was requested to clarify as to whether there was any connect with the administration

of the intravenous fluids with any infection or with the infection of leptospirosis. He urged that he would be explaining the same in detail and would be advancing his submissions on the next date, but keeping in view the short time that was available to him, he pointed out that any infection that could have possibly occurred due to the administration of intravenous fluid on 12.12.2012, the same could have been reflected in the pathological reports, but fortunately in the present case, the blood culture test was undertaken when the samples were drawn on 13.12.2012 and sent for the microbiological assessment. The said culture report which does take time, arrived on 18.12.2012, which obviously was after the patient had passed away. Nonetheless, the said report had been filed by the Complainant herself at page no. 337 of the complaint and page no. 56 of the convenience compilation filed by him. With the aid of the said report, he points out that the entire culture report is negative which establishes that there was no blood infection or infection through the blood and as such, nothing happened on account of the infusion of the IV fluids. He submits that had there been any possibility of any adverse reaction due to any infection through the fluid, the same would have definitely reflected in the blood culture report that was carried out by M/s. Religare SRL Lab. The said report remains unchallenged and is rather part of the complaint itself. He, therefore, submits that this entire theory of any adverse infusion or reaction having caused the deterioration of the health of the patient due to infusion of IV fluid is baseless and without foundation. The blood culture report does not indicate any bacteria or laptospira having entered through the IV fluids. The laptospira Igm report indicates a high count already perused by the Commission and he submits that he will be explaining the diagnosis and the impact of the said report by the next date fixed. He has also made some ancillary submissions

but it would be appropriate that he is permitted to advance his elaborate submissions on the next date fixed.

23. Mr. K. G. Sharma, learned Counsel for the Complainant also prays that he may be granted time for rebuttal in rejoinder and, therefore, as agreed by learned Counsel for the Parties and keeping in view the overflowing docket of this Commission, let this matter be listed on 29.08.2025 at 2.00 pm."

29. Finally, the matter was heard on 29.08.2025 when Dr. Shenoy concluded his arguments by pointing out that the case of *Res Ipsa loquitur* as set up by the complainant is not made out inasmuch as the allegation of contaminated IV fluid is nowhere established by any evidence.

30. He has then urged that the affidavit of Dr. Bangal is incorrect inasmuch as the mentioning of Laptospirosis in the post mortem report coincided with blood report which is on record but at the same time, the blood culture report did not reflect any contamination and was negative for any infection.

31. The fever profile report was also received where malaria was not detected but the liver appeared to be deranged. He therefore submits that there was nothing in the diagnosis which was undertaken through the pathological reports to establish any contamination in the IV fluid as the blood report did not indicate the same. To the contrary, the later blood report indicates Leptospirosis as positive and which is ultimately confirmed in the post mortem report. He, therefore, submits that the same might have been a cause of death as recorded therein and it is during this period that an expert body had been formed of doctors of the J. J. Hospital, who tendered an expert committee report confirming the cause of death as indicated in the post mortem report, and further holding that there was no evidence of negligence on the part of the treating doctors. The said report dated 02.04.2014 is on record.

32. He then submits that another Government of Maharashtra investigation by a medical team along with a report had also been tendered where the conclusion drawn is that prima facie negligence was established on several counts referred to therein.

33. It is for this reason that when the matter came up before this Commission, it was thought proper, in view of conflicting medical opinions, to get an expert opinion from the All India Institute of Medical Sciences. The said report dated 21.12.2019 was rendered where it was opined that no clear count of deficiency in management can be ascertained except for the administration of the intravenous fluid causing adverse reaction. The issue of Leptospirosis was also discussed by All India Institute of Medical Sciences in its report and it received attention with an observation that Leptospirosis on an examination can be detected in a serum only in 4 to 5 days after the patient develops symptoms.

34. Learned counsel for the OPs contend that the symptoms therefore had developed prior to 12.12.2012 and therefore to conclude that leptospirosis infection had occurred during the stay at the hospital is not correct.

35. Learned counsel for the complainant urged that this theory of leptospirosis is a complete afterthought inasmuch as no such indication was given and therefore, the conclusion drawn on this count does not appear to be correct. The submission therefore on behalf of the complainant is that leptospirosis was not the cause of death and it was the theory developed later on which was also not believed by AIIMS.

36. The submission, therefore as advanced on behalf of the complainant clearly appears to be that the opposite parties have failed to establish the cause of death as Leptospirosis and therefore, there is no reason to believe either the post mortem report or any other report in this regard. It is also pointed out by Mr. Sharma that the entire communication tendered to the

doctors, who were conducting the post mortem nowhere indicates any information forwarded or doubt regarding leptospirosis and therefore, the occurrence of leptospirosis all of a sudden in the post mortem is surprising. It is for the said reason that he heavily relied on the affidavit of Dr. Bangal that has been filed on record.

37. Mr. Sharma also emphasized on the opinion as expressed by the team appointed by the Government of Maharashtra that has found the opposite parties to be negligent. He therefore, submits that the hospital did not take any care and instead was responsible for the administration of IV fluid that was contaminated.

38. On the other hand, Mr. Aggarwal learned senior counsel once again reiterated the earlier submissions and urged that the AIIMS report does not in any way indict the hospital and the opinion of the probability of the IV fluid being contaminated cannot be accepted.

39. Dr. Shenoy also contradicts this position that this is a mere probability expressed without therebeing any evidence as there is no material to demonstrate that the IV fluid was in any way adulterated or contaminated.

40. There is yet another argument on behalf of the complainant by Mr. Sharma that the blood report relied upon by the learned counsel for the complainant regarding culture is not confirmatory and was a presumptive report. No confirmation was carried out and the blood sample could have been sent for confirmation as well but no effort was taken and therefore the blood report relied on by the opposite party cannot be accepted. To this, Dr. Shenoy has urged that the confirmatory report was impossible to take inasmuch as the patient died the next very day. He submits that the symptoms for confirmation need a gap inasmuch as according to the medical literature and according to the report of the AIIMS as well, the symptoms of Leptospirosis occurs after 5 days or a week and in the instant case, the report

indicated leptospirosis which obviously must have been prior to the admission of the patient, who seems to have been already infected with it before being admitted.

41. Dr. Shenoy has further urged that the evidence of Dr. Bangal cannot be accepted as he is qualified only in a Forensic Science and has never treated any alive patient. He therefore, cannot be an expert on either the diagnosis or pathological analysis in respect of any such disease. The affidavit of Dr. Bangal has been criticized contending that his allegations are just speculative, and he not being an expert, the affidavit deserves rejection. Dr. Shenoy has relied on the judgment of the Hon'ble Supreme Court in the case of **Ramesh Chandra Agrawal vs. Regency Hospital Ltd. & Ors., Civil Appeal No. 5991 of 2022** and the order of this Commission in the case of **Smt. Shanta V. Gowda vs. M/s Kempegowda Institute of Medical Science and Anr., First Appeal No. 74 of 2005 decided on 11.09.2012** to urge that once the witness is not an expert of the filed his statement cannot be accepted and it has been further emphasized that Dr. Bangal, who is a forensic expert had never attended on the patient as such he could not have given any opinion regarding the same. The said expert opinion should therefore be rejected. He has also invited the attention of the bench to the decision of **Kusum Sharma & Ots. Vs. Batra Hospital and Medical Research Centre and Ors.** 2010 (3) SCC 480 that has been cited on behalf of the complainant to urge that the principles laid down and emerging in respect of the medical negligence as contained in paragraph 94 of the said judgment clearly protects doctors, who are not supposed to be hounded and he further submits that a criminal case was lodged against the opposite party no. 1, who is out on bail. The submission is that the principles laid down clearly indicate that the criminal process should not be used as a tool to pressurize medical professionals.

42. Mr. Aggarwal, who has appeared for the hospital, opposite party no. 2 has again pointed out that none of the ingredients regarding the allegations made are satisfied and no treatment was carried out so as to involve the Anaesthetist, the opposite party no. 3. He further submits that no surgery was conducted by opposite party no. 1 and it is in between that the patient unfortunately suffered infection in spite of the fact that due care was taken. Hence, there is no medical negligence at all. The claim of the opposite party is based on contradictions and hypothesis and leptospirosis seems to have been present in the latent form and did not occur in the hospital. He contends that there was neither any negligence nor is there any evidence of negligence in treatment and to the contrary the patient was effectively handled for which no negligence can be attributed to the hospital. All the grounds taken by the complainant are unavailable and in the absence of any negligence, the complaint deserves to be dismissed.

43. Mr. Sharma has vehemently urged that the arguments advanced on behalf of the opposite party no. 2 could not be taken into account as they have proceeded to deal with pleadings and evidence in spite of the fact that their right to file written submission had been forfeited and therefore, any amount of evidence cited by them cannot be read in support of their arguments.

44. Mr. Aggarwal, learned senior counsel has urged that all the arguments had been advanced on the basis of material placed by the complainant and the opposite parties no. 1 and 3. The opposite party no. 2 has not relied on any evidence filed by it and therefore, the contention of the learned counsel for the complainant that the opposite party no. 2 had relied on certain evidence or pleadings is incorrect.

45. Having heard learned counsel for the Parties and having considered the submissions raised, upon a perusal of the documents on record, it is evident that the deceased patient was admitted for a simple operation of bleeding

piles. It is also evident that the Patient had been requested to arrive in the morning of 12.12.2012 but he reached the hospital later on and was admitted at about 11.40 a.m. He was kept on "No Meals" and therefore, remained fasting as he was promised a surgery at about 3.00 p.m. This timing of the surgery stood extended which the Complainant alleges due to the change of priorities by the hospital in favour of the caesarean operations as opted by would be mothers on the peculiar date of 12.12.2012. This has been countered by the hospital to indicate that other surgeries had also been listed and it is wrong to allege that the priorities were shifted to accommodate the caesarean deliveries.

46. From a perusal of the list of surgeries maintained by the hospital, it cannot be said that all the caesarean operations had been shifted or rescheduled for being accommodated as there were other surgeries in the list as stands reflected therein. The fact however is that the patient was fasting and was kept on no meals and then was administered an Intra-venous (I.V.) Fluid. Even though there is some dispute about the timing of the administration of the fluid, the fact remains that after the fluid was administered and the patient developed complications of shivering and fever, the I.V. fluid was discontinued and certain injections were administered to the patient between 5.00 p.m. and 7.00 p.m. which indicates that complications had developed after the administration of the fluid to the deceased patient.

47. It is correct that there is no chemical or forensic or any other examination of the fluid that was administered so as to gather and construe the said fluid to be contaminated, but the reports of AIIMS dated 21.12.2019 recites that it cannot be ignored the symptoms had appeared after starting of the I.V. fluids but the report of AIIMS also records "however blood and urine cultures and investigations of Malaria and Dengue were all negative". Thus, while drawing conclusions, it has been observed that the patient probably had an adverse reaction to the I.V. fluids which progressed on to septicaemia and

therefore the possibility of aspiration (breathing by drawing one's own breath) at this juncture could not be ruled out. It was further concluded that "no clear count" of deficit in management could be ascertained except administration of I.V. Fluid causing adverse reaction. The cause of adverse reaction has not been confirmed nor is there any report pathological or otherwise to establish that there was negligence in the administration of the I.V.fluids so as to infer the same as a cause for adverse reaction. The adverse reaction could have been possibly for a variety of reasons but any infection being caused or the death being on account of adverse reaction of the fluids does not seem to be established. The report of Blood Culture, the sample whereof was drawn on 13.12.2012, dated 18.12.2012 does not indicate any symptom of an infection that could be inferred through the administration of the IV fluid.

48. The cause of death in the opinion of AIIMS was a Multi-organ failure and the post Mortem report records that the death was due to "Pulmonary Embolism with pneumonia in a case of Leptospirosis with bleeding Piles". Thus, the report of AIIMS even though there was an indication of Leptospirosis in the post mortem report, the same was discussed and observed that the Committee cannot give much credence in view of the discussions in the report. The report of AIIMS is extracted hereinunder :-

> *A medical Board was constituted by the Medical Superintendent, AIIMs on subject noted above the Board consists of the following members:*
>
> *1. Dr. Sunil Chumber* - *Chairperson*
> *Prof. Deptt. Of Surgery*
>
> *2. Dr. Millo Tabin* - *Member*
> *Prof. Deptt. Of Forensic Medicine*
>
> *3. Dr.Puneet Khanna* - *Member*
> *Assoc. Prof. Deptt. Of Anaesthesia*
>
> *4. Dr. R.K. Yadav* - *Member*
> *Assoc. Prof. Deptt. Of Nephrology*
>
> *5. Dr. Neeraj Nischal* - *Member*

Assoc. Prof. Deptt. Of Medicine

6. Dr. Nishant Verma - Member
Assoc. Prof. Deptt. Of Microbiology

7. Dr.Naveen R. Gowda - Member
Department of Hospital Administration

8. Dr. Ramkrishna Mondal - Member
Department of Hospital Administration

All the members of the medical board met on 24th October (Thursday), 31st October (Thursday), 7th November (Thursday), 13th December (Friday), 18th December (Wednesday) and 21st December (Saturday), 2019 at VIP Consultation Room No.13, MS Office Wing, ground floor, AIIMS, New Delhi. All the members of the board were present.

All the documents were examined thoroughly and in detail by every member of concerned specialties. The committee members after thorough discussion came to the conclusion as below

Introduction to the case:

The said gentleman, Mr. Navondu Shrivastava, aged 42 years, was admitted for elective operation of piles and was kept fasting ***However patient had to be kept fasting as the theatre was unavailable.***

As patient was fasting, he was started on intra-venous fluids due to which he probably developed adverse fluid reactions, which was managed accordingly.

The patient was shifted to ICU, subsequently went into sepsis and eventually had to be intubated and ventilated. Over the next two days he succumbed.

Clinical course:

The patient was admitted on 12/12/12 at 11:40 am for an elective surgery for piles. He was otherwise asymptomatic at the time of

admission, as per the records provided. ***The surgery of the patient was deferred for the day (clear reason not mentioned in the case records).*** *He was started intravenous fluids after admission as he was fasting since previous night.* ***The patient developed shivering, fever and other symptoms following that. The patient was managed for intravenous fluid related reactions and he was given Injection Avil at 5 pm.***

However, patient remained symptomatic. He was re-evaluated at 6 pm and was again given Injection Avil along with Injection Emset and Perinorm. Patient was shifted to ICU by 6:30 pm. and evaluated by critical care team at 7.15 pm and ***managed as a case of acute febrile Illness, started on intravenous antibiotics and anti-malarials. Appropriate investigations were also sent.*** *Patient's condition rapidly deteriorated and inotropes were started at 9:40 am on 13/12/12. The antibiotics were changed, however, condition continued to worsen further and the patient was intubated and put on mechanical ventilator on 14/12/12 at 8:15 am.*

A multi-disciplinary approach in the management of the patient was taken. However, the patient did not respond to all above treatment and was started on Hemodialysis (polymyxin filter) in view of severe sepsis and renal dysfunction and progressed to multi-organ failure. Patient had cardiac arrest at 8:30 pm and declared dead at 9:10 pm, on 15.12.2012.

Investigations.

As per the records available, the patient had no symptoms or signs suggestive of an infective process in the morning of the day of

admission (12.12.12), however, by evening, the patient became febrile, restless and his condition deteriorated alarmingly, so much so that he had to be transferred to the ICU it cannot be ignored that these symptoms had appeared after starting of intravenous fluid. ***While in the ICU, he was subjected to various investigations such as those related to Biochemistry, Hematology, Microbiology and Radiology. The reports were suggestive of some infective process, and the complications reflecting renal, hepatic or pulmonary involvement. However, blood and urine cultures, and investigations for malaria and dengue were all negative.***

Leptospira IgM was ordered and blood sample was drawn on 13.12.2012. The report was available on 14.12.2012 and was positive for Leptospira IgM antibodies. It may be noted that as per the current literature, Leptospira IgM may be detected in human serum only after 4-5 days after the patient develops symptoms and may remain positive for up to 1 year or more. In the present case, the patient became symptomatic in the evening of 12.12.2012 and a 'positive Leptospira IgM was detected in the blood sample collected on 13.12.2012, Le just 1 day after the appearance of signs/symptoms suggestive of some infectious process. Therefore, it is unlikely that this raised Leptospira IgM in this patient is due to a current Leptospira infection in this admission and was probably related to a past infection.

The autopsy report (P.M.No 97/AKS/12 dated 16/12/2012 from NMMC General Hospital post mortem centre, Vashi) showed that the cause of death is pulmonary embolism with pneumonia in a case of Leptospirosis with bleeding piles. ***However, entire***

committee feels that the diagnosis of leptospira cannot be given much credence in view of facts discussed earlier. *The Chemical examination report (Report no. M.(T).No. 3862-63/2013 dated 26/2/2013) mentions that general and specific chemical testing does not reveal any poison in exhibit Nos 1, 2, 3 & 4. The histopathology report (Report No. PSPM No. PS/20/2013 dated 29/01/2013) shows intra-alveolar haemorrhage and congestion in lungs. Liver shows micro vesicular frothy changes.*

Conclusions

1. This patient was admitted for an operation for piles. After admission, ***he probably had an adverse reaction to the intravenous fluid,*** *which progressed on to septicaemia. Also the possibility of aspiration at this juncture cannot be ruled out. He was managed by multiple specialties but succumbed to multi organ failure.*

2. On the basis of available records ***no clear count of deficit in management can be ascertained against the hospital except administration of intravenous fluid causing adverse reaction****. No significant deviations in management from the currently* ***acceptable practices have been noted in management of patient in the ICU setting.*** *In the ICU setting treatment guidelines may not be Godlines and need to be individualized.*

The reports of other committees were also perused during preparation of this report alongwith all clinical documents. The Committee had received a request, through Director, AIIMS, for personal communication from the Complainant, which due to constraints of time, we could not accede to.

49. The contention of the Learned Counsel for the Complainant is that Leptospirosis was introduced into the Post Mortem report for which there is no foundation. The contention of Dr. Shenoy on behalf of OP No.1 is that the indication of Leptospirosis in the pathological report that has emerged has to be read with its scientific context in the literature cited by him and the distinction drawn by him to understand the indication of the IgM level which was high and the IgG rating that was negative that indicated the symptoms may have occurred only after five days or a week and therefore, it would relate back prior to the date of admission in the hospital.

50. He submits that inspite all this, the doctor had started the treatment that was required for Leptospirosis and thus, there was no negligence. The contention of the Complainant is that if the Patient did not have Leptospirosis, then a wrong treatment was being given.

51. From a perusal of these facts and the reports on record, there was a symptom of Leptospirosis suspected on 13.12.2012 and the blood test reflected positive for Leptospirosis IgM antibodies which could not be confirmed by subsequent investigations as the patient died very soon leaving no time for any further confirmatory tests. The presence of the infection as was indicated in the pathological report, and explained by Dr.Shenoy, if there was a blood report indicating the same, then the Doctors cannot be said to be negligent and the OP-1 alongwith his team promptly treated the patient based on the said assessment which cannot be said to be a negligent assessment. Dr. Shenoy contends that even assuming for the sake of arguments, that not much credence can be given to the diagnosis of death due to Leptospirosis yet the doctors possessed of the requisite skill had taken due care to treat the patient of the disease with administration of broad spectrum antibiotics. Dr.Shenoy rightly contends that a diagnosis is made and a treatment offered on the basis of symptoms and pathological reports and therefore, the treatment for Leptospirosis cannot be said to have been wrongly undertaken

without any bonafide cause for the same. The Doctor had suspected the same and upon a perusal of the pathological report even before the blood report had arrived, had commenced the treatment which cannot be said to be negligence. The report of AIIMS highlighted above on this issue confirms the same.

52. It may be pointed out that Complainant has heavily relied on the opinion of one Dr. Rajendra S. Bangal. The said expert opinion has been contested by the Opposite Parties on the ground that he is a person engaged in legal practice of Forensic Medicine, Medical Jurisprudence & Toxicology and is therefore not an expert in respect of any treatment of the symptoms or disease that was involved herein. It is urged by Mr. Agarwal and by Dr. Shinoy learned Counsel for the Opposite Parties that Dr. Bangal as per his own disclosure is no expert of the subject matter presently involved and his field is not in relation to any practice or treatment of patients. His subject only relates to autopsies and post-mortems and legal practice in respect thereto. It is, therefore, submitted that the claim by him of an experienced hand on the subject is absolutely unacceptable as he has admittedly not treated any patient in his career for any of the diseases involved and for that the learned Counsel have heavily relied on the judgment of the Apex Court in case of Ramesh Chandra Agarwal and Smt. Shanta V. Gowda (supra). To that extent, we find ourselves in agreement with the arguments of the learned Counsel for the OPs in as much as Dr. Bangal cannot be considered to be an expert on the treatment undertaken by the patient, particularly Leptospirosis. Dr. Bangal has stated in paragraph 7(p) that the inclusion of the term Leptospirosis is an afterthought. For this he has stated that there is no reference of the same in the communications between the hospital, the police and the medical officer, who conducted

the autopsy. Mr. K.G. Sharma, learned Counsel for the Complainant also emphasised on this urging that Leptospirosis has emerged as a symptom suddenly without any diagnosis or confirmatory report and without any treatment and therefore, the post-mortem report cannot be relied on. Mr. Sharma also urges that the report of AIIMS dated 21.12.2019 also does not give any credit to this theory of the patient having died due to Leptospirosis. Mr. Sharma reiterated that there was no confirmatory report regarding the same and the blood report as well as the autopsy report are merely presumptory in nature.

53. To clear the factual foundation regarding the symptom and diagnosis of Leptospirosis, learned Counsel for the OPs urged that there were no early symptoms at the time of admission to apprehend any such complication but after the patient developed problems upon the infusion of IV fluids, this symptom of Leptospirosis was suspected promptly on 13.12.2012 after the tests of malaria and dengue were found to be negative. This stands recorded at 2-00 P.M. in the medical records when Dr. Ingale, Nephrologist advised investigation for Leptospirosis as well and the same day at 7-30 P.M. blood investigations were further advised noticing the fever spikes of the patient and the fluctuating count of PBS and CBC suggestive of sepsis. Thus, the symptomatic diagnosis had been made and broad spectrum anti-biotics were initiated which according to the learned Counsel for the OPs optimally covers such a treatment.

54. The fact remains that the pathological test with positive IgM that arrived in respect of the blood tests that were carried out indicates the same. With these facts, we are unable to accept the opinion of Dr. Bangal that the theory of Leptospirosis was an afterthought. The

hospital records and the treatment papers were communicated and was perused by the Complainant as well. This is evident from the opinion of the Medical Negligence/Carelessness Committee Report dated 14.02.2014 where the said committee observed contradictions between the post-mortem report and the indoor case papers and therefore, recommended Forensic Expert Committee's opinion from Sir J.J. Hospital, Mumbai. The said opinion is signed by Dr. Yogesh Sharma of the Rajeev Gandhi Medical College, who was Member of the said Committee. The recommendations/opinion is extracted herein below:

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MEDICAL NEGLIGENCE/ CARELESSNESS COMMITTEE REPORT

Date: 14/02/14

Subject. Regarding providing opinion (Deceased Shri. Navendu Rajendrakumar Shrivastava, Age: 42 years)

Reference: 1. Letter No. 7386 Dated 02/10/13 from Assistant Police Inspector, Vashi Police Station, Navi Mumbai.
2. Discussion and opinions expressed in a meeting organized for giving opinion in this matter.

In relation to the subject matter and the references mentioned hereinabove, a meeting of the committee appointed under the chairmanship of Civil Surgeon, Thane District, was held regarding providing of opinion on the treatment provided to deceased Navendu Rajendrakumar Shrivastava by Hiranandani Fortis Hosptial, Vashi.

After scrutiny of all the available documents by all the present committee members, various issues related to the documents were discussed.

In view of all the issues discussed as per the available documents, following issues were observed:

1. The medical records do not reveal any instructions given by the concerned experts before the surgery about the diagnosis of the patient, the nature of surgery and instructions about the 'Nil By Mouth' status.
2. Inspite of the surgery being a major surgery, the medical records do not indicate that investigations like ECG, X-ray were performed.
3. It is mentioned on the patient's document that, "Operation postponed due to non available of OT", however, what instructions were provided to the patient and what treatment was administered on 12/12/2012 during 12:00 to 05:00, is not reflected in the notes.
4. The clinical notes do not reveal that the patient was examined by any doctor during these five hours. Even when there is no mention of starting of saline (IV fluid), still the notes mention the orders to stop the saline (Stop IV fluid) at 5:00.
5. There is no evidence that the doctors have obtained in writing from the relatives that the patient has refused to undergo an ECG, X-ray, however the blood samples of the patients were repeatedly obtained. This is contradictory.
6. As per the postmortem report, even if the patient has died due to Pulmonary Embolism with Pneumonia in case of Leptospirosis with Bleeding Piles, still the expert committee feels that there is no evidence in the clinical notes of other symptoms and investigations carried out in support of this diagnosis. E.g. Pulse 78/M and RSBSBE at 5:30.
7. Similarly, disparities of various sorts are observed in the patient's case paper.

Opinion: Contradictions are observed in the patient's postmortem report and indoor case papers. Hence, opinion of an expert committee from Sir J. j. Hospital, Mumbai, should be obtained.

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-Sd-
Dr. Yogesh Sharma, Physician
Rajeev Gandhi Medical College,
Kalwa, Thane – Committee Member

-Sd-
Dr Vandana Kamawat, Professor
Rajeev Gandhi Medical College,
Kalwa, Thane - Committee Member

-Sd-
Dr SP Bobhatgaonkar, Associate Professor
Civil Hospital, Thane
Committee Member

-Sd-
Civil Surgeon
And Committee Chairman
District General Hospital, Thane

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55. Accordingly, the expert committee was constituted at the J.J. Hospital and the said medical report is extracted herein under:

J. J. Hosp Medical Board Report

13

EXPERT COMMITTEE REPORT

Subject: Expert Committee Report Regarding Alleged Medical Negligence about Death Of (Late) Mr. Navendu Srivastava by His Wife Mrs. Richa Srivastava,Nerul,Navi Mumbai

With respect to the above subject, deceased Sri Navendu Rajendra Kumar Srivastava was treated at Fortis Hospital Vashi from 12/12/2012 to 15/12/2012

The Expert Committee was formed under the Chairmanship of Dr Ajay H Bhandarwar for scrutiny & report by The Dean, GGMC& SIR JJ Hospitals, Mumbai on 24/3/2014.

The Committee has scrutinised all the case papers and related documents of the patient and has made the following observations:

1) Patient name Mr Navendu Rajendra Kumar Srivastava was admitted in Hiranandani Fortis Hospital, Vashi on 12/12/2012 at 11:40 a.m. with diagnosis of Hemorrhoids under the care of Dr Sangram Karandikar(General Surgery) for Hemorrhoidectomy operation planned in the evening of 12/12/2012.

2) Before surgery, he was given IV Fluid (DNS). Patient then developed shivering. Hence IV DNS was stopped and patient was given Inj Avil IV Stat.As patient was restless with high grade fever, abdominal pain and headache, he was shifted to Medicla Intensive Care Unit(MICU). He was investigated for the following:

WBC-2200,PT-17,INR-1.36,Plasma D-Dimer>8, Pro B-Type Natriuretic Peptide-6281pg/ml which was s/o Septicemia.His S.Creat-2.8 was also high for which Hemodialysis was given. Investigations for Malaria and Dengue were negative.

Leptospira IgM was positive s/o Leptospirosis as mentioned on Page 82of case file provided.

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3) Patient's Relatives had refused investigations of Chest X Ray and ECG. They allowed only blood investigations as on Page 4 of the case file.

4) In MICU patient deteriorated on 15/12/2012 and was resuscitated but finally succumbed to the illness and expired on 15/12/2012 at 9.10 p.m.

5) Final Cause of Death as per ML Post Mortem No.97/AKS/12 dt.16/12/2012 is Pulmonary Embolism with Pneumonia in a case of Leptospirosis with Bleeding Piles.

6) X-ray chest / CT chest done on 14/12/12 & 13/12/12 as per Page 66, 67 & 68

Conclusion:

The Expert Committee, after scrutinising all case papers & Post Mortem report concludes that deceased Mr Navendu Rajendra Kumar Srivastava was admitted at Hiranandani Fortis Hospital, Vashi , Navi Mumbai from 12/12/2012 to 15/12/2012 and expired on 15/12/2012 at 9.10 p.m.

Final Cause of Death of this patient as per ML Post Mortem No.97/AKS/12 dt.16/12/2012 is Pulmonary Embolism with Pneumonia in a case of Leptospirosis with Bleeding Piles.

There is no evidence of Negligence on the part of treating Doctors.

MUMBAI

02/04/2014.

Dr Ajay H Bhandarwar
Chairman, Expert Committee
Professor ,Dept Of General Surgery
GGMC & JJH, Mumbai .

Dr. Usha Badole 2/4/14
Member, Expert Committee
Professor ,Dept Of Anaesthesiology
GGMC & JJH, Mumbai .

Dr Shailesh Jadhav
Member, Expert Committee
Professor , Dept Of General Medicine
GGMC & JJH, Mumbai .

Dr B.D. Chikhalkar 02/04/14.
Member, Expert Committee
Professor , Dept Of Forensic Medicine
GGMC & JJH, Mumbai .

56. The said expert committee categorically opined that there was no negligence on the part of the treating doctors. They all note the diagnosis of Leptospirosis.

57. The Complainant seems to have been dis-satisfied with these reports and it would be relevant to point out that the present complaint had already been instituted on 10.09.2013 before this Commission.

58. The Opposite Parties No. 1 & 3 filed their reply that stands recorded in the order dated 19.01.2015. The same was accepted on payment of costs of Rs.25,000/- to which a rejoinder was filed. The OP-2 did not file the written statement within time and the said right to file the written statement of OP-2 was forfeited vide order dated 18.12.2015. The OP-2 however filed an affidavit of evidence as stands recorded in the order dated 07.09.2016 but on 06.12.2016, the Commission observed that there was no occasion for permitting the OP-2 to file affidavit evidence and consequently, the Counsel for the OP-2 withdrew the affidavit of evidence and it was recorded that the same shall not be read in evidence.

59. The contest before this Commission was progressing and at the same time, the Complainant moved a complain before the Directorate of Medical Education & Research for conducting an enquiry as the Complainant was not satisfied with the report of the expert committee of the J.J. Medical College. The papers seem to have been tendered to the said authority and the Committee functioning under the Government orders held its meeting through Video Conferencing between B.J. Medical College, Pune and Grant Medical College, Mumbai on several

dates. The documents were scrutinized and in between on 13.01.2016, the Complainant raised objections about the participation of one of the Members of the Committee as a result whereof the Committee was resolved and the new Committee was constituted under the Chairperson of the Director. The said Committee records that the Medical Superintendent of Hira Nandani Hospital was present but declined to answer any questions stating that the matter was sub-judice before this Commission. There does not seem to be any participation of the doctors having treated the patient and a report was tendered by the Director on 16.01.2016 upon hearing "one side" . This is evident from the said DMER Report dated 16.01.2016 which is extracted herein under:

DMER-12 part ... 32

DIRECTORATE OF MEDICAL EDUCATION AND RESEARCH, MUMBAI.

Government Dental College and Hospital building, 4th Floor,
St. George's Hospital compound, P. D'Mello Road, Fort, Mumbai-400001.

Confidential/ Most Important

No. DMER/Misc/Smt-Richa-Shrivastava/2015/181/4A. Dated 16.01.2016.

To:
The Hon'ble Additional Chief Secretary,
Medical Education and Drugs Department,
G.T. Hospital Complex, 9th Floor,
Lokmanya Tilak Marg,
Mumbai-400001.

Subject : Regarding drawing conclusion about the exact cause of death of deceased Navendu Shrivastava and as to whether his death occurred due to medical negligence or not, and submitting a factual report thereon to the Government.

Reference : 1) Government Resolution No. *Vai.Ni.Ta.*-0215/C.R.11/Acts, dated 03.11.2015.
2) Government Corrigendum No. *Vai.Ni.Ta.*-0215/C.R.11/Acts, dated 12.01.2016.

The inquiry in respect of the above-mentioned subject was held, subject to the Government's orders, on 13.01.2016 at the Directorate of Medical Education and Research at 12:00 noon.

The said committee is functioning since 3rd November 2015 and the meetings of the said committee were held through video-conferencing between B.J. Government Medical College, Pune and Grant Medical College, Mumbai, on 18.12.2015, 21.12.2015 and 30.12.2015. In the said meetings, the available documents were scrutinised and point-wise discussions were held.

Since, on 13.01.2016, Smt. Richa Shrivastava (complainant), wife of the deceased Navendu Shrivastava, raised objections about a member of the committee appointed earlier, the said committee was dissolved and a new committee was constituted under the chairmanship of the Hon'ble Director, which heard the complainant in detail and video-recorded it.

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The following witnesses/ aides were present along with the complainant. They also recorded their say before the committee.

1) Dr. Ajay Patil;
2) Shri Vivek Krishna Chougule.

Dr. Trupti Rathod, Medical Superintendent, was present on behalf of Hiranandani Hospital (Fortis), Vashi. She presented the written say of the hospital's administration before the members of the committee in the form of an application. However, she refused to answer any question put to her by the members of the committee as the matter was sub-judice (consumer court). Therefore, the version of the hospital administration could not be heard.

In view of these facts, the committee took the following points into consideration:-

1) Delay in performing surgery on the patient (now deceased);
2) Keeping the patient (now deceased) on a fast (NBM);
3) Reaction of the I.V. on the patient and the inquiry report of the adverse drug event system;
4) Anaesthesia check up was not done before surgery;
5) Delay in giving the report of IGM test for Leptospirosis;
6) Use of portable sonography against the rules;
7) Delay in conducting C.T. scan;
8) Shortcomings in obtaining consent;
9) Expert/ experienced doctors were not available when the patient's condition deteriorated;
10) Doubts raised because the documents pertaining to the educational qualifications and experience of the paramedical workers were not furnished
11) Lack of co-ordination between the hospital administration and doctors regarding treatment of the patient;
12) Shortcomings in the post mortem report;
13) No standard treatment/ investigation protocol for clinical treatment.

On considering and discussing the above-mentioned points, it is revealed that points number 2, 3,9,11 and 13 are important ones and are sufficient to doubt the efficiency of the (said) hospital.

The Directorate had intimated the administration of the concerned hospital to remain present for the enquiry. Accordingly, Dr. Trupti Rathod, Medical Superintendent, Fortis Hiranandani Hospital, Vashi, appeared before the committee. She submitted to the committee a letter signed unto by Dr. Bipin Chewale, Faculty Director. Dr. Bipin Chewale, Faculty Director, stated in the said letter that since the matter is sub-

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judice, it is not binding on the hospital to present its case befor the committee.

In order to avoid any further delay in submitting the report of this committee in this matter, the committee, upon hearing one side, submits its report as follows.

Conclusion:-

"On (perusing) the available documents, reports of medical examinations as also on hearing the side of the complainant and her family friends, there is sufficient cope to draw the conclusion that *prima facie* negligence has occurred in respect of the above points number 2,3,9,11 and 13 in the report."

Signed

Director,
Medical Education and Research,
Mumbai.

True Translated Copy.

60. What we find is that on the one hand, the report from the J.J. Hospital finds no negligence and has confirmed the death of the patient after referring to the symptoms of Leptospirosis and the pathological report to support the same and on the other hand, there is no adverse comment at all on the aspect of Leptospirosis in the DMER report dated 16.01.2016.

61. The said report of the Director is a list of some "points of doubt" but at Sr.No. 5 the only reference is to the delay in giving the report of IgM test for Leptospirosis. It is, therefore, evident that the evidence regarding the pathological test report of IgM for the symptom of Leptospirosis was very much on record and has been noticed by the Director General at Item No. 5. In his final opinion, he has doubted the efficiency only on point No. 2, 3, 9, 11 & 13 but there is no comment or opinion doubting the diagnosis of Leptospirosis as mentioned in the report indicating IgM level.

62. Consequently, the contention of Mr. K.G. Sharma that this theory of Leptospirosis sprang suddenly in the Post-Mortem report is un-acceptable for all the reasons herein above and the opinion of Dr. Bangal that it was an afterthought, is an incorrect opinion against record.

63. Mr. K.G. Sharma again emphasized that the report was only presumptive and not confirmatory and therefore, the patient cannot be said to have died due to Leptospirosis. It is here we find the arguments of Mr. Agarwal and Dr. Shenoy worth considering that the patient died within two days of the said diagnosis of the symptom and there was no time span available for carrying out any confirmatory test when the patient was dead. There is no evidence or any successful challenge to

the fact of Leptospirosis having been suspected and a blood report conducted for the same. The blood report is not under challenge which indicates a positive IgM antibodies indication. Given these circumstances on record, coupled with the opinion of AIIMS, it cannot be said that the doctors were negligent in their attempt to treat the patient. AIIMS report may not have given credence to Leptospirosis but it records its opinion and has discussed all the symptoms and has opined that it "was probably related to a past infection" and was "unlikely due to a current Leptospira infection".

64. The medical literature relied on by the learned Counsel for the OPs, particularly the literature published in the 18th Edition of Harrison's Principles of Internal Medicine refers to the incubation period for Leptospirosis infection in 8 -15 days. It also states that antibody tests show positive after a duration of 1-2 weeks after the infection in the body. The patient in this case was admitted on the 12th and this symptom of Leptospirosis was suspected on the 13th and a blood test was carried out. Learned Counsel for the OPs, particularly, Dr. Shenoy has invited the attention of the Bench to a text Book of Microbiology that has been filed along with their submissions to urge that a patient suffering from Leptospirosis can also complain of body aches, breathlessness, vomiting, loose motions, lung congestion, kidney problems, desaturation and the like. Dr. Shenoy submits that all these symptoms indicated that it could not be a simple symptom of IV infusion occurring with shivering. He submits that the shivering stopped immediately after the injection Avil was administered on the 12th itself and there is no evidence regarding any contamination being found in the contents of the IV fluids. He, therefore, submits that when the patient developed sepsis and Leptospirosis was suspected, a broad spectrum

antibiotic namely, Ceftriaxone was given to the patient. Other injections have also been administered. The arguments of Dr. Shenoy therefore explain the AIIMS report and stands affirmed by the contents of the literature cited by him.

65. Dr. Shenoy, therefore, rightly contends that it is not the case of the Complainant that no care or treatment was undertaken, rather the contention of the complainant is that the diagnosis of the Leptospirosis is neither confirmed nor did the patient expire due to the said disease. The aforesaid doubt which has time and again been urged by Mr. Sharma, learned Counsel for the Complainant and has been throughout one of the main contentions, we find it difficult to accept the same as a cause of any negligence on the part of the treating doctors for all the reasons hereinabove.

66. It is by now well-settled that in the matters of medical negligence, the theory of Res Ipsa Loquitur has not much of an application except in cases of surgeries or the secondary treatments and therefore, in the present case where the treatment papers are on record and have been disclosed by the Complainant and the OPs-1 & 3, we have no reason on any ground to hold the diagnosis of the Leptospirosis to be wrong thereby attributing any negligence on the part of the OPs.

67. We may point out that the report of J.J.Hospital as also of the Expert Committee do support the explanation given by the OPs in the given circumstances and on an overall assessment, even the report of AIIMS report indicates that there were no significant deviations in the management of the patient as per the current acceptable practices in the ICU. The AIIMS therefore has not held the doctors to be negligent or the hospital having not

undertaken the legitimate exercises for the proper upkeep and management of the patient.

68. The opinion about the administration of I.V. Fluid causing adverse reaction, it is evident that the infusion of the fluid was immediately stopped as soon as the shivering was noticed and symptoms of fever were seen. Not only this, the patient was administered all medicines that were necessary for managing the patient in such circumstances as found in the AIIMS report produced above. There is no deficiency indicated so as to warrant an inference that the patient was not looked after appropriately.

69. Next comes the question of the patient being kept fasting for long. The aforesaid facts remain undisputed that the patient was kept on no meals presumably because of the surgery to be performed on the date of the admission itself. The surgery was also for bleeding piles. The AIIMS report or any of the report does not indicate that the complications which developed in the patient were due to the patient being kept fasting for long. There is no such conclusion drawn in the medical reports as produced above except the sketchy and unsubstantiated ex-parte report dated 16.01.2016 of the Director and the un-creditworthy affidavit of Dr.Bangal as discussed above.

70. The doubt with regard to the mis-management of the patient as alleged by the Complainant primarily commenced on the allegation that the patient was kept fasting for long and this prolonged fasting was coupled with the change of priorities in the availability of the operation theatre for the hospital that was diverted for utilization to the Caesarean delivery cases to extend benefits of the choice of the date of 12.12.2012 to would-be-mothers. In this regard it would be relevant to point out that the patient had been given a referral letter by the OP-1 on 05.12.2012 for being admitted in the Fortis Hospital on 12.12.2012 with an advise to arrive at 8-30 A.M. and further advise that the patient

should fast after 12 mid-night on 11.12.2012 and was instructed to take 2 tablets of Dulcolax after taking dinner. According to the OP No. 1 & 3, this advice was given because the patient himself was suffering from bleeding piles and therefore had chronic constipation.

71. From the records it appears that the patient was admitted at about 11-40 A.M. on 12.12.2012. Upon his admission, he was advised IV fluids as the surgery was planned for 3-00 P.M. However, it is admitted on record that the OT was not available till around 5-00 P.M. and the non-availability was further extended. Accordingly, the surgery was postponed to the next day at 11-00 A.M. but the complications of the patient developed at about 5-00 P.M. when the patient complained of shivering, chills, rigors and body-aches. The treatment began as is evident from the endorsement made in the hospital sheets at 5 PM onwards and then the patient was advised soft diet at about 6 P.M. The patient vomited at about 6-30 P.M. and then further treatments and investigation including ultrasonography etc. was advised. The patient developed temperature upto 103° F, but otherwise his vitals were normal. Medicines and injections were advised accordingly and was later on attended to by Dr. V.V. Krishnan, Dr. Chandra Shekhar, Dr. Rajendra and other doctors. He was shifted to the Mini-Intensive Care Unit and was attended by Dr. Chandra Shekhar and Dr. Krishnan as well as Nephrologist Dr. Ingale.

72. It is, therefore correct that the surgery had been postponed and the patient had been kept on fast. The shivering did occur immediately after the administration of IV Fluid and we find that this aspect has also been commented upon by the All India Institute of Medical Sciences (AIIMS) in its report dated 21.12.2019. The AIIMS has observed that

the symptoms had appeared after starting of IV fluids and probably had an adverse reaction to the same and therefore, the possibility of aspiration could not be ruled out.

73. The said report of AIIMS however nowhere opines that this had happened on account of fasting. The patient had to be administered IV fluids as he was fasting. Consequently, there is no firm medical opinion that fasting by itself was cause for any complications or was an act of medical negligence. The non-availability of the operation theatre and the consequences of fasting therefore has not been found by any report to be a cause of any failure so as to arrive at a conclusion of medical negligence.

74. It is by-chance and a co-incidence that while the surgery was postponed due to non-availability of the operation theatre that complications ensued after IV fluid was administered in between. That by itself is no medical neglect and cannot be construed to be a deliberate act on the part of the hospital to treat the patient negligently who was already admitted and was being looked after by doctors. Unfortunately, the patient did develop complications in the sequence as already noted in the hospital records, but the postponement of the surgery may have been initially on account of the non-availability of the O.T. at 3 P.M. but the same coincided with the infusion of IV fluids to the patient that caused further problems and the surgery could not be conducted on the same day even if the O.T. was available, and had to be postponed for the next day. It cannot be therefore said that there was no facility available or made available that had aggravated the infection of the Complainant and on the other hand, the patient in spite

of all medications, developed sepsis which the OPs contend was possibly and in all probability on account of Leptospirosis infection.

75. We may recount the facts that it is correct that the opposite party no.1 had examined the patient on 05.12.12 and the prescription indicates the advice of blood tests and investigations and had recommended admission. It may be pointed out that the diagnosis had been made of a Prolapsed Haemorrhoids Grade 4 Bleeding Piles on 19.11.12 which prescription is also on record. The advice was for traditional surgery. It is that surgery which was planned on 05.12.12 with a recommendation for admission to the hospital. The recommendation also indicated that the patient should undertake fasting after midnight on 11.12.12 and was recommended for admission at 8.30 a.m. on 12.12.12. The hospital sheets indicate that he was proposed to undertake surgery at 3.00 p.m. but there were other surgeries also planned and the chart indicating the surgeries from serial no. 110 to serial no. 126 on 12.12.12 indicate that all were not caesarean operations. It was a mixed bag of surgeries including a heart surgery as well. Thus, pre-operative recommendations for tests had been made and from the Hospital sheet dated 12.12.12 it is also admitted that a pre-anaesthetic assessment was conducted where the patient was found to be normal. The Hospital sheets also indicate that for the tests, which were carried out, including the CT scan and ultrasound, consents had been taken. The surgery could not be performed at all and therefore there does not seem to be any further involvement of the Anaesthetist, the opposite party no.3 herein. The surgery also did not take place and therefore there cannot be any possible argument about negligence in the performance of the surgery. In the given circumstances, the possibility of any negligence on the said count cannot be assumed.

76. From the arguments advanced, the main thrust appears to be the prolonged wait of the patient which, according to the complainant, in a fasting state aggravated the situation after the intravenous fluid was injected. It may be pointed out once again that the Blood Culture sample had been drawn on 12.12.12 and we agree with the argument of Dr. Shenoy and Mr. Agarwal, learned Senior Counsel, that steps had been taken in the normal and routine course to analyse any form of infection. The report of Blood Culture, which takes a few days, arrived on 18.12.12, which was obviously after the death of the patient but the said Blood Culture report is absolutely negative. We have perused the same and we do not find any material therein to infer any infection being caused by the infusion of any blood. We may point out that in none of the reports is there any indication of the existence of any possibility of an infection through the intravenous fluid that was administered to the patient even if the patient had started shivering thereafter. Thus, medically and on the basis of the said document, it cannot be concluded that the fluid was contaminated.

77. Learned counsel for the complainant has vehemently urged that it was the obligation of the Hospital to have retained the fluid bottle and it ought to have been forensically and medically examined but the Hospital failed to do this which in itself is negligence. On the other hand, learned counsel for the opposite parties have urged that since the fluid had already been infused into the patient and since the complainant also did not make any such demand or raise any such suspicion, there was no occasion for getting the fluid tested which was not even available. The report of AIIMS categorically states that the patient was managed appropriately and has not found any reason to doubt the contents of the fluid. We therefore through a judicial approximation cannot apply the

principle of *res ipsa loquitur* to assume that the intravenous fluid that was administered to the patient was contaminated or had caused any such complication. The comment made by the AIIMS regarding an adverse reaction has been preferred with the prefix "probable" but the AIIMS does not give any confirmed opinion to conclude that the fluid itself was contaminated. The possibility of any contamination as observed above could not be gathered even from the Blood Culture report which remains unchallenged. In such circumstances, it may not be possible for us to hold the opposite parties liable for any such adverse reaction having been caused due to any infection.

78. However, there is one aspect of this case namely that the Hospital, opposite party no.2, had forfeited its right to file a written statement or contest the case on the basis of any evidence proposed by it. The report of the AIIMS indicate that there was no other deficit in management of the Hospital except the administration of intravenous fluid causing adverse reaction. There seems to be no explanation forthcoming or available in this regard except the argument based on the Blood Culture report. The question of testing the status of the fluid that was administered has not been examined and if the Blood Culture report had been sent, there is no reason forthcoming as to why the Hospital did not choose to examine or get the contents of the fluid examined even from the same batch of bottles that must have been available when this incident occurred. It seems that the AIIMS report therefore seems to be casing a doubt on the management part of the Hospital. Even otherwise, we find that from the nurses' notes the intravenous fluid seems to have been started, about which there is an endorsement at 3.00 p.m. on 12.12.12. This nurses' note is Exhibit G-3 and seems to be annexed at page 241 of the complaint. A 500ml DNS

infusion is indicated at 3.00 p.m. The nurses' note further indicates that the patient was stable and there seems to be a change of nursing hands in between. The nurse who took over does indicate that there were no other complications at 4.00 p.m. and the surgery was postponed. If that is so, there is no material to contradict the timings of the infusion of the fluid and by 5.00 p.m. the complications had commenced and breathlessness was complained of at 5.30 p.m. Vomiting and other complications followed thereafter and the patient was shifted to the MICU at 7.00 p.m. The patient did not improve and had signs of breathlessness and discomfort. He was attended to by doctors and by 11.00 p.m. he was also attended to by Dr. V.V. Krishnan and other doctors. The patient was tense even though he was oriented and at 6.00 p.m. the opposite party no.1 had advised injection Evil, Dulcolex and soft diet at night but later on indicated that no meals by mouth after 12.00 midnight presumably because of the surgery having been postponed to next day. The patient was shifted to the ICU and then all his vitals were checked and tests carried out and, in view of his critical state, there was no reason to conduct any surgery on the next day. On 13.12.12 the patient was reassessed at night at 1.00 a.m. by Dr. Chandra Shekhar and his general condition was reported to be poor. The same situation continued till 5.40 a.m. whereupon he was advised a large number of tests, as is evident from the progress sheets. The aforesaid facts do indicate that the patient became critical and was again examined by the opposite party no.1 at about 12.00 noon on 13.12.12. These circumstances do indicate that the situation of the patient deteriorated gradually after the patient experienced reaction and ultimately slipped into the complicated situation whereupon he expired on 15.12.12 after two days. This absence of any attempt on the part of

the Hospital to investigate into the cause relating to the adverse impact of the infusion of the fluid in our opinion is a mismanagement which is a deficiency and this also has been opined by the AIIMS in its opinion dated 21.12.19. We therefore hold the Hospital to be liable for negligence in the management and lapse in taking appropriate steps for getting the contents of the fluid infused into the patient examined forensically and medically, and the probability casting a doubt on this aspect by the AIIMS, calls for imposition of an adequate compensation to that effect.

79. The said issue therefore can be quantified subjectively to an extent commensurate to the fact that we have not been able to locate any medical negligence against the doctors or the treatment gauged from the evidence on record as also the cause of death and we therefore in the overall circumstances find it expedient and just to impose Rs.10.00 Lakhs as compensation for this lapse as mentioned above on the Hospital, opposite party no.2, that had failed to contest the complaint and was negligent to the extent and in the background stated above. The said amount shall be paid together with 9% interest with effect from the date of death of the patient which is 15.12.12 till the date of actual payment.

80. The complaint stands disposed of accordingly.

Sd/-

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(A.P. SAHI, J.)
PRESIDENT

Sd/-

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(BHARATKUMAR PANDYA)
MEMBER

Naresh/Sonia/Jr/Mukesh/VM/Court-1,