NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION
NEW DELHI

FIRST APPEAL NO. 101 OF 2016

(Against the Order dated 27/11/2015 in Complaint No. 87/2006 of the State Commission Maharashtra)

1. PANKAJ R. TOPRANI & 3 ORS.

1122, Maker Chamber-V, 221, Nariman Point,

Mumbai - 400 021

Maharashtra

2. SMT. VASANT RANJIT TOPRANI

BOTH R/ AT 311/312, SHEFIELD TOWERS, 2ND CROSS LANE, LOKHANDWALA COMPLEX,

ANDHERI WEST,

MUMBAI-400053

3. MR. JANAK RANJIT TOPRANI

R/O. AT 311/312, SHEFIELD TOWERS, 2ND CROSS LANE, LOKHANDWALA COMPLEX,

ANDHERI WEST,

MUMBAI-400053

4. MRS. KALPAMA H. LILANI

NEELKANTH NAGAR, GHATKOPAR EAST,

MUMBAI-400077

MAHARASHTRA .....Appellant(s)

Versus

1. BOMBAY HOSPITAL AND RESEARCH & MEDICAL & 2 ORS.

RESEARCHG CENTRE OF BOMBAY HOSPITAL TRUST, THROUGH ITS TRUSTEES, AT 12 NEW MARINE LINES,

MUMBAI-400020

2. DR. P.B. DESAI

WORKING AT THE BOMBAY HOSPITAL AND MEDICAL RESEARCH CENTRE OF THE BOMBAY HOSPITAL TRUST, AT 12 NEW MARINE LINES,

MUMBAI-400020

MAHARASHTRA

3. DR. SANJAY WAGLE

WORKING AT THE BOMBAY HOSPITAL AND MEDICAL RESEARCH CENTRE OF THE BOMBAY HOSPITAL TRUST, AT 12 NEW MARINE LINES,

MUMBAI-400020
MAHARASHTRA .....Respondent(s)

BEFORE:

HON'BLE MR. JUSTICE R.K. AGRAWAL,PRESIDENT
HON'BLE MRS. M. SHREESHA,MEMBER

For the Appellant : Mr. Janak Toprani & Mr. Pankaj Toprani, Appellants in person

For the Respondent : Mr. Abhinay Sharma, Advocate
Mr. Arjun Sharma, Advocate
Ms. Neha Khandelwal, Advocate for R-1
Mr. Rohan Ganpathy, Advocate for R-2
Mr. S.B. Prabhavalkar, Advocate for R-3

Dated : 04 Jul 2019

ORDER

Per Mrs. M. Shreesha, Member

Aggrieved by the order in CC/06/87 passed by the Maharashtra State Consumer Disputes Redressal Commission, Mumbai (in short "the State Commission"), the Complainants namely, Mr. Pankaj R. Toprani, Smt. Vasant Ranjit Toprani, Mr. Janak Ranjit Toprani and Mrs. Kalpana H. Lilani have preferred this First Appeal under Section 19 of the Consumer Protection Act, 1986 (in short "the Act"). By the impugned order, the State Commission has dismissed the Complaint holding that there was no medical negligence on behalf of the Opposite Parties.

2. The Bombay Hospital and Medical Research Centre of the Bombay Hospital Trust arrayed as the first Opposite Party (is hereinafter referred to as "the Hospital"), Dr. P.B. Desai arrayed as the second Opposite Party (is hereinafter referred to as "Dr. Desai"), and Dr. Sanjay Wagle arrayed as the third Opposite Party (is hereinafter referred to as 'Dr. Wagle').

3. Mr. Ranjit Toprani (hereinafter referred to as "the Patient"), was operated in the Hospital by Dr. Desai. The Patient was 73 years old and died during the pendency of the Complaint. He was admitted in the Hospital on 26.06.2004 and operated for Carcinoma of the Sigmoid Colon. It is averred that the Patient was recommended to Dr. Desai by Dr. J.C. Kothari, who is attached to the Hospital. The Patient was certified fit for Surgery by the In-House Intensivists of the Hospital and Physician Dr. Wagle , who went through the Patient's history, which include urticaria, glaucoma tension in the eyes, chronic depression, for which the Patient was under medication since the past 20 years. The ECG report showed that there was an old septical MI and the 2D ECHO displayed 60% pumping heart rate. It is averred that Dr. Wagle went through all the medications and prescriptions of the Patient and certified him fit for the Surgery scheduled to be performed on 28.06.2004 by Dr. Desai. After the Surgery, the attendants and the Patient were informed by Dr. Desai that the Operation was successful and that the Patient would be transferred to the ward.

4. It is averred that while the Patient and his family members were waiting for the personnel to shift the Patient to the ward, to their shock, the Patient was shifted to the post-operative ICU, which is situated on the third floor of the Hospital building. It was informed to the Complainant and his family members that the shifting was being done to keep the Patient under observation. It is stated that the daily notes of the Anaesthetist showed that the Patient was supposed to be shifted to the ward. But Dr. Desai in his report noted that the Patient be shifted to the post-operative ICU, though he had earlier informed the Patient and his family Members that he would be shifted to the ward. The Patient was awake and was mentally disturbed and questioned as to why he was brought there. On the next date, i.e. 29.06.2004 the Patient complained of lack of sleep and pain in the abdomen and requested for a pain killer. At 8.45a.m., the Patient complained of throat pain, breathlessness and of a chocking sensation.

5. While the Patient's attendant, waited outside the ICU, unaware of the Patient's condition, suddenly there was a commotion inside the ICU and they saw the Patient having convulsions and was being helped to breathe with the help of an Ambu bag. The attending Doctor, who is the assistant of Dr. Desai informed the attendants that the Patient had suffered a Bradycardia Attack and had to be resuscitated. The Ambu bag was replaced with the ventilator, the only one available in the ICU. The Patient's family members were worried and requested the attending Doctor to call for the Cardiologist immediately and administer necessary treatment but they were informed that he would have to wait for the Intensivists i.e. Dr. Wagle to call for a Cardiologist. But Dr. Wagle was not available and did not turn up for a long period of time. It was only after about 2 ½ hours, that the Patient was instructed to be shifted to the ICU on the 12 th floor. It is averred that there was no reference made to the Cardiologist. The family members of the Patient were helpless seeing their father continuing to have convulsions. Thereafter, the Cardiologist Dr. Satyavan Sharma arrived after Mr. Janak Toprani, the Patient's son requested him to attend to the Patient. He observed in his remark that the cause of Bradycardia Attack cannot be explained. According to him the cause of Bradycardia Attack was due to sudden pain, fear or anxiety. The matter was referred to a Neurologist. The family members of the Patient averred that Dr. Wagle, did not find it a fit case to refer the Patient to Neurologist, despite the fact that the Patient was having convulsions.

6. The Patient was shifted to the ICU on the 12 th floor of the new building without the use of any portable ventilator in spite of his being on the ventilator earlier and in spite of his being in a state of convulsions. He was given the support of only an Ambu bag and an oxygen cylinder. Once taken to the 12 th floor ICU, the Neurologist Dr. N.E. Bharucha gave the Patient some medicines to stop the convulsions. It is averred that as the Patient's condition was critical, the Complainants did not give permission for a CT Scan as the Patient was in a state of convulsions and it is not possible for a CT to be performed. The Patient remained in the ICU of the 12 th floor till 07.07.2004 and thereafter he was shifted to a ward on the same floor. The Patient was unconscious and he was examined by a team of doctors including Dr. Wagle. On 15.11.2004, the Doctors examined him at around 9.30 a.m. and noted that there was no change in the Patient's condition at around 11.30 a.m. The relatives were informed by physiotherapist Dr. Ashaben Andhyal, that the Patient has developed congestion in the lungs and Dr. Wagle shifted the Patient to the 12 th floor ICU, where the Patient was put on a ventilator. He remained in the ICU for 8 days and thereafter was shifted to the ward on 22.11.2004. It is averred that the Patient never regained his consciousness and remained in the Hospital till 14.02.2005 and thereafter he was brought home and has been on the support of an oxygen concentrator. In the discharge summary given on 14.02.2005, it was stated that the 'Patient is unconscious in a vegetative state'.

7. It is pleaded that there was no apprehension of the surgeon prior to the operation that the Patient would suffer from any such post-operative complications. The vegetative state is an outcome of severe brain injury and the Patient's heart did not show any signs of any problem for about 17 months subsequent to the discharge. It is only on account of negligence of the Hospital and the doctors that the Patient developed a brain injury and died during the pendency of the Complaint.

8. In brief it is pleaded that the negligence was based on the following grounds:

- Though the Anaesthetist and Dr. Desai has initially remarked that the Patient would be shifted to the ward, he had shifted to the ICU.
- The cause of the alleged Bradycardia was not explained, the respiratory problem was not attended to immediately.
- There was negligence in stopping the Patient's anti-depressants abruptly without consulting a Psychiatrist.
- Though the Patient complained of lack of sleep and pain and did not sleep till 2 a.m., the Doctors did not administered proper dose and did not consult a Psychiatrist.
- The Patient was kept in an inadequately equipped and mismanaged ICU without proper qualified Doctors, on account of which the Patient has to be shifted from one ICU to another.
- There is negligence in shifting the patient from one ICU situated on the third floor of one building to another ICU situated on the 12 th floor of another building without the support of a portable ventilator, which resulted in the Brain condition deteriorating.
- Though the Patient's condition became critical at 9 a.m., Dr. Wagle arrived belatedly only at around 11:30 a.m. and the shifting was done at 1 p.m., by which time, the Patient's condition worsened.
- The physiotherapy session given at 8.45 a.m. was improper and within 15 minutes the Patient complained of breathlessness and was allegedly diagnosed of Bradycardia.
- There is gross negligence in the diagnosis and the treatment of the Patient, who was active till his Surgery and was a practicing tax advocate.

9. It is averred that the family members of the Patient suffered loss of fatherly love and affection and seeing their father in a vegetative state for two years, they suffered mental agony and trauma, for which they seek direction to the Opposite Partiers to pay to the Complainants, a compensation of 98,00,000/- together with interest and costs.

10. The Hospital filed their Written Version denying the allegations of medical negligence and only contended that it was the Complainants, who did not give permission for CT Scan and that

the entire team of Doctors have followed due care and caution in rendering treatment to the Patient and no negligence can be attributed either to the Hospital or to the Doctors and prayed for dismissal of the Complaint with costs.

11. Dr. Desai filed his Written Version stating that the Patient had undergone Surgery on 28.06.2004, he was absolutely normal subsequent to the Surgery; that the Surgery went on smoothly, stitches healed nicely and therefore there is no negligence on his behalf as the Surgery was performed by him and it was successful. It is averred that the only allegation against the Doctor is that post Surgery he had directed the Patient to be shifted to the post-operative ICU, when the Anaesthetist has recommended that the Patient be shifted to the ward. It is averred that since the Patient was 72 years of age, it was only as a matter of abundant caution that he has suggested that the Patient be shifted to ICU for monitoring for a day or so. It is stated that the drugs that were administered from the time of admission till the time of operation are as follows:

T. Cilentra 1 od - 8am

T. Primox ½ bd – 10 am : 10pm

T. Alprax 0.5 mg bd – 8am : 8pm

T. Trazine H – ½ od – 8 pm

T. Mitaz 7.5 mg old – 10 pm

12. These drugs were withheld because of anaesthesia, which was administered and the decision was taken by the Anaesthetist. The doctor further stated that subsequent to the Surgery the Patient was given pain relieving injections and sedition with Tramadol and an injection of Calmpose. The Patient was stable throughout the night.

13. It is averred that administration of physiotherapy was not done on his instructions and that it is a normal post-operative procedure, which is carried out after all surgeries and does not require recommendation of any doctor; the Patient collapsed due to severe Bradycardia and it appears from the case sheet that immediate resuscitative measures were taken and that necessary drugs were administered; that a senior Doctor from the adjoining ICCU was summoned, who promptly inserted the endotracheal tube to maintain his breathing; the Patient was stable and upon the advice of Dr. Wagle, he was transferred to 12 th floor ICU, which had better facilities where one nurse is dedicated to each Patient; that on 04.07.2004 the Doctor had performed 'Tracheostomy' on the Patient by bedside; that the role of the surgeon is a back seat role and the Intensivist takes over and looks after the recovery of the Patient; that despite the same, the Doctor and his team repeatedly visited the Patient to make sure that he was being monitored properly; that the usual pain medication (tramadol 100 mg and calmpose 10 mg) were given at 4 p.m., 10 p.m. and 2 a.m., respectively; that the Patient was shifted to ICU on the 12 th floor with an Ambu bag to continue his oxygen supply, which is a normal practice and thereafter he was put on the ventilator; Bradycardia developed due to unexplained reasons, which cannot be attributed to Surgery or any post-operative complications. It was definitely not a result of the operation, which was performed.

The Doctor denies that the Patient suffered a panic attack and that excessive doses were given in the postoperative phase and pleads that there was no negligence on his behalf and seeks dismissal of Complaint with costs.

14. The third Opposite Party Dr. Wagle filed his Written Version stating that he was not aware as to what had transpired between the Complainant and his family members and the junior Doctor assisting Dr. Desai; that Dr. J. C. Kothari was called to the post-operative ICU before he had reached the ICU; that he was not aware that the Patient demanded that the Cardiologist be called immediately; that it was only on his instructions, the Patient was shifted from post-operative ICU to the ICU on the 12 th floor; the Doctor denies that he did not refer the case to the Cardiologist; the Patient was given support of Ambu bag and oxygen cylinder, which is a normal practice; the medicines to stop convulsions had been started before the Patient was shifted to the 12 th floor; the Complainants did not give permission to perform a CT Scan; the Doctor denies that on 15.11.2004 at about 11.30 a.m., he confirmed that the Patient had severe congestion in the lungs as a result of which the Patient would be required to be shifted to the 12 th floor; that the Doctor noted in the case papers that the Patient was suffering from lung pneumonia on that day and for the purpose of observation he was shifted to the 12 th floor ICU; that he had no occasion to examine the Patient after June 2005;that he is not aware of the subsequent treatment and the discharge of the Patient as he did not examine the Patient after June 2005; that the actual cause of the complication remained undetected because the Complainants did not cooperate with respect to CT Scan; that on 29.06.2004 at about 10.15 in the morning, when he was taking his rounds he received a call from the post-operative ICU on the third floor, at 10.20 a.m. he examined the Patient; he was in the Hospital since 8.15 a.m. but only received a call at 10.15 a.m.; that before he reached the ICU the Patient was also resuscitated by Dr. Shaikh as can be seen from the noting made by him on 29.06.2004; the Patient was unconscious and hemodynamically stable and the ECG did not show any fresh changes and the blood gas examination showed acidosis. It is averred that at around 10.45 a.m. the Cardiologist Dr. Satyavan Sharma reached the ICU and confirmed his finding, the same treatment was continued and no further drug was added. The Patient was referred to Dr. N.E. Bharucha, Neurologist who also advised to continue Eptoin, Midazolam and added Clonazepam. The Doctor averred that the case papers show that two hours prior to the transfer of the Patient from post-operative ICU to the 12 th floor ICU, the Patient was in a stable condition, his blood pressure was normal, his oxygen saturation was 60%, he was administered anti-convulsions, his heart rate was monitored throughout the transport and the Patient's condition did not deteriorate during the transfer.

15. The Doctor further averred that the Patient was ventilated with an Ambu bag, as the Patient did not require PEEP or high IE ratio to maintain oxygenation and the transport time was short. It was a standard procedure to transport the Patient with a hand ventilator or an Ambu bag and a portable ventilator was not used at that stage. On 15.11.2004, the Patient developed lung infection and not severe congestion as alleged by the Complainant. The chest X-ray taken confirms this finding. It is stated that it is not unusual for a Patient with tracheostomy for five months to develop such an infection. Even after the Patient was discharged and till June 2005, whenever the Complainants messaged him, he visited the Patient's residence and examined the Patient and suggested appropriate treatment. His advice was sought whenever necessary and he had adhered to all standards of due care and caution and there is no negligence on his behalf.

16. The State Commission based on the evidence adduced dismissed the Complaint observing as follows:

"18. It was contended that shifting of patient from first ICU to second ICU without portable ventilator is negligence on the part of opponents. Learned Advocates for the opponents argued that in the complaint itself Ambu Bag was used while shifting the patient from one ICU to another ICU. It was contended that use of Ambu Bag is sufficient and there is no necessity of portable ventilator. Ambu Bag is for the same function and hence, there is no negligence on the part of the opponents. We find much substance in the arguments of the opponents for the reason that the complainant has not brought on record anything to show that Ambu Bag cannot be worked as alike of portable ventilator and non-use of ventilator is negligence on the part of the opponents and use of portable ventilator was must. It was contended that first ICU was not adequately equipment and that is deficiency on the part of opponents. Learned Advocates for the opponents have argued that both ICUs were well equipped. It was contended that first ICU was post-operative ICU and hence, after operation immediately patient was taken to said ICU and thereafter, as it was necessary to keep the patient for longer period in the ICU, he was shifted to regular ICU and contention of the complainant that first ICU was not adequately equipped is baseless. We find much substance in the said argument for the reason that the complainant has not shown what was inadequacy in the first ICU. Only because the patient was shifted from first ICU to second ICU, it cannot be said that first ICU was inadequately equipped. Learned Advocates for the opponents have already argued as referred above that first was post-operative ICU and hence, patient was taken to first ICU immediately after operation and afterwards as it was necessary to keep the patient for longer time he was shifted to regular ICU.

19. It was alleged that problem was caused because of improper physiotherapy of the patient. Learned Advocates for the opponents have argued that the physiotherapy is a routine procedure after operation and hence, it cannot be said that problem occurred because of physiotherapy. It was submitted that nothing is brought on record by the complainant with the help of expert evidence that because of physiotherapy patient suffered the problem of bradycardia attack.

20. There is no complaint about operation which was done by opponent No.2. As it is clear from recital of the complaint itself, it is specifically mentioned in the complaint that the operation was successful and after operation, patient was all right and he has talked with his relatives. On the next day at about 8.00 a.m. the patient relatives met him and the patient was fine. Even it is argued by Advocate of the complainant that there is no complaint about surgery done by opponent No.2. Thus, it is clear that the complaint is about post-operative care and not about operation.

21. As discussed above, the problem was bradycardia attack. As submitted before us, bradycardia means "slow pumping of heart". It is mentioned in the complaint itself that on Dr. Satyavan Sharma, who was called by brother of the complainant, examined the patient and observed in his remarks that the 'cause of bradycardia attack has remained unexplained'. It is submitted by Advocate of the complainant that the patient was advised to be referred to Neurologist by Dr. Satyavan Sharma. However, intensivist Dr. Wagle did not seem it fit to refer the patient to the Neurologist. Learned Advocate for the opponents have argued that is false statement made by the complainant. Advocates of the opponents brought to our notice para 8 of the complaint wherein it is mentioned that after admitting the patient in 12 th floor,

Neurologist Dr. N.E. Bharucha put the patient under medication to stop his convulsions. Thus, it is clear that contention of the complainant that intensivist did not fit it necessary to refer the patient to the Neurologist is inconsistent with the recital in the complaint itself. Thus, the contention that the patient was also not referred to Neurologist and that is deficiency is baseless.

22. It is material to note that though the Complainant alleged medical negligence against the opponents, it is not his case that doctors were not qualified. The complainant did not lead any expert evidence to support the contention that there was medical negligence on the part of opponents while treating the patient after operation. In absence of any expert evidence to that effect, the contention of the complainant that there was negligence on the part of opponents in treating the patient after operation cannot be accepted. We already discussed above the allegations of the complainant against the opponent on the point of medical negligence and found that those allegations are baseless.

23. It is material to note that Learned Advocate for the opponent No.2 has argued that there was no problem of heart of the patient and even the complainant has mentioned in the complaint itself that there was no heart problem to the complainant even after 19 months since he was discharged from the hospital. It was argued by learned Advocate for opponent No.2 that here was no problem of lungs. It was submitted that it might be a problem of brain and that is supported by recital in the complaint itself where the complainant has mentioned that Dr. Sharma, who was called by brother of the complainant, examined the patient and advised to refer to Neurologist. We have already referred above that Neurologist Dr. Bharucha examined the Patient after the patient was admitted in ICU on 12 th floor. Learned Advocate for opponent No.2 has submitted that as it was a problem of brain, it was necessary to do CT Scan which was suggested. However, the complainant and other relatives of the patient have not given consent for CT Scan. It is material to note that it is mentioned in Para 8 of the complaint itself that on the advice of some of the doctors, complainant and his relatives did not give permission for CT Scan. Learned Advocates for the opponents have argued that because of relatives of the patient, proper investigation with the help of CT Scan could not be done and there is no fault on the part of the opponents. In view of recital in the complainant itself, we find that contention of the opponents is to be accepted. In absence of expert evidence, only contention of the complainant that there was medical negligence on the part of opponent is of no help to the complainant. Hence, we answer Point No.1 in negative."

17. For better understanding of the case, the sequences of events, as seen from the medical record, for the period 26.06.2004 to 29.06.2004 is detailed as hereunder:

Date	Particulars

26.06.2004	The Patient, aged 73 years, was admitted in the Hospital on 26.06.2004 for operation of Carcinoma Sigmoid Colon. The said patient was recommended to Dr. P.B. Desai by Dr. J.C. Kothari and was advised Surgery by Dr. Desai. On the same day the Patient was certified fit for Surgery by In-House Intensivist and Physician Dr. Sanjay Wagle.
28.06.2004	The Patient was successfully operated by Dr. Desai and the Doctor opined that the patient be shifted to the Post-operative Intensive Care Unit (ICU), rather than a ward.
29.06.2004	
9.00 AM 10.00 AM 10.30 AM	In the morning at about 8.00 a.m., the Patient met his relatives. At about 8.45 a.m., the patient was given physiotherapy. At 9.00 a.m., the Patient complained of throat pain, breathlessness and choking sensation. The medical records of the Patient for 29.06.2004, at 9.00 a.m., show that the Patient had throat pain became unconscious with alleged Bradycardia. The Patient was, intubated by the ICU Registrar, resuscitated and put on a ventilator. Between 9.00 a.m. and 9.15 a.m., the Patient was administered Atropin, Adrenaline, Soda Bicarbonate and other similar medications. At 10.00 a.m. the Patient was seen by Dr. Chaudhary and was administered further medication in the form of Cefoprim and Rantac. At 10.30 a.m., the patient was examined by Dr. Wagle, who noted his observation, including the ECG report. Dr. Wagle further explained 'guarded prognosis to the relatives' of the patient. It was advised that the Patient was required, by way of abundant caution, be shifted to the Intensive Care Unit (ICU) on the 12 th floor from the post-operative ICU.

10.35 AM 12.00 Noon 1.00 PM	At 10.35 a.m., it was noticed that the Patient was having tonic type of convulsions and Dr. Chaudhary was accordingly informed. At 12.00 noon, the patient was administered Epsolin (one ½ an hour period) and Midazalone on the advice of Dr. Chaudhary. The patient was also examined by Dr. Satyawan Sharma, a Cardiologist and in view of the medical condition of the Patient, Dr. Sharma suggested that as the cause of the Bradycardia remained unexplained, a Cardiac Injury Profile of the Patient be undertaken and further an opinion of a Neurologist be sought. Dr. Sharma further suggested that ECG of the Patient be repeated every two hours. At 12.00 noon, the Patient was again examined by Dr. Desai, and the opinion of dr. N. E. Bharucha, Neurologist was sought on the medical condition of the patient. At 1.00 p.m., the patient was examined by Dr. Bharucha, Neurologist.
	Thereafter the Patient was shifted to the ICU on the 12 th Floor.

18. The main points which arise for consideration and the contentions of the parties is detailed as hereunder:

- The Complainants submitted that there is a variation in the oral and written communication of Dr. Desai and the Anaesthetist regarding the decision to shift the Patient to the ICU. The Complainants family contended that Dr. Desai specifically mentioned to the attendants that the operation had gone well and the Patient would be shifted to the ward. Even in the operation report the Anaesthetistremarked that the Patient to be shifted to the ward. But once again in the same report Dr. Desai had directed to shift the Patient to the ICU. It is the

Complainants' case that the Doctors failed to apply their mind with respect to shifting of the Patient.

Learned Counsel appearing for the Hospital and the counsel appearing for the treating Doctors submitted that the Patient was recommended to be shifted to the post-operative ICU rather than the ward, considering the age of the Patient, who was 73 years old and only out of abundant caution and in the best interest of the Patient.

- It is also the contention of the Complainants that the process of shifting per se was not as per standards of protocol and also that there was a time lapse in the shifting, which caused deterioration in the condition of the Patient. The Patient was ordered to be shifted at 10.30 a.m. but was finally shifted around 1 p.m. It is the Complainants' case that the Hospital and the Doctors were negligent in shifting the Patient from one ICU, which is situated on the 3 rd floor in one building to another ICU, which is situated on the 12 th floor of another building, while the Patient's condition was unstable and critical. It is further contended that when the facilities in both the ICUs, listed in the Hospital rate card are the same, there are no substantial grounds for the Patient to be shifted from one ICU to another in this critical condition. The Complainants who are present in person further contended that there were no qualified doctors in the first ICU and therefore they had to shift the Patient to another ICU; the reasons for transfer was not given; that records of ICU from 8 a.m. to 9 a.m. were missing; that when amount paid is the same, the Patient is under the impression that both ICUs have the same facilities.

The Complainants further argued that the cause of the alleged Bradycardia was never explained to them and that it had occurred due to the possible respiratory problems in the ICU and known cause of any heart induced problem. It is their case that only because timely assessment of the respiratory problem was not done, that the Patient went into a brain dead situation because of deprivation of oxygen.

Learned Counsel appearing for the Hospital and the Doctors vehemently contended that the medical record made it abundantly clear that the Patient developed Bradycardia, i.e. a medical condition of slowing of the heart rate, due care and caution was taken as per standards of normal medical practice, which include immediate resuscitation measures, administration of drugs, which were administered by the attending nurses in the ICU under the supervision of a senior doctor who was immediately summoned from the adjoining Intensive Critical Care Unit (ICCU). It is submitted that the Patient was stable with the heart rate, respiration and oxygenation being stable. Dr. Wagle was consulted and all the drugs suggested by him were administered.

The material on record evidences that the cause for the Bradycardia was admittedly not explained. The Hon'ble Supreme Court in ***Smt. Savita Garg Vs. Director, National Heart Institute (2004) 8 SCC 56,*** has laid down the principle that the onus shifts on the Hospital to explain the exact line of treatment rendered and as to why a particular condition had occurred. In the instant case, it is for the Hospital and the team of Doctors to explain as to how the condition of Bradycardia had occurred. The contention of the Hospital and the treating Doctors that the Complainants did not give consent for CT Scan and therefore, there could not be any diagnosis and further that no expert evidence was led in the case is

untenable in the light of the fact that admittedly the Patient had convulsions and was in a critical state and hence the Complainants had admittedly not given consent for the CT Scan. The Hon'ble Supreme Court in ***V. Kishan Rao Vs. Nikhil Super Speciality Hospital & Anr. (2010) 5 SCC 513*** , have observed that no expert evidence is necessary for every case and that the Consumer Fora can adjudicate the aspect of medical negligence based on the material on record, the medical literature and the submissions made by the parties. The necessity of expert evidence depends on facts and circumstances of each case and in the instant case we do not find it a fit case to refer it to any expert. Thought it is an admitted fact that the Complainants did not agree to the conduction of the CT Scan as the Patient was having continuous convulsions, yet we are unable to understand as to why the Hospital and the treating Doctors could not give any reasons for the onset of Bradycardia. There is no material on record to evidence that only the conduction of CT Scan could have explained the causes for the Bradycardia. At the cost of repetition, admittedly there is no reason given for the onset of Bradycardia which has occurred post-operatively, when the Patient was in the ICU. In this aspect, we find the Hospital and the treating Doctors negligent, since the onus is on them to explain the reasons for the occurrence of Bradycardia.

- Now we address ourselves to whether there was any negligence on behalf of the Hospital in the process of shifting of the Patient from ICU of the third floor of one building to the ICU of the 12 th floor of another building. It is the Hospital's case that the Patient was stable for the purpose of shifting from one ICU to another; the Patient was monitored throughout the transport; that even in the present ICU there were proper qualified Doctors and the only reasons for shifting to another ICU was because not that it was inadequately equipped as alleged by the Complainant, but only because there was one nurse attached to each bed and better care could be taken.

  It is the Complainant's case that the 3 rd floor ICU was ill equipped and the Patient was shifted to the 12 th floor in the critical condition and if both the ICU had the same facilities and rates, there are no reasons for shifting the Patient in such a critical condition. The Complainants argued that the Patient was not stable and having convulsions during the process of shifting to the 12 th floor.

  A brief perusal of the ICU record of 29.06.2004, the date on which the Patient was taken to the 12 th floor ICU, it is observed that the nurse has recorded that his condition was unsatisfactory, therefore the contention of the Hospital and the treating Doctors that the Patient's condition was stable, is untenable. It is also the Complainant's case that the submission of the Hospital and the treating Doctors that there would be better care in the 12 th floor ICU, where one nurse is dedicated to each Patient, should not be taken into consideration as the Patient was being billed by the Hospital for provision of extra nurse. A reading of the bill, wherein extra charges were provided for the nurse evidences the same. Further reliance was placed on the brochure which mentioned that the same facilities would be provided in both the ICUs.

  Though we are of the considered view that the decision to shift from one ICU to another, is the Doctors prerogative based on the Patient's condition, it is to be seen whether during the process of transporting the Patient any time lapse had taken place and the ' golden hours' as defined in the medical dictionary have been lost. The record shows that the decision to shift the Patient was taken at 10.30 a.m. but the Patient was only shifted at around 1 p.m. The

reasons for this 2 ½ hours gap is unexplained. For adjudicating this issue, we find it relevant to further take into consideration the contention of the Complainants that the Patient was transported only with an Ambu bag which is alleged is not in conformity with the standard protocol.

It is the case of the Complainants that when the Patient was having convulsions, he was being helped to breathe with the help of an Ambu bag as there was only one ventilator in the said 3 rd floor ICU. The Ambu bag was later replaced by a ventilator.

Learned counsel for the Hospital relied on the compilation regarding Ambu bag (Bag Valve Mask), given by the Complainants in which it is stated as follows:

"A bag valve mask, abbreviated to BVM and sometimes known by the proprietary name Ambu bag or generally as a manual resuscitator or "self-inflating bag", is a hand-held device commonly used to provide positive pressure ventilation to patients who are not breathing to not breathing adequately. The device is a required part of resuscitation kits for trained professionals in out-of-hospital settings (such as ambulance crews) and is also frequently used in hospitals as part of standard equipment found on a crash cart, in emergency rooms or other critical care settings. Underscoring the frequency and prominence of BVM use in the Unites States of American Heart Association (AHA) Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiac Care recommended that "all healthcare providers should be familiar with the use of the bag-mask device". Manual resuscitators are also used within the hospital for temporary ventilation needs to be examined for possible malfunction, or when ventilator-dependent patients are transported within the hospital."

(Emphasis supplied)

Learned Counsel further argued that State Commission has rightly noted that the use of the Ambu bag is sufficient and there is no necessity of portable ventilator as the Ambu bag is also used for the same purpose.

The question arises here is whether the Patient, who had a fit of convulsions and admittedly required better care as per Doctors' own admission was shifted in a timely and proper manner or not.

When ,it is an admitted fact that the Patient was on drip and breathing with the support of an Ambu bag, it cannot be construed that the Patient was in a very stable condition. The submitssion of the learned Counsel read together with the medical literature relied on, establishes that the Ambu bag is used within the hospital for temporary ventilation and during emergency cardiac care, and therefore it cannot be construed that the Patient was in a stable condition, when he was being shifted from one ICU to another. Though as per the medical literature the Ambu Bag is used for Hospitals for transport within the Hospital area, it is also stated that manual resuscitator is not a suitable device for accurate ventilation. Strictly construed, this act of using an Ambu Bag cannot be termed as negligence perse attributable to a Doctor, merely because the Doctor thinks one course of action in preference to the other one available, he would not be liable if the course of action chosen by him was acceptable to the medical profession. Be that as it may, we are of the view that while shifting the Patient who was admittedly not in a stable condition from 3 rd to 12 th

floor ICU due care and caution ought to have been taken with respect to ventilation of the Patient and in a timely manner, specially keeping in view the fact that the cause for Bradycardia, which the Patient had developed was never explained and thereafter the Patient had slipped into a coma and remained in a vegetative state for a period of almost three years. At the cost of repetition, the time lapse of 2 ½ hours from 10.30 a.m. to 1 p.m. has not been explained. The medical records do not show any substantial reasons for the lapse of these 'golden hours' which was critical.

- The next contention of the Complainants is that Dr. Wagle has not been recognised as an 'Intensivist' by the Hospital as per their own brochure dated March 2015. It is argued that in both the brochures his name was included 'General Medicine' whereas the names of the other Doctors are shown against 'Intensivist' and he was only asked to step in as an Intensivistbecause the regular Intensivist was not presentin the third floor ICU, when the Patient was taken after the Surgery on 28.06.2004. Though the Hospital is advertised as a Super Speciality Hospital, Dr. Wagle contracted as a physician and performed also the role of Intensivist and Anaesthetist by doing a pre-investigative examinations on the Patient. It was argued that the ICU Registrar is not a senior Doctor and cannot deal with medical emergency. The meaning of Registraras per the medical dictionary is that he is an official keeper of records, a resident specialist, who acts as an assistant to the chief or attending specialist; and administrative officer whose responsibility is to maintain the records of an institutions and that he is not equipped to deal with any emergency moreover, he was notpresent in the ICU at the time when the complication arose. It is also submitted by the Complainants that no ICU Registrar had examined the Patient either on the date he was admitted i.e. on 26 th or even when the complication i.e. on 29 th , when the Patient was in the 3 rd floor. The Complainant drew our attention to the noting in the medical record made when the Patient was in the 12 th floor ICU, where whenever the ICU Registrar had examined the Patient a specific noting was made.

  It is the Complainant's case that it was only because no senior Doctor was present at that point of time, a senior Doctor had to be summoned from the adjoining ICCU, who promptly inserted endotracheal tube to maintain the Patient's breathing and sustained his heart. It is their case that as no senior Doctor was present in the ICU, when the complication arose, precious time was lost.

  Learned counsel appearing for the Hospital and the treating Doctors strongly contended that there was no time lost and that the Patient was adequately resuscitated in the post-operative ICU on the 3 rd floor by the ICU Registrar Dr. Sheikh and necessary notings were made in the medical record of the Patient at 10:30 a.m. The Patient was treated with all care and caution till 12:30 P.M. and subsequently was transported to the ICU on the 12 th floor.

  We do not wish to address to the issue as to whether the Doctors name was included under 'General Medicine' and the other Doctors' names were included under 'Intensivist' and that the said Doctor was asked to step in as an Intensivist because the regular Intensivist was not present. We find it more relevant to address the issue of medical negligence with respect to whether the treatment was rendered as per standards of Normal Medical Parlance.

  At this juncture we find it a fit case to place reliance on the catena of judgements of the Hon'ble Supreme Court with respect to medical negligence.

The "Bolam test" has been the subject of academic debate and evaluation in India and other jurisdictions. Among scholars, the Bolam test has been criticized on the ground that it fails to make the distinction between the ordinary skilled doctor and the reasonably competent doctor (Michael Jones, Medical negligence, Sweet and Maxwell, Fifth Edition (2017).

In a catena of judgements, the Hon'ble Supreme Court has laid down the essential components of 'Negligence' as follows:-

- *The existence of a duty to take care which the defendant owes to the plaintiff;*
- *The breach of that duty towards the plaintiff and*
- *Damage or injury by the complainant as a result of such breach.*

The 'Duty of Care' for a medical professional starts from the time the patient gives an implied consent for his treatment and the medical professional accepts him as a patient for treatment, irrespective of financial considerations. This duty starts from taking the history of the patient and covers all aspects of the treatment, like writing proper case notes, performing proper clinical examination, advising necessary tests and investigations, making a proper diagnosis, and carrying out careful treatment.

In 1969, the Supreme Court in the case of ***Dr.Laxman Balakrishna Joshi v. Dr. Trimbak Babu Godbole AIR 1969 SC 128*** held:-

> *A person who holds himself out ready to give medical advice and treatment impliedly undertakes that he is possessed of skill and knowledge for that purpose,*
>
> *1. he owes a duty of care in deciding whether to undertake the case,*
>
> *2. he owes a duty of care in deciding what treatment to give and,*
>
> *3. he owes a duty of care in the administration of that treatment.*
>
> *A breach of any of these duties gives a right of action for negligence to the patient.*

This means that when a medical professional, who possesses a certain degree of skill and knowledge, decides to treat a patient, he is duty bound to treat him with a reasonable degree of skill, care, and knowledge.

> *Failure to act in accordance with the medical standards in vogue and failure to exercise due care and diligence are generally deemed to constitute medical negligence.*

In the instant case, the nurse record shows that when the Patient developed complications the Doctor was called by the nurse; that Dr. J.C. Kothari was called by the Complainants, who is a chest specialist and not an Intensivist; he was referred to at 10:30 a.m. on 29.06.2004 and he was present when Dr. Wagle had arrived; Dr. Satyavan Sharma, who is

a Cardiologist arrived at about 11.45 to 12.00 noon. Dr. Bharucha was referred to only past 2 p.m. and arrived at about 5.30 p.m., which was noted in the ICU record. Between 9 a.m. and 10. 30 a.m., it is the Complainants case that the Patient was not attended to by any senior Doctor, leave alone the Intensivist.

As can be seen from the medical record once Dr. Wagle had arrived, he had increased 'minute ventilation'. The medical record does not evidence anywhere as to whether the Patient had received appropriate supply of oxygen from 9 a.m. till post 10.30 a.m. when Dr. Wagle had arrived at the post-operative ICU. There is no recording of the ICU Registrar as long as the Patient was there in the post-operative ICU on the 3 rd floor. It is an admitted fact that the Patient suffered Bradycardia which caused Hypoxia of the brain on account of lack of supply of oxygen to the brain.

The reasons with respect to Hypoxia and the treatment rendered between 9 a.m. to 10.30 a.m. with specific reference to ventilation being maintained is to be answered by the Hospital based on the principle laid down by the Hon'ble Supreme Court in ***Savita Garg (Supra)*** . The Hon'ble Supreme Court held that *"Once an allegation is made that the patient was admitted in a particular hospital and evidence is produced to satisfy that he died because of lack of proper care and negligence, then the burden lies on the hospital to justify that there was no negligence on the part of the treating doctor/ or hospital. Therefore, in any case, the hospital which is in better position to disclose that what care was taken or what medicine was administered to the patient. It is the duty of the hospital to satisfy that there was no lack of care or diligence. The hospitals are institutions, people expect better and efficient service, if the hospital fails to discharge their duties through their doctors being employed on job basis or employed on contract basis, it is the hospital which has to justify and by not impleading a particular doctor will not absolve the hospital of their responsibilities."* *(Emphasis Supplied)*

As can be seen from the record Dr. Wagle instructed only at 10.30 a.m. to repeat ECG and the blood tests and prescribed intravenous fluids. He also increased minute ventilation, which is a Respiratory Minute Volume or Minute Volume given by the volume of gas inhaled (inhaled minute volume) or exhaled (exhaled minute volume) from a person's lung per minute. It is not understood as to how the ICU Registrar had not thought it fit to repeat the ECG and the blood test which were prescribed by Dr. Wagle at 10.30 a.m. It is also evidenced from the record that the resident Doctor assisting Dr. Bharucha has examined the Patient at 1 p.m. and Dr. Bharucha the Neurologist examined the Patient only at 5.30 p.m. of 29.06.2004. Hence, the principle laid down in ***Savita Garg (Supra)*** , once again squarely applies as we are of the view that explanation with respect to ventilation given between 9 a.m. to 10.30 a.m. has not been sufficiently given and we are of the view that the Hospital is negligent with respect to this issue.

- It is the case of the Complainants that the sedative calmpose, being a schedule 'H' drug, under the Drugs and Cosmetics Rules, 1945, could not have been administered by the Hospital and the treating Doctors without a proper prescription. It is the Hospitals case that the Patient was given a proper dose i.e. 10mg at 10 p.m. on 28.06.2004; that the provisions of Drugs and Cosmetics Rules, 1945 only prohibits the sale of schedule 'H' drugs in retail and that the said medicine was administered on the prescription of the treating Doctor. It is the Complainants' case that because of Calmpose not being administered in the proper dosage the side effect of Bradycardia could have developed.

The Complainant had relied on the protocol which is followed internationally and also some standards laid down by the Joint Commission International Accreditation Standards for Hospitals and also a national Accreditation Board for Hospitals and Healthcare Providers. Learned Counsel appearing for the Hospital and also the Counsel for the Doctors vehemently contended that the international standards relied upon to be the Complainants cannot be construed by the Government standard protocol in India and that there are no such rules and regulations stipulated for the medical professional in most of the issues raised by the Complainants.

We are of the view that the administration and the drug dosage of 'Calmpose' do not fall within the essential components of Negligence namely 'duty', 'breach' and 'resulting damage'. We find force in the contention of the learned Counsel appearing for the Hospital and the Treating Doctors that Calmpose was administered as per standards of normal medical practice and as per prescription given by the treating Doctor and therefore we do not find any negligence regarding this aspect.

- The next contention of the Complainants is that because of improper physiotherapy, the Patient complained of breathlessness causing him extreme pain which could have led to the complications. Having gone through the material on record, we find force in the contention of the Hospital and the treating Doctors that physiotherapy is a normal procedure which is carried out post-Surgery and does not require any specific recommendation.

  In the instant case, though the Complainants relied on international conventions followed, we are of the view that having regard to the fact that there is no documentary evidence to substantiate any connection between the physiotherapy session and the Bradycardia attack, we are of the considered view that merely because there is no specific prescription for physiotherapy, it cannot be construed as negligence per se on behalf of the Hospital or the treating Doctors.

- We now address ourselves to the contentions of the Complainants that the Patient was suffering from chronic depression and was on anti-depressantsfor more than 20 years and that the anti–depressants were stopped abruptly before the operation without consulting a Psychiatric. It is the case of the Hospital and the treating Doctors that the anti-depressants were not stopped abruptly, were withheld only on the date of Surgery on the recommendation of the Anaesthetist. To adjudicate whether such a recommendation was made by the Anaesthetist or not we need to examine the pre-anaesthetic report of the concerned Doctor. It is pertinent to note that such a report is not placed on record. The Hospital treatment record does not evidence whether these anti-depressant drugs were given from the date of admission till the date when the complications arose. The medical chart depicting the drugs administered to the Patient do not include all these anti-depressants. Though the medical literature filed by the Complainants does show that there is a nexus between the two, it cannot categorically be stated that it was solely because of the abrupt stopping of the anti-depressant drugs that the said post-operative complication arose. Be that at it may, the fact remains that medical records do not evidence the administration of anti-depressant drug to the Patient except stopping of the same on the Surgery date. In the absence of the pre-anaesthetic report, we are of the considered view that the medical records filed by the Hospital does not depict whether the anti-depressants were administered/ tapered off from the date of admission till date of Surgery.

19. Learned counsel appearing for the Hospital vehemently contended that Complainants have sought to place guidelines of private associations, the statement of purpose of the association of physicians of India and have also previously sought to place certain standards issued by United States of America non-governmental organizations dealing with accreditation of Hospitals, despite it being an admitted position that the Hospital was never accredited to the said non-governmental organization and therefore any such standards are neither mandatory nor binding. He further argued that the documents which are placed on record have no applicability to them as regarding the submission of the Complainants that bed no. 385 has reflected in the medical records of the Patient was the bed of the post-operative Intensive Care Unit (ICU) where the Patient was taken after his operation on 28.06.2004. On the 12 th floor ICU he was allotted bed no. 1252 and therefore there is no contradictory reports of the respective beds. We are of the considered view that the submissions made by the learned counsel regarding bed no. 385 and 1252 is satisfactory. We find force in his contention that though the medical records and case papers of the Patient are maintained by different departments, at the time of discharge all medical records pertaining to the particular Patient are transferred to the medical records department and therefore the case papers of different departments have been arranged accordingly. We do not find any negligence or otherwise on behalf of the Hospital merely because the bed numbers are reflected differently in the ICU record.

20. Learned Counsel appearing for Dr. Desai vehemently contested that the Surgery was successful and the role of the surgeon ended with the completion of the surgical procedure and that there is no specific allegation against Dr. Desai except for stating that he was shifted to post-operative ICU instead of the ward. He contended that Dr. Desai cannot be held liable as no negligence has been attributed or proved against him.

21. In ***P.B. Desai vs State of Maharashtra & Anr. (2013)15 SCC 481 ,*** the 'Duty of Care' which a doctor owes towards his patient has been clearly explained as follows:-

> *"Once, it is found that there is 'duty to treat' there would be a corresponding 'duty to take care' upon the doctor qua/his patient. In certain context, the duty acquires ethical character and in certain other situations, a legal character. Whenever the principle of 'duty to take care' is founded on a contractual relationship, it acquires a legal character. Contextually speaking, legal 'duty to treat' may arise in a contractual relationship or governmental hospital or hospital located in a public sector undertaking. Ethical 'duty to treat' on the part of doctors is clearly covered by Code of Medical Ethics, 1972. Clause 10 of this Code deals with 'Obligation to the Sick' and Clause 13 cast obligation on the part of the doctors with the captioned "Patient must not be neglected".*

Having regard to what the Hon'ble Supreme Court has laid down about the 'Duty of Care' to be followed by a medical professional viewed from any angle, it cannot be construed that 'Duty of Care' of a treating doctor ends with the 'Surgery'. *(Emphasis Supplied)*

22. This Commission has also held in ***P.D. Hinduja National Hospital & Medical Research Centre Vs. Mrs. Veera Rohinton Kotwal, II (2018) CPJ 342 (NC),*** that the 'Duty of Care does not end with the Surgery'.

23. We find it a fit case to place reliance on the judgement of the Hon'ble Supreme Court in ***Arun Kumar Manglik Vs. Chirayu Health And Medicare Private Limited & Anr., 2019 (3) SCALE 333,*** in which the Hon'ble Apex Court has laid emphasis on 'Patient Centric Approach' and observed that the 'Standard of Care' as enunciated in the *Bolam Case* must evolve in consonance with its subsequent interpretation by English and Indian Courts.

24. In Halsbury's Laws of England the degree of skill and care required by a medical practitioner is detailed as follows:-

> *"The practitioner must bring to his task a reasonable degree of skill and knowledge, and must exercise a reasonable degree of care. Neither the very highest nor a very low degree of care and competence, judged in the light of the particular circumstances of each cases, is what the law requires, and a person is not liable in negligence because someone else of greater skill and knowledge would have prescribed different treatment or operated in a different way; nor is he guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art, even though a body of adverse opinion also existed among medical men.*
>
> *Deviation from normal practices is not necessarily evidence of negligence. To establish liability on that basis it must be shown (1) that there is a usual and normal practice; (2) that the defendant has not adopted it; and (3) that the course in fact adopted is one no professional man of ordinary skill would have taken had he been acting with ordinary care."*
>
> *A doctor has a legal duty to take care of his patient. Whenever a patient visits a doctor for treatment there is a contract by implication that the doctor will take reasonable care to treat him. If there is a breach of that duty and if it results in injury or damage, the doctor will be held liable. The doctor must exercise a reasonable degree of care and skill in his treatment; but at the same time he does not and cannot guarantee cure.*
>
> *(Emphasis Supplied)*

25. The Hon'ble Supreme Court in ***Malay Kumar Ganguly v. Dr. Sukumar Mukherjee, (2009) 9 SCC 221, case has preferred Bolitho test to Bolam test*** . The Supreme Court redefined medical negligence saying that the quality of care to be expected of a medical establishment should be in tune with and directly proportional to its reputation. The decision also says that the court should take into account patient's legitimate expectations from the hospital or the concerned specialist doctor.

(Emphasis Supplied)

26. In the instant case we are of the considered view that there is negligence in the treatment rendered to the Patient with respect to the time and manner in which the Patient was shifted from

the 3 rd floor ICU to the 12 th floor ICU, the unexplained cause for Bradycardia, which is not in accordance with what was laid down by the Hon'ble Supreme Court in ***Savita Garg (supra),*** the absence of medical record specifying the treatment rendered to the Patient between 9 a.m. to 10.30 a.m. in the ICU.

27. Having regard to the fact that the Patient was in the Hospital for a period of 8 months; in a coma for a period of almost three years; the bills filed towards medical expenses amounting to 16,93,010.00 (excluding the medi-claim amount of 3,75,000/-) and the expenses incurred post discharge, when the Patient was in a coma, and also the mental agony suffered by the Patient's family, the aspect of *restitutio in integrum*, and the Patient's age, we are of the view that awarding an amount of 30,00,000/- (Thirty Lakhs) to be paid by the Hospital would meet the ends of justice. We also award costs of 1,00,000/- (One Lakh) to be paid by both the Doctors jointly and severally as we hold that 'Duty of Care does not end with the Surgery'.

28. In the result, this Appeal is allowed in part and the order of the State Commission is set aside and we direct the Hospital to pay an amount of 30,00,000/- (Thirty Lakhs) and costs of 1,00,000/- (One Lakh) to be paid by both the Doctors jointly and severally. Time for compliance four weeks from the date of receipt of a certified copy of this order, failing which the amount shall attract interest @ 9% p.a. from the date of filing of the Complaint till the date of realisation.

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

.....
M. SHREESHA
MEMBER