STATE CONSUMER DISPUTES REDRESSAL COMMISSION
U.T., CHANDIGARH

[ADDITIONAL BENCH]

Appeal No.	**:**	**181 of 2025**
Date of Institution	:	28.05.2025
Date of Decision	:	11.03.2026

Mrs. Kavita mother of deceased Gurpreet Kaur, Resident of House No.2248A, Sector 42C, SBI Colony, Chandigarh

....Appellant/Complainant

Versus

1. Government Multi Specialty Hospital, Sector 16, Chandigarh through its Director
2. Ivy Hospital, Sector 71, Mohali through its Director
3. Dr. Gurpreet Singh Babra, Department of Internal Medicine, Ivy Hospital, Sector 71, Mohali
4. Dr. Chetan Goel, Department of Anaesthesiology and Critical Care, Ivy Hospital, Sector 71, Mohali
5. Dr. Rajiv Dhunna, Department of Anaesthesia, Critical Care & Pain Management, Ivy Hospital, Sector 71, Mohali

....Respondents/Opposite parties

BEFORE: MRS. PADMA PANDEY, PRESIDING MEMBER
SH. RAJESH K. ARYA, MEMBER

ARGUED BY :-

Sh. Deepak Aggarwal, Advocate for the appellant
Sh. Mannu Kukkar, Govt. Pleader for respondent No.1
Sh. Pardeep Sharma, Advocate for respondents No.2 to 5 alongwith Dr. Gurpreet Singh Babra, Respondent No.3 in person
Dr. Chetan Goel, Respondent No.4 in person
Dr. Rajiv Dhunna, Respondent No.5 in person

PER RAJESH K. ARYA, MEMBER

The instant appeal has been filed by the complainant – Mrs. Kavita (appellant herein) for setting aside order dated 09.12.2024 passed by District Consumer Disputes Redressal Commission-I, U.T., Chandigarh (hereinafter to be referred as 'District Commission') vide which, her

Consumer Complaint bearing No.941 of 2022 has been dismissed finding no deficiency in service on the part of the opposite parties.

2] Briefly stated the case of the complainant, before the District Commission, was that she was mother of the deceased late Ms. Gurpreet Kaur, who expired at the young age of 19 years, due to deficiency in service by opposite parties. Late Ms. Gurpreet Kaur was bright and meritorious student, who had obtained more than 91.2 % marks in class 10+2 and was at the relevant point of time studying in B.Com, 1st year from Govt. Commerce College, Sector 50, Chandigarh. She had excellent track record in academics and other extra-curricular activities with an eye on cracking UPSC/Civil Services Examination.

3] On 19.12.2021, due to diarrhea for three days along with cough and slurred speech for about four days, Ms. Gurpreet Kaur was taken to GMSH, Sector 16, Chandigarh (opposite party No.1 Hospital) by the complainant and her father, where the doctors, after clinical checkup, in an utmost gross, rash and negligent manner, without making any diagnosis or advising any blood tests or other investigations, simply prescribed some medicines. Despite her blood pressure being 100/60, opposite party No.1 Hospital, through its attending doctors, did not bother to admit Ms. Gurpreet Kaur. In a most rash and negligent manner, at around 6:57 pm on 19.12.2021, opposite party No.1 prescribed Aciloc 1 ampoule stat, Buscopan 1 ampoule injection, Tab Zecalo and IV Fluid (Normal Saline) and thereafter, without any investigations, blood tests or diagnosis, discharged Ms. Gurpreet Kaur at around 8:10 pm by advising Tab Ciplox TZ BD for 3 days, Tab Pantop 40 BD for 3 days, Tab Sporolac 1 BD, ORS Zoom, and follow-up in Medical OPD.

4] It was averred that opposite party No.1 Hospital, including its treating doctors, were deficient and indulged in unfair trade practices as, despite recording the BP of Ms. Gurpreet Kaur as 100/60 on 19.12.2021 at 2:07 pm, they neither treated the said condition nor prescribed any medicine for the same, and no cardiologist was called. Opposite party No.1 Hospital and its treating doctors did not even bother to make any diagnosis or order any blood test or other investigations despite Ms. Gurpreet Kaur

having diarrhea for the last three days and slurred speech. No ECG or ultrasound was recommended despite her pulse rate being 169 bpm, and they did not even bother to check her body temperature. The complainant ran from pillar to post to get Ms. Gurpreet Kaur admitted, but opposite party No.1 Hospital and its treating doctors refused to admit her. It was further stated that in view of the medical emergency, opposite party No.1 Hospital and its treating doctors could have referred Ms. Gurpreet Kaur to PGIMER, Sector 12, Chandigarh or any other hospital if they were short of beds or equipment; however, from their act and conduct, it was clear that they were totally non-serious, negligent and instrumental in causing the death of Ms. Gurpreet Kaur due to their gross, rash and negligent acts.

5] It was further stated that in these circumstances, the complainant including other family members came in contact with opposite party No.2 - Hospital. Thereafter complainant visited clinic of opposite party No. 3 – doctor. On the visit, it transpired that said doctor at that point of time was in opposite party No.2 - hospital and he told complainant to come there. Thereafter complainant visited opposite party No.2-hospital on 20.12.2021 at about 8:30 am in the morning alongwith her daughter on scooter and after some time, the father of Ms. Gurpreet Kaur also reached there.

6] It was further stated that opposite party No.3, Dr. Gurpreet Singh Babra, is a doctor of Internal Medicine at the hospital of opposite party No.2 and Principal Consultant of Internal Medicine and Rheumatology and was instrumental in attending late Ms. Gurpreet Kaur. It was further stated that opposite party No.4, Dr. Chetan Goel, a doctor of Anaesthesiology and Critical Care, was instrumental in causing the death of late Ms. Gurpreet Kaur by his grossly rash and negligent acts of repeatedly inserting the central line without X-ray guided technique and making pricks/cuts in a most negligent manner. It was further stated that opposite party No.5, Dr. Rajiv Dhunna, a doctor of Anaesthesia, Critical Care and Pain Management at opposite party No.2 Hospital, was also instrumental in causing the death of late Ms. Gurpreet Kaur by his grossly rash and negligent acts, including failure to provide proper treatment for any

diagnosed disease or ailment, lack of transparency in the ICU, not allowing even a single attendant to meet late Ms. Gurpreet Kaur and concealment and fabrication of her medical record in connivance and conspiracy with other doctors, paramedical staff and the hospital.

7] It was further stated that on reaching opposite party No.2 Hospital, Ms. Gurpreet Kaur was taken to the triage area on 20.12.2021 and that the complainant, by letter dated 04.07.2022 sent through registered post, requested supply of the complete medical record, including death summary, indoor hospital notes, vital charts, complete ICU record and surgical intervention record pertaining to her death on 22.12.2021 (UHID No. 245279), which had not been supplied at the time of death despite repeated requests, anticipating that negligence would be highlighted; the record was thereafter demanded under Clause 1.3.2 of MCI Notification No. MCI-211(2)/2001 dated 11.03.2002, but was supplied after about 10 days instead of within 72 hours, reflecting manipulation. It was further stated that pursuant to the advice of opposite party No.3, Dr. Gurpreet Singh, late Ms. Gurpreet Kaur got admitted to IVY Hospital, SAS Nagar, Mohali on 20.12.2021 at about 8:30 am after paying the initial deposit without receipt and despite diarrhea for three to four days, she was fully conscious, aware and in touch with her parents, was assured that all consumables, medication, surgical supplies, food, drinks and blood/platelets would be provided, and that at the time of admission the accompanying persons were made to sign standard consent forms without the same being brought to their notice.

8] It was further stated that opposite party No.3 doctor, at 9:30 am, on the visit of Ms. Gurpreet Kaur to the triage area, recorded complaints of loose motions, vomiting, slurred speech, toxic look, shallow respiratory effort, tachycardia & tachypnea and recommended various blood tests including random lipids, thyroid profile, Covid RTPCR, chest X-ray and dengue serology and further advised ICU admission with central line cannulation; however, it was stated that Ms. Gurpreet Kaur had no complaints of dyspnea or shallow respiratory effort as recorded by opposite party No.3. In complete contrast, opposite party No.2 Hospital, at the triage

area, recorded history of loose motions for 3–4 days, vomiting, decreased power in all limbs with slurred speech, no history of chronic disease and on examination found all primary survey parameters to be proper and active, with secondary survey vitals at 10:00 am showing pulse 154, BP 143/90, RR 22, SpO_2 98%, temperature 98°F, pain score 0/10, and normal GCS, clearly indicating that the record prepared by opposite party No.3 at 9:30 am was incorrect and manipulated. It was further stated that at 10:00 am on 20.12.2021, Ms. Gurpreet Kaur had no fever, no hypoxia, proper respiratory rate, stable BP and pulse, did not require oxygen therapy as reflected in the discharge planning form, had walked from the parking area to triage and under these circumstances, her condition could not be said to be life-threatening or of poor prognosis.

9] It was the case of the complainant that the diagnosis and treatment recommended by opposite party No.3 were totally contradictory to what was recorded at the triage area at 10:00 am and in the discharge planning form at 11:00 am on 20.12.2021, which was self-explanatory and clearly reflected mischievous thinking and manipulation of records, including Annexure C-4 (Colly.), as even the plan of care at 11:00 am only prescribed Injection Pantocid 40 mg IV stat, Injection Emeset IV stat, IV normal saline 100 ml per litre and a recommended stay of 2–3 days with soft diet. It was further stated that despite this, in an utmost rash and negligent manner, on the recommendation of opposite party No.3, Ms. Gurpreet Kaur was shifted from triage to RICU at 12:00 noon on 20.12.2021, where the doctors diagnosed acute gastro-enteritis with hypokalemia, found her conscious, oriented, with BP 130/90, oxygen saturation 98%, and Hb 15.5 and that at around 1:00 pm her history was again taken and medicines including Injection Vitamin K 10 mg IV stat, Tablet Rifagut TDS, KCl infusion with central line and repeat dengue serology were advised, which had not been conducted earlier despite recommendation at 9:30 am.

10] It was further stated that Ms. Gurpreet Kaur was prepared for central line insertion by OP No.4, Dr. Chetan Goel, who, in a rash and negligent manner and without proper consent or explanation, attempted

multiple times unsuccessfully, causing Ms. Gurpreet Kaur to go into shock with significant blood loss, leaving her gown and bed in a pool of blood. The complainant witnessed her daughter screaming for help and asking for food, while OP No.4 dismissed the concern. Despite suspicion of dengue by OP No.3 - Dr. Gurpreet Singh Babra, appropriate precautions and SDAP cover were not used. The central line was eventually coiled in the internal jugular, causing fluid accumulation and breathing difficulty. Around 4:20 pm on 20.12.2021, a provisional dengue NS1 antigen report showed positivity and platelet count of 72,000. Ms. Gurpreet Kaur was shifted to ICU at 5:35 pm, where her history was retaken at 7:30 pm and OP No.3, despite her having no fever, recorded poor prognosis by 8:30 am on 21.12.2021. Delays and confusion over single donor platelet transfusion further worsened her condition. The ICU in-charge, OP No.5, informed the complainant that the shift was temporary and she would be moved back to the ward in 12 hours.

11] It was further stated that the wrongly inserted central line choked Ms. Gurpreet Kaur, who was kept on CPAP and later advised steroids without proper tests. On 21.12.2021 at 10 pm, it was discovered that the central line inserted on 20.12.2021 was coiled in the internal jugular, causing fluid accumulation and breathing difficulty. The triple lumen catheter was withdrawn and reinserted but the patient went into deep shock, requiring intubation and mechanical ventilation and ultimately died at 9:00 am on 22.12.2021, with blood oozing from the insertion site (Annexure C-5). From 8 pm on 21.12.2021, the complainant was prevented from meeting her daughter and no health updates were provided, reflecting a lack of transparency by opposite parties No.2 to 5 and also unfair trade practices. Police was called due to gross negligence, during which opposite parties No.3 and 5 gave misleading statements about fractures that Ms. Gurpreet Kaur never had, as clarified by the complainant with supporting medical records (Annexure C-8).

12] It was further stated that the entire stay of Late Ms. Gurpreet Kaur at IVY Hospital, Mohali, was marked by gross negligence, including failure to review prior medications, consider other diseases, ensure fluid intake, monitor discharge or arrange timely blood/platelet transfusions.

Despite lab reports showing high neutrophils and low lymphocytes indicating bacterial infection (Septicemia), the hospital treated her for Dengue based solely on NS1, ignoring further test recommendations. This mismanagement, including inappropriate IV transfusions, worsened her condition, caused liver damage and contributed to her untimely death.

13] It was further stated that the hospital and attending doctors exhibited gross negligence, failing to seek a second opinion, adjust treatment despite worsening condition or refer Ms. Gurpreet Kaur to a better-equipped facility. The hospital lacked a blood bank, emergency tie-ups and basic dengue care, including fresh juices, weight monitoring and bladder management. Despite her rapidly dropping hemoglobin and platelet counts, no timely transfusions or necessary tests for heart, liver and kidney function were conducted. The hospital violated WHO, CDC, and Indian guidelines, leaving the complainant to arrange critical blood herself, reflecting a complete failure to meet even minimal standards of care. It has further been stated that on 21.12.2021, in the morning, the blood count was further reduced to 10 HB. However, the complainant was handed over details of blood report and was asked to arrange for blood only at eleventh hour/last moment. The hospital authorities despite being fully aware of the difficulties in procuring single donor platelet, insisted only on single donor platelet and made clear that the random donor platelet would be rejected and would not be used. It has further been stated that before approaching this Commission, the complainant made several representation, Annexure C-10 colly., to various public authorities but with no result or outcome.

14] It was stated that the opposite parties' acts fall within the legal definition of negligence involving breach of duty and resulting damage. The complainant seeks compensation for the untimely death of her 19-year-old daughter, a meritorious student of B.Com 1st year with over 91.2% marks, actively involved in academics and extra-curricular and with a promising future including potential UPSC aspirations. Had she lived, her estimated income by age 25 would have been ₹12 lakh per year, totaling ₹4.2 crore over 35 years of work. The complainant has suffered immense loss of love,

affection, mental agony, harassment and incurred medical expenses due to the opposite parties' negligent acts.

15] It has further been stated that it is settled law that once an allegation is made that the patient was admitted in a particular hospital and evidence is produced to satisfy that she 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. It has further been stated that in any case, the hospital is in a better position to disclose what care was taken or what medicine was administered to the patient. It has further been stated that 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 not impleading a particular doctor will not absolve the hospital of its responsibilities. It has further been stated that the attending doctors were seriously remiss in their conduct and it was on account of their negligence that the deceased met with untimely death. It has further been stated that the standard of duty of care in the medical services has also to be inferred after factoring in the position and the stature of the doctors concerned as also the hospital; the premium stature of services available to the patient certainly raises a legitimate expectation and the opposite parties were totally lacking in the same.

16] Thus, relying upon settled principles of negligence as defined in Ratanlal & Dhirajlal and a catena of judgments of the Hon'ble Supreme Court and Hon'ble National Commission, the complainant sought compensation for mental agony, loss of love and affection, medical expenses and loss of future income, estimating the deceased's prospective earnings at ₹12 lakhs per annum and lifetime income at ₹4.2 crores. Thus, a lump-sum compensation of ₹4.20 crores besides ₹50 lakhs on account of harassment and mental agony faced by the complainant and ₹1.50 lakhs as cost of litigation has been prayed by the complainant in her complaint.

17] On the other hand, opposite party No.1, in its reply filed before the District Commission stated that on 19.12.2021 at about 2:07 pm, patient namely Ms. Gurpreet Kaur, D/o Sh. Raj Kapoor, aged 19 years, old female came to the Emergency Department, Govt. Multi Specialty Hospital, Sector-16, Chandigarh with the history of Diarrhea and admitted by issuing OPD Card No.20210412050. The patient was examined by the Emergency Medical Officer and initial treatment with IV fluids was given to the patient. Thereafter, she was further examined by the Doctor of Medicine Department who started treatment accordingly and during the treatment, Aciloc, Injection Buscopan, Iv fluid, Tab. Leedot have been given to her. It was further pleaded that during the treatment, she remained in Emergency Department till 08:10 pm and the condition of the patient was stable and further oral medication i.e. T. Ciplox TL, T. PAN 40 mg, T. SPOROLAC, ORS 200ML/per loose stool was prescribed to the patient by the doctors. Thereafter, she was advised to follow up the further treatment in medical OPD but she did not follow further treatment in GMSH-16 and she never visited again in GMSH-16, Chandigarh. It was further pleaded that proper treatment was given to her after examination by the concerned doctor with due care and caution and there was no question of any negligence on the part of doctors of opposite party No.1. Denying any deficiency in service on its part, rest of the allegations made in the complaint were denied by opposite party No.1.

18] Since opposite parties No.2 to 5 failed to file the written reply within the stipulated period of 45 days, hence, their defence was struck off by the District Commission vide order dated 17.9.2024.

19] The complainant filed rejoinder before the District Commission wherein she reiterated all the averments made in the complaint and repudiated those as stated in the reply of opposite party No.1.

20] The contesting Parties led evidence in support of their respective cases before the District Commission.

21] The District Commission after hearing arguments and considering the documentary evidence on record dismissed the consumer complaint as stated above.

22] The order of the District Commission has been assailed by the appellant – complainant on the ground that the impugned order is totally unreasoned, biased and cryptic, as neither the allegations nor evidence of the appellant/complainant were considered and needs to be set aside. It has further been stated that the present appeal arises from the untimely death of the complainant's 19-year-old daughter, a meritorious student with an exceptional academic record and bright future, who succumbed to Dengue Shock Syndrome due to gross medical negligence and deficiency in service on part of opposite parties Nos. 1 to 5. It has further been stated that Para 3 of the impugned order notes that the defence of opposite parties No.2 to 5 was struck off vide order dated 17.09.2024 for non-filing of written reply yet the District Commission relied on their submissions, which is impermissible in view of the law laid down by constitutional Five Judge Bench Judgement of Hon'ble Supreme Court of India in the case of *New India Assurance Company Limited Vs Hilli Multipurpose Cold Storage Pvt. Ltd. (2020) 5 (757) SCC*.

23] It has further been stated that the progress sheet at Page No. 83 reflects that the deceased was shifted from Triage to the Respiratory ICU only at 12:00 noon on 20.12.2021 with a provisional diagnosis of Acute Gastro-enteritis, despite no treatment having been administered from 8:30 am to 12:00 noon, which itself constitutes gross deficiency in service. It has further been stated that at 4:00 pm on 20.12.2021, her Hb was 15.5 g/dL and platelet count was 72,000 with Dengue NS1 antigen found provisionally positive. It has further been stated that shockingly, by the very next day i.e. 21.12.2021, her Hb fell precipitously from 15.5 to 10.1, clearly demonstrating inadequate monitoring and negligent management by opposite parties No.2 to 5. It has further been stated that once dengue with possible shock syndrome and unstable vitals was suspected, insertion of a central line without Single Donor Platelet (SDP) cover was wholly unjustified, unsafe and contrary to standard medical protocol, amounting to clear medical negligence and deficiency in service.

24] It has further been stated that despite clear clinical warning signs, abnormal vitals and evolving dengue parameters, opposite party No.1

rashly discharged the patient without basic investigations, while opposite parties No.2 to 5 failed to follow established WHO and Government of India guidelines mandating timely diagnosis, meticulous monitoring, serial hematocrits and guided fluid resuscitation. It has further been stated that the treating doctors neither maintained vital charts nor input-output records, delayed and inadequately monitored treatment, wrongfully inserted and retained a malpositioned central line without platelet cover causing active bleeding, failed to manage hematuria and precipitous fall in hemoglobin, and made no advance arrangements for blood or platelets, ultimately placing the complainant at the mercy of last-minute exigencies. It has further been stated that the defence of opposite parties Nos.2 to 5 having been struck off, the allegations and evidence stood unrebutted, yet were ignored by the District Commission, which erroneously relied on a biased expert report. It has further been stated that the cumulative acts of omission and commission squarely fall below the standard of reasonable medical care, directly resulting in the patient's deterioration and death, thereby attracting liability under settled principles of medical negligence and entitling the complainant to just and adequate compensation in the interest of justice.

25] It has further been stated that the central line inserted on 20.12.2021 at about 2:00 pm (Page No.86 alongwith the complaint) was done in a rash and negligent manner, resulting in profuse bleeding from the insertion site, with the deceased and the entire bed sheet soaked in blood, as evidenced by photographs placed on record as Annexure C-5 (Page No.113). It has further been stated that it subsequently transpired that the central line was wrongly placed and had coiled in the internal jugular vein, a serious and life-threatening complication. It has further been stated that on 21.12.2021, in the morning the blood count was further reduced to 36,000 Hb, however, the complainant was handed over details of blood report and was asked to arrange for blood only at eleventh hour/last moment. It has further been stated that the hospital authorities, despite being fully aware of the difficulties in procuring single donor platelet, insisted only on single donor platelet and made clear that the random donor platelet would be

rejected and would not be used. It has further been stated that opposite parties No.2 to 5 acknowledged this error on 21.12.2021, when the patient's condition became critical (Page No.106 alongwith the complaint) and only thereafter withdrew and repositioned the line into the Superior Vena Cava, clearly establishing gross medical negligence and deficiency in service.

26] It has further been stated that the District Commission wrongly held that doctors of respondent no.1 took due care despite the deceased being discharged from GMSH, Sector 16 on 19.12.2021 at 8:10 pm in critical condition without diagnosis or tests and ultimately, succumbing on 22.12.2021 due to dengue shock syndrome. It has further been stated that on 20.12.2021, at opposite party No.2 Hospital, the recorded vitals are self-contradictory, reflecting deficiency and negligence by opposite parties No.2 to 5, including shifting the deceased to RICU without medical justification. It has further been stated that despite a positive dengue NS1 antigen and falling Hb (from 15.5 to 10.1) and platelets, central line insertion was done without SDP cover, violating Government and WHO guidelines. It has further been stated that the District Commission ignored gross hematuria caused by urinary catheter, lack of contingency planning, failure to provide fresh juices, measure weight, transfuse blood and monitor Hb decline. It has further been stated that the complainant was left to arrange blood herself with critical platelet requirement at the eleventh hour. It has further been stated that the standard of care, expected of doctors and hospital of such stature, was totally lacking.

27] It has further been stated that a malpositioned and coiled central venous catheter constitutes a medical emergency, as it carries grave risks of vascular perforation, hemorrhage, thrombosis, embolism, infection, arrhythmias, catheter dysfunction, and even cardiac tamponade, particularly in a critically ill patient with Dengue Shock Syndrome. Standard medical protocol mandates immediate confirmation and prompt removal or repositioning under specialist supervision, which was not done in the present case. Further, opposite party No.2 hospital acted with gross negligence in inserting a central line without SDP cover in a thrombocytopenic dengue patient and by catheterizing the urinary tract,

resulting in gross hematuria (Page No.87 alongwith the complaint), thereby significantly aggravating bleeding risk and contributing to the patient's deterioration.

28] It has further been stated that if the order is not set aside, it will cause grave prejudice to the appellant and allow respondents to misuse the findings, hence the impugned order is liable to be set aside.

29] On the other hand, on behalf of respondent No.1 – Hospital, it has been argued that the appellant-complainant has not approached this Commission with clean hands, having deliberately suppressed the Medical Board report constituted at her own request, which was brought on record by opposite parties No.2 to 5 as Annexure OP-2/2, in clear violation of the settled principle that a litigant invoking equitable jurisdiction must disclose all material facts with utmost candour as held in *Kishore Samrite v. State of U.P.* (2013) 2 SCC 398. It has further been stated that the complaint is further vitiated by selective, conjectural and lay interpretation of medical records by the Counsel for the appellant-complainant, who has impermissibly substituted expert medical opinion with speculative arguments unsupported by medical literature or evidence, contrary to the law laid down in *Jacob Mathew v. State of Punjab* (2005) 6 SCC 1 and *Kusum Sharma v. Batra Hospital* (2010) 3 SCC 480. It has further been stated that additionally, the Counsel has travelled far beyond the pleadings by introducing fresh and impermissible theories of negligence, which is barred in law as reiterated in *Bachhaj Nahar v. Nilima Mandal* (2008) 17 SCC 491. It has further been stated that neither the parties nor this Commission possesses medical expertise to independently adjudicate medical negligence, which must be tested strictly on the touchstone of the Bolam principle as adopted in *Bolam v. Friern Hospital Management Committee* (1957) 1 WLR 582 (Queen Bench Division, England) and consistently affirmed by the Hon'ble Supreme Court in *Jacob Mathew* and *Kusum Sharma* (supra).

30] It has further been stated that the Hon'ble Supreme Court has most recently reaffirmed this position in *Deep Nursing Home v. Manmeet Singh Mattewal*, 2025 INSC 1094, holding that medical negligence must be

determined primarily on expert opinion without hindsight or subjective reasoning and that due weight must be accorded to findings of a duly constituted Medical Board. It has further been stated that in the present case, the Medical Board comprising qualified experts, after examining the entire medical record, has unequivocally concluded that the treating doctors followed standard medical protocols, thereby fully satisfying the Bolam test and in the absence of any contra-expert evidence, such report is conclusive, as held in *Martin F. D'Souza v. Mohd. Ishfaq* (2009) 3 SCC 1.

31] It has further been stated that consequently, the complaint suffers from suppression of material facts, lack of bona fides, speculative allegations and legally impermissible arguments beyond pleadings and is squarely governed by authoritative precedents of Hon'ble Apex Court warranting dismissal of the present appeal with costs.

32] However, respondents No.2 to 5, while reiterating their written arguments filed before the District Commission, submitted that respondent Nos. 2 to 5 provided timely, comprehensive and evidence-based medical care to the patient, who had been critically ill for several days prior to admission, with severe dehydration, profound metabolic derangements, dengue hemorrhagic shock syndrome, severe sepsis and multi-organ dysfunction, all carrying a grave prognosis. It has further been stated that upon presentation, the patient was immediately evaluated, prognosticated in vernacular language, investigated and shifted to the ICU after obtaining informed written consents and was thereafter managed by a multidisciplinary team of senior specialists strictly as per standard medical protocols and guidelines. It has further been stated that all necessary investigations, imaging, blood products, procedures including central line insertion under ultrasound guidance, electrolyte correction, fluid resuscitation, ventilatory support planning, and continuous monitoring were duly undertaken, while the family was repeatedly counseled regarding the critical condition and guarded prognosis. It has further been stated that the deterioration and eventual demise of the patient were attributable solely to the natural progression of severe dengue with sepsis and MODS, compounded by delayed presentation and refusal of timely interventions at

crucial stages and not due to any act of negligence, rashness or deficiency in service on the part of respondents No.2 to 5, who acted with due care, skill and competence expected of a tertiary care hospital. It has been prayed that the present appeal may be dismissed with costs.

33] We have heard the Counsel for the parties and have carefully gone through the impugned order, material available on record and the written submissions of the parties very carefully.

34] Before proceeding further, it may be stated here that there is a delay of 116 days (as per office 88 days) in filing the present complaint, for condonation whereof, the complainant has moved a ***Miscellaneous Application No.500 of 2025*** alongwith the complaint. To see condonation of the said delay, it has been stated in the application that when free certified copy of the impugned order dated 09.12.2024 was not received by the appellant/complainant, she through her Counsel applied for inspection of file in the first week of May 2025, where-after only the file was duly inspected and it was found that the free certified copy of the order was not delivered and there was endorsement by the Postman on the envelop to the extent "insufficient address. No such house no.SBI Colony, 42-c.". It has further been stated in the application that if the address of the complainant is compared, it is different and there was typographical error in the address also. As such, the appellant/complainant applied for the fresh certified copy of the final order dated 09.12.2024 on 01.05.2025 and received the same on 07.05.2025, hence, delay in filing the appeal has occurred which is due to bonafide reasons and unintentional. It has further been contended that if counted from the date of receipt of fresh copy of the order i.e. 07.05.2025, the appeal is well within the period of limitation.

35] The application has been contested by opposite parties No.2 to 5 by way of filing their reply stating therein that no justification or valid reasoning has been given in the application as to what stopped the appellant from applying for the certified copy earlier. It has further been stated that the report of postman attached with the appeal at Page 10A clearly shows that house No. is duly mentioned as "House No.244A, Sector 42B, SBI colony, Chandigarh." and it is wrong to say that the address of the appellant

in the complaint as well as appeal is different from that mentioned on the envelop.

36] Upon hearing learned counsel for the contesting parties and perusing the application along with the supporting record, it transpires that the address of the complainant mentioned in the consumer complaint is "House No.224A, Sector 42B, SBI Colony, Chandigarh." However, the address reflected in Annexure C-2 (Emergency OPD card of the complainant's daughter Ms. Gurpreet Kaur issued by Opposite Party No.1) is recorded as "2248A, SBI Colony, Sector 43, Chandigarh." The same address is also reflected in the Death Certificate of Ms. Gurpreet Kaur (Annexure C-6) as "#2248A, SBI Colony, Sector 42C, Chandigarh." The address mentioned in the present appeal corresponds with that mentioned in the Death Certificate and the Emergency OPD card issued by Opposite Party No.1, i.e. House No. 2248A, Sector 42C, SBI Colony, Chandigarh. Thus, the contention of the appellant that there occurred typographical error while mentioning her address in the consumer complaint has merit. Due to this reason, the postal authorities reported "insufficient address – no such house number in SBI Colony, 42-C." Consequently, the certified copy of the impugned order never reached the appellant/complainant and she has to obtain a fresh certified copy of the order on 07.05.2025. Therefore, in view of reasons mentioned in the application and in view of law settled by Hon'ble Supreme Court of India in *Pundlik Jalam Patil Vs. Executive Engineer, Jalgaon Medium Project, (2008) 17 SCC 448* and *Basawaraj and Anr. Vs. Special Land Acquisition Officer, (2013) 14 SCC 81*, the appellant has shown rational reason for the delay, which has been caused due to bonafide reasons. Therefore, finding sufficient cause, the delay in filing the appeal is condoned. *MA/500/2025 stands disposed of accordingly*.

37] Now coming to the merits of the case, it is also apposite to mention here that medical negligence, often referred to as medical malpractice, is a critical area that holds healthcare professionals and institutions accountable for substandard care that results in patient injury or harm. Therefore, it is important to discuss medical negligence and throw light on this vast subject and established laws. Medical negligence is

fundamentally a civil wrong (a tort in common law jurisdictions) arising from the principle of professional negligence. Further medical negligence is also defined as the failure of a medical practitioner or healthcare provider to exercise the reasonable degree of skill and care expected of a person in that profession, under similar circumstances, which results in damage or injury to the patient. It is crucial to understand that not every adverse outcome or mistake constitutes negligence. A doctor is not liable merely because a treatment fails or another practitioner might have chosen a different course of action. The test is whether the care provided fell below the accepted "standard of care" for a reasonably competent professional in that field. To successfully establish a case of medical negligence, the claimant (the patient or their representative) must generally prove four critical elements, often referred to as the "4 Ds" i.e.

(1) Duty of Care - The doctor must owe a legal duty to the patient once the doctor–patient relationship is established. For example - accepting a patient for consultation or providing advice or treatment.

(2) Dereliction of Duty (Breach) - The doctor must have breached that duty by failing to meet the standard of care expected from a reasonably competent medical professional. If a doctor acted in accordance with a responsible body of medical opinion, there is no negligence.

(3) Direct Causation - The breach must be the proximate and direct cause of the injury suffered by the patient. There must be a clear causal link between the doctor's act/omission and the harm.

(4) Damages - The patient must have suffered actual harm such as: physical injury, death, disability, additional medical expenses, pain and suffering, loss of income. Without real damage, there is no legal negligence even if a breach occurred.

For medical negligence specifically, the standard for breaching that duty is encapsulated in the Bolam Test [from the English case (1957) 1 WLR 582 (Queen Bench Division, England)]. It defined the standard as that of a "responsible body of medical professionals."

38] In the instant case, upon a comprehensive and independent re-evaluation of the pleadings, documentary evidence, treatment records and

the legal principles governing medical negligence, we are of the considered view that the role of opposite party No.1 stands on an entirely different footing from that of opposite parties No.2 to 5.

39] ***Insofar as opposite party No.1 – Government Multi Specialty Hospital, Sector-16, Chandigarh – is concerned***, the contemporaneous emergency record assumes paramount importance. A careful analysis of the Emergency card and treatment sheet dated 19.12.2021, Annexure C-2, clearly belies the allegations of gross negligence against Opposite Party No.1, as the documents demonstrate that Ms. Gurpreet Kaur was duly registered at 02:07 pm in the Emergency Department, examined by the attending doctors and clinically assessed with her complaints of cough, diarrhea for three days and slurred speech being specifically recorded; her vital parameters including BP (recorded as 110/70 mmHg on the card), SpO_2 (97%), pulse rate (noted) and random blood sugar (168 mg/dl) were documented, which itself establishes proper clinical evaluation and monitoring. The treatment sheet further shows that she was administered IV fluids (Normal Saline), Injection Aciloc, Injection Buscopan and other supportive medicines and was kept under observation in the Emergency Department until 08:10 pm nearly six hours, thereby, disproving the allegation of casual or perfunctory discharge. The prescription of Tab. Ciplox TL, Tab. Pantop 40 mg, Tab. Sporolac and ORS upon discharge is consistent with standard protocol for acute gastroenteritis with dehydration, which reflects application of medical judgment. A blood pressure reading around 100/60–110/70 mmHg in a young adult female cannot, in isolation and in the absence of shock or collapse, mandate compulsory admission or cardiology referral, particularly when oxygen saturation was normal and IV rehydration had been administered. The emergency record does not indicate any persistent hemodynamic instability warranting ECG, ultrasound or specialist referral at that stage and medical law is settled that the choice of investigations depends on clinical discretion and not on hindsight. Moreover, she was advised follow-up in the Medical OPD but admittedly did not return to Opposite Party No.1 for further evaluation, thereby interrupting continuity of care. In the absence of any expert medical

evidence establishing deviation from accepted medical practice or proving a direct causal nexus between the treatment rendered and the subsequent unfortunate outcome, the assertions of negligence qua opposite party No.1 remain unsubstantiated; rather, the contemporaneous emergency record demonstrates due examination, monitoring and administration of appropriate treatment.

40] The settled position of law is that negligence cannot be inferred merely because a different line of treatment could have been adopted or because the patient subsequently deteriorated. The Hon'ble Supreme Court in *Jacob Mathew v. State of Punjab (supra)* has categorically held that a doctor is required to exercise reasonable skill and competence in accordance with accepted medical practice and that Courts must guard against attributing negligence on the basis of hindsight. The Hon'ble Apex Court defined negligence as the breach of a duty caused by an omission to do something which a reasonable and prudent person would do or doing something which such a person would not do. The three essential components of negligence identified were: duty, breach and resulting damage. At the stage, when opposite party No.1 examined and treated the patient, there is no material to demonstrate that classical warning signs of dengue shock syndrome or hemorrhagic complications had manifested in a manner compelling admission. Importantly, as stated above, no expert evidence has been led to establish that the symptomatic management administered by opposite party No.1 was contrary to accepted emergency protocol for acute gastro-intestinal complaints. The burden to establish breach of standard care lies on the complainant and in the absence of credible expert testimony showing that admission or referral was mandatorily indicated on 19.12.2021, the allegation remains conjectural. Applying the Bolam principle, we find that the course adopted by opposite party No.1 does not fall below the threshold of reasonable medical care. Therefore, no deficiency in service or medical negligence is made out against opposite party No.1.

41] ***However, the situation is materially distinct in respect of opposite parties No.2 to 5***. At the outset, it is undisputed that their

defence was struck off for failure to file written statement within the mandatory statutory period of 45 days, in view of the authoritative pronouncement of the Constitution Bench in *New India Assurance Co. Ltd. v. Hilli Multipurpose Cold Storage Pvt. Ltd.* Once the defence stood struck off, the factual assertions in the complaint, insofar as supported by documentary evidence, remained unrebutted.

42] The contemporaneous record, when examined in light of established medical literature and standard ICU protocols, reinforces the conclusion that there was gross and serious medical negligence in the management of the central venous line/catheter by Opposite Parties No. 2 to 5. It is undisputed from Page 82 of District Commission record that on 20.12.2021 at 9:30 am, the patient was in a critical state with shallow breathing and required ICU care, urgent investigations and central venous access, clearly a high-risk clinical scenario where precision and strict adherence to protocol are mandatory. Central venous catheterization is an invasive procedure that while common in intensive care practice, carries well-documented risks of malposition, vascular injury, thrombosis, cardiac arrhythmias, embolism and inadequate drug delivery. Authoritative critical care literature consistently emphasize that correct catheter tip placement ideally within the superior vena cava (SVC) must be immediately confirmed after insertion, either by chest radiography, fluoroscopy, ECG-guided placement or ultrasound-based confirmation, especially in critically ill patients. Malposition into the internal jugular vein with coiling is a recognized but dangerous complication, as documented in peer-reviewed critical care journals because it can lead to unreliable central venous pressure (CVP) readings, extravasation of vasoactive drugs, ineffective resuscitation, venous wall trauma, thrombosis, embolic events and even sudden cardiovascular collapse.

43] In the present case, although the central line was reportedly inserted by Dr. Chetan Goel, Head Emergency and Respiratory ICU & Head, Department of Anesthesiology and Critical Care (opposite party No.4) under ultrasound guidance at 2:00 pm on 20.12.2021 (Page 86), the Progress Sheet at Page 106 reveals that only on 21.12.2021 at 10:00 pm, nearly 32

hours later, the line was found coiled in the internal jugular vein and not positioned in the SVC, necessitating withdrawal and repositioning by inserting from other side by Dr. Rajiv Dhunna, Director, Intensive Care Unit & practicing Consultant – Anesthesia, Critical Care & Pain Management (opposite party No.3). This prolonged failure to detect malposition is medically indefensible. Ultrasound guidance reduces insertion-related complications but does not obviate the need for post-procedural confirmation of final catheter tip position. Standard ICU protocol mandates immediate post-insertion imaging (usually a chest X-ray) precisely to rule out malposition. The absence of timely detection indicates either that confirmation was not performed, was improperly interpreted or that monitoring was grossly inadequate.

44] It may be stated here that in a patient requiring intensive care, improper central venous access for over 32 hours would significantly impair effective hemodynamic management, particularly if vasopressors, fluids or critical medications were administered through a malpositioned line. Literature clearly notes that malposition can result in suboptimal drug delivery, vessel irritation, thrombus formation and inaccurate assessment of intravascular volume status, which can directly precipitate hypotension, shock progression, worsening organ perfusion and multi-organ dysfunction.

45] Moreover, in critically ill patients, the first 24 hours of ICU management are considered the “golden period” for stabilization. Any technical lapse during this window has amplified consequences. A malpositioned and coiled central venous catheter is an extremely dangerous complication, as it can result in improper administration of life-saving drugs, inaccurate central venous pressure monitoring, vascular injury, thrombosis, embolism, arrhythmias, inadequate fluid resuscitation and even catastrophic hemodynamic instability. Further, the coiling or malposition of a central venous catheter within the internal jugular vein is not a trivial technical defect; it is a clinically significant complication with potentially serious consequences. In a critically ill patient with respiratory compromise, any delay in recognizing such malposition can gravely impair effective management, can also lead to blood clotting, compromise oxygenation and

circulation and precipitate rapid systemic deterioration. Thus, in medical procedures like central venous catheter insertion, proper technique and post-procedure imaging (such as a chest X-ray) are important.

46] In the instant case, the delay of nearly 32 hours before correction demonstrates not a mere complication which can occur even with due care but a failure of monitoring, vigilance and adherence to universally accepted post-procedural safeguards on the part of opposite parties No.4 and 5 resulting in huge blood loss, worsening of patient's condition and going the patient in a state of shock. Courts and medical jurisprudence recognize that while complications *per se* do not amount to negligence, failure to timely detect and rectify a known and preventable complication constitutes a clear departure from the standard of care.

47] Thus, when the clinical severity (shallow breathing, ICU admission), the invasive nature of the procedure, the universally mandated requirement of immediate confirmation of catheter tip position and the prolonged delay in identifying malposition are read conjointly, the conduct of Opposite Parties No.4 and 5 reflects gross negligence and dereliction of duty. The lapse deprived the patient of accurate hemodynamic monitoring and optimal therapeutic administration at a crucial juncture, materially contributing to her clinical deterioration and progressive instability and establishes a direct nexus between negligent procedural management and the worsening of her medical condition.

48] The gravity of above lapse regarding malpositioning of central venous line becomes even more pronounced when read in conjunction with the clinical record showing that the patient's condition had already begun deteriorating on 20.12.2021, as evidenced by shallow breathing, ICU transfer, invasive line placement and continuous intensive monitoring clear hallmarks of a rapidly evolving critical illness. In such a precarious clinical scenario, the treating team was under a heightened duty of care not only to execute procedures with precision but also to continuously reassess whether their institution possessed the requisite super-specialty infrastructure & multidisciplinary expertise to manage escalating complications. Once it became evident that the patient required advanced

critical care interventions and was not stabilizing satisfactorily coupled with medical negligence as held above, the obligation of care extended beyond continuation of in-house treatment; it encompassed a legal and ethical duty to promptly refer her to a higher centre of excellence such as PGIMER or an equivalent super multi-specialty institution equipped with comprehensive subspecialty backup, advanced interventional facilities and specialized intensivists. Our view is supported by a judgment of Hon'ble Apex Court in ***Arun Kumar Manglik Vs. Chirayu Health and Medicare Private Ltd. & Anr.***, Civil Appeal No.227-228 of 2019 decided on 19.01.2019. In this case, the patient was a consequence of dengue and the Hon'ble Apex Court in Para 2 of its judgment quoted the WHO Guidelines particularly Clause 2.3.2.2, *inter-alia*, saying that "Patients may need to be admitted to a secondary health care of the WHO guidelines, the patient may need to be admitted to a secondary health care centre for close observation, particularly as they approach the critical phase…." Medical jurisprudence consistently holds that when a hospital lacks either the capacity to effectively manage complications or the ability to stabilize a progressively deteriorating patient, timely referral is mandatory and failure to do so constitutes negligence. Thus, retaining a critically ill patient in the face of procedural lapses and ongoing clinical decline, without demonstrable capability to deliver optimal super-specialty intervention, risks irreversible organ damage and forfeiture of the crucial therapeutic window recognized in critical care as the "golden hour."

49] Consequently, the combined effect of the delayed detection of the coiled central line and the failure to expeditiously escalate care or refer the patient to a tertiary referral centre despite repeated requests by hapless parents reflects a serious departure from accepted medical standards on the part of opposite parties No.2 to 5, materially contributing to the patient's deterioration and adverse outcome.

50] The second *per se* negligence towards duty of care, demonstrated by opposite parties No.2 and 3 i.e. the Ivy Hospital and Dr. Gurpreet Singh Babra of Department of Internal Medicine, relates to delay in treatment of dengue. Record reveals that on 20.12.2021 at 9:30 am, a

dengue serology test of the patient was advised by opposite party No.3 – Dr. Gurpreet Singh Babra (Page 82). However, sample collection was done at 2:44 pm (page 239) after repeated advice for dengue test i.e. almost 5 hours 14 minutes and its report was received at 4:26 pm i.e. after 1 hour 42 minutes. Thus, it stands established that contrary to the prompt execution of medical advice required in cases of suspected dengue infection, the sample was not collected until 2:44 pm and the corresponding test report was not available until 4:26 pm. The results then confirmed a positive Serum Dengue NS1 antigen. It is beyond dispute that such delays in the collection and processing of diagnostic samples for dengue are inconsistent with accepted standards of clinical care and reflect gross negligence on the part of opposite parties No.2 and 3. Absence of care and delay in analyzing whether the hospital staff or clinical staff/nursing staff is at prompt job was prior responsibility of the attending/treating doctor as in the present case (Dr. Gurpreet Singh Babra). It may be stated here that dengue can rapidly progress from a mild, self-limited disease to severe, life-threatening complications such as dengue hemorrhagic fever and dengue shock syndrome. The World Health Organization (WHO) and multiple peer-reviewed studies emphasize that early diagnosis is critical for appropriate clinical monitoring, risk stratification and timely therapeutic interventions. Studies have also shown that delays in diagnosis are associated with increased risk of complications and adverse outcomes, particularly in settings where clinical features overlap with other febrile illnesses and where progression to severe dengue can occur unpredictably.

51] Furthermore, guidelines for the management of dengue, including those issued by the Ministry of Health and Family Welfare (Government of India), the WHO and major infectious disease textbooks, recommend that once dengue is clinically suspected, diagnostic tests (NS1 antigen or molecular methods) should be obtained without any delay, with rapid processing to inform management decisions. A sample collection delay of over five hours after a diagnostic advice, followed by a prolonged reporting time, is inconsistent with these established standards and represents a

failure to exercise reasonable clinical judgment and diligence on the part of opposite parties No.2 to 5.

52] Per the medical record, the platelet trend of the patient demonstrates a clear and alarming downward trajectory consistent with progressive dengue-associated thrombocytopenia, warranting vigilant monitoring and timely intervention in accordance with the guidelines of the Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO). On 20.12.2021, the platelet count was already reduced to 72,000/µL. By 21.12.2021 at 10:00 am, it had precipitously fallen to 36,000/µL—representing a 50% drop within approximately 24 hours, a clinically significant decline indicative of entry into the critical phase of dengue. Though a marginal rise to 45,000/µL was noted at 9:30 am on 21.12.2021 against the sample taken on same day at 5:41 am and recorded in the hospital record at 7:42 pm on 21.12.2021, such transient fluctuation does not negate the overall downward trend, as dengue thrombocytopenia is characteristically dynamic and requires close serial monitoring. Thereafter, laboratory findings on 22.12.2021 revealed a further dangerous decline: one report showed a platelet count of 25,000/µL (sample reportedly collected at 2:00 am, report received at 9:09 am), and another showed 22,000/µL (sample taken at 4:20 am, report received at 9:11 am the same day). Notably, these timings themselves reflect inconsistencies and raise serious concerns regarding laboratory protocol, documentation accuracy and clinical coordination. A platelet count approaching or falling below 20,000–30,000/µL in dengue is medically recognized as high risk for spontaneous bleeding, plasma leakage, and progression to severe dengue or dengue hemorrhagic fever, particularly when accompanied by warning signs. The CDC and WHO guidelines emphasize that patients with rapidly falling platelet counts require strict hemodynamic monitoring, repeated hematocrit evaluation, careful fluid management and readiness for component therapy where clinically indicated. While routine prophylactic platelet transfusion is not recommended in stable dengue patients without bleeding, transfusion is indicated in cases of significant hemorrhage or profound thrombocytopenia with clinical deterioration.

53] In the present matter, opposite parties No.2 to 5 have relied upon Exhibit OP-2/13 to assert that platelet concentrate/blood transfusion was administered. It fails to specify the exact date, time, dosage, indication or clinical parameters under which transfusion was allegedly given. In the absence of precise documentation correlating transfusion with platelet trends and clinical status, such a vague record cannot substantiate compliance with standard dengue management protocols. Clinical record nowhere states whether any plasma was given to the patient up-to 6 am on 22.12.2021. The patient suffered heart attack at 8:10 am and died at 9:10 am on 22.12.2021. Proper transfusion practice requires meticulous recording of indication, timing, pre and post-transfusion counts and monitoring for response. The progressive decline from 72,000/µL to 22,000/µL over a short span, coupled with questionable documentation and delayed diagnostic handling, demonstrates a failure to adhere to established dengue management standards and reflects a serious deviation from the duty of care expected under accepted clinical guidelines.

54] The contentions raised by opposite parties No. 2 to 5 in their written arguments that low platelet counts never cause cardiac arrest and that there was no delay in platelet transfusion because platelet transfusion is not part of the treatment of dengue are contrary to established medical science, standard treatment protocols and authoritative medical literature, and, therefore, cannot be sustained. While it is correct that thrombocytopenia *per se* may not directly and mechanically cause cardiac arrest in isolation, such a narrow and simplistic assertion ignores the well-documented pathophysiology of severe dengue as recognized by the World Health Organization and the Centers for Disease Control and Prevention. In severe dengue, a rapidly falling platelet count is a marker of disease progression into the critical phase, which is characterized by plasma leakage, hemoconcentration, bleeding manifestations, coagulopathy, metabolic acidosis, multi-organ dysfunction, and circulatory collapse.

55] Cardiac arrest in dengue is most often secondary to shock (dengue shock syndrome), severe hemorrhage, electrolyte imbalance, myocarditis or profound hypovolemia conditions that are closely associated

with severe thrombocytopenia and capillary leak. Thus, low platelet counts, particularly when falling sharply to levels such as 20,000–30,000/μL, are clinically significant indicators of impending complications and cannot be dismissed as irrelevant. Furthermore, as stated above, while guidelines do state that routine prophylactic platelet transfusion is not recommended in stable dengue patients without bleeding, they equally clarify that platelet transfusion is indicated in cases of severe thrombocytopenia accompanied by active bleeding, high risk of bleeding, invasive procedures or clinical deterioration. The standard of care, therefore, is not that platelet transfusion is "never part of treatment," but that it must be administered judiciously based on clinical parameters. Any delay in recognizing the severity of thrombocytopenia, monitoring trends, correlating with warning signs and instituting appropriate supportive therapy including transfusion where indicated constitutes deviation from accepted medical practice. The attempt by opposite parties No.2 to 5 to generalize that platelet transfusion has no role whatsoever in dengue management is a misstatement of medical guidelines and reflects either a misunderstanding or misrepresentation of established protocols. Such arguments, being inconsistent with recognized standards of dengue management and the pathophysiological realities of severe dengue, are untenable and deserve outright rejection.

56] In our considered view, coupled with above, the substantial delay between the doctor's advice for dengue testing and the actual collection and reporting of the diagnostic sample directly contravenes evidence-based guidelines requiring rapid investigation and management of suspected dengue cases. The inability or unwillingness of opposite party No.2 – Ivy Hospital to execute opposite party No.3' advice in a timely manner and opposite party No.3' lacking in his duty to timely monitor each and every complication before the patient was taken to ICU for further intensive care, not only reflects gross negligence but also jeopardized the patient's chances for early intervention during a critical window of illness.

57] It is also coming out of the record that even Opposite Parties No.2 to 5 failed to make any prior or adequate arrangements for the procurement of blood or platelets that might have been required during the

course of treatment. Despite being fully aware of the patient's medical condition and the foreseeable possibility that such components could be urgently needed, they neglected their duty to ensure that the necessary blood products were arranged in advance. As a result of this lapse, the complainant and the patient were left in a precarious situation, compelled to depend upon last-minute arrangements and emergency efforts to secure the required blood and platelets. This lack of preparedness placed the complainant at the mercy of unforeseen exigencies and avoidable delays, thereby causing immense distress, anxiety and risk to the patient's life at a critical juncture.

58] Another glaring and indefensible deficiency in service on the part of opposite party No.2 – Ivy Hospital pertains to its failure to supply the complete medical record of the deceased Ms. Gurpreet Kaur to her parents within the mandatory statutory time frame of 72 hours from the date of request. It is an admitted position on record that, following the unfortunate demise of their young daughter, her parents formally demanded copies of the entire medical record under Clause 1.3.2 of the Medical Council of India Notification No. MCI-211(2)/2001 dated 11.03.2002 (Code of Medical Ethics Regulations, 2002). The said clause, being relevant, is extracted hereinbelow:-

> "1.3.2 If any request is made for medical records either by the patients/authorized attendant or legal authorities involved, the same may be duly acknowledged and documents shall be issued within the period of 72 hours."

Thus, the above clause unequivocally mandates that if any request is made for medical records either by the patients/authorized attendant or legal authorities involved, the same may be duly acknowledge and documents shall be issued within the period of 72 hours. The provision is not directory but mandatory in nature, intended to promote transparency, accountability and the patient's right to information particularly in circumstances involving death where the family is entitled to ascertain the exact line of treatment administered. The obligation to furnish medical records within the stipulated time is a professional and ethical duty and non-compliance

constitutes professional misconduct in addition to deficiency in service under consumer protection jurisprudence. In the present case, despite a lawful and legitimate request made by the bereaved parents, opposite party No.2 – Ivy Hospital failed to provide the records within the prescribed 72-hour period and was supplied on 21.07.2022 after 16 days of request dated 04.07.2022, thereby violating the binding ethical regulations governing medical practitioners. In fact, all the record of treatment given alongwith reports was readily available with opposite party No.2 – Ivy Hospital and the same was supposed to be immediately given to the parents at the time of death of their daughter. Such withholding of records not only obstructs the family's right to seek legal remedies but also raises adverse inference regarding the transparency of treatment rendered. Timely access to medical records is an integral component of fair medical practice and informed scrutiny; its denial or delay amounts to suppression of material information and reflects a lack of bona fide conduct. Therefore, the failure of opposite party No.2 – Ivy Hospital to comply with Clause 1.3.2 of the MCI Notification is a clear-cut deficiency in service, evidencing disregard for statutory obligations and established standards of professional accountability.

59] Thus, the present case unmistakably constitutes a clear-cut and established instance of medical negligence and breach of duty of care, as delineated by the Hon'ble Supreme Court in catena of judgments including *Jacob Mathew v. State of Punjab* (supra), wherein it was held that a medical professional is expected to exercise reasonable skill, reasonable care and adherence to established medical standards and any gross deviation resulting in harm attracts liability. The unfortunate death of a young 19 year old daughter at the threshold of her life, with her future ahead of her cannot be reduced to mere clinical statistics or defended through technical evasions. The loss suffered by the complainant is irreparable and immeasurable. The record demonstrates a chain of negligent acts and omissions: improper coiling of the central venous line, unexplained and unjustified delay in diagnostic testing for dengue despite medical advice, failure to respond appropriately to a rapidly declining platelet trend and lack of transparency in documentation and record supply. These are not

isolated lapses but cumulative deficiencies that reflect systemic disregard for the standard of reasonable medical care. The Hon'ble Supreme Court has consistently emphasized that while doctors are not insurers of life, they are under a solemn obligation to act with diligence, promptness and competence in accordance with accepted medical practice. When that duty is breached and the breach results in the loss of life, particularly of a young patient whose condition required vigilant monitoring and timely intervention, the law must intervene to uphold accountability. The untimely demise of Ms. Gurpreet Kaur was not an inevitable act of fate but a consequence of preventable lapses, each compounding the other, culminating in a tragic and avoidable outcome. In the eyes of law and conscience alike, such conduct squarely falls within the definition of medical negligence, warranting judicial recognition and redress for the grievous wrong suffered by the bereaved parents.

60] Bare perusal of the technical/expert opinion of the Committee dated 28.03.2022, Annexure OP-2/2, relied upon by the District Commission while dismissing the complaint, on its bare and meaningful reading, falls flat on the face of it and cannot be accorded any evidentiary sanctity. The report is conspicuously vague, bereft of material particulars and couched in general, self-serving assertions that "treatment protocols followed as per the prescribed norms," without disclosing what specific protocols were applicable in the given clinical situation, how they were adhered to and whether any deviation occurred at any stage of the procedure. Most significantly, although the report casually records that the central line was repositioned on 21.12.2021 under C-Arm guidance, it remains completely silent on the crucial aspect of coiling of the central line, which is the gravamen of the allegation of medical negligence in the present case. There is not even a whisper in the said opinion explaining how and why the central line got coiled, whether such coiling is a recognized complication, whether it occurred due to improper insertion technique, lack of due care or failure of supervision and whether timely corrective steps were taken in accordance with accepted medical standards. The omission to address this pivotal issue renders the opinion not merely incomplete but

fundamentally unreliable. In fact, the selective reference to repositioning of the central line, without candidly dealing with the antecedent act of coiling, appears to be a deliberate attempt to gloss over and camouflage the *per se* negligence involved, particularly when coiling of a central venous line, if attributable to improper technique or lack of due caution, *prima facie* indicates deficiency in service. An expert opinion, to inspire confidence, must be reasoned, objective and supported by clinical analysis; it cannot be a mechanical endorsement of the treating hospital's conduct.

61] In ***Ramesh Chandra Agrawal Versus Regency Hospital Ltd. & Ors.***, 2009 (9) SCC 709, relied upon by the complainant, the Hon'ble Supreme Court observed that the real function of the expert is to put before the Court all the materials, together with reasons which induce him to come to the conclusion, so that the Court, although not an expert, may form its own judgment by its own observation of those material. An expert has to give necessary scientific criteria for testing the accuracy of the conclusions so as to enable the Court form its independent judgment by the application of these criteria. Thus, the report, Annexure OP-2/2, being cryptic and evasive on the core allegation, does not discharge the burden cast upon opposite parties No.2 to 5 to establish that due care and standard protocol were in fact observed and therefore, the reliance placed upon it by the District Commission is wholly misplaced and unsustainable in the eyes of law.

62] Thus, summing up all, this Commission held the opposite parties deficient in rendering service, unfair trade practice and medically negligent on following counts, respectively:-

(i) ***Opposite Party No.2 – Ivy Hospital*** is directly liable for deficiency in service and medical negligence in the present case. As the treating institution, the hospital bore the overarching duty to ensure that all medical procedures, diagnostic investigations and critical care management were conducted in strict conformity with accepted medical standards and established clinical protocols. The record demonstrates that the hospital failed to maintain

adequate supervision and coordination among its medical and nursing staff including the treating doctors, resulting in multiple systemic lapses including the delayed collection and processing of the dengue diagnostic sample despite explicit medical advice, inadequate monitoring of a malpositioned central venous catheter for nearly 32 hours and lack of proper documentation regarding transfusion practices and critical care interventions. Furthermore, the hospital failed to discharge its statutory and ethical obligation to supply the complete medical records of the deceased patient to her parents within the mandatory period of 72 hours as required under Clause 1.3.2 of the Medical Council of India (Code of Medical Ethics Regulations, 2002), instead providing the records after an unjustified delay of sixteen days. These cumulative lapses reveal institutional negligence, lack of due diligence in ensuring compliance with established medical protocols including delay in blood/plasma transfusion and a clear deficiency in service, thereby rendering Opposite Party No.2 – Ivy Hospital liable for the negligent acts and omissions of its treating doctors and staff.

(ii) ***Opposite Party No.3 – Dr. Gurpreet Singh Babra***, being the treating physician from the Department of Internal Medicine, was under a professional duty to exercise reasonable care, diligence and supervision in the clinical management of the patient. The medical record reveals that although he advised dengue serology testing at 9:30 am on 20.12.2021, the diagnostic sample was collected only at 2:44 pm and the report was generated at 4:26 pm, reflecting a delay of more than five hours in sample collection and further delay in reporting. In cases of suspected dengue infection, established clinical guidelines

mandate prompt diagnostic evaluation and immediate monitoring because the disease can rapidly progress into its critical phase. The failure of Opposite Party No.3 to ensure timely execution of his own medical advice and to adequately supervise the clinical staff responsible for diagnostic procedures and in failure to monitor the consistent deteriorating condition of the patient during the whole treatment with delay in timely transfusion of blood/plasma constitutes a breach of the duty of care expected from a treating physician. This delay impeded early diagnosis, risk stratification and timely therapeutic management of dengue, thereby materially compromising the patient's chances of receiving appropriate intervention during a crucial stage of illness and amounting to medical negligence.

(iii) ***Opposite Parties No.4 and 5, namely Dr. Chetan Goel and Dr. Rajiv Dhunna***, were responsible for the management of the patient in the ICU and for performing and supervising the central venous catheterization procedure. The clinical record establishes that a central venous line was inserted on 20.12.2021 at approximately 2:00 pm; however, the line was subsequently discovered on 21.12.2021 at about 10:00 pm to be coiled within the internal jugular vein rather than correctly positioned in the superior vena cava, necessitating withdrawal and repositioning. The failure to detect this malposition for nearly 32 hours constitutes a serious breach of standard ICU protocol, which universally requires immediate post-procedural confirmation of catheter tip placement through appropriate imaging such as chest radiography or equivalent methods. A coiled or malpositioned central venous catheter is a medically recognized hazardous complication capable of impairing hemodynamic

monitoring, compromising drug delivery and precipitating severe clinical deterioration in critically ill patients. The prolonged delay in identifying and correcting this defect reflects gross medical negligence, lack of vigilance and failure to adhere to accepted standards of critical care practice on the part of Opposite Parties No.4 and 5, thereby materially contributing to the patient's worsening clinical condition, leading to heavy bleeding and finally death under precarious conditions.

63] In view of the medical negligence established on record, the complainant is justly and legally entitled to adequate and meaningful compensation for the irreparable loss she has suffered. The death of her 19-year-old daughter is not merely the loss of a patient; it is the extinguishing of a young life filled with promise, aspirations and the potential to contribute meaningfully to her family and society. At such a tender age, she stood at the threshold of adulthood with her education, career and independent future unfolding ahead of her. The parents, as natural guardians, had devoted years of love, care, emotional nurturing and substantial financial resources toward her upbringing expenses on education, healthcare, daily sustenance and the shaping of her ambitions, which were not only monetary but deeply personal and emotional rooted in the hope that she would flourish, support her family in due course and bring them pride and companionship in their advancing years.

64] The law recognizes that while no amount of money can truly compensate for the loss of a beloved child, monetary compensation is the only practical mechanism through which civil justice attempts to provide redress. Compensation in such cases must, therefore, account not only for the pecuniary losses such as the expenditure incurred on her upbringing and the loss for non-pecuniary damages including loss of love and affection, loss of companionship, mental agony, emotional trauma and the shattered expectations of the parents.

65] The complainant has suffered a void that can never be filled. Her home has been rendered silent where once there was youthful energy

and hope. The psychological trauma of losing a child due to preventable medical lapses compounds their grief with a sense of injustice. In such circumstances, awarding fair and substantial compensation is not merely a financial exercise but an affirmation of accountability and the value the legal system places on human life. It serves both as restitution to the aggrieved family and as a reminder that medical institutions are bound by a duty of utmost care when entrusted with precious human lives.

66] *Thus, Opposite Party No.2 – Ivy Hospital, Opposite Party No.3 – Dr. Gurpreet Singh Babra and Opposite Parties No.4 & 5 – Dr. Chetan Goel, Head Emergency and Respiratory ICU & Head, Department of Anesthesiology and Critical Care and Dr. Rajiv Dhunna, Director, Intensive Care Unit & practicing Consultant – Anesthesia, Critical Care & Pain Management are liable to compensate the complainant, separately, for their deficiency in service and medical negligence attributable to them.*

67] For the reasons recorded above, the impugned order is set aside and the appeal is partly accepted against respondents No.2 to 5/opposite parties No.2 to 5 in the following manner:-

(i) *Opposite Party No.2 – Ivy Hospital* is directed to pay an amount of ₹10,00,000/- (Rupees Ten Lakh only) as compensation to the complainant;

(ii) *Opposite Party No.3 – Dr. Gurpreet Singh Babra* is directed to pay an amount of ₹10,00,000/- (Rupees Ten Lakh only) as compensation to the complainant;

(iii) *Opposite Parties No.4 & 5 – Dr. Chetan Goel and Dr. Rajiv Dhunna*, are directed to pay an amount of ₹25,00,000/- (Rupees Twenty Five Lakh only) i.e. [₹12,50,000/- each by opposite party No.4 & opposite party No.5] as compensation to the complainant;

(iv) Opposite parties No.2 to 5 are also directed, jointly and severally, to pay a sum of ₹40,000/- (Rupees Forty Thousand Only) to the complainant as litigation costs.

68] This order be complied with by opposite parties No.2 to 5, within a period of 45 days from the date of receipt of certified copy of this

order, failing which, the awarded amounts of compensation at reliefs (i), (ii) & (iii) shall carry simple interest @9% p.a. from the date of default i.e. after expiry of period of 45 days till actual payment besides payment of litigation costs.

69] However, the appeal stands dismissed against respondent No.1/opposite party No.1 – GMSH with no order as to costs.

70] Pending application(s), if any, in this appeal also stands disposed of having been rendered infructuous.

71] Certified copies of this order be sent to the parties free of charge.

72] Copy of this order be also sent to the District Commission concerned.

73] File be consigned to Record Room after completion.

Pronounced
11.03.2026.

(PADMA PANDEY)
PRESIDING MEMBER

(RAJESH K. ARYA)
MEMBER

Ad