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BEFORE THE DISTRICT CONSUMER DISPUTES REDRESSAL COMMISSION, COLLECTORATE CAMPUS, COIMBATORE-18

PRESENT: Thiru R.THANGAVEL, B.Sc., B.L., President

Thiru P.MARIMUTHU, M.A.M.L., Member

C.C.No.01/2022

Tuesday, the 23rd day of June, 2026

G.Bhuvaneswari W/o.Mr.Ganesan,
213/216, Ramasamy Compound,
Dr.Radhakrishnan Road West,
Sivanandha Colony, Tatabad,
Coimbatore – 641 012. ….. Complainant

... Vs …

1. Dr.Chandrakala Makutapathy, DGO, DNB (OG), MRCOG (UK),
   Director of Genesis Royal Infirnary Pvt Ltd.,
   75-A, 1st Floor, First street, New scheme road,
   Papanaickenpalayam, Coimbatore.

2. M/s. Genesis Royal Infirnary Pvt Ltd.,
   75-A, 1st Floor, First street, New scheme road,
   Papanaickenpalayam, Coimbatore.

3. M/s. Hindustan Hospital,
   Unit of Hindustan Educational and Charitable Trust,
   Avinashi Road, Nava India,
   Coimbatore – 641 004. …..Opposite Parties

The present complaint has been instituted under Section 35 of the Consumer Protection Act, 2019, against Dr. Chandrakala Makutapathy, Coimbatore, Genesis Royal Infirmary Pvt. Ltd., Coimbatore, and Hindustan Hospital, Coimbatore (hereinafter referred to as "OP1", "OP2", and "OP3" respectively, and collectively as the "OPs"), seeking the following reliefs:

a. To direct the OPs to pay a sum of Rs.50,00,000/- as compensation for the mental agony and sufferings suffered by the complainant; and

b. To direct the OPs to pay the costs of the proceedings.

This complaint came up for final hearing before this Commission on 11.06.2026. Thiru R. Vinoth, learned counsel, appeared for the complainant, and Thiru M. Arumugam, learned counsel, appeared for the OPs.

This Commission has carefully considered the pleadings, affidavit of evidence, documents placed on record, and the submissions made on behalf of the parties. Upon such consideration, the following order is passed:

ORDER

THIRU. P. MARI MUTHU, MEMBER-I

The brief averments of the complaint are as follows:

1. The complainant was working in the GKNM hospital as a lab technician and opposite party no.1 doctor by profession and opposite party no.1 is the director of m/s. Genesis royal infirmary pvt. Ltd., and opposite party no.1 also working as doctor at GKNM hospital. The complainant was suffering from severe stomach pain and so she had consulted opposite party no.1 for the medical advice at opposite party no.2 hospital. After examining her condition, opposite party no.1 have advised the complainant that she is suffering from the uterus and hernia problem and the reason for her stomach pain is due to the problem that has arosed in the uterus and the same has to be treated immediately in order to get rid of the pain and that the treatment would be the removal of her uterus. The complainant has started her treatment on 11.10.2018. The opposite party no. 1 told the complainant that the operation will cost of rs.60,000-. The opposite party no. 1 advised the complainant to get admit in "Hindustan hospital" for the operation purpose. The complainant have got admitted on 16.11.2018. She got discharged on the next day ie., 17.11.2018. The hospital bill has gone upto Rs.1,00,000/-. The husband of the complainant borrowed some amount from the relatives and paid the entire hospital bill. Even after the operation continuously suffer the pain. Without even checking her, the opposite party no.1 have negligently answered her that the pain she is having might be because of the operation and advised her to take the pain

killers. Her condition after the operation had become worse day by day, she could not even tolerate the pain but sill she remains in opposite party no. 1 treatment till 23.03.2019. On a certain day, the health condition of the complainant has became worse and she started to bleed heavily along with the stomach pain. The bleeding which is discharged through her vagina has got stools also mixed with the blood. She has approached the "ESIC medical college and hospital. Singanallur Coimbatore " for the emergency. On examining the complainant health condition, the doctors said that during the operation for removal of uterus the doctors have negligently and carelessly put a cotton inside her stomach and the operation was completed negligently without removing the medical gauze which is inside her stomach and due to which, she is having rectum damage which is caused by the presence of such medical gauze inside her stomach by operation on 29.03.2019 which was removed in the ESIC hospital. The doctors in the ESIC hospital also stated that the complainant's health condition is too serious that the ESIC hospital have not got the facilities to treat her and hence they have referred the complainant to the "Stanley hospital - Chennai" for the advanced treatment. The complainant came to opposite party no.1 to seek her advice on 01.04.2019, but opposite party no.1 and her staff have behaved rudely with her. The complainant with no option went to the Stanley hospital for further treatment and admitted on 02.04.2019 at unit no. 2. Doctor diagnosis was intraperitoneal abscess with colovaginal fistula and treatment for the colovaginal fistula + repair of colonic rent + diversion loop ileostomy and also 16.04.2019 further surgery was done by the doctors in unit ii of Stanley hospital, Chennai and also discharged 25.04.2019 and after the completion of 4 months again the complainant was admitted for the further treatment in unit I of Stanley hospital, Chennai on 18.08.2019 for the treatment lap RVC repair with covering loop diversion ileostomy. Further she was advised by the doctors to go for a "coloplast bag" since her intestine and the excretion track got completely damaged and needs some time for healing and on 26.08.2019 further surgery was made for the above said treatment and after the said surgery on 04.09.2019. She was discharged from the hospital and till now she is under the treatment and also doctor advised to the complainant for further surgery. On 06.05.2019 the

complainant's husband preferred a complaint against opposite party no. 1 about the negligence caused before the commissioner of police, Coimbatore. But they have did not register any action. On 10.06.2019 the complainant preferred a complaint to the collector, collector office, Coimbatore. The district collector forwarded the complaint to joint. Director, (medical and rural welfare) for the enquiry and report. The above said authorities after conducting an enquiry have said that as Mrs. Bhuvaneswari had often gone to medical check up after operation and at the time of medical check-up, there is possibility of used cotton (gauze) were not removed. The inspection authorities were informed that the complainant is taking treatment at Stanley hospital, Chennai. She is in continuous treatment till date and her present health, mental agony, family's financial condition and her sufferings are caused by the careless and negligence by opposite party no. 1 in performing the operation. This irresponsible attitude of opposite party no. 1 in performing the operation negligently is absolutely a deficiency in service and amounts to medical negligence. The complainant continuously under the treatment for every month and also lastly 08.09.2021 she admitted in Sri Ramakrishna hospital for the surgery and on 09.09.2021. Further surgery was done by the doctors in Sri Ramakrishna hospital and also discharged from the hospital on 15.09.2021 and the hospital bill has gone upto Rs.1,50,000.After that the complainant sent legal notice to the opposite parties on 23.09.2021 for the demand of compensation and opposite party no.3 was served and opposite party no.1 and 2 notice returned as addressee left without intimation. Hence, the present complaint is filed.

The brief averments of the written version filed by the 1st and 2nd opposite parties are as follows:-

2. The opposite party No.1 -Dr.Chandrakala submits that she is a doctor by profession and she is a consultant Obstetrician and Gynaecologist and first she worked at M/s. GKNM Hospital. Coimbatore and then moved on to M/s. Hindustan Hospital, Coimbatore and also that simultaneously she was running her own clinic by name Genesis Women and Child Care, situated at 75-A, 1s Floor, First Street, New Scheme Road, Papanaickenpalayam, Coimbatore - 641018 and now she has shifted her own clinic to 59-

62, Puliakulam Main Road, Coimbatore -641045 with the name and the entity is changed as M/s. Genesis Royal Infirmary Pvt., Ltd. Dr. Chandrakala had moved on to Kurinji Hospital (now Hindustan Hospital) on Feb.2016 itself from GKNM Hospital and the fact is that the complainant consulted the opposite party No.1 - Dr Chandrakala at her old clinic, (ie.,) Genesis Women and Child Care and not at GKNM Hospital. The complainant consulted the opposite party No.1 during Oct.2018 for discharge and bleeding from vagina on irregular and frequent intervals for a long period and not for stomach pain. The diagnosis revealed that the complainant had implanted a Mesh in her pelvis (lower abdomen) during 2007 and due to passage of time, the implanted Mesh haderoded and that the mesh had affected the vagina and stomach to discharge and bleeding from vagina. The diagnosis of erosion of Mesh is documented in detail in the complaint's OP notes. The contents of this OP notes will reveal and will evidence that due to the complainant's mental agony and pain she preferred for the removal of uterus. The complainant had many operations prior to this treatment due to her inherent diseases like complete uterine prolapse-Uterus, bowel and bladder all have descended out of vagina and that the complainant had already operated in 2007 at Chennai and that in 2007 operation in, Chennai hospital itself a prolift mesh was kept in pelvis. The known complications of mesh include mesh erosion in to bladder, bowel and even bone. The complainant had also underwent LSCS (Lower segment Cesarian section) (LSCS) - A Cesarian section in which the surgical incision (cut) is made in the lower segment of the uterus in 2015 with umbilical hernia repair. The complainant also had eye transplant for loose tissue. The opposite party No.1 diagnosed her to have Mesh erosion and pelvic infection and was treated conservatively with antibiotics. The complainant initially responded but then again had discharge and she wished Hysterectomy. The opposite party No.1 advised the complainant to consult her primary doctor in Chennai but then came back with allegations against that doctor saying that the doctor was rude on her and cried for hysterectomy. Dr. Chandrakala prior to operation informed that the complainant had a progressive disease process including mesh erosion and all complications of Mesh erosion and Hysterectomy are all discussed with her and risks of bowel, bladder injury, vault

prolapse and progressive mesh erosion are all explained to her and obtained written consent before surgery. The complainant and her husband were explained about the surgical cost of Rs. 50,000 - 60,000 and that she was given a concession of fees as her HOD Dr. Radha from GKNM Hospital requested for concession and that the total fees she paid was Rs.44203/- (Rs.27,903/- to opposite party No.2 and 16,300/-to opposite party 1 and 2) and not Rs.1,00,000/- as stated in the complaint. The complainant wanted early discharge from the hospital to take care of her child and hence she was discharged early. The complainant was advised OPD (Outpatient department treatment) for follow up and that on her postoperative follow up on 27.11.18 - Speculum examination of the vagina and wounds evidences that they healed well as documented in her OPD file enclosure 2. Further subsequently she was diagnosed to have vault infection after taking a culture of the vault on 5th Dec 2018 and treated with appropriate antibiotics and not pain killers. On 18th Dec 2018, the opposite party No.1, ensured wound healing after vaginal and wound examination and that the complainant was all well. During March 2019 i. e., 4 months after the uterus operation, the complainant came to the opposite party No.1 for bleeding through vagina and that on diagnosis it was found recurrent mesh erosion and pelvic infection right fornix and that she responded to IV antibiotics and was asymptomatic for few weeks. On 23.03.2019 she came with bleeding through vagina and hence she was advised further evaluation in opposite party No.2 hospital and that but she did not wait for opposite party No.1 and that walked out of the hospital, fighting with hospital staff and the opposite parties have no idea where she consulted on that day. She had MRI scan at KG hospital on 24.03.2019. The MRI scan did not show any foreign body inside the abdomen or pelvis and was diagnosed to have Colovaginal fistula with abscess and inflammation and not recto vaginal fistula. She was diagnosed to have Colovaginal fistula and pelvic abscess which could very well be secondary due to Mesh erosion and infection. Mesh can erode bladder, bowel and even bone and cause fistula, infection and osteitis pubis. For these the reasons placing of meshes have been banned across the world since 2018 by FDA and that the now banned Prolift mesh by WHO was implanted to complainant in 2007 itself. The police did not find any merit

in that complaint and closed the complaint and had sent a complainant closure report to the commissioner of police. The collector did/could not find any medical negligence on the part of the opposite parties he did not take any action against the opposite parties. The Hon'ble Supreme Court, in a number of rulings has directed the lower courts to obtain expert doctors opinion while dealing with cases related to medical negligence. The District Collector, vide his letter Ref No.2959/2019 dated22.10.2019 forwarded the report of the Joint Director (Medical and Rural Welfare) Coimbatore along with its enclosures to Director of Medical Sciences, Chennai and had requested her to take necessary action on the report. After enquiry, the expert doctors headed by Joint Director (Medical and Rural Welfare) Coimbatore had opined that the opposite party No.1 did the operation on the complainant on 17.10.2018and that subsequently she had visited the hospitals for her various ailments and that she started taking treatment from ESI hospital from 27.03.2019 and that gauze like substance was found in her vagina on examination of her vagina and that there is a possibility of leaving the used gauze inside the vagina. The expert doctors have not opined that the cotton/gauze was removed found in the stomach or abdomen which was left during the operation done on 17.10.2018 by the opposite party No.1 in opposite party No.3 hospital but a used gauze, was found in the vagina on 27.03.2019. The complainant last visited the opposite party No.1 at opposite party No.2 on 23.03.2019 and the used gauze was found on 27.03.2019 only. The pictures produced by the complainant evidences that the gauze was soaked in betadine and it is a fresh gauze within few hours of its recovery. There has been several enquiries and inspections by various government authorities at Genesis Royal Infirmary and the opposite party No.1 and 2 do have all the required licenses, facilities and manpower. The complainant was taking treatment at the new hospital i.e., Genesis Royal Infirmary at Puliakulam Road from March 2019 It is submitted that cunningly and with ill motive the complainant had sent the legal notices to the old premises so that opposite parties could not get the legal notices. There was no fault or negligence on the health care system adopted and also no medical negligence on the part of the opposite parties. The complainant is not entitled to receive any relief as claimed. There is neither any deficiency in

service nor any negligence. It is, therefore prayed that the present complaint deserves to be dismissed.

The brief averments of the written version filed by the 3rd opposite party are as follows:-

3. The complainant was admitted as an inpatient of Dr.Chandrakala - opposite party No.1 of this complaint and provided the room, operation theatre, nurses to attend, food for the patient, pharmacy etc. to the complainant for a charge and these facilities are provided on daily rent/lease/charge basis only and that the opposite party No. 3 has nothing to do with neither the treatment given to the complainant nor with the decease of the complainant nor with the operation of the complainant. The complainant was operated on 17.11.2018 and discharged on the same are true and admitted. The complainant paid Rs.27,903/- only to this opposite party towards all charges payable to the hospital. There is no negligence or deficiency in service on the part of this opposite party. Therefore, prayed that the present complaint deserves to be dismissed.

4. The complainant has filed his Proof Affidavit and Ex.A1 to Ex A27 have been marked. The 1st and 2nd opposite parties have filed their Proof Affidavit and Ex.B1 to Ex. B5 have been marked. The 3rd opposite party has filed his Proof Affidavit and Ex.B6 to Ex. B8 have been marked.

5. The points for consideration in this complaint are:

1) Whether the allegations of negligence and deficiency in service on the part of the OPs have been established?
2) What are the reliefs to which the complainant is entitled?

Point No.1:

SUBMISSIONS OF THE COMPLAINANT:

6. The complainant was suffering from severe stomach pain and consulted OP1 at OP2 Hospital. After examination, OP1 informed her that she was suffering from uterus and hernia problems and advised that removal of the uterus was necessary. OP1

advised her to undergo treatment at OP2 and informed her that surgery followed by medication would be required at a cost of Rs.60,000/-. After consulting her family members, the complainant agreed to undergo the surgery. Thereafter, OP1 advised her to get admitted at OP3 Hospital and accordingly she was admitted on 16.11.2018.

7. The complainant submits that the surgery was performed by OP1 at OP3 Hospital on 16.11.2018 and she was discharged on 17.11.2018. Despite the surgery she continued to suffer from pain and again consulted OP1 at OP2 Hospital. She informed OP1 that the pain persisted even after surgery, but was advised to take painkillers, which she continued to consume for a prolonged period.

8. The complainant further submits that her condition worsened gradually and she continued treatment with OP1 till 23.03.2019. Subsequently, she experienced severe bleeding along with stomach pain, and blood mixed with stools was discharged through the vagina. She approached ESIC Medical College and Hospital, Singanallur, Coimbatore. The doctors informed her that a cotton gauze had been left inside her body during the surgery performed by OP1 at OP3 and that the same had caused damage to the rectum. The gauze was removed on 29.03.2019. The doctors at ESIC Hospital informed her that her condition required advanced treatment and referred her to Stanley Hospital, Chennai.

9. The complainant further submits that thereafter, she was admitted at Stanley Hospital, Chennai on 02.04.2019. She was diagnosed with Intraperitoneal Abscess with Colovaginal Fistula and underwent treatment, including surgery on 16.04.2019, and was discharged on 25.04.2019. She was again admitted on 18.08.2019 and underwent further surgery on 26.08.2019. She was advised to use a Coloplast Bag and was discharged on 04.09.2019. She continued under treatment and was advised to undergo further surgery.

10. The complainant further submits that, following her complaint to the District Collector, Coimbatore on 10.06.2019, an enquiry was conducted by the Joint Director (Medical and Rural Welfare), Coimbatore on 28.06.2019. The enquiry report referred to complaints made by three persons, namely the complainant, Smt. Nithya and Mr. A. Moorthy, regarding treatment rendered by OP1. The report recorded the complainant's

allegation that cotton gauze had been left inside her body during surgery, resulting in rectal damage and continued treatment. The report further recorded that there was a possibility that the used cotton gauze had not been removed during medical treatment. Further, the report referred to the following aspects regarding OP2 and OP1: (i) OP2 was functioning without proper sanction; (ii) Lack of medical equipment to conduct delivery and surgery; (iii) OP2 was functioning without proper construction; and (iv) Deficiency of service and negligence on the part of OP1.

11. The complainant further submits that she continued to undergo treatment and suffered deterioration of her health, mental agony, financial difficulties and physical suffering. The same resulted from the surgery performed by OP1. She continued treatment thereafter and was admitted in Sri Ramakrishna Hospital on 08.09.2021, underwent surgery on 09.09.2021 and was discharged on 15.09.2021. The hospital expenses amounted to about Rs.1,50,000/-.

12. The complainant further submits that although it was alleged that she had complained of vaginal discharge and bleeding at frequent intervals in October 2018, no such complaint was recorded in the treatment records maintained by OP1.Though she had previously undergone a Lower Segment Caesarean Section (LSCS), the allegation that she had insisted upon a hysterectomy is incorrect. She was suffering from severe abdominal pain due to mesh erosion and OP1 informed her that the mesh could not be removed without also removing the uterus. She further submits that, during the surgery, an umbilical hernia procedure was also performed. According to the complainant, her present complications arose from the surgery performed by OP1.

13. The complainant further submits that the records of ESI Hospital describe her condition as "Post-Hysterectomy / Pelvic Abscess due to Retained Foreign Body." She submits that she has suffered physical injuries, permanent health complications, mental agony and financial hardship and that she is required to undergo further surgeries and continue medication. Her husband is employed as a food delivery executive and the family has been facing financial difficulties on account of her continuing medical condition and

treatment expenses. The complainant further denies that she was informed of the risks of bowel and bladder injury and submits that, though Rs.1,00,000/- was collected from her, no bill or receipt was issued.

14. The complainant further submits that she experienced persistent pain and other symptoms following the surgery and attributes the same to the retention of cotton gauze inside her body during the surgical procedure. She relies upon the principles of negligence and res ipsa loquitur and places reliance on the decisions in V. Kishan Rao v. Nikhil Super Speciality Hospital (2010), Kusum Sharma & Others v. Batra Hospital & Medical Research Centre & Others (2010), Dr. Shyam Kumar v. Rameshbhai Harmanbhai Kachhiya (2006), and Kousik Pal v. B.M. Birla Heart Research Centre (2019), in support of her contention that retention of a foreign object inside a patient's body during surgery, lack of informed consent, failure to maintain or produce proper medical records, and performance of procedures without requisite skill or care constitute medical negligence and deficiency in service.

15. The complainant further argues that leaving cotton gauze or a surgical sponge inside the body during surgery, described as gossypiboma or retained foreign body, constitutes medical negligence and attracts the principle of res ipsa loquitur, under which the occurrence itself raises an inference of negligence. The complainant contends that, on account of the treatment rendered by OP1 to OP3 and the subsequent complications arising therefrom, she has suffered physical pain, mental agony, trauma, financial loss and continuing medical expenses and is therefore entitled to compensation.

SUBMISSIONS OF OP1 and OP2:

16. OP1 and OP2 submit that OP1 is an Obstetrician and Gynaecologist by profession. OP1 had worked at GKNM Hospital and thereafter at Hindustan Hospital, Coimbatore. Simultaneously, OP1 was running a clinic under the name Genesis Women and Child Care at Papanaickenpalayam, Coimbatore, which was subsequently shifted to Puliakulam Road, Coimbatore and renamed as Genesis Royal Infirmary Pvt. Ltd. The complainant consulted OP1 during October 2018 with complaints of vaginal discharge and

bleeding at irregular and frequent intervals for a prolonged period. According to them, examination revealed erosion of a mesh implanted in the complainant's pelvis during a surgery performed in 2007 and that the mesh erosion had affected the vagina and resulted in discharge and bleeding. The diagnosis of mesh erosion is recorded in the complainant's OP notes.

17. OP1 and OP2 further submit that the complainant had undergone several surgeries prior to the treatment in question, including surgery in 2007 for complete uterine prolapse, during which a prolift mesh was implanted in the pelvis. They further submit that the complainant underwent LSCS with umbilical hernia repair in 2015 and had also undergone eye transplant surgery. According to OP1 and OP2, known complications of mesh include erosion into the bladder, bowel and bone.

18. OP1 and OP2 further submit that the complainant was diagnosed with mesh erosion and pelvic infection and was initially treated conservatively with antibiotics. According to them, although the complainant initially responded to treatment, she subsequently experienced discharge and wished to undergo hysterectomy. They submit that OP1 advised the complainant to consult her primary doctor at Chennai, but she returned and sought hysterectomy. The complainant was advised to undergo surgery at OP3 Hospital and was admitted on 16.11.2018.

19. They further submit that the complainant was informed about the progressive disease process, mesh erosion and complications associated with mesh erosion and hysterectomy, including risks of bowel injury, bladder injury, vault prolapse and progressive mesh erosion, and that written consent was obtained before surgery. The complainant underwent surgery at OP3 Hospital on 16.11.2018 and was discharged on 17.11.2018. OP1 and OP2 deny that the complainant paid Rs.1,00,000/- towards surgery expenses. According to them, the complainant paid a total sum of Rs.44,203/-, comprising Rs.27,903/- towards hospital charges and Rs.16,300/- towards professional charges, and consolidated bills were issued.

20. OP1 and OP2 further submit that the complainant was normal on the day following surgery and sought early discharge in order to take care of her child. According to them, she was thereafter advised follow-up treatment in the Outpatient Department. They submit that examination on 27.11.2018 revealed satisfactory healing of the vagina and surgical wounds. They further submit that a vault infection was subsequently diagnosed on 05.12.2018 through culture testing and treated with appropriate antibiotics. According to them, examination on 18.12.2018 confirmed satisfactory healing and the complainant was doing well.

21. OP1 and OP2 deny the allegation that cotton gauze was negligently left inside the complainant's body during surgery. They submit that the ESI Hospital records do not state that OP1 performed the surgery negligently. According to them, the ESI records merely record that a "gauze like structure" adherent to the vagina was removed.OP1 and OP2 contend that the uterus removal surgery was performed on 16.11.2018 and that the abdomen was closed thereafter. According to them, if any cotton gauze had been present inside the abdomen, it could have been removed only through a further surgical procedure, whereas no such surgery was performed at ESI Hospital.

22. OP1 and OP2 further submit that the MRI scan dated 24.03.2019 did not reveal the presence of any foreign body in the abdomen or pelvis. According to them, the complainant was diagnosed with colovaginal fistula, pelvic abscess and inflammation and not rectovaginal fistula.OP1 and OP2 further submit that colovaginal fistula and pelvic abscess could have arisen due to mesh erosion and infection associated with the prolift mesh implanted in 2007. Such mesh had been banned internationally since 2018 and that the complainant had undergone implantation of such mesh in 2007.

23. OP1 and OP2 further submit that the complainant's subsequent treatment at Stanley Hospital, Chennai, further surgeries and continuing treatment were attributable to her pre-existing disease condition and medical history dating back to 2007. OP1 and OP2 submit that, pursuant to the complaint lodged before the Commissioner of Police, an enquiry

was conducted by the C-2 Race Course Police Station and no case was registered against them. According to them, the complaint was closed and a closure report was submitted.

24. OP1 and OP2 further submit that the complaint submitted before the District Collector, Coimbatore did not result in any action against them. They further submit that the enquiry conducted by the Joint Director (Medical and Rural Welfare), Coimbatore did not find fault with them. OP1 and OP2 submit that the Hon'ble Supreme Court has, in various decisions, directed that expert medical opinion should be obtained while dealing with allegations of medical negligence.

25. OP1 and OP2 deny negligence, deficiency in service and liability. They further contend that the complaint is not maintainable, that no cause of action exists against them, that the complainant is not entitled to any relief and that the complaint is liable to be dismissed.

SUBMISSIONS OF OP3:

26. OP3 submits that the complainant was admitted as an inpatient under the care of OP1 and that OP3 provided facilities such as room accommodation, operation theatre, nursing services, food and pharmacy services on payment of charges. According to OP3, such facilities were provided on a chargeable basis and OP3 had no role in the treatment administered to the complainant or in the conduct of the surgery performed by OP1. OP3 further submits that the complainant was informed by OP1 about the surgery, the procedure involved and its consequences and that the complainant's consent was obtained. The complainant underwent surgery on 16.11.2018 and was discharged on 17.11.2018. OP3 denies the allegation that a sum of Rs.1,00,000/- was charged by the hospital and contends that the complainant paid a sum of Rs.27,903/- towards all charges payable to the hospital. OP3 denies any negligence or deficiency in service on its part and contends that the complaint is liable to be dismissed.

ANALYSIS, REASONING, AND CONCLUSION:

27. All the materials available on record including the pleadings, affidavit of evidence, medical records, enquiry report, and the submissions made by both parties have been duly considered.

28. The main question for consideration is whether the complainant has established that cotton gauze was left inside her body during the surgery performed by OP1 on 16.11.2018 and whether the subsequent complications suffered by her were connected to the said surgery.

29. It is well settled that a medical practitioner is required to exercise reasonable skill and care while rendering treatment. Mere occurrence of a complication or an unsuccessful outcome does not by itself establish negligence. However, where the facts proved on record disclose circumstances which ordinarily would not occur in the absence of negligence, the principle of res ipsa loquitur may become applicable and an inference of negligence may arise from the facts themselves.

30. In the present case, it is noted that the complainant underwent hysterectomy and related surgical procedures under OP1 on 16.11.2018 at OP3 Hospital (ExA5). It is also noted that after the surgery the complainant continued to suffer pain and subsequently developed serious complications requiring treatment at ESI Hospital, Coimbatore, Stanley Hospital, Chennai and Sri Ramakrishna Hospital, Coimbatore (Ex A6, ExA15, and ExA19).

31. The records of ESIC Medical College and Hospital, Coimbatore (ExA6) assume considerable importance. The said records show that when the complainant was examined and treated in March 2019, a gauze-like structure was found adherent near the vaginal vault and was removed. The records further refer to infection, pus discharge, pelvic abscess and retained foreign body following hysterectomy.These records were prepared by an independent Government institution during the course of treatment and there is no material on record to discredit their contents.

32. The certificate dated 06.04.2019 issued by the Department of Surgical Gastroenterology, Government Stanley Hospital, Chennai (ExA16), also assumes significance. The said certificate records that the complainant was diagnosed with Deep Organ Surgical Site Infection and Colovaginal Fistula following Total Abdominal Hysterectomy and Bilateral Salpingo-Oophorectomy (TAH & BSO). The certificate establishes that the complainant developed serious post-operative complications requiring specialized treatment and further management. The said certificate, read along with the ESI Hospital records regarding the discovery and removal of a gauze-like foreign material from the operative site, lends support to the complainant's case regarding the complications that arose following the surgery performed on 16.11.2018.

33. The MRI scan (ExA7) and subsequent records of Government Stanley Hospital, Chennai (ExA15 to ExA18), further reveal pelvic abscess and colovaginal fistula for which the complainant underwent major corrective surgeries and prolonged treatment. The records show that the complainant had to undergo repeated hospitalization and surgical intervention on account of the complications that developed after the surgery performed on 16.11.2018.

34. OP1 and OP2 have contended that the complainant had a history of earlier surgeries and that mesh erosion from a prolift mesh implanted in the year 2007 was responsible for the subsequent complications. This defence has been carefully considered.It is true that the complainant had undergone previous surgeries and that mesh erosion is a recognized medical complication. However, the medical records also show that a gauze-like foreign material was found and removed from the operative site after the surgery performed by OP1. The development of infection, pelvic abscess and fistulous communication thereafter cannot be ignored.

35. The contention of OP1 and OP2 that the ESI records merely refer to a "gauze-like structure" and therefore do not establish negligence cannot be accepted. The records of ESI Hospital show that a gauze-like foreign material was found adherent near the vaginal vault, which was the operative site of the surgery performed by OP1. Gauze is not a

material naturally found within the human body. In the absence of any intervening surgical procedure, the presence and subsequent removal of such material from the operative site is a significant circumstance. When considered together with the subsequent infection, pelvic abscess and colovaginal fistula, the records raise a strong inference that surgical material had remained at the operative site following the surgery. The use of the expression 'gauze-like structure' in the ESI records does not affect the evidentiary value of the clinical findings recorded therein. The further contention that the MRI scan did not specifically reveal the presence of a foreign body also does not advance the case of OP1 and OP2, since the subsequent clinical findings recorded during treatment carry greater evidentiary value.

36. The contention of OP1 and OP2 that no abdominal surgery was performed at ESI Hospital and therefore no gauze could have been removed is also unpersuasive. The records indicate that the gauze-like material was found adherent near the vaginal vault and removed from that region. Therefore, the absence of any abdominal surgery at ESI Hospital does not negate the findings recorded in the treatment records.

37. The enquiry conducted by the Joint Director (Medical and Rural Welfare), Coimbatore (ExA14) also records that there was a possibility that used cotton gauze had not been removed during treatment. Though the enquiry report is not conclusive proof by itself, it lends support to the complainant's case and corroborates the medical records.

38. OP1 and OP2 have also relied upon the doctor's notes (ExA2) showing that swab and instrument counts were correct and have contended that no negligence occurred during surgery. However, such entries cannot by themselves outweigh the subsequent medical records showing the presence of a gauze-like foreign material at the operative site and the complications that followed. The purpose of maintaining swab and instrument counts is precisely to ensure that no surgical material remains within the patient.

39. Further the contention of OP1 and OP2 that expert medical opinion is mandatory , cannot be accepted in the present case. The complainant has produced medical records prepared during the course of treatment from Government hospitals which show the discovery and removal of foreign material from the operative site and the subsequent

complications. The facts disclosed by the records are sufficient for adjudication of the present complaint. In V. Kishan Rao v. Nikhil Super Speciality Hospital (2010) 5 SCC 513, cited by the complainant, the Hon'ble Supreme Court held that in cases where negligence is apparent from the facts and no expert knowledge is required to evaluate the same, it is not necessary to obtain expert medical evidence. Retention of surgical material inside a patient's body following surgery is a circumstance which is self-evidently indicative of negligence and does not require expert opinion for its evaluation.

40. The closure of the police complaint is of no consequence to the present proceedings, as the issue before this Commission is to be decided on the basis of the evidence available on record. Likewise, the fact that no further administrative action was taken pursuant to the complaint before the District Collector does not discredit the contents of the enquiry report or the medical records.

41. On an overall consideration of the evidence, this Commission is of the view that the complainant has established that a gauze-like foreign material was found and removed from the operative site following the surgery performed by OP1 and that the complainant subsequently suffered pelvic abscess, colovaginal fistula, repeated hospitalization, multiple surgeries, prolonged treatment, pain and suffering. The medical records establish a direct and proximate nexus between the retention of foreign material at the operative site and the subsequent development of pelvic abscess and colovaginal fistula. While the complainant's pre-existing mesh erosion condition is noted, the sequence of events — namely, the discovery and removal of foreign material, the discharge of pus, the formation of abscess and the development of fistula — is more consistent with a post-surgical foreign body reaction than with mesh erosion alone. The facts and circumstances of the case attract the principle of res ipsa loquitur and establish negligence and deficiency in service on the part of OP1.

42. OP2 is the hospital through which OP1 examined and treated the complainant before and after surgery. The pre-operative consultation, diagnosis and post-operative follow-up were all conducted at OP2. OP1 being a doctor attached to and

operating through OP2, the latter is the service provider within the meaning of Section 2(42) of the Consumer Protection Act, 2019. The negligence of OP1 in the course of rendering services through OP2 renders OP2 jointly and severally liable.

43. Insofar as OP3 is concerned, the materials on record only establish that the surgery was performed at its hospital under the care of OP1 and that OP3 provided hospital facilities. No independent act of negligence or deficiency in service on the part of OP3 has been established by acceptable evidence. Therefore, no liability can be fastened upon OP3.

44. For the foregoing reasons, this Commission holds that the complainant has successfully established negligence and deficiency in service on the part of OP1 and OP2. Point No.1 is answered accordingly.

Point No.2:

45. Having held that OP1 and OP2 were negligent and deficient in rendering medical services to the complainant, the next question relates to the quantum of compensation. The materials on record establish that, on account of the negligence and deficiency in service of OP1 and OP2, the complainant suffered serious post-operative complications, including pelvic abscess, deep organ surgical site infection and colovaginal fistula. She was required to undergo repeated hospitalisation, multiple corrective surgeries and prolonged medical treatment. The evidence further shows that she underwent considerable physical pain, mental agony, trauma and hardship affecting her normal day-to-day life.

46. The complainant has claimed a sum of Rs.50,00,000/- as compensation. However, taking into consideration the nature of negligence established, the injuries suffered, the prolonged treatment undergone by the complainant and the overall facts and circumstances of the case, this Commission is of the view that a sum of Rs.12,00,000/- (Rupees Twelve Lakhs only) would constitute just and reasonable compensation. Accordingly, OP1 and OP2 are jointly and severally directed to pay the complainant a sum of

Rs.12,00,000/- (Rupees Twelve Lakhs only) as compensation for the physical pain, mental agony, emotional trauma and financial caused by their negligence and deficiency in service. The complainant shall also be entitled to Rs.5,000/- (Rupees Five Thousand only) towards the costs of the proceedings. Point No. 2 is answered accordingly.

47. In the result, the complaint is partly allowed. The 1st and 2nd opposite parties are directed a) to pay the complainant a sum of Rs. 12,00,000/- (Rupees Twelve Lakhs Only) as compensation for the mental agony, emotional trauma and financial loss caused by their negligence and deficiency in service b) to pay a sum of Rs. 5,000/- (Rupees five thousand only) towards the cost of proceedings. All the above payments shall be made within a period of one month from the date of receipt of this order, failing which the opposite party shall be liable to pay interest at the rate of 9% p.a towards the above said total amount till it is realized. The complaint against 3rd opposite party is dismissed.

Pronounced by us in Open Commission on this the 23th day of June, 2026.

(Sd/-)	(Sd/-)
(P.MARIMUTHU)	(R.THANGAVEL)
Member	President

List of Exhibits marked by the complainant:

1.	Ex. A1/ -	Copy of Aadhar Card
2.	Ex. A2/ 11.10.2018	Medical Record
3.	Ex. A3/ 14.11.2018	Clinical Pathology Report
4.	Ex. A4/ 05.12.2018	Final Test Report
5.	Ex. A5/ 17.11.2018	Discharge Summary
6.	Ex. A6/ 27.03.2019	Copy of Medical Record
7.	Ex. A7/ 29.03.2019	MRI Scan Report
8.	Ex. A8/ 06.05.2019	Copy of Police Complaint
9.	Ex. A9/ 10.06.2019	Copy of Complaint to District Collector
10.	Ex. A10/ 10.06.2019	News Paper
11.	Ex. A11/ 11.06.2019	News Paper

12.	Ex. A12/ 26.07.2019	Copy of Letter to District Collector
13.	Ex. A13/ 28.06.2019	Copy of Letter from Rural Development
14.	Ex. A14/ 22.10.2019	Copy of Letter from District Collector
15.	Ex. A15/ 25.04.2019	Copy of Discharge Summary
16.	Ex. A16/ 06.04.2019	Copy of Letter from Hospital
17.	Ex. A17/ 04.09.2019	Copy of Discharge Summary
18.	Ex. A18/ -	Copy of Permission Letter
19.	Ex. A19/ 02.04.2019	Case Sheet
20.	Ex. A20/ 15.09.2021	Copy of Discharge Summary
21.	Ex. A21/ 15.09.2021	Copy of Inpatient Bills
22.	Ex. A22/ -	Copy of Photographs
23.	Ex. A23/ 23.09.2021	Copy of Legal Notice
24.	Ex. A24/ -	Acknowledgement Card
25.	Ex. A25/ -	Return Postal Cover
26.	Ex. A26/ -	Return Postal Cover
27.	Ex. A27/-	Copy of Letter from Rural Development

List of witnesses examined on the side of complainant:

1.	PW1/ 05.09.2022	G.Bhuvaneswari W/o.Mr.Ganesan, Complainant

List of Exhibits marked on the side of 1st and 2nd opposite parties:-

1.	Ex. B1/ 05.12.2018	Out Patient Billing
2.	Ex. B2/ 17.11.2018	In Patient Billing
3.	Ex. B3/ -	Copy of Medical Bills
4.	Ex. B4/ -	Copy of Consent Form
5.	Ex. B5/ 17.11.2018	Copy of In Patient Billing

List of witnesses examined on the side of 1st and 2nd opposite parties:

1.	RW1/ 21.04.2026	Chandrakala Makudapathi, Authorized Signatory, 1st Opposite Party

List of Exhibits marked on the side of 3rd opposite party:-

1.	Ex. B6/ 17.11.2018	Copy of In Patient Billing
2.	Ex. B7/ -	Copy of Consent Form
3.	Ex. B8/ -	Copy of In Patient Billing's

List of witnesses examined on the side of 3rd opposite party:

1. RW1/ 30.04.2026 Sathish Prabhu, Authorized Signatory, 3rd Opposite Party

(Sd/-)
(P.MARIMUTHU)
Member

(Sd/-)
(R.THANGAVEL)
President