

C.C.No. : 103/2023

Date of filing : 03.11.2023

Date of Disposal : 07.11.2025

BEFORE THE DISTRICT CONSUMER DISPUTES REDRESSAL

COMMISSION, HASSAN – 573 201

CONSUMER COMPLAINT NO.103/2023

Dated on this the 7th day of November 2025

Present : 1) Hon'ble Smt. Chanchala.C.M, B.A.L, LL.B., PRESIDENT

2) Hon'ble Smt. Anupama.R, B.COM., LL.B., L.MEMBER

COMPLAINANT	Nagesh S/o Late Sanke Gowda Aged about 38 years, R/o Vidya Nagar Hassan Dist.-573121 (Rept. by Sri PSD/Smt RDDA, Adv.,)
V/s	
OPPOSITE PARTIES	1. Management, Sparsh Hospital, B M Road, Hassan-573201 (Rept. by Sri SVJ, Adv.,) 2. Dr. Prema, Physician, Sparsh Hospital, B M Road, Hassan-573201 (Rept. by Sri PMV, Adv.,) 3. The Director, BMC & RI Super Specialty Hospital (PMSSY), Victoria Hospital Campus, K R Road, Bangalore-560002 4. Dr. Gautham, BMC & RI Super specialty Hospital, Victoria Hospital Campus, K R Road, Bangalore-560002 (OP.3&4 Rept. by Sri SVM, Adv.,) 5. The Management / Director, St. John's Medical College and Hospital, Sarjapur Road, Bangalore-560002 6. Dr. Bhuvana Krishna, HOD, Critical Care Medicine, Sarjapur Road, St. John's Medical College

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	and Hospital, Bangalore-560002 (OP.5&6 Rept. by Sri SYP, Adv.,) 7. The Principal Secretary, Dept. of Health and Family Welfare, No 105, 1st Floor, Vikasa Soudha, Bangalore 560001 (Ex-parte) 8. Dr.Syed Shsfiq Dept. of Gastroenterology St.John's Medical College and Hospital Bangalore-560002 (Rept. by Sri SVJ, Adv.,)
Date of filing of complaint	03.11.2023
Date of service of notice to OPs	9, 10, 16 & 22.11.2023
Date of order	07.11.2025
Total period taken	2 years 4 days

Pronounced on : 07.11.2025

Smt Chanchala.C.M. – Hon'ble President.

:: ORDER ::

1. This is a complaint filed under section 35 of the Consumer Protection Act 2019 by Sri Nagesh praying to direct the OPs to pay Rs.50,00,000/- towards act of medical negligence, mental agony, medical expenses and deficiency of service etc.,

Complaint:

2. The case of the complainant is that the complainant is the son of deceased Gangamma who visited the hospital of the OP.1 for the pain in the abdomen on 04.01.2023. The OP.2 after having done initial investigation and CT abdomen and pelvis plain study diagnosed that mother of the said complainant was suffering from Gall Bladder stone and Choledocholithiasis. Further the OP.2 had referred Gangamma to the higher centre for management with a referral letter dtd 04.01.2023. Accordingly, Gangamma got admitted in the hospital of the OP.3 i.e., BMC and RI Super specialty hospital, Victoria Hospital campus, Bangalore on 05.01.2023 and she was under the treatment of

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OP.4 i.e., Dr.Gautham and was further referred to higher management to St.John's Medical College and Hospital Sarjapur Road, Bangalore i.e., OP.5. The mother of the complainant was under the treatment of Dr.Bhuvana Krishna i.e., OP.6 from 05.01.2023 and discharged on 10.01.2023 for the reasons best known to the said OP.6 only. The said Gangamma underwent ERCP procedure with stent placing on 06.01.2023 by the OP.8 and was infested with E, Coli and Stenotrophomonas Noso Comial Infection (antibiotic resistance bacteria) during the course of the treatment in the said hospital of OP.5. She was readmitted in the hospital of the OP.5 on 11.01.2023 and was under treatment of OP.6 till 30.01.2023. Later she had developed acute respiratory distress on 17.01.2023 and bronchospasm and underwent tracheotomy on 21.01.2023. On 30.01.2023 at about 4.15 am she had developed sudden onset of acute respiratory distress and died of pneumothorax. Hence the complainant alleged that his mother Gangamma died due to hospital acquired infection is an act of medical negligence on the part of the hospital management and also of the treating doctors and the management and treating doctor have failed to treat her with minimum required care and skill resulting her death. In this regard a legal notice dtd 09.10.2023 is got issued to the said OPs and that the same is duly served and no reply. Hence the complainant filed the present complaint against the Ops alleging medical negligence and also deficiency of service.

3. After hearing on admission the complaint was admitted and notices were ordered to be issued to the OPs to file written version under the provision of the Consumer Protection Act, (in short "the Act"). The Ops.1 to 6 and 8 are appeared before the Commission and filed their written version. Inspite of service of notice to OP.7, did not appear before the Commission and hence they placed ex-parte.

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Defence of OP.1:

4. In the written version the Op.1 has denied any medical negligence and also deficiency of service on their part. They further contended that the patient Gangamma visited their hospital on 04.01.2023 with h/o abdomen pain and vomiting since one day and she was evaluated for the same. As she has evidence at CBD calculus, she would need ERCP for further management. Since ERCP and surgical gastro facility are not available at their hospital, she has been referred to higher center for further management on same day. Hence they have denied any medical negligence and deficiency of service on their part and prays for dismiss the complaint.

Defence of OP.2:

5. In the written version Op.2 also denied any medical negligence and also deficiency of service on her part. She further contended that the patient by name Smt Gangamma has come to Sparsha Hospital with a history of abdominal pain on 04.01.2023 and after preliminary evaluation by duty doctor at 7.30 pm on the same day about the patient and attended the patient and immediately she has administered emergency medicines and advised other investigations troponinl, 2D echo and C.T.Abdomen. After the reports available, after going through the reports she was referred to higher center for further management of the patient on the same day. There is no delay or latches from her part as and when she noticed the report, since the hospital did not have the required facilities for further management of the patient, she referred the patient to higher center for better management. Hence she prayed to dismiss the above complaint against her.

Defence of OP.3&4:

6. In the written version, the Op.3 and 4 denied medical negligence on their part and they further contended that the complainant had brought his mother Smt Gangamma with a referral letter issued by OP.2 to the hospital of OP.3 and



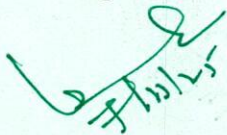
visited the triage on 05.01.2023 wherein she was attended by OP.4 and she was advised to get admitted in the high dependency unit of the hospital under the department of surgical gastroenterology for treatment. They further contended that the patient was planned to be treated with ERCP after admission and accordingly advised the patient to get admission in the hospital. However the patient who is none other than the mother of the complainant did not get admitted to the hospital without heeding to the advice of the Op.4 and without the knowledge of the op.3 &4 was taken elsewhere for treatment. However OP.3 & 4 came to know that the Smt Gangamma the mother of the complainant got admitted to the hospital of Op.5 on the very same day that is on 05.01.2023, after reading the copy of the complaint. Under the aforesaid circumstances there is no negligence on the part of Op.3&4 in treating the mother of the complainant and the complainant cannot allege deficiency of service on the part of the OP.3&4 and hence they have prays for dismiss the complaint against them.

Defence of OP.5&6:

7. In the written version, the Op.5 and 6 denied medical negligence on their part and they further contended that the complainant's mother admitted in OP.5 hospital on 05.01.2023 at 8.30 am to emergency room and the emergency department took care of the patient from 05.01.2023 to 09.01.2023. The patient presented with pain in the abdomen and vomiting for 2 days, associated with chills, associated with cough, breathing difficulty on exertion for 3 months and decreased urine output since 1 day. The patient had a history of DM for 4 years, HTN for 10 years and pemphigus on steroids 4 years back. On examination, the patient was afebrile, tachycardia, tachypneic and hypoxic. The patient had jaundice, and an abdominal examination revealed diffuse tenderness. CT done from outside hospital on 04.01.2023, showed multiple radiodense calculi – cholellithiasis, mild to Mod IHBRD,

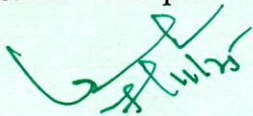


CBD dilated CBD calculi. It is further submitted that a diagnosis of obstructive jaundice due to cholelithiasis/choledocholithiasis/cholangitis was made. Pancreatitis, AKI and sepsis were suspected, pending further reports. The patient was treated in the emergency room with intravenous fluids, antibiotics and analgesics. Gastroenterology advised ERCP procedure after stabilization. The patient was admitted to EICU and treated with antibiotics, fluids and vasopressors. On 06.01.2023 patient was intubated in view of respiratory distress and the patient was taken up for ERCP. ERCP showed choledocholithiasis + cholangitis partial CBD clearance done with stenting. The patient was brought back to EICU and supportive measures were continued. On 07.01.2023, vasopressors were tapered off and the patient was weaned from the ventilator. At 10.15 am, the patient was extubated. On 08.01.2023 the patient developed fever spikes, and a chest x-ray showed increased haziness. Antibiotics were escalated to meropenem. The patient developed worsening respiratory distress; a BIPAP trial was given and the patient developed a wheeze. At 2.30 pm, the patient was reintubated as respiratory distress did not improve despite BIPAP, nebulization and Magnesium sulphate injection. The patient was continued on Antibiotics and ventilation and on 09.01.2023, was shifted to MICU for further care. The patient was shifted to the first floor ICU from EICU. The patient Mrs Gangamma from 09.01.2023 to 15.01.2023 was seen by consultant Dr.Natesh prabhu, Associate professor critical care medicine. The patient was received from EICU on 9th January 2023 around 11.45 pm to the first floor ICU on the endotracheal tube, controlled mode of ventilation. She had severe hypoxia, possibly moderate to severe acute respiratory distress syndrome or worsening of respiratory infection of suspected aspiration pneumonia. She had severe hypoxia needing high ventilator support and required prone ventilation. The endotracheal tube was changed due to a suspected block, right subclavian line


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was removed. Other standard ICU monitoring and care was continued. The patient had a fever and respiratory failure, which improved over the next two days, antibiotics were optimized based on culture sensitivity and deescalated because of clinical improvement. The patient had improvement in lung function and was breathing well on partial ventilator support. The fever lasted for a few more days and subsided. Due to clinical recover, the patient was planned for further weaning. The patient was discharged on 11.01.2023 and readmitted for the ayushman bharath scheme on 11.01.2023.

8. They further contended that the patient Mrs Gangamma presented with an infection of the biliary system. She had cholecystitis, choledocholithiasis, and cholangitis with sepsis. The bile pus culture grew a bacteria on 06.01.2023 E.coil which warranted antibiotics from day one. Patient had developed pneumonia during the ICU stay as shown in the culture report from her lungs sent on 17.01.2023 which grew proteus Mirabilis and Acinetobacter Baumanii. The infection she developed while in the ICU was after 10 days of stay in the ICU with a failed extubation from the ventilator twice. She had several risk factors for the development of multi-drug resistant pneumonia in ICU. She was admitted in an outside hospital where she was advised procedure EPCP for the biliary tree stones, for the family refused and came DAMA to OP.5 hospital. That the prolonged ventilator day, patient was on ventilator from 06.01.2024 till 17.01.2024 when she developed the pneumonia. Patient came to hospital with sepsis and shock which is a risk factor. The patient did not tolerate extubation twice because of multiple reasons she had to be put back on the ventilator on 08.01.2023 and second time on 16.01.2023 patient has received steroids in the past for pemphigus vulgaris. Patient had ARDS at the time of admission which is a risk factor for hospital acquired pneumonia. The patient was infected with drug resistant

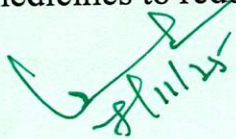


bacterial infections because of the above risk factors which was appropriately recognized and treated.

9. They further contended that the hospital acquired pneumonia especially ventilator associated pneumonia is one of the most common hospital acquired infections in the ICU and can range from 5-40% with high mortality. The risk factor for VAP is the same as given above. Since the patient had several risk factors for developing VAP, that too with multi drug resistant bacteria, the hospital acquired infection is not a medical negligence. Hospital acquired infections prevalence is high globally. The WHO report on the burden of hospital acquired infections especially in the ICU is as high as 30%. In an ICMR study published recently HAI with antimicrobial resistance is a global crisis with constant rise. The risk factors for same as included in a WHO report were age 65 years, longer than 7 days of hospital stay, which our patient had and being on the ventilator, emergency basis admission to the intensive care unit, prior admission to another hospital and co-existing underlying diseases like in their patient who had diabetes mellitus and hypertension and had received steroids in the past for pemphigus vulgaris.
10. They further contended that the patient was prepared for further weaning and received steroids for anticipated airway edema. The patient was extubated on 15th January around 8.30 am. The patient did well after extubation till the afternoon. Then she had mild stridor, for which she received steroids, nebulizer steroids and medications and was initiated on noninvasive ventilator support. The patient did well with non invasive ventilation thereafter till the next day. That the complainant and family were counseled by the ICU team regularly multiple times a day. The family explained about the biliary sepsis, lung failure needing mechanical ventilation and possible need for a longer ICU stay, she has a high risk for secondary infections and anticipated difficulty weaning from the ventilator. The complainant was explained about

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improving lung function and plan for further weaning and extubation. The need for noninvasive ventilation and reintubation was explained in detail, the presence of mild stridor was communicated and the treatment plan was explained. The patient Mrs Gangamma was seen by consultant Dr. Bhuvana Krishna from 16.01.2023 to 22.01.2023. On 16.01.2023 on assessment was extubated 24 hours back. This was her second extubation trial. She was drowsy and had wheezing with steroids and had fever. Oxygen levels were 10% on 6 liters of oxygen on face mask. She was already on antibiotics injection meropenem in view of bile culture that was growing E. coli bacteria. The bile culture was sent on 06.01.2023 after ERCP procedure for cholangitis, which was what the patient presented to OP.5 hospital with. On 16.01.2023 patient was suspected to have ventilator associated pneumonia and was started on injections colistin and vancomycin along with meropenem and also received nebulization and steroids for her wheezing. She was suspected to have airway edema because of a previous extubation failure. On 16.01.2023 night patient developed respiratory distress with rise in carbondioxide levels hence had to be re-intubated and put on mechanical ventilator. During intubation it was noted that there was vocal cord edema and only a small size tube of 6.5 could be passed. Treatment for the vocal cord edema in the form of steroids and adrenaline nebulization was continued. Chest-xray that was done on 17.01.2023 early morning after endotracheal intubation shows left side non-homogenous opacities of the lung suggestive of ventilator associated pneumonia. The mini-bronchioalveolar lavage (BAL) was sent along with blood and urine cultures. On 17.01.2023 patient was fully awake and responding, and was on the ventilator support. She was being treated for the cholangitis and pneumonia with antibiotics. She was also being treated for the vocal cord edema with medicines to reduce the edema.


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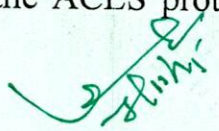
11. They further contended that the complainant was counseled regarding the issues and the difficulties in removal of the ventilator due to vocal cord edema and need for tracheotomy to help weaning from the ventilator. Complainant wanted time to discuss and get back with the consent for tracheotomy, as it was a surgical procedure and the patient may be unable to speak after the procedure. On 18.01.2023 tracheotomy was discussed with attendees, ENT surgeons and anesthetists had also discussed the procedure and complications, complainant did not give consent and had taken a status report of patient condition for second opinion. Patient was stable, but on the ventilator, was on antibiotics for the cholangitis and the pneumonia. She was also on treatment for the vocal cord edema. ENT surgeons had advised that if family consents will plan for the procedure. On 19.01.2023 the complainant had consented for the tracheotomy in view of the 2 failed extubations leading to vocal cord edema. Patient's culture report of the BAL showed two organisms – proteus mirabilis which was sensitive to meropenem injection, which the patient was already on and acinetobacter baumani bacteria which was sensitive to Inj. Colistin, which she was already on. Patient was conscious and obeying commands, she was stable for undergoing the tracheostomy procedure. On 20.01.2023, the patient was planned for the tracheostomy procedure, which could not be completed because of operation theatre was busy with emergency procedures. This was explained to the complainant and that ENT team will perform it on 21.01.2023 and since it is only an elective procedure. Patient on 20.01.2023 received 1 blood transfusion because hemoglobin had dropped to 7.8 gm/dl, as per the requirements for the ENT surgical procedure. Patient had an increase in serum creatinine to 1.45, all antibiotics were dose modified as per the creatinine clearance. The cause for the rise in serum creatinine was being evaluated. The urine cultures were being followed up. Inj vancomycin was stopped. On 21.01.2023, patient underwent the tracheotomy under



general anesthesia in the operation theatre by the ENT surgeons, after consent for the procedure. The procedure was uneventful and patient was shifted back to the ICU at 2 pm on 21.01.2023. chest x-ray showed that the tracheotomy tube was in place and left side non homogenous opacities were present suggestive of a pneumonia. Patient was started on injection linezolid and fluconazole suspecting a fungal urinary traction as per the urine culture on 17.01.2023. On 22.01.2023, patient's serum creatinine was stable at 2.46, with good urine output and was conscious and was planned for weaning from ventilator from controlled mode on the ventilator she was changed to pressure support mode. She was being continued on antibiotics for the pneumonia- Inj colistin, she was antibiotics for the cholangitis – Inj meropenem and for urine infection – fluconazole and linezolid. The patient Mts Ganagamma from 23.01.2023 to 25.01.2023 and 27.01.2023 to 29.01.2023 seen by consultant Dr.Carol D'silva Associate Professor Critical care Medicine. On 23.01.2023 patient was noted to have fever, blood cultures were sent, central line was planned for removal and antibiotics continued. Her BAL culture showed *Stenotrophomonas maltophilia* on 23.01.2023 and she was started on T Levofloxacin 750 mg OD once the culture sensitivity reports were reported on the hospital information system. She was continued CPAP PS mode of ventilation with stable oxygenation on 23.01.2023. She was weaned to T piece with oxygen on 24.01.2023. The treating team planned to observe her in ICU for 2 days on T-piece with oxygen and shift out if stable after 2 days. On 26.01.2023 night, at around 10 pm noted to have clots via tracheostomy tube with minimal bleed at around 9 pm she was switched to CPAP PS mode of ventilation for about 4 hours. No desaturation was noted and saturation was maintained at 100% with FiO₂ 0.35. Arterial blood gas analysis (ABG) taken on 27th morning at 3 am which showed paO₂ of 75 mmHg on 2L oxygen through T piece. A chest Xray (CXR) was done on 27.01.2023 which didn't



show any new infiltrates as compared to previous CXR on 24.01.2023. Prophylactic anticoagulation was withheld and sequential compression devices were used thereafter for DVT prophylaxis. The patient was continued to be on T piece and observed on 27.01.2023 and remained stable. Small clots were noted again on suctioning the tracheostomy tube on 28.01.2023 with bloody TT secretions. Injection tranexamic acid 500 mg TID was started suspecting airway trauma during suctioning. Serial Hb monitoring was done, no drop in hemoglobin noted. On 29th afternoon at around 3.45 to 4 pm, tracheoscopy and upper airway bronchoscopy was performed. TT was patent, clots noted in the proximal portion however no source of bleed identified on inspecting the right and left main bronchi and its divisions with normal mucosa. Procedure was uneventful. Patient was continued on CPAP PS ventilation post procedure and was hemodynamically stable with stable oxygenation. At around 4.15 am on 30.01.2023, patient had an episode of desaturation to 76% spO2 and acute onset respiratory distress. She was ventilated with 100% FiO2 and changed to a controlled mode of ventilation immediately. The ventilator was unable to deliver the set tidal volume. Suspecting tracheostomy tube block, suction and ventilating with an AMBU Bag with 100% oxygen was attempted. The treating doctor was still unable to ventilate due to increased resistance. The tracheostomy tube was removed and a new 7.0 mm cuffed portex tracheostomy tube was inserted over a bougie. Inability to ventilate the patient persisted. There was reduced air entry noted over the left side of the chest by clinical examination and by auscultation. USG lung was immediately performed which showed absent pleural slide on the left. Suspecting tension pneumothorax, a 28 Fr ICD was immediately inserted and connected to an underwater seal which showed bubbling. In the meanwhile patient went into bradycardia and cardiac arrest. CPR was initiated and the ACLS protocols for cardiac arrest was followed.



After 15 cycles of CPR, no return of spontaneous circulation was observed and the patient was declared dead at 5.00 am on 30.01.2023. The cause of death was suspected to be due to tension pneumothorax, which might have occurred secondary to a possible tube block resulting from intrapulmonary haemorrhage. Both the tension pneumothorax and tube block were addressed appropriately in an emergency manner, despite which patient would not be revived. The patient's son, has been explained in detail at regular intervals by all the treating doctors, about her clinical condition, the ERCP procedure, infection in bile and lungs, treatment for same. The extubation failures leading to the swelling the airways for which she needed tracheostomy. The risk of infections because of the prolonged ICU stay, which was being duly treated was explained to the son. The bleeding through the tracheostomy tube and the events that ensued till the terminal event was continuously updated and explained in a timely manner to the son. They further contended that there is neither negligence nor deficiency of service as alleged by the complainant and whatever diagnosis made by them and hospital was as per established medical protocol. Hence they pray for dismiss the complaint.

Defence of OP.8:

12. In the written version the Op.8 has denied any medical negligence and deficiency of service on his part. He further contended that the patient Mrs Gangamma was brought to the emergency department of St.John's Hospital with sepsis secondary to choledocholithiasis causing cholangitis. In fact, during her short stay in the emergency department, she went into shock (secondary to sepsis) necessitating ICU admission with vasopressor support. She subsequently underwent ERCP with CBD stent placement on 06.01.2023 after explaining the procedure of ERCP and its related complications thoroughly with the complainant. The bile which was aspirated during ERCP grew E.coli which was sensitive to all the antibiotics which it was tested



against. Patient was already on broad spectrum antibiotics during her ICU stay given her septic shock, He further submitted that patient Mrs.Gangamma presented to the emergency department with cholangitis with sepsis. The bile pus culture grew a bacteria on 06.01.2023 – E.coil for which appropriate antibiotic was initiated. This bacteria was from the patient's infected bile and not hospital induced/acquired as ERCP is a sterile procedure. During her course of ICU stay she developed pneumonia and grew proteus Mirabilis and Acinetobacter Baumanii. The infection she developed while in the ICU was after 10 days of stay in the ICU. As elucidated by OP no.6, patient had several risk factors for the development of multi-drug resistant pneumonia in ICU.

13. He further contended that as per his knowledge as no such event occurred during patient's stay in the ICU and it was not documented anywhere in the medical records nor on the imaging studies that the patient underwent during her ICU stay. Furthermore, CBD stent migration occurs in about 8 to 10% of patients who undergo ERCP. The subsequent events which culminated in patient's death were purely related to her underlying respiratory issues as elaborated by Dr.Bhuvana and her ICU team. The condition of patient's respiratory status was also explained to the patient's relatives at regular intervals. He strongly denying the allegations, state that there is neither negligence nor deficiency of service as alleged by the complainant and whatever diagnosis made by him in OP No.5 hospital was as per established medical protocol. Hence he prays for dismiss the complaint.

Evidence:

14. The complainant got himself examined as CW-1 by filing his affidavit as a part of examination in chief and also got marked the documents as Ex.C-1 to C-42 and closed his evidence.

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On behalf of the OP.1, Sri Manjegowda.R, Facility Head has been examined as RW-1 by filing his affidavit as a part of chief examination and also got marked the documents as Ex.R-1 to R-8.

On behalf of the OP.2, Dr.Prema has been examined as RW-4 by filing her affidavit as a part of chief examination.

OP.3 & 4 have not filed their affidavit evidence.

On behalf of Op.5 & 6, Op.6 Dr.Bhuvan Krishna has been examined as RW-2 by filing her affidavit as a part of chief examination and also got marked the documents as Ex.R-9 to R-36.

OP.8, Dr.Syed Shafiq has been examined as RW-3 by filing his affidavit as a part of chief examination.

Arguments:

15. We have heard the counsels of complainant as well as OPs and perused the documents produced by both the parties. Complainant and Op.1,5,6 & 8 have filed their written arguments.

Issues:

16. The points that arise for our determination are:-

1. Whether complainant proves that medical negligence of the OPs which caused the death of Smt. Gangamma?
2. Whether complainant is entitled for the relief prayed in the complaint?
3. What order?

17. Our finding on the above points are as under;

Point No.1: In the Affirmative against Ops.5,6 &8.

Point No.2: In the Partly Affirmative

Point No.3: As per the final order

For the following ;

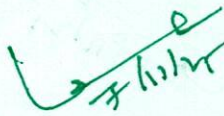
Discussion and Reasoning:



// REASONS //

Point No.1 to 3:

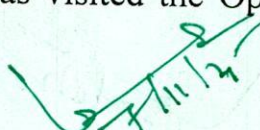
18. In the instant case, the allegation of the complainant is that his mother Smt. Gangamma aged about 65 years was visited the hospital of the OP.1 for the pain in the abdomen on 04.01.2023, the OP.2, after having done initial investigation and CT abdomen and pelvis plain study, it was diagnosed that Smt. Gangamma was suffering from Gall Bladder stone and Choledocholithiasis. Hence the OP.2 had referred Smt. Gangamma to the higher centre for management with a referral letter dtd 04.01.2023. Accordingly, Gangamma got admitted in 3rd Op hospital i.e., BMC and RI Super specialty hospital, Victoria Hospital campus, Bangalore on 05.01.2023 and she was under the treatment of OP.4 i.e., Dr.Gautham and was further she taken to higher management to St.John's Medical College and Hospital Sarjapur Road, Bangalore i.e., OP.5, the mother of the complainant was under the treatment of Dr.Bhuvana Krishna i.e., OP.6 from 05.01.2023 and discharged on 10.01.2023. The said Gangamma underwent ERCP procedure with stent placing on 06.01.2023 by the OP.8 and was infested with E, Coli and Stenotrophomonas Noso Comial Infection (antibiotic resistance bacteria) during the course of the treatment in the said hospital of OP.5, she was readmitted in the hospital of the OP.5 on 11.01.2023 and was under treatment of OP.6 till 30.01.2023. Later she had developed acute respiratory distress on 17.01.2023 and bronchospasm and underwent tracheotomy on 21.01.2023. On 30.01.2023 at about 4.15 am she had developed sudden onset of acute respiratory distress and died of pneumothorax. Hence the complainant alleged that his mother Gangamma died due to hospital acquired infection which is an act of medical negligence on the part of the hospital management and also of the treating doctors and the management and treating doctor have failed to treat her with minimum required care and skill resulting her death.



19. To prove the case, the complainant has produced, consultation record dtd 04.01.2023 as Ex.C-1, CT abdomen & Pelvis – plain study as Ex.C-2, Bowel loops report as Ex.C-3, 2D Echocardiography study as Ex.C-4, Laboratory investigation report dtd 04.01.2023 as Ex.C-5, ECG report as Ex.C-6, Referral form as Ex.C-7, Laboratory Investigation report dtd 05.01.2023 as Ex.C-8, PMSSY OPD book as Ex.C-9, Letter from Dr.Netra, St.John's Medical college hospital as Ex.C-10, Intensive care unit /Admission document dtd 05.01.2023 as Ex.C-11, Intensive care unit /Admission document dtd 11.01.2023 as Ex.C-12, Letter from Dr.Carol D'Silva, St.John's Medical college Hospital as Ex.C-13, Medical certificate of cause of death as Ex.C-14, Legal notice dtd 09.10.2023 as Ex.C-15, Postal receipts as Ex.C-16, Postal acknowledgments as Ex.C-17, Statement of account as Ex.C-18, Op sale draft of Rs.1,129.53 as Ex.C-19, Op Pharmacy – Tax invoice Rs.343-00 as Ex.C-20, Invoice cum receipt dtd 04.01.2023 Rs.1,950-00 as Ex.C-21, Invoice cum receipt Rs.4800-00 as Ex.C-22, Invoice cum receipt Rs.1200-00 as Ex.C-23, Invoice cum receipt Rs.5660-00 as Ex.C-24, Invoice cum receipt Rs.1200-00 as Ex.C-25, In patient voucher Rs.56.40 as Ex.C-26, In patient voucher Rs.1495-00 as Ex.C-27, In patient voucher Rs.8478.48 as Ex.C-28, In patient voucher Rs.1997.75 as Ex.C-29, In patient voucher Rs.8363.11 as Ex.C-30, In patient voucher Rs.309.30 as Ex.C-31, In patient voucher Rs.2586.24 as Ex.C-32, IP patient Return details Rs.726-00 as Ex.C-33, In patient voucher Rs.906-00 as Ex.C-34, In patient voucher Rs.4365.80 as Ex.C-35, In patient voucher Rs.799.62 as Ex.C-36, IP patient Return details Rs.3400.72 as Ex.C-37, In patient voucher Rs.540.00 as Ex.C-38, In patient voucher Rs.8560.20 as Ex.C-39, In patient voucher Rs.6259.29 as Ex.C-40, In patient voucher Rs.7416.51 as Ex.C-41 and In patient voucher Rs.11.021.99 as Ex.C-42.
20. In contrary to the above statement the 1st Op contended that the patient Gangamma visited their hospital on 04.01.2023 with h/o abdomen pain and

vomiting since one day and she was evaluated for the same, as she has evidence at CBD calculus, she would need ERCP for further management. Since ERCP and surgical gastro facility are not available at their hospital, she has been referred to higher centre for further management on same day, hence they have denied any medical negligence and deficiency of service on their part.

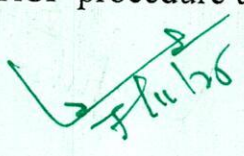
21. The 2nd Op contended that the patient Smt Gangamma has come to Sparsha Hospital with a history of abdominal pain on 04.01.2023 and after preliminary evaluation by duty doctor at 7.30 pm on the same day about the patient and attended the patient and immediately she has administered emergency medicines and advised other investigations troponinl, 2D echo and C.T.Abdomen. After the reports available, after going through the reports she was referred to higher center for further management of the patient on the same day and there is no delay or latches from her part as and when she noticed the report, since the hospital did not have the required facilities for further management of the patient, she referred the patient to higher center for better management.
22. 3rd and 4th Ops contended that Smt. Gangamma with a referral letter issued by OP.2 to the hospital OP.3 visited the triage on 05.01.2023 wherein she was attended by OP.4 and she was advised to get admitted in the high dependency unit of the hospital under the department of surgical gastroenteriology for treatment, the patient was planned to be treated with ERCP after admission and accordingly advised the patient to get admission in the hospital, however the patient who is none other than the mother of the complainant did not get admitted to the hospital without heeding to the advice of the Op.4 and without the knowledge of the op.3 &4 was taken elsewhere for treatment.
23. EX-C.1 to C.9 produced by the complainant proves that Smt. Gangamma, mother of the complainant has visited the Op.1 hospital on 04/01/2023 with



complaint of pain in abdomen, after having done CT abdomen and pelvis study by the 2nd Op it was diagnosed that she was suffering from Gallbladder stone and choledocholithiasis, hence 2nd Op has referred Smt. Gangamma to higher centre for treatment. Later on 5/1/2023 the complainant along with Smt. Gangamma visited to 3rd Op hospital where in as per EX- C 9 the 4th Op planned for ERCP and advised the patient to get admitted in the hospital, but no records produced by the complainant to show that Smt. Gangamma got admitted to 3rd Op hospital as per the advice of Op 4.

24. The Hon'ble court in Smt. Vimlesh Dixt Vs Dr.R.K. Singhal 1(2004) CPJ 123 (Uttarachal) held that "*The term negligence is defined to mean absence of lack and care which a reasonable man should have taken in the circumstances of the case*". In the present case not even single document produced by the complainant to prove lack of care from the Op.1 to 4. Hence we hold that medical negligence or deficiency of service cannot be attributed against them.
25. With regard to Op.5, 6 and 8, the complainant alleged that his mother Gangamma was admitted to Op.5 hospital on 05.01.2023 she was under the treatment of Dr.Bhuvana Krishna i.e., OP.6 from 05.01.2023 till 30.01.2023, the said Gangamma underwent ERCP procedure with stent placing on 06.01.2023 and was infested with E, Coli and Stenotrophomonas Nosocomial Infection (antibiotic resistance bacteria) during the course of the treatment in OP.5 hospital, and later she had developed acute respiratory distress on 17.01.2023 and bronchospasm and underwent tracheotomy on 21.01.2023 by Op 8, on 30.01.2023 at about 4.15 am she had developed sudden onset of acute respiratory distress and died of pneumothorax. Hence the complainant alleged that his mother Gangamma died due to hospital acquired infection is an act of medical negligence on the part of the 5th hospital management and also of the treating doctors i.e., Op 6 and 8 and the management and treating doctors have

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- failed to treat his mother with minimum required care and skill resulting her death.
26. Mainly as stated in the complaint, the concern of the complainant is with regard to the hospital acquired infections, which prolonged the treatment in 5th Op hospital. It is admitted fact that the mother of the complainant deceased Gagamma with the complaint of pain in abdomen and vomiting has visited the Op1 hospital on 04/01/2023, after conducting several test the 2nd Op notices that in gall bladder there was multiple radiodense calculi, largest measuring upto 7 mm with mild to moderate Hepatobiliary dilatation, CBD dilatation 14.5 mm, choledocholithiasis with proximal biliary dilalation. As patient needed ERCP she referred her to higher centre. The mother of the complainant was taken to 3rd Op hospital on 5/1/2023 wherein advised ERCP+ Stunting but patient was then taken to 5th Op hospital on the same day.
27. The 5th and 6th Ops contended that, the complainant's mother admitted in OP.5 hospital on 05.01.2023 at 8.30 am to emergency room, the patient presented with pain in the abdomen and vomiting for 2 days, associated with chills, associated with cough, breathing difficulty on exertion for 3 months and decreased urine output since 1 day, the patient had a history of DM for 4 years, HTN for 10 years and pemphigus on steroids 4 years back, on examination, the patient was afebrile, tachycardic, tachypneic and hyposic and the patient had jaundice, and an abdominal examination revealed diffuse tenderness. As per the CT done from outside hospital on 04.01.2023, showed multiple radiodense calculi – cholellithiasis, mild to Mod IHBRD, CBD dilated CBD calculi. They further contended that a diagnosis of obstructive jaundice due to cholelithiasis/chiledocholithiasis/cholangitis was made. Pancreatitis, AKI and sepsis were suspected, pending further reports. The patient was treated in the emergency room with intravenous fluids, antibiotics and analgesics. Gastroenterology advised ERCP procedure after stabilization. The patient was
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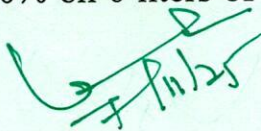
admitted to EICU and treated with antibiotics, fluids and vasopressors. On 06.01.2023 patient was intubated in view of respiratory distress and the patient was taken up for ERCP. ERCP showed choledocholithiasis + cholangitis partial CBD clearance done with stenting. The patient was brought back to EICU and supportive measures were continued. On 07.01.2023, vasopressors were tapered off and the patient was weaned from the ventilator. At 10.15 am, the patient was extubated. On 08.01.2023 the patient developed fever spikes, and a chest x-ray showed increased haziness. Antibiotics were escalated to meropenem. The patient developed worsening respiratory distress; a BIPAP trial was given and the patient developed a wheeze. At 2.30 pm, the patient was reintubated as respiratory distress did not improve despite BIPAP, nebulization and Magnesium sulphate injection. The patient was continued on Antibiotics and ventilation and on 09.01.2023, was shifted to MICU for further care. The patient was shifted to the first floor ICU from EICU. The patient Mrs Gangamma from 09.01.2023 to 15.01.2023 was seen by consultant Dr. Natesh prabhu, i Associate professor critical care medicine.e, 8th Op. The patient was received from EICU on 9th January 2023 around 11.45 pm to the first floor ICU on the endotracheal tube, controlled mode of ventilation. She had severe hyposia, possibly moderate to severe acute respiratory distress syndrome or worsening of respiratory infection of suspected aspiration pneumonia. She had severe hypoxia needing high ventilator support and required prone ventilation. The endotracheal tube was changed due to a suspected block, right subclavian line was removed. Other standard ICU monitoring and care was continued. The patient had a fever and respiratory failure, which improved over the next two days, antibiotics were optimized based on culture sensitivity and deescalated because of clinical improvement. The patient had improvement in lung function and was breathing well on partial ventilator support. The fever lasted for a few more days and subsided.

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Due to clinical recover, the patient was planned for further weaning. The patient was discharged on 11.01.2023 and readmitted for the ayushman bharath scheme on 11.01.2023. They further contended that the patient Mrs Gangamma presented with an infection of the biliary system. She had cholecystitis, choledocholithiasis, and cholangitis with sepsis. The bile pus culture grew a bacteria on 06.01.2023 E.coil which warranted antibiotics from day 1. Patient had developed pneumonia during the ICU stay as shown in the culture report from her lungs sent on 17.01.2023 which grew proteus Mirabilis and Acinetobacter Baumanii. The infection she developed while in the ICU was after 10 days of stay in the ICU with a failed extubation from the ventilator twice. She had several risk factors for the development of multi-drug resistant pneumonia in ICU. She was admitted in an outside hospital where she was advised procedure EPCP for the biliary tree stones, for the family refused and came DAMA to OP.5 hospital. That the prolonged ventilator days, patient was on ventilator from 06.01.2024 till 17.01.2024 when she developed the pneumonia. Patient came to hospital with sepsis and shock which is a risk factor. The patient did not tolerate extubation twice because of multiple reasons she had to be put back on the ventilator on 08.01.2023 and second time on 16.01.2023 patient has received steroids in the past for pemphigus vulgaris. Patient had ARDS at the time of admission which is a risk factor for hospital acquired pneumonia. The patient was infected with drug resistant bacterial infections because of the above risk factors which was appropriately recognized and treated. They further contended that the hospital acquired pneumonia especially ventilator associated pneumonia is one of the most common hospital acquired infections in the ICU and can range from 5-40% with high mortality. The risk factors for VAP is the same as given above. Since the patient had several risk factors for developing VAP, that too with multi drug resistant bacteria. The hospital acquired infection is not a medical

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negligence. Hospital acquired infections prevalence is high globally. The WHO report on the burden of hospital acquired infections especially in the ICU is as high as 30%. In an ICMR study published recently HAI with antimicrobial resistance is a global crisis with constant rise. The risk factors for same as included in a WHO report were age 65 years, longer than 7 days of hospital stay, which our patient had and being on the ventilator, emergency basis admission to the intensive care unit, prior admission to another hospital and co-existing underlying diseases like in their patient who had diabetes mellitus and hypertension and had received steroids in the past for pemphigus vulgaris. They further contended that the patient was prepared for further weaning and received steroids for anticipated airway edema. The patient was extubated on 15th January around 8.30 am. The patient did well after extubation till the afternoon. Then she had mild stridor, for which she received steroids, nebulized steroids and medications and was initiated on noninvasive ventilator support. The patient did well with non invasive ventilation thereafter till the next day. That the complainant and family were counseled by the ICU team regularly multiple times a day. The family explained about the biliary sepsis, lung failure needing mechanical ventilation and possible need for a longer ICU stay, she has a high risk for secondary infections and anticipated difficulty weaning from the ventilator. The complainant was explained about improving lung function and plan for further weaning and extubation. The need for noninvasive ventilation and reintubation was explained in detail, the presence of mild stridor was communicated and the treatment plan was explained. The patient Mrs Gangamma was seen by consultant Dr.Bhuvana Krishna from 16.01.2023 to 22.01.2023. On 16.01.2023 on assessment was extubated 24 hours back. This was her second extubation trial. She was drowsy and had wheezing with steroids and had fever. Oxygen levels were 10% on 6 liters of oxygen on face mask. She was

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already on antibiotics injection meropenem in view of bile culture that was growing E.coli bacteria. The bile culture was sent on 06.01.2023 after ERCP procedure for cholangitis, which was what the patient presented to Op.5 hospital with. On 16.01.2023 patient was suspected to have a ventilator associated pneumonia and was started on injections colistin and vancomycin along with meropenem and also received nebulization and steroids for her wheezing. She was suspected to have airway edema because of a previous extubation failure. On 16.01.2023 night patient developed respiratory distress with rise in carbondioxide levels hence had to be re-intubated and put on mechanical ventilator. During intubation it was noted that there was vocal cord edema and only a small size tube of 6.5 could be passes. Treatment for the vocal cord edema in the form of steroids and adrenaline nebulization was continued. Chest-xray that was done on 17.01.2023 early morning after endotracheal intubation shows left side non-homogenous opacities of the lung suggestive of ventilator associated pneumonia. The mini-bronchioalveolar lavage (BAL) was sent along with blood and urine cultures. On 17.01.2023 patient was fully awake and responding, and was on the ventilator support. She was being treated for the cholangitis and pneumonia with antibiotics. She was also being treated for the vocal cord edema with medicines to reduce the edema. They further contended that the complainant was counseled regarding the issues and the difficulties in removal of the ventilator due to vocal cord edema and need for tracheostomy to help weaning from the ventilator. Complainant wanted time to discuss and get back with the consent for trachesotomy, as it was a surgical procedure and the patient may be unable to speak after the procedure. On_18.01.2023 tracheostomy was discussed with attenders, ENT surgeons and anesthetists had also discussed the procedure and complications, complainant did not give consent and had taken a status report of patient condition for second opinion. Patient was stable, but on the

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ventilator, was on antibiotics for the cholangitis and the pneumonia. She was also on treatment for the vocal cord edema. ENT surgeons had advised that if family consents will plan for the procedure. On 19.01.2023 the complainant had consented for the tracheostomy in view of the 2 failed extubations leading to vocal cord edema. Patient's culture report of the BAL showed two organisms – proteus mirabilis which was sensitive to meropenem injection, which the patient was already on and acinetobacter baumani bacteria which was sensitive to Inj. Colistin, which she was already on. Patient was conscious and obeying commands, she was stable for undergoing the tracheostomy procedure. On 20.01.2023, the patient was planned for the tracheostomy procedure, which could not be completed because of operation theatre was busy with emergency procedures. This was explained to the complainant and that ENT team will perform it on 21.01.2023 and since it is only an elective procedure. Patient on 20.01.2023 received 1 blood transfusion because hemoglobin had dropped to 7.8 gm/dl, as per the requirements for the ENT surgical procedure. Patient had an increase in serum creatinine to 1.45, all antibiotics were dose modified as per the creatinine clearance. The cause for the rise in serum creatinine was being evaluated. The urine cultures were being followed up. Inj vancomycin was stopped. On 21.01.2023, patient underwent the tracheostomy under general anesthesia in the operation theatre by the ENT surgeons, after consent for the procedure. The procedure was uneventful and patient was shifted back to the ICU at 2 pm on 21.01.2023. chest x-ray showed that the tracheostomy tube was in place and left side non homogenous opacities were present suggestive of a pneumonia. Patient was started on injection linezolid and fluconazole suspecting a fungal urinary traction as per the urine culture on 17.01.2023. On 22.01.2023, patient's serum creatinine was stable at 2.46, with good urine output and was conscious and was planned for weaning from ventilator from controlled mode on the



ventilator she was changed to pressure support mode. She was being continued on antibiotics for the pneumonia- Inj colistin, she was antibiotics for the cholangitis – Inj meropenem and for urine infection – fluconazole and linezolid. The patient Mts Ganagamma from 23.01.2023 to 25.01.2023 and 27.01.2023 to 29.01.2023 seen by consultant Dr.Carol D'silva Associate Professor Critical care Medicine. On 23.01.2023 patient was noted to have fever, blood cultures were sent, central line was planned for removal and antibiotics continued. Her BAL culture showed *Stenotrophomonas Maltophilia* on 23.01.2023 and she was started on T Levofloxacin 750 mg OD once the culture sensitivity reports were reported on the hospital information system. She was continued CPAP PS mode of ventilation with stable oxygenation on 23.01.2023. She was weaned to T piece with oxygen on 24.01.2023. The treating team planned to observe her in ICU for 2 days on T-piece with oxygen and shift out if stable after 2 days. On 26.01.2023 night, at around 10 pm noted to have clots via the tracheostomy tube with minimal bleed at around 9 pm she was switched to CPAP PS mode of ventilation for about 4 hours. No desaturation was noted and saturation was maintained at 100% with FiO₂ 0.35. Arterial blood gas analysis (ABG) taken on 27th morning at 3 am which showed paO₂ of 75 mmHg on 2L oxygen through T piece. A chest Xray (CXR) was done on 27.01.2023 which didn't show any new infiltrates as compared to previous CXR on 24.01.2023. Prophylactic anticoagulation was withheld and sequential compression devices were used thereafter for DVT prophylaxis. The patient was continued to be on T piece and observed on 27.01.2023 and remained stable. Small clots were noted again on suctioning the tracheostomy tube on 28.01.2023 with bloody TT secretions. Injection tranexamic acid 500 mg TID was started suspecting airway trauma during suctioning. Serial Hb monitoring was done, no drop in hemoglobin noted. On 29th afternoon at around 3.45 to 4 pm, tracheoscopy and upper airway

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bronchoscopy was performed. TT was patent, clots noted in the proximal portion however no source of bleed identified on inspecting the right and left main bronchi and its divisions with normal mucosa. Procedure was uneventful. Patient was continued on CPAP PS ventilation post procedure and was hemodynamically stable with stable oxygenation. At around 4.15 am on 30.01.2023, patient had an episode of desaturation to 76% spO₂ and acute onset respiratory distress. She was ventilation with 100% FiO₂ and changed to a controlled mode of ventilation immediately. The ventilator was unable to deliver the set tidal volume. Suspecting tracheostomy tube block, suction and ventilating with an AMBU Bag with 100% oxygen was attempted. The treating doctor was still unable to ventilate due to increased resistance. The tracheostomy tube was removed and a new 7.0 mm cuffed portex tracheostomy tube was inserted over a bougie. Inability to ventilate the patient persisted. There was reduced air entry noted over the left side of the chest by clinical examination and by auscultation. USG lung was immediately performed which showed absent pleural slide on the left. Suspecting tension pneumothorax, a 28 Fr ICD was immediately inserted and connected to an underwater seal which showed bubbling. In the meanwhile patient went into bradycardia and cardiac arrest. CRP was initiated and the ACLS protocols for cardiac arrest was followed. After 15 cycles of CPR, no return of spontaneous circulation was observed and the patient was declared dead at 5.00 am on 30.01.2023. The cause of death was suspected to be due to tension pneumothorax, which might have occurred secondary to a possible tube block resulting from intrapulmonary haemorrhage. Both the tension pneumothorax and tube block were addressed appropriately in an emergency manner, despite which patient would not be revived. The patient's son, has been explained in detail at regular intervals by all the treating doctors, about her clinical condition, the ERCP procedure, infection in bile and lungs, treatment for same.



The extubation failures leading to the swelling the airways for which she needed tracheostomy. The risk of infections because of the prolonged ICU stay, which was being duly treated was explained to the son. The bleeding through the tracheostomy tube and the events that ensued till the terminal event was continuously updated and explained in a timely manner to the son and thereby they denied negligence on their part.

28. The 8th Op contended that the patient Mrs Gangamma was brought to the emergency department of St.John's Hospital with sepsis secondary to choledocholithiasis causing cholangitis, and in fact, during her short stay in the emergency department, she went into shock (secondary to sepsis) necessitating ICU admission with vasopressor support and subsequently underwent ERCP with CBD stent placement on 06.01.2023 after explaining the procedure of ERCP and its related complications thoroughly with the complainant. The bile which was aspirated during ERCP grew E.coli which was sensitive to all the antibiotics which it was tested against. Patient was already on broad spectrum antibiotics during her ICU stay given her septic shock. He further submitted that patient Mrs.Gangamma presented to the emergency department with cholangitis with sepsis, the bile pus culture grew a bacteria on 06.01.2023 – E.coli for which appropriate antibiotic was initiated. This bacteria was from the patient's infected bile and not hospital induced/acquired as ERCP is a sterile procedure. During her course of ICU stay she developed pneumonia and grew proteus Mirabilis and Acinetobacter Baumannii. The infection she developed while in the ICU was after 10 days of stay in the ICU. As elucidated by OP no.6, patient had several risk factors for the development of multi-drug resistant pneumonia in ICU. He further contended that as per his knowledge as no such event occurred during patient's stay in the ICU and it was not documented anywhere in the medical records nor on the imaging studies that the patient underwent during her ICU stay. Furthermore, CBD

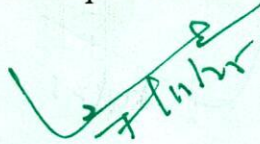
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stent migration occurs in about 8 to 10% of patients who undergo ERCP. The subsequent events which culminated in patient's death were purely related to her underlying respiratory issues as elaborated by Dr.Bhuvana and her ICU team. The condition of patient's respiratory status was also explained to the patient's relatives at regular intervals. He strongly denying the allegations, state that there is neither negligence nor deficiency of service as alleged by the complainant.

29. The Op.1, 5 & 6 have produced Referral Form dtd 04.01.2023 as Ex.R-1, Consultation record as Ex.R-2, Laboratory investigation report dtd 04.01.2023 as Ex.R-3, CR abdomen & pelvis plain study as Ex.R-4, 2D Echo cardiography study as Ex.R-5, ER nursing initial assessment as Ex.R-6, Nurse record as Ex.R-7, Intake / output chart as Ex.R-8, Letter of authorization as Ex.R-9 Intensive Care Unit /Admission document dtd 11.01.2023 as Ex.R-10, Nurses assessment initial as Ex.R-11, Death summary as Ex.R-12, Medical certificate of cause of death as Ex.R-13, Intubation record as Ex.R-14, Initial assessment sheet section-A as Ex.R-15, Evaluation and treatment form as Ex.R-16, Physiotherapy assessment and treatment form as Ex.R-17, Drug charts as Ex.R-18, Haermodynamic monitoring chart as Ex.R-19, Intensive care unit progress record as Ex.R-20, Nurses evaluation : Daily as Ex.R-21, Death notes as Ex.R-22, Critical care unit as Ex.R-23, Pre-anesthesia assessment as Ex.R-24, Consent for administration of anesthesia as Ex.R-25, Consent to surgical procedures as Ex.R-26, Operation record contd..... as Ex.R-27, Consent for invasive procedure as Ex.R-28, Consent form for blood transfusion as Ex.R-29, Blood component/product compatibility and issue report as Ex.R-30, Subjective global assessment for adults as Ex.R-31, Reassessment form adult as Ex.R-32, Appendix-4 Form No.3E as Ex.R-33, Consent for ERCP as Ex.R-34, Medicine sheet as Ex.R-35 and Inpatient voucher dtd 14.01.2023 as Ex.R-36.

A handwritten signature in green ink, appearing to read 'Pulver', is written over the bottom of the text.

30. Specific allegation of the complainant is that while performing ERCP procedure his mother was infected with E-coli and stenotrophomonas, Maltophilia, Gram negative Bacteria Nosocomial infection causing tension pneumonia, interpulmonary haemorrhage, hospital acquired pneumonia, gram negative sepsis, hyper tension due to which his mother was died and hence the act of the Ops is medical negligence.
31. In the written version, the Op.5 and 6 contended that the complainant's mother admitted in OP.5 hospital on 05.01.2023 at 8.30 am to emergency room and the emergency department took care of the patient from 05.01.2023 to 09.01.2023, the patient presented with pain in the abdomen and vomiting for 2 days, associated with chills, associated with cough, breathing difficulty on exertion for 3 months and decreased urine output since 1 day, the patient had a history of DM for 4 years, HTN for 10 years and pemphigus on steroids 4 years back. On examination, the patient was afebrile, tachycardic, tachypneic and hypoxic, the patient had jaundice, and an abdominal examination revealed diffuse tenderness, CT done from outside hospital on 04.01.2023, showed multiple radiodense calculi – cholelithiasis, mild to Mod IHBRD, CBD dilated CBD calculi and a diagnosis of obstructive jaundice due to cholelithiasis/choledocholithiasis/cholangitis was made, Pancreatitis, AKI and sepsis were suspected, pending further reports. On perusal of EX- C2 and 3 above facts reflected and hence the 2nd Op referred the patient for ERCP.
32. EX-C.11 endoscopy report shows that ERCP procedure performed on 06/01/2023 at 12.32 pm and stent placed and also noted under endoscopic diagnosis it is noted that "choledocholithiasis with cholangitis ERCP and partial CBD clearance done CBD stenting done". It is also revealed in the said document that on 8/1/2023 patient developed respiratory distress, tachypnea, desaturation, developed severe bronchospasm and she was treated



for the same. Discharge summary Dtd: 10/01/2023 reflected under the head of **course in ICU** it is stated that on arrival to MICU from EICU she was conscious, stable vitals, on PRVC more of mechanical ventilator support, she was continued antibiotics, in view of ARDS she was sedated and paralysed for a day, her pus cultures grew E-coli, antibiotics was optimised, she was transfused 1 unit of PRBC for low hemoglobin, she was in PRVC mode of ventilation, conscious, making adequate urine output and she was getting discharged for insurance purpose. So, this document clearly proves the Op 6 notices the development of E-Coli in the patient on early 06/01/2023 itself.

33. On reading the Medical literature related to E.Coli it reveals that, E.coli is a bacterium commonly found in the gut of warm-blooded organisms, and it cause various diseases including pneumonia, urinary tract infections and diarrhea. Symptoms may appear 3 to 4 days after being exposed to the bacteria. However, symptoms may appear as early as 24 hours or as late as 1 week later.
34. EX.C-12 shows that the patient readmitted to the 5th Op hospital on 11/01/2023 and R.16 reflected that she was shifted to MICU in 5th of Hospital with complaint of Shortness of breath and Generalized weakness.
35. On perusal of contents of affidavit evidence of Op No. 6 and 8 it clearly proves that after ERCP procedure of 6/1/2023 the patient developed multiple bacterial infections in the ICU and MICU of 5th Op hospital.
36. As per EX-C.2 liver, pancreas, kidneys of the patient were normal on 04/01/2023. EX-C.12 proves that ERCP procedure done on 06/01/2023. The Op.8 in para 2 of his affidavit evidence stated that "the bile pus culture grew a bacterial on 06/01/2023 E-coli for which for which appropriate antibiotic were initiated". E-coli developed in the patient and same was noticed by Op.6 and 8 on 06/01/2023 itself. Being doctors they well know the risk factor of the above said bacterial infections. Such being the case, the Op.6 and 8

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should have taken steps early to perform Tracheostomy. But when the condition of the patient became worst then only they had taken decision for Tracheostomy on 21/01/2023. Ops should have taken early steps to perform Tracheostomy to facilitate early weaning and prevent complication. The Ops should have taken extra care in the immediate ERCP procedure keeping in view of the patient is diabetic. Delay in Tracheostomy proved it to be no use after development of severe bacterial infections as it was too late to intervene. If proper care and attention was taken, the complication like Hospital acquired pneumonia could have been avoided.

37. The Ops 5, 6, and 8 failed to take appropriate precautions while the deceased was on ventilator. They did not proactively look for ventilator associated pneumonia and the Ops should have known that chances of pneumonia was certainly high in case of those who was diabetic and infected patient.
38. 6th Op in his cross examination admitted that when he met the patient on 09/01/2023 she was on the endotracheal tube, controlled mode of ventilation and she had severe hyposia, possibly moderate to severe acute respiratory distress syndrome sepsis and septic shock. He also admitted that on 09/01/2023 itself he noticed breathing difficulty in patient. But he denied that due to improper insertion of tube vocal card edema occurred. Admittedly when the patient got admitted to Op.5 hospital on 05/01/2023 there was no complaint of vocal card edema. But Op.6 failed to explain for what reason vocal card edema occurred in the patient while she was in ICU. In the affidavit as well as written version of the 6th Op it shows that they have intubation and extubation many times definitely which may cause infection.
39. Moreover, prior medical conditions of the patient were known to the Ops 6 and 8 even before ERCP performed. The patient was suffering from chronic disease and was also susceptible to complications on account of her weak condition but at the same time what aggravated the same is the hospital

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associated infections that seems to have compounded the worsening situation of the patient. So, worsening of the deceased patient's condition after the ERCP was the result of deficient service by 5th Op hospital which thus contributed the patient death.

40. Further in para 3 of the Affidavit evidence filed by the Op.8 he clearly stated that **"I submit that I concur with Op 6 and agree with her explanation with regard to allegation to the effect that Hospital acquired infection is nothing but medical negligence"**. So, the Op.8 being a doctor has admitted that Hospital acquired infection is medical negligence.
41. The Ops have not produced single documents to prove that while admitting the patient to 5th Op hospital, she was suffering from respiratory infection. Further in the EX-C.14 it clearly reflected that the cause of death of the patient is "Tension pneumonia, inter pulmonary haemorrhage, hospital acquired pneumonia, gram negative sepsis and hyper tension"
42. The diabetic patients are prone to infections after surgery or procedures and adequate preventive steps should have been taken by the Op.6 and 8 to prevent infections. If proper care and attention was taken, the complications like infections and speticaemia could have been avoided. In the 5th Op Hospital after ERCP procedure initially complication was started with poor infections. At that time proper care should have been taken immediately. It was not done.
43. While reserved the complaint for orders, the Hon'ble Commission sent the file to HIMS for expert opinion in the matter. On 26/05/2025 the expert committee of HIMS sent a report. In para 2 of the report it is stated that "as per the record patient was examined in triage and advised admission. But patient was shifted to St.John's medical college, Here patient is not admitted, but treated on outpatient basis. No invasive procedures are done that may lead to development of hospital acquired infection". As against this


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statement, the medical record produced by the complainant as well as Ops it clearly reflected that as per the advice of 2nd Op, patient was taken to 4th Op on 05/01/2023, he advised for ERCP, but against his advice, patient was taken to 5th Hospital on the same day and admitted her without any delay. Hence we cannot agree with the opinion of experts made in their report. Further all the medical record produced by the parties proves that after ERCP the patient developed infections and there was a delay in treating the patient properly. In para 3 of the said report it is stated that "Stenotrophomonas species bacteria grown in BAL sample taken on 23rd January. As this event occurred around 17 days after hospitalization, this infection can be considered as hospital acquired infection". The Hon'ble Apex court in *Najrul Seikh Vs Dr Sumit Benerjee and another* held that " ***While the report of medical council can be relevant for determining deficiency of service before a consumer forum, it cannot be determinative***, especially when it contradicts the evidentiary finding made by a consumer forum". Further Hon'ble State Commission of West Bengal on 06/10/2023 in the case of *Chandra Paul vs Narayana Multi Speciality Hospital*, has observed while passing the judgment that " ***Expert opinion is advisory in nature and not binding on court***".

44. All the documents produced by parties prove that the infections occurred during the stay of the deceased at the 5th Op hospital. On the other hand, there is nothing to show that the bacterial infections law outside the hospital. Thus there is preponderance of possibilities of the infection having been acquired in the hospital itself. Consequently, in the light of the evidence produced by both parties, the patient condition after the ERCP from 06/01/2023 onwards deteriorated due to the hospital associated infections which is a clearly defiant in the part of Ops.5, 6 and 8. The deceased died due to tension pneumonia, inter pulmonary haemorrhage, hospital acquired pneumonia,



gram negative sepsis on account of failure of the Op.6 and 9 to prevent infection. Hence we hold that Ops.5, 6 and 8 have committed medical negligence while treating the patient and their negligence caused the death of patient.

45. The citations produced by the Ops not applicable to the present case as the facts and circumstances are deferent from each others.
46. The Apex court in the judgment passed in Malay Kumar Gangully Vs Sukumar Mukherjee and other (2009) 9 SCC 221 held that, "***Failure to prevent Nosocomia infection i.e., disease originating in hospitals- held it is the responsibility of the hospital to prevent such infection specially where patient has high risk infection due to nature and disease suffered***".
47. The Hon'ble State Commission of West Bengal on 06/10/2023 in the case of Chandra Paul vs Narayana Multi Speciality Hospital, held that "***It is not the case that the patient expired suffering from the disease for which he got admitted but for the ICU borne infection which cause his death***" In the present complaint also patient got admitted to Op.5 hospital with the complaint of Gall Bladder stone and Choledocholithiasis, but she died due to Tension pneumonia, inter pulmonary haemorrhage, hospital acquired pneumonia, gram negative sepsis and hyper tension. Hence the above said observation is clearly applicable to the present complaint.
48. Doctors have a legal duty to comply with the applicable ethical and legal regulations in their daily practice. Ignorance of law and its implications will be detrimental to the doctor, even though he treats the patient in good faith for the alleviation of the patient's suffering.
49. Res ipsa loquitur is a rule of evidence which in reality belongs to the law of torts. Inference as to negligence may be drawn from proved circumstances by applying the rule if the cause of the accident is unknown and no reasonable explanation as to the cause is coming forth from the defendant.

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50. This has been so held in **V.Kishan Rao V/s Nikhil Super Specialist Hospital** [2010 (5) SCC 513]. In the said case it has been held that *“the principle of Res Ipsa Loquitur applies where negligence is evident and in such a case, Complainant is not required to prove anything as Res proves itself. In such a case it is for the respondent to prove that he has taken care and done his duty”*.
51. In Poonam Verma (Supra) Honble Apex Court has observed as follows:
40. *Negligence has many manifestations-- it may be active negligence, collateral negligence, comparative negligence, concurrent negligence, continued negligence, criminal negligence, active and passive negligence, willful or reckless negligence or negligence per se, which is defined in Blacks Law Dictionary as under:*
- Negligence per se: Conduct, whether of action or omission, which may be declared and treated as negligence without any argument or proof as to the particular surrounding circumstances, either because it is in violation of a statute or valid municipal ordinance, or because it is so palpably opposed to the dictates of common prudence that it can be said without hesitation or doubt that no careful person would have been guilty of it. As a general rule, the violation of a public duty, enjoined by law for the protection of person or property, so constitutes.*
41. *A person who does not have knowledge of a particular System of Medicine but practices in that System is a quack and a mere pretender to medical knowledge or skill, or to put it differently, a charlatan.*
42. *Where a person is guilty of negligence person, no further proof is needed.*
52. A professional may held liable for negligence on one of the two findings either he does not possess of the requisite skill which he professed to have possessed or he did not exercise with reasonable competent in the given cases the skill which he did possess.
53. As per Jacob Mathews case, Apex Court held that, *Rashness or negligence-doctor who administered medicine known to or use in a particular branch of*


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medical- offence entirely- declare that he has knowledge of that branch of science and if it does in fact does not knowledge he is prima facie acting a rashness or negligence.

54. The Hon'ble National commission in Deep Nursing Home versus Manmeet Singh Mattewal and others" III (2012) CPJ 154(NC) "*where standard diagnostic protocol was not followed, it was held to be a case of gross medical negligence in management of patient by the treating doctor*". For the aforesaid reasons we are of the considered view that in failing to provide medical treatment in accordance with medical guidelines, the Op.6 and 8 failed to satisfy the standard of reasonable care as laid down in the Bolam case and adopted by Indian Courts.
55. Admittedly Op.6 and 8 had treated the mother of complainant in 5th Op hospital. As per the legal maxim & rule of vicarious liability, an employer i.e., 5th Op is liable for the negligence of its employees. So, the hospitals become legally liable for any medical malpractice case done by its doctor or any other medical practitioner who has been on roll with the hospital.
56. In the catena of judgments of Hon'ble Supreme Court, different methods to determine 'just and adequate compensation' were laid down. The Hon'ble Supreme Court in the **Kunal Sha's Case**, (2014) 1 SCC 384 held that there is no strait-jacket formula for determining the quantum of compensation.
57. The counsel of the complainant, during the argument has produced the document which reflected that at the time of death the patient Gangamma was drawing the pension. In view of the same, it is just and proper to award reasonable compensation. Accordingly, we pass the following orders.

ORDERS

- The complaint filed by the complainant is partly allowed.
- The opposite party no.5, 6 and 8 are jointly and severally directed to pay total compensation of Rs.30,00,000/-

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(Rupees Thirty Lakh rupees only) to the complainant, within six weeks from the ^{date of w} receipt of the copy of this order. In case of non-compliance of the order the entire amount shall carry interest @ 10% per annum from the date of complaint till its realization.

- Complainant against opposite party No.1 to 4 and 7 is hereby dismissed.
- Office is directed to send free copies of this order to all the parties at free of cost within three days from today.

(Dictated to the Stenographer, transcribed & typed by her, transcript corrected by us and then pronounced in open commission on this the 7th day of November 2025)

Anupama R
(ANUPAMA.R)
LADY MEMBER

Chanchala C.M
(CHANCHALA.C.M)
PRESIDENT

:: ANNEXURES ::

Witness examined on complainant/s side:

CW.1 - Nagesh

Documents marked on behalf of complainant/s side:

Ex.C-1	Initial visit dtd 04.01.2023
Ex.C-2	CT abdomen & Pelvis – plain study
Ex.C-3	Bowel loops report
Ex.C-4	2D Echocardiography study
Ex.C-5	Laboratory investigation report dtd 04.01.2023
Ex.C-6	ECG report
Ex.C-7	Referral form
Ex.C-8	Laboratory Investigation report dtd 05.01.2023
Ex.C-9	PMSSY OPD book
Ex.C-10	Letter from Dr.Netra, St.John's Medical college hospital
Ex.C-11	Intensive care unit /Admission document dtd 05.01.2023
Ex.C-12	Intensive care unit /Admission document dtd 11.01.2023
Ex.C-13	Letter from Dr.Carol D'Silva, St.John's Medical college Hospital
Ex.C-14	Medical certificate of cause of death
Ex.C-15	Legal notice dtd 09.10.2023

Ex.C-16	Postal receipts
Ex.C-17	Postal acknowledgments
Ex.C-18	Statement of account
Ex.C-19	Op sale draft of Rs.1,129.53
Ex.C-20	Op Pharmacy – Tax invoice Rs.343-00
Ex.C-21	Invoice cum receipt dtd 04.01.2023 Rs.1950-00
Ex.C-22	Invoice cum receipt Rs.4800-00
Ex.C-23	Invoice cum receipt Rs.1200-00
Ex.C-24	Invoice cum receipt Rs.5660-00
Ex.C-25	Invoice cum receipt Rs.1200-00
Ex.C-26	In patient voucher Rs.56.40
Ex.C-27	In patient voucher Rs.1495-00
Ex.C-28	In patient voucher Rs.8478.48
Ex.C-29	In patient voucher Rs.1997.75
Ex.C-30	In patient voucher Rs.8363.11
Ex.C-31	In patient voucher Rs.309.30
Ex.C-32	In patient voucher Rs.2586.24
Ex.C-33	IP patient Return details Rs.726-00
Ex.C-34	In patient voucher Rs.906-00
Ex.C-35	In patient voucher Rs.4365.80
Ex.C-36	In patient voucher Rs.799.62
Ex.C-37	IP patient Return details Rs.3400.72
Ex.C-38	In patient voucher Rs.540.00
Ex.C-39	In patient voucher Rs.8560.20
Ex.C-40	In patient voucher Rs.6259.29
Ex.C-41	In patient voucher Rs.7416.51
Ex.C-42	In patient voucher Rs.11,021.99

Witnesses examined on OP/s side:

RW.1 – Manejgowda.R

RW.2 – Dr.Bhuvana Krishna

RW.3 – Dr.Dyed Shafiq

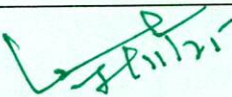
RW.4 – Dr.Prema

Documents got marked on OP/s side:

Ex.R-1	Referral Form dtd 04.01.2023
Ex.R-2	Consultation record
Ex.R-3	Laboratory investigation report dtd 04.01.2023
Ex.R-4	CR abdomen & pelvis plain study
Ex.R-5	2D Echo cardiography study

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7.1.23

Ex.R-6	ER nursing initial assessment
Ex.R-7	Nurse record
Ex.R-8	Intake / output chart
Ex.R-9	Letter of authorization
Ex.R-10	Intensive Care Unit /Admission document dtd 11.01.2023
Ex.R-11	Nurses assessment initial
Ex.R-12	Death summary
Ex.R-13	Medical certificate of cause of death
Ex.R-14	Intubation record
Ex.R-15	Initial assessment sheet section-A
Ex.R-16	Evaluation and treatment form
Ex.R-17	Physiotherapy assessment and treatment form
Ex.R-18	Drug charts
Ex.R-19	Haermodynamic monitoring chart
Ex.R-20	Intensive care unit progress record
Ex.R-21	Nurses evaluation : Daily
Ex.R-22	Death notes
Ex.R-23	Critical care unit
Ex.R-24	Pre-anesthesia assessment
Ex.R-25	Consent for administration of anesthesia
Ex.R-26	Consent to surgical procedures
Ex.R-27	Operation record contd.....
Ex.R-28	Consent for invasive procedure
Ex.R-29	Consent form for blood transfusion
Ex.R-30	Blood component/product compatibility and issue report
Ex.R-31	Subjective global assessment for adults.
Ex.R-32	Reassessment form adult
Ex.R-33	Appendix-4 Form No.3E
Ex.R-34	Consent for ERCP
Ex.R-35	Medicine sheet
Ex.R-36	Inpatient voucher dtd 14.01.2023



PRESIDENT

District Consumer Commission,
Hassan.