BEFORE THE DISTRICT CONSUMER DISPUTES REDRESSAL COMMISSION: AT NALGONDA:

PRESENT: SRI MAMIDI CHRISTOPHER,
PRESIDENT.

SMT.S.SANDHYA RANI,
FEMALE MEMBER.

SRI KATEPALLY VENKATESHWARLU,
MALE MEMBER.

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[Thursday, the Thirtieth day of October, 2025]

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CONSUMER COMPLAINT No. 11 OF 2021

Date of filing of complaint : 04.02.2021
Date of disposal : 30.10.2025

Between:

1. Asnala Devansh Showrya S/o Asnala Kranthi Kumar, Aged: 2 years, minor, under the guardianship of his father and natural guardian Asnala Kranthi Kumar S/o Asnala Manohar, Aged: 30 years, Occ: Agriculture,
2. Asnala Kranthi Kumar, S/o Asnala Manohar, Aged: 30 years, Occ: Agriculture,

Both are R/o H.No.1-28, Kadavendi Village, and Devaruppula Mandal, Janagaon District-506 302, Telangana State.

Both the Complainants are represented through their GPA Holder Sapidi Sathyanarayana, S/o Sapidi Balaiah, Aged: 45 years, Occ: Agriculture, R/o H.No.5-167, Aregudem, Peddakaparthi Village, Chityal Mandal, Nalgonda District, Pin: 508114, Telangana State.

...COMPLAINANTS.

AND

1. Dr.Madhavi, Professor and Head of Department, Obstetrics & Gynecology and Consulting Doctor in M/s Kamineni Institute of Medical Sciences Hospitals, Sreepuram, Narkatpally, Nalgonda District, Telangana State-508254.
2. Dr.Sunita Mishra, Professor of Obstetrics & Gynecology and Consulting Doctor in M/s Kamineni Institute of Medical Sciences Hospitals, Sreepuram, Narkatpally, Nalgonda District, Telangana State-508254.
3. Dr.Prasad, Anesthesia Senior Resident & Consulting Doctor in M/s Kamineni Institute of Medical Sciences Hospitals, Sreepuram, Narkatpally, Nalgonda District, Telangana State-508254.
4. Dr.Maruthi, Assistant Professor of Emergency Medicine Department and Consulting Doctor in M/s Kamineni Institute of Medical Sciences Hospitals, Sreepuram, Narkatpally, Nalgonda District, Telangana State -508254.
5. M/s Kamineni Institute of Medical Sciences Hospitals, Sreepuram, Narkatpally, Nalgonda District, Telangana State-508254. Represented through its Medical Superintendent/ Managing Director.

...OPPOSITE PARTIES.

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This complaint coming on before us for final hearing, in the presence of Sri M.Narsimha Reddy, Advocate for the Complainants, and Sri G.Prakash, Advocate for the Opposite Parties, and on perusing the material papers on record, and having stood over for consideration till this day, the Commission passed the following:

ORDER

BY SRI MAMIDI CHRISTOPHER, PRESIDENT

1. This is a Consumer Complaint filed by the Complainant under Section 35 of Consumer Protection Act, 2019, against the Opposite Parties as under:

a) To reimburse all the expenses incurred in relation to treatment of the deceased Swathi, (deceased patient) prior to her death and on the date of death including the hospital expenses together with interest @ 24% per annum from the date of complaint till realization,

b) To pay the compensation of Rs.6,00,00,000/- for causing agony, pain, hardship, inconvenience, trouble, etc., both mentally, monetarily and physically as a result of sheer negligence, carelessness, failure to exercise reasonable care and caution at the hands of the Opposite Parties No.2 and 3,

c) To pay the costs of the complaint and also award,

2. The facts leading to the filing of this complaint are as follows:

The Complainant No.1 is son of the Late Asnala Swati and complainant No.2 herein. The complainant No.2 is husband of the said deceased person namely said Asnala Swati, who died on 14/07/2018 at 10:55, after giving birth to complainant No.1 by C-Section (Caesarean) operation conducted by the Doctor/Opposite Party No.2 in the Opposite Party's Hospital and while undergoing treatment.

3. Both the Complainants are representing through their GPA holder namely Sri Sapidi Satyanaraya, S/o Sapidi Balaiah, vide GPA document marked as Ex.A-1 and accorded permission by the commission to deal with the case on behalf of the complainants.

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4. The Opposite Party No.1, Dr.Madhavi is Professor and Head of Department of Obstetrics & Gynecology & consulting doctor, in Opposite Party No.5 hospital. The Opposite Parties Nos. 2 to 4 are the doctors working in the Hospital of Opposite Party No.5 as Professor of Obstetrics/ Gynecology/Consulting Doctor, Anesthesia Senior Resident/ Consulting Doctor and Professor of Emergency Medicine Department/Consulting Doctor namely Dr. Sunitha Mishra, Dr. Prasad and Dr. Maruthi respectively, who are said to be attended the concern treatment rendered to patient Asnala Swathi during the period of her hospitalization in the said Hospital.

5. After marriage of complainant No.2 and Asnala Swathi, who is none other than the daughter of GPA holder herein, the said Swathi, wife of the complainant No.2 was conceived and was gone to her parental house place at Aregudem village for proper care and attention by the concern elders. She was under the complete medical observation under the supervision of the doctors in the Hospital of the Opposite Party No.5.

6. After some time when she was taken to Opposite Party No.5's Hospital, on 25.06.2018. The Opposite Party No.1 had diagnosed the said patient Swathi and after scanning she informed the attendants of the patient that Fetus were good and functioning well, accordingly advised to visit on 02.07.2018 by prescribing some medicines.

7. On 09.07.2018 at 10:00 a.m. the said patient along with her Husband, i.e., the complainant No.2 and parents visited the Hospital and then the Opposite Party No.1 has attended the Patient and confirmed that the patient and the baby in her Womb are fine and good after carrying-out all the relevant Tests and collected the Blood and Urine samples of the Patient. Accordingly, the patient got admitted at 3:40 p.m. on the same day, the said doctors informed once again that the patient is quite well and nothing abnormal after checking the B.P.(Blood Pressure).

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8. It is stated by the Complainants that the Opposite Party No.1 who is Medical Superintendent of the Opposite Party No.5's Hospital, and who examined from the date of at first instance of medical check-up for pregnancy of the said patient and who had carried-out routine procedures like checking the B.P and condition of the patient consecutively on 10.07.2018, 11.07.2018 and 12.07.2018 and 13.07.2018 duly informing that the patient and the Fetus in the womb are quite well and good and delivery can be happened at anytime.

9. Thereafter, at 9:00 p.m., on the same day, i.e., 13.07.2018, the Opposite Party No.2 had attended and the patient and informed the family members of Swathi (Patient) that operation is required to be conducted and accordingly the said patient was shifted to operation theatre at 10:00 p.m. In order to perform the C-Section (Caesarean) surgery, the Opposite Party No.3 had administered anesthesia to the patient in the presence of other Junior Doctors, the said surgery was done at about 10:55 to 11:00 p.m. a male baby was delivered out of the said surgery by the doctors.

10. At 12:00 p.m., the patient was shifted on the structure to the post-operative ward and the doctors, i.e. Opposite Parties No.2 and 3 and some Junior Doctors were present at that time and the patient was under still unconscious condition and would regain consciousness after two hours. The Complainant asked Opposite Party No.3 as to why Swathi was still unconscious since yesterday, then he replied that while doing the stitches after C-Section, the patient regained consciousness and not allowing them to complete the sutures, hence anesthesia is administered once again for second time with no emergency doctor available.

11. At 5-00 a.m. on 14/07/2018, the patient was still unconscious and then the duty nurse, called the doctors over phone, who attended the patient and informed that the matter is still little bit serious and shifted her to ICU. It is mentioned in the

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complaint that even in ICU, there was bleeding heavily and the bed sheets on the bed wet with blood and the patient was still in unconscious or comatose condition.

12. Thereafter, the duty doctors had informed at 8-00 a.m., that there is a need for transfusion of blood to the patient very urgently, for which the family members of the patient complied, duly providing blood from Blood Bank. The Complainants and their family members were informed by the doctor that transmission of blood into the body of the patient could not be taken place when it was transferred and blood stopped clotting and there is no urination.

13. Ultimately, at 9-00 a.m., the Opposite Party No.1 had arrived and consoled, duly stating "what they have to do, they have done". But, at 10-30 a.m., it was informed that the patient entered into coma. On such situation, the relatives of the Complainants went to have glimpse of the patient in the ward, they surprisingly found to see that the patient (Swathi) expired. The fact of the same was not informed, either by the hospital staff or anybody in the hospital, but still pretended as the patient is under treatment.

14. Thereafter, again the parents, relatives of the patient and the village elders strongly questioned the Opposite Parties, then they replied that 'the operation was successful and that one stray case like this will happen in hundreds', in the meantime, the Police arrived due to the death of Swathi. The incident happened due to sheer negligence, carelessness and fault on the part of the Opposite Parties, who failed in performing their duties to act properly with due care, diligence, more particularly in administering the anesthesia.

15. It is further alleged by the Complainants that only due to the negligent acts of the Opposite Parties, the patient died, because a) in failure to exercise proper post operative car, b) non-availability of emergency doctor round the clock, c) improper monitoring of C-Section, resulting in blood clotting, stoppage of urine and not

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regaining consciousness, d) twice administering anesthesia leading to coma, or unconsciousness and thereby resulting heavy blood loss, ultimately, which led to the death of the patient. As such, there are acts of omissions, commissions and mis deeds on the part of the Opposite Parties and even the patient had lost her life without having looked at her newly born child, which is miserable and is totally distressing.

16. It is revealed that death of Swathi was happened due to injecting of anesthesia overdose. It is also mentioned that the complaint that the causes of overdose of the anesthesia, which is a toxic to the body, which includes: injecting too much anesthetic, injecting the anesthetic at an improper rate, choosing the wrong anesthetic, monitoring or equipment failure, contradictory instrument values between anesthetic vaporizers/respirators and the anesthetic gas monitor, gas flow setting error, inappropriate ventilation, combing incompatible drugs, injecting the anesthetic too quickly, which can lead to increased plasma levels of local anesthetic. It is further mentioned by the Complainants that if there is a great level of toxicity, there will be more serious symptoms. If the toxicity exceeds, then it effects, i) central nervous system excitation, which include confusion, muscle twitches, seizures and agitation, ii_ A CNS depression typically follows (coma, unconsciousness, drowsiness), iii) metallic taste, and iv) numbness.

17. It is thus alleged by the complainants that the Opposite Parties No.1 to 5 and other junior doctors, who were present at the time of the C-Section are totally responsible for the death of the Patient, Swathi and as such they are all liable and responsible to answer the claim of the complainants herein. It is further alleged that there are some contradictions found in the documents, which are deciphered as mentioned hereunder:

18. The Medical Report of the Superintendent of the Hospital/Opposite Party No.5 which submitted to the Police shows:

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- the name of the Dr. Maruti (Opposite Party No.4) only mentioned but he is nothing to do and not found during the patient's hospitalization stay or in the case sheet or doctor's progress notes. The signature of complainant No.2 for the consent of high risk does not pertain to him.

- why could be obtained high risk consent on 14/07/2018 at 9.15 a.m., for consent signature at the time of patient's underwent coma and before death? However, it is declared that the patient died on 14/07/2018 at 10:55 p.m. and even before declaring death of the patient, one sachet of blood transmission recorded in case sheet on the same day in between 7.30 p.m. to 8.00 p.m., which proves to be false or either concocted.

- As per the Anesthesia Doctor, the anesthesia was given on 13/07/2018 at 10.40 p.m. to 10.15 a.m. on 14/07/2018 to spinal of the patient and patient was unconscious for (24) hours, but as per Post Mortem which conducted in Govt.Hospital, Nalgonda, at 6-00 p.m., as such there are omissions in recording. Even the time of admission is not tallying, whereas the patient was admitted in hospital on 09/07/2018 at 4.41 p.m., but it was mentioned as 3.41 a.m.

- The hospital report, which submitted to the Police, discloses at Page-84 that the date of death mentioned as 14/07/2017 instead of 14/07/2018, which is not progress notes.

- As per the case summary, the patient had no complaints of any ailments before admission and how and why it is termed as high risk case after admission into the hospital. Is it highlighted as high risk case, only to save and safeguard the skin of the consulting doctors and the hospital management? Actually, the doctor, who examined at first instance, i.e. Opposite Party No.1 either before or after admission into the hospital, she assured the delivery will be normal, but later how it was observed by the concerned doctors No.1 to 4 and other junior doctors and nurses available in the Opposite Party No.5's hospital, have decided and

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observed for necessity of C-Section surgery, basing on the complications which arose and as such, it is a concocted, created or developed and forced the patient for C-Section, during which time anesthesia was given twice, without proper care and diligence, which is nothing but negligence and carelessness on their part by performing the operation and also neglected post operative emergency care, which exhibited by the hospital staff that they have taken care and resulted the death of the patient and thereby the Complainant No.1 became orphan, and also the parents lost their daughter (Swathi), i.e. the deceased patient.

- On the side of the hospital/Opposite Party No.5, there are two different out-patient IDs, differently two reports.

- The another similar nature of incident had occurred at the very same hospital to another patient by name Lakshmi Parvathi.

- As per the medical investigation reports and diagnosis done to the patient, there were no major ailments reported and the condition of the patient is informed as healthy and good to the Complainant No.2, either before or on the date of admission into the hospital and also informed that the delivery will be normal without any complications. The patient was directly under the supervision of Opposite Party No.1 and no major ailments reported when the reports shown to the doctors concerned during the gestation of the pregnancy and the consulting doctor after due examination instructed to admit the patient in the hospital, but on the fourth day of admission, they decided or opted for surgery, for which the doctors have not informed the attendants the possibility of any life threat to the patient. As such, even otherwise, based on the diagnostic references and the reports, there was no high risk situation. If there was high risk condition, why the hospital authorities maintained to keep the patient admitted for three days without C-Section and why they had not opted for C-Section on the first day of admission, which go to show that the Opposite Parties have staged a drama to cover up their latches.

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19. Later, the father of the patient, i.e. GPA holder of Complainants herein, had lodged a Police complaint against the doctors at the concern Police Station and same is registered as Crime No.122/2018 on 14/07/2018, U/s. 174 Cr.P.C. which is pending for medical report from the District Committee by the DMHO, Nalgonda. The medical negligence committed by the Opposite Parties resulted in toxicity to the patient, which led to the immobility and damage of nervous system leading to death of the patient.

20. The Complainants have explained about the facts before conceiving pregnancy by the said patient, that she was hale and healthy and after confirmation of pregnancy also her health was in good position and even at the time of admission into the hospital. But, unfortunately due to the acts of the doctors involved in the treatment and surgery, who are working in the said hospital had met fatal accident immediate after surgery only due to medical negligence and thereby the Complainants, especially the infant/baby, i.e. Complainant No.1 and the husband of the patient, parents and other family members are put to untold agony, shock and pain, only due to carelessness, callousness and improper treatment of the Opposite Parties. Apart, the said deceased patient was only just (23) years old and she completed B.Tech and was well qualified and at the conceiving of first pregnancy, she was unfortunately no more, who is expecting her bright future life with abandoned happiness. As such, due to her untimely death, all the concerned persons as stated above have been continuously suffering and put to heavy loss.

21. The Complainant No.1, being infant, no one to give motherhood, who requires specially care and attention. The complainant No.2 is a young aged person who lost his life partner and which cannot be compensated in any manner.

22. It is also alleged that the patient died only due to excess dosage of anesthesia and improper treatment at the hands of Opposite Parties No.1 to 4 and other junior doctors at Opposite

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Party No.5 hospital during C-Section surgery. It is, therefore, all the Opposite Parties are held liable and responsible to answer the case of the Complainants. Though the Opposite Parties orally contended that the said hospital/Opposite Party No.5 has been provide with insurance, but they failed to furnish the particulars of insurance and insurers address, to make insurance company as a party to the Complaint.

23. The doctors 1 to 4 and other junior doctors have failed to exercise the proper degree of care, skill and diligence in monitoring the patient at the time of C-Section. It is also alleged that the Opposite Parties are vicariously liable and responsible for omissions and commissions on their part including junior doctors. The hospital also owns a duty vested as per the corporate liability theory and his premised on the notion that the duty lies on it, directly to the patients to render quality medical care and to protect its patients safety.

24. The Complainants have incurred huge amount for the treatment of deceased patient, for Rs.5,00,000/-. The irreparable loss caused to them as explained above, which is in tolerate and un-explainable and hence, any compensation will not sufficient for the loss occasioned to the Complainants in the hands of the Opposite Parties. However, the Complainants notionally estimates the loss at rupees Six Crores towards compensation to be paid by the Opposite Parties herein.

25. The relief claimed though exceeds the pecuniary limit of this Commission, but as per the consideration paid to the hospital is within the pecuniary limits. The present complaint had firstly filed before the Hon'ble Telangana State Consumer Commission, vide S.R.No.1598/2020, dated 16/07/2020 by paying fees of Rs.4,000/-, however the said complaint was returned by the said Hon'ble State Commission, vide orders, dated 18/08/2020 to represent the same before the appropriate Commission, which is having jurisdiction to entertain the complaint. Hence, the present

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complaint is filed before this Commission along with separate application, vide I.A.No.9/2021 seeking condonation of delay in resubmitting the complaint and the same was allowed by condoning the delay of 164 days, vide order dated 13/02/20221.

26. The damage sustained by the Complainants described above, cannot be compensated even by the relief sought by the Complainants, because there is much hardship, agony and pain, financial loss both mentally, monetarily and physically.

27. By stating aforesaid events, facts, which happened in the said treatment and subsequent C-Section Surgery performed in the Hospital by the doctors the Complainant, without due care and attention with negligent manner, and the consequences arising thereupon regarding the events of sufferings caused to the complainants mentally, physically, the present consumer complaint is necessitated to get relief as prayed for alleging that the opposite Parties committed medical negligence and deficiency of service and they are liable for the same. Hence, the complaint.

28. The Opposite Parties No.1, 3, 4 & 5 filed written version and the same was adopted by Opposite Party No.2, vide Memo filed by Opposite Party No.2 on 15/04/2021. The Opposite Parties submitted that there was no negligence on the part of Opposite Parties herein. It is submitted that the Complainant is not a consumer as defined in Consumer Protection Act. Further, the complaint is hopelessly barred by limitation against Opposite Parties, as filed after limitation period.

29. The Opposite Parties submitted that the Complainant was hopelessly barred by the limitation as the patient expired on 14-07-2018 whereas she filed the complaint before this Hon'ble Court in the month of January, 2021 i.e. after 2½ years. As such complaint is liable to be dismissed on this ground alone. Even as per the averments made in para 22 that they initially filed the complaint before the State Commission on 16-07-2020, vide

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S.R.No.1598 of 2020 i.e. they filed the complaint after 2 years 2 days of the last cause of action i.e. death of the patient. Further, the complainants have not filed any document pertaining to the complaint, filed before the State Commission. As such they cannot claim any benefit on the pretext of filing in wrong forum. As such viewing in any angle, the complaint is barred by limitation on the face of the averments of the complaint and the same is liable to be decided as a preliminary issue before conducting trial.

30. The Opposite Parties submitted that the patient was treated free of cost at the Opposite Party No.5 KIMS Hospital. Hence, the complainant is not a consumer as defined in Consumer Protection Act, as such the Complaint is liable to be dismissed on this ground alone. The Opposite Parties submitted that the before traversing the allegations of the Complaint, the Opposite Parties ALC would like to submit the true facts as follows to put the record straight.

31. The Opposite Parties submitted that the patient firstly came to the hospital on 25-06-2018 along with her mother and relative namely Anjaiah, with 9 months of pregnancy (36 Weeks). Anjaiah brought the patient to the hospital, as she was having history of Hypertension, pedal edema, and seen by a private practitioner outside at 9 months of pregnancy and was started on Anti-hypertensive Tab. Labetolol which the patient was not taking regularly as told by her mother. Hence it is incorrect to say the entire period of pregnancy the patient was under care of the Opposite Parties.

32. The Opposite Parties submitted that the patient was admitted for evaluation on 26/6/18 and have done all the required investigations for evaluation of Hypertension in Pregnancy and monitored her blood pressure every 4th hourly. Accordingly, the patient was discharged after 48 hours on 28/6/18. At the time of discharge, all the reports being normal and blood pressure was within normal limits. She is a known case of Hypothyroidism, on the drug Thyronorm100mcg. Further, during discharge she was

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advised home monitoring of blood pressure which the patient has monitored and recorded in a note book. All the readings were normal. The patient was advised to come for review with Urine Culture report.

33. The Opposite Parties submitted that the patient was reviewed again on 2/7/18 in Ante natal OPD. She showed the note book of BP monitoring which was normal. Patient was examined since all parameters were within normal limits and pregnancy was 37 weeks, the patient was advised to review after one week.

34. The Opposite Parties submitted that the patient has reported on 9/7/2018. By that time, she was 38 weeks 2 days pregnancy. Blood pressure recorded was 110/90 mm of Hg. Since, diastolic BP was 90 mm of Hg she was advised for admission. Initially patient and mother were hesitant for admission but after counseling about the risks of Hypertension, they agreed for admission and were admitted on 9/7/2018 at 3.40 pm. All relevant blood and urine samples sent to lab.

35. On 10/7/2018 patient was again investigated for all the parameters of pregnancy induced hypertension which were normal. She was monitored hourly with blood pressure recordings which were normal. It is submitted that on 11/7/2018 from 4 pm her Diastolic Blood Pressure was persistently high at 130/90 mm of Hg which was monitored every 4th hourly.

36. The Opposite Parties submitted that on 12/7/2018 since she was a primigravida with 38 weeks 5 days pregnancy with hypertension and cervix was 1-2 cm dilated, Soft in consistency, induction was started with Oxytocin at 11.AM. Prior to Induction consent for High risk was taken on 12/7/18 explaining risk and complications involved including stating she might require surgical intervention as she was undergoing induction of labour and not progressing spontaneously. The Oxytocin drip was stopped in the evening (as per protocol) and patient was monitored continuously.

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37. On 13/7/2018 the Oxytocin drip was restarted again at 5 AM by Opposite Party No.2, who was on duty. Since there was no progress in labour, she did ARM (Artificial rupture of membranes) in order to accelerate labour. Patient was monitored for 4 hours after ARM. As there was no progress and Foetal heart was abnormal, Opposite Party No.2 has decided for Emergency Caesarean Section (LSCS) at 9.30 pm. High risk consent for surgery was taken at 9.30 pm explaining all the complications which was signed by patient's Husband A. Kranthi Kumar.

38. The Opposite Parties submitted that pre-anesthesia check-up was done by OP 3. She was found to having Gestational Hypertension and was also having Hypothyroidism and on Tab Thyronorm 100 mcg/OD. That the Indication for caesarean section was failed induction and foetal distress. At Pre-anesthetic check-up patient was conscious coherent had elevated diastolic BP of 130/90 mmHg recorded and pulse rate of 130/min. In view of persisting tachycardia medical history was taken but clinically systemic examination was found normal. Investigations in antenatal period were within normal limits. Spinal Anesthesia was planned. Then the patient was shifted to operation theatre, Monitors were connected, Suction Apparatus, Anesthesia Workstation, Airway equipment were in order and spinal anesthesia was given using 0.5% Hyperbaric Bupivacaine (2ml/10mg) maintaining strict aseptic conditions at 10:40 pm. Dermatomal level achieved till D6. Anesthetist on duty was OP 3.

39. The Opposite Parties submitted that baby delivery time was 10.55 pm. Caesarean section was performed under spinal anaesthesia by Opposite Party No.2. During the abdominal closure. Rapid Sequence General Anaesthesia was administered with Fentanyl 100 mcg, Propafol 100 mg, Succinylcholine 100mg. Followed by Vecuroniom 4 mg, once the mother came out of Scoline effect. Surgery lasted till 12.15 AM waited for another 15 minutes for patient to have adequate attempts of spontaneous breathing. At 12:30 AM neuromuscular blocking agent was

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reversed using Neostigmine 2.5 mg and glycopyrrolate 0.4mg as the patient generated good tidal volume, then she was extubated. Post extubation, after about 10 min later, patient started complaining of symptoms of breathlessness and tidal volume was also low when Bain circuit was put on patient. A repeat reversal 0.5mg Neostigmine and 0.2 mg glycopyrrolatewas given, but no improvement. Patient was re-intubated for postoperative ventilation and was shifted Post Op ICU. At 1.30 AM Attenders were informed about events of OT and counseled about the need for mechanical ventilation and need for further evaluation.

40. The Opposite Parties submitted that at 4.15 am Opposite Party No.2 and Opposite Party No.3 noticed decreased urinary output but other parameters were maintained like blood pressure. At 5 am patient was developed sudden hypotension, which was managed by Fluid bolus and vasopressors. EMD physician has seen the patient and all relevant investigations were sent, there were low platelets, coagulation profile deranged, ABG showed severe metabolic acidosis, ECG shown S1Q3T3 pattern (suggestive of embolism) and 2D-Echo shows "Global Hypokinesia". At 6 am Hb: 9.1 gm%, TC: 36200 (indication of sepsis), Platelets 55000/m3. Patient was on two vasopressors, Noradrenaline and Dobutamine. 6.30 am BP was not recordable even with vasopressors. Pulse rate was at 120-130/minute.

41. The Opposite Parties submitted that at 7.20 am central vein catheterized. At 7.30 am 1 unit of PRBC and 1 unit FFP were transfused. At 7.40 am seen by Dr.Vinay, Assistant Professor Anaesthesia. He has advised investigations and more blood and FFP transfusions. At 7.40 am Opposite Party No.4 documented ECG as SIQ3T3 pattern, Rt ventricular strain pattern, Embolic phenomenon, Cardiogenic shock, and advised for 2-D Echo. 2-D Echo was done. ECG showing sinus tachycardia with S1Q3T3 with Right ventricular strain which is suggestive of Acute Pulmonary embolism. 2D ECHO showed Global Hypokinesia, Moderate to severe LV dysfunction with moderate pericardial effusion

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suggestive of Peripartum cardiomyopathy. At 9.15 am Bed side Ultrasound abdomen was done which was normal. At 10.05 am on 14/7/18 seen by Dr. Manohar HOD Anaesthesia, advised for platelet transfusion.

42. The Opposite Parties submitted that Patient had cardiac arrest at 10.25 am. CPR was done and patient could not be retrieved and declared dead at 10.55 am.

43. The Opposite Parties submitted that the patient came to hospital with term gestation of first pregnancy with gestational hypertension, with hypothyroidism underwent emergency lower segment caesarean section for failed induction and fetal distress under spinal anesthesia which was supplemented by general anesthesia. Patient was reintubated in view of respiratory distress and put on mechanical ventilator. Subsequently patient developed hypotension which was managed by IV Fluids and vasopressors. ECG showed S1Q3T3 pattern suggestive of pulmonary embolism, 2-D ECHO showed global hypokinesia, moderate to severe let ventricular dysfunction suggestive of peripartum cardiomyopathy. Elevated PT and APTT suggested Disseminated Intravascular Coagulation. Pulmonary Embolism and Peripartum cardiomyopathy resulted in refractory hypotension and cardiac arrest.

44. The Opposite Parties submitted that the risk of thromboembolism in pregnancy and post-partum period is 0.5% to 3%. Incidence of thromboembolism in pregnancy is 7 to 10 times higher than in non-pregnant women, where as it is 15 to 35 times higher in post-partum period. Pulmonary embolism is fatal in almost 15% of the patients, and 66% of deaths occur within 30 min of embolic event. Deep venous thrombosis is often unnoticed in pregnancy and postpartum period. Thus it usually presents with dreaded complication that is pulmonary embolism. Pulmonary thromboembolism with hypotension and right ventricular dyskinesia has high mortality. Peripartum cardiomyopathy

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commonly occurs in primigravida. The symptoms appear predominantly in post-partum period in 70-80% of cases. The mortality rates of peripartum cardiomyopathy are 18-50%. The combination of pulmonary embolism and Peripartum cardiomyopathy significantly increases the maternal mortality rate.

45. The Opposite Parties submitted that the risk of pulmonary embolism in post-partum period is rare known complication. The Opposite Parties denied that on 09-07-2018 after conducting tests and after checking blood pressure, the patient is quite well and nothing abnormal. It is pertinent to submit here that the patient and attendants were informed about persistent high blood pressure. She was known case of pregnancy induced hypertension and hypothyroidism and she was prescribed anti-hypertensive by private practitioner but she was irregular in taking medicine.

46. The Opposite Parties denied that on 10, 11, 12 and 13, after checking blood pressure of the patient, informed that patient condition was normal. It appears the Complainant conspicuously suppressing the fact that the patient has gestational hypertension and there is no progress of delivery and foetal heart rate was abnormal. At around 9.00 - 9.30 p.m. on 13-07-2018 since there was no progress in delivery in spite of all efforts, the attendants of the patient were explained about the necessity of the surgery and risk and complications involved including various complications such as PPH, DIC etc. The Opposite Parties admitted that caesarean section has performed and male baby delivered at around 11.00 p.m.

47. The Opposite Parties denied that the patient was in unconscious condition and Opposite Party No.3 replied that during the stitches she regained consciousness and not allowed to complete the sutures and anaesthesia was administered second time, since spinal anaesthesia does not produce unconsciousness. General Anaesthesia was supplemented at a later stage. It is further denied that doctors left the place by informing the duty

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nurse to take care of the patient. Opposite Party No.3 submitted that she was monitored by the duty gynaecologist along with duty doctors. The Opposite Parties denied that in ICU the patient bled heavily and the bed sheets on the bed were wet with blood. The Opposite Parties submitted that the duty doctors are monitoring the patient regularly and there is no bleeding at any point of time and blood was transfused at 7.30 a.m. as such the allegations of the Complainant are totally incorrect.

48. The Opposite Parties denied that Opposite Party No.4 belonged to Emergency Medicine Department and when patient was referred to Emergency Medicine Department at 5.30 and he was part of the Team of the Doctors, who treated the patient. The Opposite Parties denied that the signature of the Complainant in high risk consent not pertains to him and the signature of the complainant No.2 was obtained by Opposite Party no.1 after explaining the condition of the patient. Basing on the risks and complications of the patient condition, high risk consent will be obtained after explaining the risks and complications involved and prognosis of the patient. The blood was transfused at 7.30 AM Not at 7.30PM to 8PM as alleged by the complainant. It is evident from the notings of the case sheet.

49. As stated above, initially she was given spinal anesthesia and later, it was supplemented by general anesthesia. Mentioning of A.M and P.M probably confused by the author of the document out of may be bonafide mistake. It means patient had no existing ailments however, it can be seen that patient has persistent pregnancy induced hypertension, hypothyroidism, and with abnormal foetal heart rate and no progress of delivery despite induction. As such it can be said as high risk pregnancy.

50. The Opposite Parties submitted that they are unable see such different OP ID in record. However sometimes, different OP IDs will be given when the patient fails to bring earlier OP card on the next visit. As such the hospital may generate another ID.

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51. The Opposite Parties denied that assurance given by the doctor that delivery will be normal and that without proper due diligence, utter negligence and carelessness, the operation was performed and post-operative emergency care by the hospital staff was negligible. The Opposite Parties denied that after death of the patient, the Opposite Party 5, to protect, safeguard themselves has projected it as a high risk case and the same was never told or informed to the Complainant to her or to parents of the patient. It is pertinent to submit that the attendants of the signed two High Risk consents.

52. The Opposite Parties denied that the condition of the patient has healthy and good before the date of admission in the hospital. With reference to the reports and diagnosis done to the patient. Opposite Parties submitted that the patient was known case of pregnancy induced hypertension and hypothyroidism and the Complainant and his in-laws were counseled in detail, about the risks and complications and prognosis and also about the threat to life in certain circumstances.

53. It is a standard protocol that initially every gynecologist tries for normal delivery, later try for induced delivery with medication, if both options fail, thereafter; the gynecologist will opt for C Section only. The Opposite Parties submitted that the father of the Complainant lodged a Police Complaint and the same is pending for medical report from the DMHO.

54. The Opposite Parties denied that the patient died due to excess dose of anesthesia and improper treatment at the hands of the Opposite Parties No.1 to 4 at Opposite Party No.5 hospital. The Opposite Parties denied that Opposite Party No.5 hospital provided with insurance. The Opposite Parties denied that due to sheer negligence and carelessness in monitoring the patient resulting in the death of the patient while administering anesthesia by the Opposite Parties' doctor during the performance of C-Section and

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after operation, as a result the Complainants became handicap forever and the Complainant No.2 lost his companion at an early age and suffered mentally and monetarily.

55. The Opposite Parties denied that Opposite Parties No.1 to 4 and other Junior Doctors failed to exercise proper degree of care, skill and diligence in monitoring the patient at the C-Section and during the C-Section, which resulted in the death of the patient and that the Opposite Parties are vicariously liable for omissions and commissions on the part of Opposite Parties. The Opposite Parties denied that the Complainants incurred huge amounts which is less than Rs.5,00,000/- and the agony faced by Complainants are intolerable and unexplainable and any amount of compensation will not suffice the loss to the Complainants. The Opposite Parties denied that the negligence of the Opposite Parties resulted in the toxicity to the patient which led to the immovable damage of nerve system leading to the death of the patient and claiming Rs.10 crores as compensation and moderately assessed at Rs.6 crores only apart from actual medical expenses.

56. The Opposite Parties submitted that the Complainant is claiming exorbitant amounts under the guise of alleged negligence without any basis since the Opposite Parties treated the patient by following standard protocols, so the question of paying compensation does not arise. The Opposite Parties submitted that the Complainant has not filed any evidence to substantiate his monetary claims. The Opposite Parties submitted that the treating doctors are highly reputed with vast experience and having professional ethical medical practice. There is neither negligence nor deficiency in service on the part of the Opposite Parties in treating the patient. Hence, the Opposite Parties are not liable to pay any amounts. Therefore, the complaint is liable to be dismissed.

57. The GPA Holder filed affidavit and got marked Exs.A-1 to A-25. The Opposite Party No.1 filed affidavit and got marked Ex.B-1. Sri Sappidi Sathyanarayana, GPA Holder was examined

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as PW-1. Dr.Madhavi (OP-1) was examined as RW-1. Dr.Sunitha Mishra (OP-2) was examined as RW-2. Dr.M.D.N.Prasad (OP-3) was examined as RW-3. Dr.Maruthi Rama Krishna Rao (OP-4) was examined as RW-4.

58. The points for consideration are:

1) Whether there is any medical negligence on the part of the Opposite Parties as alleged by the complainants?
2) Whether the complainants are entitled for compensation for the alleged medical negligence?
3) If so, to what extent

59. POINT No.1:

The Complainant No.1 is son of the Late Asnala Swati and complainant No.2 herein. The complainant No.2 is husband of the said deceased person namely said Asnala Swati, who died on 14/07/2018 at 10:55, after giving birth to complainant No.1 by way C-Section (Caesarean) operation conducted by the Doctor/Opposite Party No.2 in the Opposite Party's Hospital.

60. Both the complainants are representing through their GPA holder namely Sri Sapidi Satyanarayana, S/o.Sapidi Balaiah, vide GPA document marked as Ex.A-1 and accorded permission by the commission to deal with the case on behalf of the complainants. The Late Asnala Swati was the deceased patient. Exs.A-12, 13 and 18 are the People's Hospital Prescriptions. Ex.A-14 is the TIFA Report. Ex.A-15 is the Diagnostic Reports. Ex.A-16 is the Fetal Echo Report. Ex.A-17 is the Out-Patient Details of Happy Hospital. Ex.A-19 is the Apollo Clinic Prescription.

61. After marriage of complainant No.2 with Asnala Swathi, who is the daughter of GPA holder herein, the said Swathi, wife of the complainant No.2 was conceived and was gone to her parental house at Aregudem village for proper care and attention by the concern elders. During the entire period of pregnancy, she was under the complete medical observation and supervision of the doctors in the Hospital of the Opposite Party No.5.

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62. After some time when she was taken to Opposite Party No.5's Hospital, on 25.06.2018, then, The Opposite Party No.1, consulting doctor had diagnosed the said patient Swathi and after scanning she informed the attendants of the patient that Fetus were good and functioning well, accordingly advised to visit on 02.07.2018 by prescribing some medicines.

63. On 09.07.2018 at 10:00 a.m. the said patient along with her husband, i.e., the complainant No.2 and parents visited the Hospital and then the Opposite Party No.1 has attended the Patient and confirmed that the patient and the baby in her womb are fine and good after carrying-out all the relevant Tests and collected the Blood and Urine samples of the Patient. Accordingly, the patient got admitted at 3:40 p.m. on the same day. Ex.A-4 is the Admission Record. Ex.A-20 is the KIMS Hospital Prescription.

64. It is stated by the Complainants that the Opposite Party No.1 examined from the date of at first instance of medical check-up for pregnancy of the said patient and who had carried-out routine procedures like checking the B.P and condition of the patient consecutively on 10.07.2018, 11.07.2018 and 12.07.2018 duly informing that the patient and the Fetus in the womb are quite well and good and delivery can be happened at anytime.

65. Thereafter, at 9:00 p.m., on the same day, i.e., 13.07.2018, the Opposite Party No.2 had attended and the patient and informed the family members of Swathi (Patient) that operation is required to be conducted and accordingly the said patient was shifted to operation theatre at 10:00 p.m., as per Ex.A-3, i.e. Case Sheet. Ex.A-21 is the Liver Function Test Report.

66. In order to perform the C-Section (Caesarean) surgery, the Opposite Party No.4 had administered anesthesia to the patient in the presence of other Junior Doctors for delivery, the said operation of caesarian conducted by the doctors and at about 10:55 to 11:00 p.m. a male baby was delivered on 13.07.2018.

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67. At 12:00 p.m., the patient was shifted on the stretcher to the post-operative ward and the doctors. The patient regained consciousness and not allowing them to complete the sutures, hence anesthesia is administered once again for second time. While stating so, the doctors left the place by informing the then duty nurse to take care of the patient, but at that time there was no emergency doctor available.

68. Even in the morning at 5-00 a.m. on 14/07/2018, the patient was still unconscious and supine, who attended the patient and informed that the matter is still little bit serious and shifted her to ICU. *It is mentioned in the complaint that even in ICU, there was bleeding heavily and the bed sheets on the bed got wet with blood and the patient was still in unconscious or comatose condition.* Ex.A-5 is the Case Summary.

69. At 10-30 a.m., it was informed that the patient entered into coma and found to see that the patient (Swathi) expired. Ex.A-2 is the Death Certificate. The fact of the same was not informed, either by the hospital staff or anybody in the hospital, but still pretended as the patient is under treatment.

70. The death of Swathi happened due to sheer negligence, carelessness and fault on the part of the Opposite Parties in performing their duties to act properly with due care, diligence, more particularly in administering the anesthesia. Ex.A-9 is the F.I.R. Ex.A-6 is the P.M.E.Report. Ex.A-7 is the F.S.L.Report. Ex.A-8 is the Inquest Report. Ex.A-28 is the Scene of offence Panchanama. Ex.A-29 is the Section Alteration Memo from 174 to 304-A IPC. Ex.A-10 is the newspaper article. Ex.A-30 is the Chargesheet. Ex.A-11 is another newspaper article. Ex.A-22 is the letter of Constitution of Committee causing enquiry into medical negligence cases.

71. It is further alleged by the Complainants that only due to the negligent acts of the Opposite Parties, the patient died, because a) in failure to exercise proper post operative care, b) non-availability

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of emergency doctor round the clock, c) improper monitoring of C-Section, resulting in blood clotting, stoppage of urine and not regaining consciousness, d) twice administering anesthesia leading to coma, or unconsciousness and thereby resulting heavy blood loss, ultimately, which led to the death of the patient.

72. After due enquiries made by Complainant No.2 and his family members, it is revealed that it all happened due to injecting of anesthesia overdose, as a result of which, the patient died.

73. As per the Anesthesia Doctor, the anesthesia given on 13/07/2018 at 10.40 p.m. to 10.15 a.m. on 14/07/2018 to spinal of the patient and patient is unconscious for (24) hours, but as per Post Mortem which conducted in Govt.Hospital, Nalgonda, at 6-00 p.m., it varies the time, as such it is nothing but carelessness.

74. Even the time of admission is not tallying, whereas the patient was admitted in hospital on 09/07/2018 at 4.41 p.m., but it was mentioned as 3.41 a.m.

75. As per the case summary, the patient has no complaints of any ailments before admission and how and why it is termed as high risk case after admission into the hospital. The OP doctors No.1 to 4 and other junior doctors and nurses available in the Opposite Party No.5's hospital, have decided and observed for necessity of C-Section, due to the said complications, forced the patient for C-Section, during which time twice, given anesthesia twice without proper care and diligence, which is nothing but sheer negligence and carelessness on their part by performing the operation and also neglected post operative emergency care.

76. After the death of patient, the Opposite Party No.5 had projected the case as a high risk case only to safeguard their interest.

77. The another similar nature of incident had occurred at the very same hospital to another patient by name Lakshmi Parvathi.

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78. As per the medical investigation reports and diagnosis done to the patient, there were no major ailments reported and the condition of the patient is informed as healthy and good to the Complainant No.2, either before or on the date of admission into the hospital and also informed that the delivery will be normal without any complications. The patient was directly under the supervision of Opposite Party No.1 and no major ailments reported when the reports shown to the doctors concerned during the gestation of the pregnancy and the consulting doctor after due examination instructed to admit the patient in the hospital, but on the fourth day of admission, they decided or opted for surgery, for which the doctors have not informed the attendants the possibility of any life threat to the patient. As such, even otherwise, based on the diagnostic references and the reports, there was no high risk situation.

79. Later, the father of the patient, i.e. GPA holder of Complainants herein, had lodged a Police complaint against the doctors at the concern Police Station and same is registered as Crime No.122/2018 on 14/07/2018, U/s. 174 Cr.P.C. which is pending for medical report from the District Committee by the DMHO, Nalgonda. Ex.A-26 is the Medical Opinion given by Govt.Maternity Hospital, Sultan Bazar, Hyderabad. Ex.A-27 is the letter from Superintendent, Govt.Maternity Hospital, Sultan Bazar, Hyderabad to the Commissioner, Telangana Vaidya Vidhana Parishad, Hyderabad, regarding submission of Medical Opinion of Medical Enquiry Board on medical negligence over the death of Smt.Swathi.

80. It is also alleged that the patient died only due to excess dosage of anesthesia and improper treatment at the hands of Opposite Parties no.1 to 4 and other junior doctors at Opposite Party No.5' hospital during C-Section surgery. It is, therefore, all the Opposite Parties are held liable and responsible to answer the case of the Complainants. Though the Opposite Parties orally contended that the said hospital/Opposite Party No.5 has been

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provide with insurance, but they failed to furnish the particulars of insurance and insurers address, to make insurance company as a party to the Complaint.

81. The doctors 1 to 4 and other junior doctors have failed to exercise the proper degree of care, skill and diligence in monitoring the patient at the time of C-Section and that the Opposite Parties are vicariously liable and responsible for omissions and commissions on their part including junior doctors.

82. The present complaint had firstly filed before the Hon'ble Telangana State Consumer Commission, vide S.R.No.1598/2020, dated 16/07/2020 by paying fees of Rs.4,000/-, however the said complaint was returned by the said Hon'ble State Commission, vide orders, dated 18/08/2020 to represent the same before the appropriate Commission, which is having jurisdiction to entertain the complaint. Ex.A-23 is the Demand Draft. Ex.A-24 is the Certificate issued by the Hon'ble Telangana State Commission. Ex.A-25 is the Order of Hon'ble State Commission. Hence, the present complaint is filed before this Commission along with separate application seeking condonation of delay in resubmitting the complaint.

83. The Opposite Parties submitted that the patient firstly came to the hospital on 25-06-2018, with 9 months of pregnancy (36 Weeks). She was having history of Hypertension, pedal edema, and seen by a private practitioner outside at 9 months of pregnancy and was started on Anti-hypertensive Tab. Labetolol which the patient was not taking regularly as told by her mother. Hence it is incorrect to say the entire period of pregnancy the patient was under care of the Opposite Parties.

84. The Opposite Parties submitted that the patient was admitted for evaluation on 26/6/18 and have done all the required investigations for evaluation of Hypertension in Pregnancy and monitored her blood pressure every 4th hourly. Accordingly, the

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patient was discharged after 48 hours on 28/6/18. At the time of discharge, all the reports being normal and blood pressure was within normal limits. She is a known case of Hypothyroidism, on the drug Thyronorm100mcg. Further, during discharge she was advised home monitoring of blood pressure which the patient has monitored and recorded in a note book. All the readings were normal. The patient was advised to come for review with Urine Culture report.

85. The Opposite Parties submitted that the patient has reported on 9/7/2018. By that time, she was 38 weeks 2 days pregnancy. Blood pressure recorded was 110/90 mm of Hg. Since, diastolic BP was 90 mm of Hg she was advised for admission. Initially patient and mother were hesitant for admission but after counseling about the risks of Hypertension, they agreed for admission and were admitted on 9/7/2018 at 3.40 pm. All relevant blood and urine samples sent to lab.

86. The Opposite Parties submitted that on 10/7/2018 patient was again investigated for all the parameters of pregnancy induced hypertension which were normal. She was monitored hourly with blood pressure recordings which were normal. It is submitted that on 11/7/2018 from 4 pm her Diastolic Blood Pressure was persistently high at 130/90 mm of Hg which was monitored every 4th hourly.

87. The Opposite Parties submitted that on 12/7/2018 since she was a primigravida with 38 weeks 5 days pregnancy with hypertension and cervix was 1-2 cm dilated, Soft in consistency, induction was started with Oxytocin at 11.AM. Prior to Induction consent for High risk was taken on 12/7/18 explaining risk and complications involved including stating she might require surgical intervention as she was undergoing induction of labour and not progressing spontaneously. The Oxytocin drip was stopped in the evening (as per protocol) and patient was monitored continuously.

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88. The Opposite Parties submitted that on 13/7/2018 the Oxytocin drip was restarted again at 5 AM by Opposite Party No.2 (Professor) who was on duty did ARM (Artificial rupture of membranes) in order to accelerate labour. Patient was monitored for 4 hours after ARM. As there was no progress and Foetal heart was abnormal, Dr.Sunita Mishra has decided for Emergency Caesarean Section (LSCS) at 9.30 pm. High risk consent for surgery was taken at 9.30 pm explaining all the complications which was signed by Complainant No.2.

89. Pre-anesthesia check-up was done by OP 3. She was found to having Gestational Hypertension and was also having Hypothyroidism and on Tab Thyronorm 100 mcg/OD. That the Indication for caesarean section was failed induction and foetal distress. At Pre-anesthetic check-up patient was conscious coherent had elevated diastolic BP of 130/90 mmHg recorded and pulse rate of 130/min. In view of persisting tachycardia medical history was taken but clinically systemic examination was found normal. Investigations in antenatal period were within normal limits. Spinal Anesthesia was planned. Then the patient was shifted to operation theatre, Monitors were connected, Suction Apparatus, Anesthesia Workstation, Airway equipment were in order and spinal anesthesia was given using 0.5% Hyperbaric Bupivacaine (2ml/10mg) maintaining strict aseptic conditions at 10:40 pm. Dermatomal level achieved till D6. Anesthetist on duty was OP 3.

90. The Opposite Parties submitted that baby was delivered at 10.55 pm. on 13.07.2018. Caesarean section was performed under spinal anaesthesia by Opposite Party No.2. During the abdominal closure. Rapid Sequence General Anaesthesia was administered with Fentanyl 100 mcg, Propafol 100 mg, Succinylcholine 100mg. Followed by Vecuroniom 4 mg, once the mother came out of Scoline effect. Surgery lasted till 12.15 AM waited for another 15 min for patient to have adequate attempts of spontaneous breathing. At 12:30 AM neuromuscular blocking agent was

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reversed using Neostigmine 2.5 mg and glycopyrrolate 0.4mg as the patient generated good tidal volume, then she was extubated. Post extubation, after about 10 min later, patient started complaining of symptoms of breathlessness and tidal volume was also low when Bain circuit was put on patient. A repeat reversal 0.5mg Neostigmine and 0.2 mg glycopyrrolatewas given, but no improvement. Patient was re-intubated for postoperative ventilation and was shifted Post Op ICU. At 1.30 AM Attenders were informed about events of OT and counseled about the need for mechanical ventilation and need for further evaluation.

91. The Opposite Parties submitted that at 4.15 am Opposite Party No.2 and Opposite Party No.3 noticed decreased urinary output but other parameters were maintained like blood pressure. At 5 am patient was developed sudden hypotension, which was managed by Fluid bolus and vasopressors. EMD physician has seen the patient and all relevant investigations were sent, there were low platelets, coagulation profile deranged, ABG showed severe metabolic acidosis, ECG shown S1Q3T3 pattern (suggestive of embolism) and 2D-Echo shows "Global Hypokinesia". At 6 am Hb: 9.1 gm%, TC: 36200 (indication of sepsis), Platelets 55000/m3. Patient was on two vasopressors, Noradrenaline and Dobutamine. 6.30 am BP was not recordable even with vasopressors. Pulse rate was at 120-130/minute.

92. The Opposite Parties submitted that at 7.20 am central vein catheterized. At 7.30 am 1 unit of PRBC and 1 unit FFP were transfused. At 7.40 am seen by Dr.Vinay, Assistant Professor Anaesthesia. He has advised investigations and more blood and FFP transfusions. At 7.40 am Dr.Maruti documented ECG as SIQ3T3 pattern, Rt ventricular strain pattern, Embolic phenomenon, Cardiogenic shock, and advised for 2-D Echo. 2-D Echo was done. ECG showing sinus tachycardia with S1Q3T3 with Right ventricular strain which is suggestive of Acute Pulmonary embolism. 2D ECHO showed Global Hypokinesia, Moderate to

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severe LV dysfunction with moderate pericardial effusion suggestive of Peripartum cardiomyopathy. At 9.15 am Bed side Ultrasound abdomen was done which was normal. At 10.05 am on 14/7/18 seen by Dr. Manohar HOD Anaesthesia, advised for platelet transfusion. The Opposite Parties submitted that Patient had cardiac arrest at 10.25 am. CPR was done and patient could not be retrieved and declared dead at 10.55 am. on 14.07.2018.

93. The Opposite Parties admitted that the patient came to hospital with term gestation of first pregnancy with gestational hypertension, with hypothyroidism underwent emergency lower segment caesarean section for failed induction and fetal distress under spinal anesthesia which was supplemented by general anesthesia. Patient was reintubated in view of respiratory distress and put on mechanical ventilator. Subsequently patient developed hypotension which was managed by IV Fluids and vasopressors. ECG showed S1Q3T3 pattern suggestive of pulmonary embolism, 2-D ECHO showed global hypokinesia, moderate to severe let ventricular dysfunction suggestive of peripartum cardiomyopathy. Elevated PT and APTT suggested Disseminated Intravascular Coagulation. Pulmonary Embolism and Peripartum cardiomyopathy resulted in refractory hypotension and cardiac arrest.

94. As stated above, initially she was given spinal anesthesia and later, it was supplemented by general anesthesia. Mentioning of A.M and P.M probably confused by the author of the document out of may be bonafide mistake. It means patient has no existing ailments however, it can be seen that patient has persistent pregnancy induced hypertension, hypothyroidism, and with abnormal foetal heart rate and no progress of delivery despite induction. As such it can be said as high risk pregnancy.

95. The Opposite Parties submitted that the father of the Complainant lodged a Police Complaint and the same is pending for medical report from the DMHO.

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96. The Opposite Parties submitted that the Complainant has not filed any evidence to substantiate his monetary claims. The Opposite Parties submitted that the treating doctors are highly reputed with vast experience and having professional ethical medical practice. There is neither negligence nor deficiency in service on the part of the Opposite Parties in treating the patient. Hence, the Opposite Parties are not liable to pay any amounts. Ex.B-1 is the Decision of the Telangana State Medical Council, dated 23/12/2023, which had given "No Negligence on the part of Opposite Parties No.1 to 4 treating doctors of Opposite Party No.5 Hospital".

97. The Complainant/GPA Holder is examined as PW-1 and filed chief affidavit with the contents of the complaint. Ex.A-1 is the GPA on behalf of Complainants No.1 and 2 and he was cross-examined by the counsel for Opposite Parties. PW-1 stated that he has no personal knowledge about the treatment and there is no any signature of PW-1 on any hospital document, much less in Ex.A-4 and that the patient was admitted on 26/06/2018 and discharged on 28/06/2018 and before consulting Opposite Parties' hospital, the patient was consulted in Peoples Hospital, Patancheru and Jeevan Sai Hospital. PW-1 denied of any health complications and using of drugs relating to thyroid and hypertension. PW-1 denied that the patient was diagnosed thyroid in Thyrocare lab as in Ex.A-15. PW-1 stated that he was not aware about the patient being admitted in Happy Hospital under Ex.A-17 and regarding abdominal pain and vomiting. PW-1 is not aware of admission of the patient in Apollo Hospital and other health complications. PW-1 admitted that patient did not consult Kamineni Hospital from the beginning of the pregnancy. PW-1 denied that the patient suffered with high BP and Thyroid, as such she was high risk patient. PW-1 stated that he was present at the time of admission of patient in Opposite Parties hospital. PW-1 stated that the patient was shown at local RMP doctor and he has no knowledge of patient having high BP and injecting overdose of anesthesia as stated in para-6 of the complaint. PW-1 stated that

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no doctor has given written opinion stating that there was negligence on the part of the Opposite Parties. PW-1 denied that the Opposite Parties have informed with regard to the high risk patient and had various complications including death of the patient. PW-1 denied the suggestion that no overdose of anesthesia was administered to the patient and that there was no proper treatment by Opposite Parties. PW-1 denied the suggestion that there is no bleeding after conducting the surgery and there is no negligence on the part of the Opposite Parties and the patient due to medical complications.

98. Dr.Madhavi/Opposite Party No.1 is examined as RW-1 and filed chief affidavit, stating that she is the Professor of KIMS, Narkatpally and deposed the contents as in the written version and stated that the patient. RW-1 stated in the cross-examination that she along with Opposite Parties No.2 to 4 have attended the deceased in Opposite Party No.5 hospital. RW-1 admitted that a criminal case was registered on the complaint given by the father of the deceased in Cr.No.122/2018. After investigation, the section of law was altered from 174 Cr.P.C. to 304-A IPC. RW-1 admitted that in the report, it is mentioned that there were over writings in the case in different page numbers. But, the witnesses added that there were correction regarding one word, i.e. Feeble was struck off and written as not pulpable. RW-1 denied the suggestion that the correction in the case sheet was made subsequent to the death of the patient. RW-1 admitted that the contents mentioned in the report and added that the said finding is false. RW-1 admitted the mentioning of the contents of the Investigation Report.

99. RW-1 stated that whether bleeding started at the time of surgery and that they have not observed the bleeding. The Witness adds that she was not present at the time of surgery. RW-1 denied that the patient was not hypertensive at the time of admission and that she was not having any thyroid problem. RW-1 admitted that the patient was admitted under my supervision, but she had not conducted surgery. RW-1 denied the suggestion that the patient

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died due to C-Section failure and due to negligence of the doctors, who have attended her. RW-1 denied that the risk factor has not been explained to the attendants of the patient.

100. Dr.Sunitha Mishra/Opposite Party No.2 was examined as RW-2 and filed chief affidavit. In the cross-examination, RW-2 admitted that a Committee was formed to give medical opinion over the death of deceased Swathi and that the Committee consists of four Gynecologists, two Anesthetists and one Civil Surgeon/RMO Administrative Department. RW-2 denied that the Committee has opined that the deceased died due to our negligence. RW-2 admitted that, basing on the said report, they have been charged for the offence Under Section 304-A of IPC. and that it is mentioned in the report that there is discrepancy noted in the findings in the case sheet which is showing uterus well retracted with clear dressing. RW-2 admitted that it is mentioned in the report that PME report is showing massive, broad ligament hematoma and hematoma below the rectus sheet. Witness added that to her knowledge, there is no hematoma in the broad ligament and also below the rectus sheath. RW-2 admitted that in the PME report in the injuries column the presence of hematoma below the rectus sheath extra peritoneally massive broad ligament hematoma, right side, if the suturing is not done properly, it would result in hematoma. RW-2 denied the suggestion that there was excessive bleeding at the time of surgery and they have not noticed. RW-2 denied that the case sheet was fabricated subsequent to the death of patient and that the patient died due to their negligence and to her knowledge the cause of the death of the deceased is pulmonary embolism. RW-1 admitted the in the committees report they have given finding that investigation reports and PME reports are not suggestive of DVT, Thromboembolism, Aminotic fluid embolism and Cardiac embolic.

101. Dr.M.D.N.Prasad/Opposite Party No.3 was examined as RW-3 and filed chief affidavit as in the contents of the written version and he was cross-examined.

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102. RW-1 admitted that he had given anesthesia to the patient and that he attended the patient from 13/07/2018 9.30 p.m., to 14/07/2018 10.55 a.m. RW-3 admitted that he had no personal knowledge about the condition and complications of the patient prior to my attending the patient and that he has not explained about the high risk of the patient to the attendants. RW-3 stated that Anesthesia was given twice to the patient and that general anesthesia was given as per requirement for the second time. RW-3 denied the suggestion that, overdose anesthesia was given to the patient. RW-3 stated that Patient died due to pulmonary thromboembolism. RW-3 admitted that none of the doctors have suggested the patient or her attendants to shift for any better hospital and that he had been charged for the offence U/s 304-A for the death of the patient herein. RW-3 admitted that it is mentioned in CPR notes that at about 10:20 a.m., the patient suddenly become unresponsive with absent central and peripheral pulses. RW-3 denied that the patient was hale and healthy at the time of admission in our hospital. RW-3 admitted that their Gynecologist have informed the patient that she would have normal delivery. RW-3 denied that, the case sheet was tampered subsequent to the death of the patient and that the patient died due to their gross negligence and improper treatment against the protocols. RW-3 admitted that the Police have charged for the offence U/s 304-A IPC. after obtaining the opinion of Medical Board.

103. Dr.Maruthi Ramakrishna Rao was examined as RW-4 and filed Chief Affidavit.

104. RW-4 stated that he is the General Physician in Emergency Department and he attended the patient Swathi at about 5.30 in the morning on 13/07/2018. RW-4 admitted that he was informed by the hospital authorities that the patient's condition was unstable, as such he attended the patient. RW-4 admitted that he I visited the patient for the first time, the patient was on ventilation and that he is the accused No.3 in the Police case

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registered on account of death of the deceased patient, for the offence U/S 304-A IPC and that he had gone through the Post Mortem Report. As per the PME Report, in the injuries column, it is mentioned that there is massive blood collection near the uterus of the patient. RW-4 admitted that it is not recorded in the case sheet about the presence of blood collection near the uterus. Witness adds that as it was not there, they have not recorded the same. RW-4 denied that the case sheet was prepared after the death of the deceased to escape from the liability. RW-4 admitted that, basing on the Report submitted by the above said Committee, he and other doctors, who attended the patient were charged for the offence U/S 304-A of IPC. RW-4 denied that the patient died due to negligent treatment of our doctors including myself, who attended the patient.

105. The Complainant No.1 and 2 are the husband and son of late Asnala Swathi and being represented by the GPA Holder Sappidi Sathyanarayana, who is the father of the deceased Swathi. It is submitted that Swathi was pregnant and she was under the observation of Opposite Party No.5 hospital and doctors. The Opposite Parties No.1 and 2 have conducted all the tests, scanning and did regular check-ups to confirm that the patient and the baby in the womb are good and regularly noted the blood pressure and took all the necessary measurements to keep the patient well and in good condition. Swathi was admitted in the hospital on 13/07/2018 and all the necessary tests were taken and the Opposite Party No.1 administered medicine for labour pain, but as the delivery could not be done in normal way, the patient's family members were informed that operation is required to be done and Swathi was shifted to operation theatre at 10-00 p.m. on 13/07/2018. Opposite Party No.4 administered anesthesia at about 10-55 to 11-00 p.m., and Swathi delivered baby boy through C-Section. Later, at 12-00 a.m., the patient was shifted to post operative ward and at that time, Opposite Party No.2 and 3 and some other junior doctors were present. The patient was unconscious. The family members were informed that Opposite

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Party No.3 administered anesthesia for the second time as the patient regained consciousness and did not allow the doctors to complete the sutures. Even by 5-00 a.m., on 14/07/2018 Swathi did not regain conscious and the family members were anscious about the condition of the patient as the patient did not regain conscious even by 8-00 a.m., and they were informed blood transfusion is required and blood was got by the family members. It was found that transmission could not be taken place and the blood stopped clotting and there was no urine output. At 9-00 a.m., Opposite Party No.1 informed that patient had gone into coma. At 10-00 a.m., when the relatives of the Complainant went to see Swathi, they found that Swathi had already died and Opposite Party No.1 and 2 replied that operation was successful, but she could not be saved. The Complainants submitted that it was due to sheer negligence, carelessness and fault of the Opposite Parties in not giving proper care and treatment with due diligence and administering anesthesia in abnormal doses, resulted in death of Swathi.

106. The GPA Holder after the death of Swathi, lodged a complaint, upon which the Police, Narkatpally registered a case in Cr.No.122/2018, vide Ex.A-9. The Police, Narkatpally called for the Casesheet from KIMS Hospital, Narkatpally. The Medical Superintendent, KIMS Hospital has supplied the Casesheet to the Police, Narkatpally, vide Ex.A-3 and also issued Ex.A-6, i.e. Post Mortem Examination and the doctors opined that the cause of death is due to Hemorrhagic Shock. Ex.A-7 is the FSL Report, which states that 'no poisonous substance found in the items 1 to 4'. Ex.A-22, which is the Proceedings for Constitution of Committee for Causing Enquiry into Medical Negligence Cases, consisting of District Collector as Chairman, Medical Superintendent of District Hospital, District Coordinate Health Services, Nalgonda, District Medical & Health Officer, Nalgonda, General Physician/HOD, District Hospital, General Surgeon/HOD, District Hospital, Anesthetist/HOD, District Hospital as Members.

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107. The Police further sent a letter to Government Maternity Hospital, Sultan Bazar, Hyderabad for medical opinion over the death of Swathi. Ex.A-26 is the Medical Opinion of Government Maternity Hospital, Sultan Bazar, Hyderabad, who has given detailed report on perusal of the Casesheet and the treatment done at KIMS Hospital to Swathi. The Report also mentioned about re-writings in findings and variations in the line of treatment given to Swathi by Opposite Parties No.1 to 4. The report also mentioned that there is discrepancy noted between the findings in the Casesheet which is showing Uterus well retracted with clear dressing, ultra sound lower abdomen and pelvis is not documented contrary to the PME Report is showing massive broad ligament hematoma and hematoma below the rectus sheath. The Police, Narkatpally filed Ex.A-30, i.e. Chargesheet, had charged Opposite Parties No.1 to 4 under medical negligence U/s 304-A IPC. It reveals that the Opposite Parties No.1 to 4 have negligently treated the patient Swathi giving rise to high risk and unable to manage the high risk, due to which Swathi died.

108. RW-3, who is Anesthetist admitted that he had given anesthesia twice to the patient and he had admitted that he had no personal knowledge about the condition and complications of the patient prior to his attending the patient. This shows that there was no coordination between the doctors, i.e. Opposite Parties No.1 to 4 in treating the patient Swathi.

109. The Opposite Parties had filed Ex.B-1, which is the decision of the Medical Council, had summoned for the enquiry report along with other documents. The Ethics Committee after going through the enquiry report submitted by the Complainants has noted that there was no negligence on the part of treating doctors. The Ethics Committee without discussing the findings of the enquiry report and without giving the reasons for finding Opposite Parties No.1 to 4 not negligent in treating the patient Swathi and had closed the case that there was no negligence on the part of treating doctors and directing the Opposite Parties No.1 to 4 doctors to maintain

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the records properly in future. The Ethics Committee had overlooked the findings of the enquiry report and given the finding that there was no negligence amounts to biased judgmental decision. The Opposite Parties No.1 to 4 have stated that there were normal condition of the patient in all the investigation reports since the conceivement till delivery and it was found to be sudden hypertension and hypothyroidism, which led to high risk to the patient and Opposite Parties No.1 to 4 have detected pulmonary embolism and as per Anesthesia Report recorded by Opposite Party No.3, wherein it is mentioned that there was HELLP Syndrome Amniotic Fluid Embolism and also the high risk informed consent has also the recordings.

110. As per Case Summary, i.e. Ex.A-5, the mmediate cause of death is due to Refractory hypotension with severe metabolic acidosis with severe coagulopathy, antecedent cause is due to cardiogenic shock with pericardial tamponade with presence of amniotic fluid/Thromboembolism. Thus, the above factors were not managed and Opposite Parties No.1 to 5 have failed to give right treatment in order to save the patient. It is only due to sheer negligence and improper treatment that Swathi had lost her life.

111. The Opposite Party No.3 had administered anesthesia twice, i.e. spinal anesthesia and other general anesthesia, which is against the protocol of C-Section delivery. Generally, anesthesia is regional like spinal or epidural, to numb the lower part of the body, but in the instant case, there is overdose of anesthesia that the patient did not regain conscious for more than 24 hours and Opposite Party No.3 administered anesthesia without knowing the condition of the patient nor verifying from other doctors' notes. As such, it proves that there is no coordination between the doctors in treating the patient.

112. The finding of the Ethics Committee is only an advisory nature, but not expert opinion. As such, the report of Ethics Committee cannot be considered and believed. There is clear

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findings with regard to discrepancies of the Casesheet and PME Report. Thus, the principle of res-ipso-loquitor is applicable as the record itself speaks about the negligence and improper treatment given by the Opposite Parties No.1 to 4 of Opposite Party No.5 hospital, as there were variations in findings in Ex.A-6, i.e. P.M.E. Report and in the Chargesheet, i.e. Ex.A-30.

113. In a decision reported in IV (2023) CPJ 9 (NC), between Baby Samhitha K.S. and 2 others Vs. Cloud Nine and 2 others, the Hon'ble National Commission observed that: Medical Negligence – Caesarean LSCS delivery – Cardiac failure – Termination of pregnancy should have been done at 37 weeks, but delivery was delay beyond 38 weeks despite uncontrolled hypertension – Before C-Section treating doctors failed to conduct necessary investigations like Coagulation profile, LFT, RFT and Opthalmic examination – Patient was pre-eclamptic, showing high blood pressure after C-Section – After C-Section she should have been kept under strict observation and discharged after 72 hours – Patient developed breathlessness two days after delivery and taken to OP-1 in wee hours – OPs have just suspected it as asthma and gave nebulization with Duolin and Budacort – Basic investigations like x-ray chest was not done to rule out pulmonary oedema at that stage – OPs failed to diagnose possibility of amniotic fluid embolism – Medical negligence is attributed to OPs – OPs-1 & 2 were duty bound to treat the patient with reasonable degree of skill, care, but they failed to exercise due care and diligence which constitutes medical negligence – OP-1 hospital is vicariously liable for the acts of OPs-2 & 3, who failed in their duty of care – Compensation – Deficiency in service – Basis of computing compensation under common law lies in principle of restitution in integram' which when translated refers to ensuring that person seeking damages due to wrong committed to him/her is in a position that he/she would have been had wrong not been committed – Young doctor lost her precious life at 31 years, left behind husband, minor girl child and aged father – There is no

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straight jacket formula for award of compensation, but it is difficult to quantify value of human life in monetary terms – Ends of justice would be met if the Complainants are compensated with compensation of Rs.1 Crore along with Rs.1 Lakh as litigation costs, which appear to be just and adequate.

114. In the case of Smt.Savith Garg Vs. The Director, National Heart Institution IV (2004) CPJ 40 (SC), the Hon'ble Supreme Court observed that once an allegation is made that the patient was admitted in a particular hospital and evidence is produced to satisfy that he died because of lack of proper care and negligence, then the burden lies on the hospital to justify that there was no negligence on the part of treating doctor or hospital.

115. In a decision reported in IV (2013) CPJ 63 (SC), between P.B.Desai Vs. State of Maharashtra and another, the Hon'ble Supreme Court observed that: A breach of any duty gives rise to right of action for negligence to the patient.

116. The above citations are relevant and applicable to the present facts of the case. In the instant case, the Opposite Parties No.1 to 4 were duty bound to treat the patient with reasonable degree of skill, care, but they failed to exercise due care and diligence, which constitutes medical negligence. It is evident that the patient treated with ventilators, but Opposite Parties have ignored the possibility of pulmonary embolism and the findings in case sheet are contrary to the PME Report, showing massive broad ligament hematoma and hematoma below the rectus sheath. The administering of anesthesia twice to the patient also gave rise to high risk in causing the death of the patient. Therefore, Opposite Parties have failed to treat the patient according to the medical protocol and due to the negligence, Swathi, a 23 years old young woman lost her precious life leaving behind minor son, i.e. Complainant No.1 and her husband, i.e. Complainant No.2 and her father, i.e. GPA Holder. The loss of Swathi cannot be

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compensated in any monetary terms. The Opposite Party No.5 hospital is vicariously liable for the acts of the Opposite Parties No.2 to 4 who failed in their duties.

117. POINT Nos.2 & 3:

In view of the above said reasons, the Complainants are entitled for compensation of Rs.100,00,000/- along with costs.

In the result, the complaint is allowed in part, directing the Opposite Party No.5 Hospital, i.e. Kamineni Institute of Medical Sciences Hospital, Nalgonda to pay Rs.100,00,000/- [Rupees One Crore only] towards compensation and Rs.1,00,000/- [Rupees One Lakh only] towards litigation costs to the Complainant No.1 and the GPA Holder.

i) Out of the awarded compensation, an amount of Rs.90,00,000/- [Rupees Ninety Lakhs only] shall be fixed deposited in any Nationalized Bank in the name of Asnala Devansh Showrya, i.e. Complainant No.1 until he attains majority. The GPA Holder can withdraw periodic interest for care and welfare of the child.

ii) The remaining compensation amount of Rs.10,00,000/- [Rupees Ten Lakhs only] shall be paid to the GPA Holder.

iii) Rs.1,00,000/- [Rupees One Lakh only], i.e. the costs of the litigation shall be paid to the GPA Holder.

iv) The entire awarded amount shall be paid within 30 days from the date of receipt of this order, failing which, it will carry interest @ 9% p.a. till its realization.

Dictated to Steno-Typist, transcribed by him, corrected and pronounced by us in the open Commission on this 30th day of October, 2025.

FEMALE MEMBER MALE MEMBER PRESIDENT

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APPENDIX OF EVIDENCE
WITNESSES EXAMINED

For Complainant:	**For Opposite Parties:**
Chef Evidence by way of Affidavit of GPA holder of the Complainants along with Cross Examination recorded as **PW-1.**	Chief Evidence by way of Affidavit of Opposite Party No.1 along with Cross Examination recorded as **RW-1.**
PW-1: GPA Holder of the Complainants. (Sri Sapidi Sathyanarayana)	Chief Evidence by way of Affidavit of Opposite Party No.2 along with Cross Examination recorded as **RW- 2.**
	Chief Evidence by way of Affidavit of Opposite Party No.3 along with Cross Examination recorded as **RW- 3.**
	Chief Evidence by way of Affidavit of Opposite Party No.4 along with Cross Examination recorded as **RW-4.**
	[**RW-1:** The Opposite Party No.1]. [**RW-2:** The Opposite Party No.2]. [**RW-3:** The Opposite Party No.3]. [**RW-4:** The Opposite Party No.4].

EXHIBITS MARKED

For Complainants:

Ex.A-1	Dt.21/01/2021	Original General Power of Attorney.
Ex.A-2	Dt.25/07/2018	Photostat copy of Death Certificate of the deceased Asnala Swathi.
Ex.A-3	--	Photostat copy of Letter, issued by the Superintendent, KIMS Hospital, Narkatpally, regarding submission and furnishing the information about the Case Sheet in respect of the deceased Asnala Swathi.
Ex.A-4	Dt.09/07/2018	Photostat copy of Admission Record of the deceased Swathi, issued by KIMS Hospital, Narkatpally.
Ex.A-5	--	Photostat copy of Case Summary of the deceased Swathi, issued by KIMS Hospital, Narketpally.

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Ex.A-6	Dt.14/07/2018	Photostat copy of Post Mortem Examination (P.M.E.) Report.
Ex.A-7	Dt.15/10/2018	Photostat copy of Telangana State Forensic Science Laboratories Report/Opinion (FSL Report).
Ex.A-8	Dt.14/07/2018	Photostat copy of Inquest Report.
Ex.A-9	Dt.14/07/2018	Photostat copy of F.I.R., in Crime No.122/2018 of PS.Narkatpally along with complaint.
Ex.A-10	--	Photostat copy of News Paper article.
Ex.A-11	Dt.01/08/2018	Photostat copies (3) of News Paper article.
Ex.A-12	Dt.24/11/2017	Photostat copy of Medical Prescription, issued by People's Hospital, Patancheru.
Ex.A-13	Dt.06/02/2018	Photostat copy of Medical Prescription, issued by People's Hospital, Patancheru.
Ex.A-14	Dt.17/02/2018	Photostat copy of Targeted Imaging For Fetal Anomalies (TIFFA) Report, issued by Shatayu Diagnostics, Chanda Nagar, Hyderabad.
Ex.A-15	Dt.02/03/2018	Photostat copies of Medical Reports of the deceased Swathi, issued by People's Hospital & Diagnostics, Patancheru.
Ex.A-16	Dt.03/03/2018	Photostat copy of Fetal Echo Report, issued by Shatayu Diagnostics, Chanda Nagar, Hyderabad.
Ex.A-17	Dt.05/04/2018	Photostat copy of Out Patient Details, issued by Happy Hospital, Hyderabad along with Medical Reports.
Ex.A-18	Dt.22/05/2018	Photostat copy of Medical Prescription, issued by People's Hospital, Patancheru, Hyderabad along with Medical Reports.
Ex.A-19	Dt.19/06/2018	Photostat copy of Medical Prescription, issued by Apollo Hospital, Hyderabad, along with Lab Tests Invoice and Medical Reports.

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Ex.A-20	Dt.27/06/2018	Photostat copy of IP/OP Ticket along with Investigations Requisition Form, issued by KIMS Hospital, Narkatpally, Nalgonda District.
Ex.A-21	Dt.14/07/2018	Photostat copy of Liver Function Test Report along with Serum Electrolytes Report, issued by Prasad Diagnostic Center, Nalgonda.
Ex.A-22	Dt.16/11/2019	Photostat copy of Note submitted to the District Collector, Nalgonda regarding constitution of Committee for causing enquiry into Medical Negligence Cases.
Ex.A-23	Dt.29/06/2020	Photostat copy of Demand Draft for Rs.4,000/-, drawn in favour of Hon'ble State Commission, drawn on SBI, Chityal Branch towards fee.
Ex.A-24	Dt.19/08/2020	Original Certificate, issued by the Hon'ble State Commission, Hyderabad, regarding filing of CC (SR) No.1598/2020 along with DD by Sri Sapidi Sathyanarayana.
Ex.A-25	Dt.24/08/2020	Original Order passed by the Hon'ble State Commission, Hyderabad in CC.(SR) No.1598/2020.
Ex.A-26	Dt.07/03/2022	Certified copy of Medical Opinion over the death of Swathi, given by Enquiry Committee.
Ex.A-27	Dt.09/03/2022	Certified copy of letter addressed by the Superintendent, Govt.Maternity Hospital, Sultan Bazar, Hyderabad to the Commissioner, Telangana Vaidhya Vidhana Parishad, Hyderabad.
Ex.A-28	Dt.14/07/2018	Certified copy of Scene of Offence Panchanama along with sketch map.
Ex.A-29	Dt.12/04/2023	Certified copy of Section Alteration Memo submitted by the Police, Narkatpally to the JFCM, Nalgonda.
Ex.A-30	Dt.22/05/2023	Certified copy of Chargesheet.

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For Opposite Parties No.1 to 5:

Ex. B-1	Dt.23/12/2023	Attested copy of Order/Decision Passed by the Council General Body/Telangana State Medical Council in the Complaint of Sri Sapidi Sathyanarayana against Dr.Madhavi and Others.

PRESIDENT
DISTRICT CONSUMER DISPUTES
REDRESSAL COMMISSION,
NALGONDA

Order Pronounced on :

Copy made ready on :

Dispatch Number & Date :

Free copy of order furnished to the Complainant/s on :

Free copy of order furnished to the Opposite Party/Parties on :