NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION
NEW DELHI

FIRST APPEAL NO. 501 OF 2008

(Against the Order dated 30/09/2008 in Complaint No. 25/2001 of the State Commission Kerala)

1. ABHISHEK V.S. & ORS.
(Minor, Represented by Dr. Satish B, Uncle (R-3) TC 13/1827(58), Smriti, Kalakaumudi Road, Medical College P.O
Trivandrum - 695 011
Kerela.
2. VISHNU V.S. (MINOR)
Represented by Uncle Dr. Satish B. TC 13/1827(58), Smriti, Kalakaumudi Road, Medical College P.O
Trivandrum - 695 011
3. DR. SATISH B.
TC 13.1827 (58), Smriti, Kalakaumudi Road, Medical College P.O
Trivandrum - 695 011 .....Appellant(s)

Versus

1. K.V.M. HOSPITAL & ORS.
Represented by Dr. Haridas, M.D. Chief Medical Officer, K.V.M. Hospital, Cherthala
Kerala
2. DR. MOHAN PAUL, MBBS (CASUALTY MEDICAL OFFICER)
Department of Physiology, Government T.D. Medical College,
Alappuzha
Kerala
3. DR. KURUVILLA, MS, MCH
Plastic Surgeon, Mary Queens Hospital, Kanjirapally,
Kottayam
Kerala
4. DR. PYARILAL, MD
(Anesthetist), K.V.M. Hopsital, Cherthala
Kerala
5. DR. HARRIS, MD
(Anesthetist) K.V.M. Hospital, Cherthala
Kerala
6. DR. KAMATH, MS
(Orthopedic Surgoen) K.V.M. Hospital, Cherthala
Kerala
7. DR. RAVINDRAN NAIR, MDS
(Facio Maxillary Surgeon) Alleppy Medical College, Alappuzha
Kerala .....Respondent(s)

BEFORE:

HON'BLE MR. JUSTICE R.K. AGRAWAL,PRESIDENT
HON'BLE DR. S.M. KANTIKAR,MEMBER

For the Appellant : Appeared at the time of arguments
For the Appellants: Mr. Raghenth Basant, Advocate

For the Respondent : Appeared at the time of arguments
For the Respondents: Ms. Preetha John K., Advocate for R-1
Mr. K.K. Vinosh, Advocate for R-2
Ms. Sweena Nair, Advocate for R-3 to 6
Mr. Jaimon Andrews, Advocate for R-7

Dated : 01 Jun 2022

ORDER

Pronounced on: 1st June 2022

ORDER

DR. S. M. KANTIKAR, MEMBER

1. The instant Appeal is preferred by the Appellants/Complainants (Abhishek & Ors.) under Section 19 of the Consumer Protection Act, 1986 against the impugned Order dated 30.09.2008, passed by the Kerala State Consumer Disputes Redressal Commission (hereinafter referred to as the "State Commission"), wherein the Complaint was dismissed.

2. The Complainants are minor sons of the deceased - Dr. Sudha. They have filed the Complaint through their uncle Dr. Satish (Complainant No.3). The Opposite Parties consist of K.V.M. Hospital, Cherthala and the treating doctors. For the convenience, the Parties are being referred to their position as before the State Commission.

3. Brief facts are that on 30.12.1999, in a major road accident, three persons suffered injuries and they were brought to K.V.M Hospital (hereinafter referred to as the "Opposite Party No. 1"). One Dr. Sudha (since deceased, hereinafter referred to as the "patient") was examined by the doctors. Her face and neck was swollen, she suffered maxillo facial injuries. The C.T. scan of head revealed no significant intra-cranial injury. Patient's X-ray of the neck and chest were done, but the fracture of the 6th cervical vertebra was not seen. However, it was informed that her condition was not serious. It was alleged that the Opposite Party No. 7, Dr. Ravindran Narain performed the wiring procedure with the help of the Opposite Parties Nos. 3 to 6 for the fractured maxilla. During the procedure, there was a sudden spurt of bleeding, which caused airway obstruction and the patient died due to oxygen insufficiency. It was further alleged that the doctors failed to secure patient's airway; prior to the wiring and they rather performed tracheostomy or Intubation. The Postmortem (PM) report of the deceased clearly showed that the patient's air passage was full of blood and her finger nails were blue which was suggestive of her death due to hypoxia (oxygen insufficiency). Alleging medical negligence by improper clinical evaluation and wrong treatment from the Opposite Parties, the Complainants filed a complaint before the State Commission seeking compensation of Rs. 20,00,000/- with 12% interest under different heads.

4. The Opposite Parties Nos. 3 to 6 filed a joint reply and denied the allegations leveled against them. OP-1 & 2 filed separate written versions. The contention of the Opposite Parties Nos. 1 & 2 was that the patient had major facio-maxillary fractures with bleeding from mouth and nostrils at the time of admission. The Opposite Parties Nos. 3 to 6 submitted that the First Aid procedure of wiring of the Maxilla was performed by the Opposite Party No. 7 with the assistance of the Opposite Parties Nos. 3, 4 and 5. The Opposite Party No. 3 was the plastic surgeon/general surgeon, the Opposite Party No. 4 was the Anesthetist and the Opposite Party No. 5

was also an Anesthetist of the Opposite Party No. 1 Hospital. They had conducted all emergency investigations including blood investigations, X-ray of the skull including upper cervical spine and C.T. scan of the head with scanogram of the upper cervical spine. The Opposite Party No. 7, Dr. Ravindran Nair was called from Medical College, Alleppey to attend the patient; as the facio-maxillary surgeon, who was attached to the hospital was out of station and the relatives of the patient were not willing to shift the patient to some other hospital. The Opposite Parties Nos. 3 to 6 also submitted that the patient was fully conscious and well oriented and answered all the questions regarding previous history. On examination, the airway was patent and the patient did not experience any difficulty in breathing. Moreover, at the time when the patient was taken to the Operation Theatre, the bleeding was not active. The Opposite Party No. 5 discussed with the patient (herself being a doctor) regarding possible need of a tracheostomy, she gave only guarded consent to go ahead in case of absolute necessity. Hence, it was the consent given only for First Aid under a local anesthesia to prevent further bleeding from the maxillary fracture and then to shift her to another center for definitive surgery. It was further submitted that the condition of the patient did not warrant tracheostomy or any intubation as she had no difficulty in breathing before or during the First Aid procedure. As the wiring was near to complete, the patient complained of breathlessness due to severe bronchospasm. As mask ventilation was difficult, the Opposite Party No. 4 tried auro-tracheal intubation, but it was difficult to visualize the larynx through laryngoscope. The Opposite Party No. 3 was asked to proceed with an emergency tracheostomy. The procedure became practically difficult as the patient was struggling. Oro-tracheal intubation was tried again and intubated. But it was impossible to ventilate through the tube as the 'bag' was too tight, due to severe Bronchospasm (Reflex Shrinking of lumen of the air passages). Immediate and prompt measures were taken to facilitate ventilation, including endotracheal suction and bronchodilator drugs. As the ventilation through the oro-tracheal tube was still difficult, the Opposite Party No. 3 again proceeded with tracheostomy with the help of an ENT Surgeon, a colleague of the Patient who volunteered to come in and help. The patient developed cardiac arrest and immediately cardio pulmonary resuscitative (CPR) was started.

5. The State Commission dismissed the Complaint. Being aggrieved, the Complainants filed the instant Appeal.

6. We have heard the arguments from both the sides and perused the entire record.

7. The learned Counsel for the Complainant vehemently argued that the death would not have occurred in the present case if the basic precautions were undertaken by the Opposite Parties. The State Commission dismissed the Complaint by merely holding it as an 'error of judgment.' It observed that "if there was an error of judgment in not resorting to tracheostomy earlier, the same cannot be treated as negligence on part of the opposite party doctors."

8. The learned Counsel for the Complainant further argued that the treating doctors have not examined the patient properly and failed to do complete investigations. The patient's neck movements were examined without taking X-rays of neck and chest. They acted casually and failed to do proper airway assessment and active steps to protect the airway prior to the major surgical procedure. He further argued that the maxillo-facial surgery was absolutely not necessary, but the doctors told it was to control the bleeding from the oral cavity, but in fact, there was no active bleeding. The life of the patient could have been saved by tracheostomy or intubation which could have secured the airway. The airway management was not done by ENT Surgeon, but it was done by inexperienced doctors. Thus, it was not standard of practice in the instant case of maxillo-facial injuries. As per the Medical Record, on putting the incision for tracheostomy, there was gushing out of blood from trachea, which indicates the patient aspirated blood into lungs and death was due to suffocation. The learned Counsel relied upon the following judgements:

Srimannarayana A. v. Dasari Santakumari & Anr., 2013 (9) SCC 496,

Jacob Mathew v. State of Punjab & Anr., 2005 (6) SCC 1 ,

Martin F. D'Souza v. Mohd. Ishfaq, 2009 (3) SCC 1

Minor Marghesh K. Parikh v. Dr. Mayur H. Mehta, 2011 (1) SCC 31

Kishan Rao V. v. Nikhil Super Speciality Hospital & Anr., 2010 (5) SCC 513

Samira Kohli v. Dr. Prabha Manchanda and Another, 2008 (2) SCC 1;

Nizam Inst. of Medical Science v. Prasanth S. Dhananka & or, 2009 (6) SCC 1,

State of Haryana v. Santra, 2000 (5) SCC 182;

Bolam v. Friern Hospital Management Committee (1957 (2) ALL ER 118;

State of Haryana v. Santra, 2000 (5) SCC 182

Ashish Kumar Mazumdar v Aishi Ram Batra Charit. Hosp Tr. 2014 (9) SCC 256

9. The learned Counsel for the Opposite Party No. 1 (Hospital) argued that on 30.12.1999, at around 2:45 PM, three persons were brought to the casualty with severe injuries sustained in road traffic accident. Dr. Mohan Paul, the Casualty Duty Doctor attended the patients and called the other doctors to attend the emergency to injured persons. However, Mr. Vijayakumar Nair succumbed to the injuries. The instant patient - Dr. Sudha was conscious at the time of admission, who gave information about the injured persons. On examination, she suffered severe facio maxillary fracture with bleeding from mouth and nose. X-ray of the skull including upper cervical spine and CT scan of head with scanogram and blood investigations were done immediately to know the gravity of injuries. She was attended by a team of doctors including the Opposite Parties Nos. 2 to 7. The X-Ray chest revealed no chest injury and she had no breathing difficulties. The air entry was fair and equal on both sides. There was no neck rigidity and her limb movements were normal. Intermittent throat suction was carried out. In the oral cavity, right upper incisor tooth was missing and the dental surgeon tried to trace the missing tooth. However, there was no sign that the said tooth had entered into the lungs.

10. It was further submitted that after relevant investigations, immediately around 5 P.M., maxillo- facial surgical reference was made to attend the fracture. There was non-availability of maxilo facial surgeon in the Opposite Party Hospital and the patient's attendants were not willing to take the patient to higher centre. Therefore, the maxilla- facial surgeon Dr. Ravindran Nair (the Opposite Party No. 7) was called from Alleppey Medical College. After clinical evaluation of the patient, Dr. Ravindran decided for the First Aid procedure of wiring of upper jaw teeth and suturing under local Anesthesia. Same was discussed with the patient, who gave an oral consent only for First Aid to prevent further bleeding from the maxillary fracture and then to shift her to another higher centre for proper surgery. Therefore, no major surgery was planned. Clinically, the doctors never felt any need and the condition of the patient did not warrant for intubation or tracheostomy as the air entry was fair and equal on both sides and she had no difficulties in breathing before or during the first aid procedure. At the end of the First Aid procedure, the patient complained of breathlessness and immediate steps were taken as per medical protocol including tracheostomy.

11. The learned counsel for the Opposite Parties further submitted that the Appellants deliberately suppressed the compensation of Rs.19,30,627/- received from the National Insurance Company as awarded by MACT, Ernakulum.

12. We gave our thoughtful consideration to the arguments on both the sides and the material on record, *inter-alia,* the Order of State Commission.

13. On considering the totality and the sequence of events of the case, admittedly the patient suffered maxillo-facial injuries in the road accident. It was an emergency. The patient was taken to casualty at the Opposite Party hospital as an emergency. She herself was a doctor and attended by the team of doctors from Orthopedics, Dental and Maxillo-Facial surgery. On examination faciomaxillary injuries noted, however, the patient had no chest injury or breathing difficulty; therefore, X-ray chest was not taken. There was no neck rigidity and her limb movements were within normal limits.

14. Immediately, all the necessary investigations including blood tests, X-ray of the skull including upper cervical spine and C.T. scan of the head and the upper cervical spine were done. There were no intra cranial injuries, but serious maxillary fractures injuries noted and the patient was referred to faciomaxillary surgeon. As per the general protocol, there was need to reduce the fracture within 5 hours to 5 days. The faciomaxillary surgeon attached to the hospital was out of station and the relatives of the patient were not willing to shift the patient to some other hospital. Therefore the Opposite Party No. 1 Hospital requested the Opposite Party No. 7 from Medical College, Alleppey to attend the patients.

15. From the clinical notes, it is apparent that the patient was fully conscious and well oriented and answered all the questions regarding previous history. The condition of the patient was stable. On examination, the airway was patent and the patient did not experience any difficulty in breathing. Moreover, at the time when the patient was taken to the operation theatre, the bleeding was not active.

16. The P.W.4 was an ENT Surgeon and the expert has stated that the best judge to decide whether the tracheostomy to be done or not, is the attending doctor and incubation would not have been possible as the procedure of wiring was to be done in the oral cavity by the maxillo facial surgeon. The subjective variables as patient being stable influenced the decision of the doctors as tracheostomy was not an easy procedure. The failure to take the X-ray of the chest cannot be considered to be a serious lapse considering that Opposite Party No. 7 and the dental surgeon had made all the attempts to trace the missing tooth and that if the tooth had entered the lungs there would have been a violent reaction.

17. The Opposite Party No. 7 performed wiring procedure. He asked the Opposite Parties Nos. 4 and 5 to stay stand by, if general anesthesia needed. At the completion of FIRST-AID procedure, the patient complained of breathlessness. On examination, the patient was suffering from severe bronchospasm. Mask ventilation being difficult due to the injuries sustained by the patient, the Opposite Party No. 4 tried oro-tracheal intubation, but difficult to visualize the pharynx through the laryngoscope. The procedure became difficult as it was impossible to ventilate through the tube as the bag was too tight. Therefore, emergency measures like endotracheal suction done and bronchodilator drugs were administered. Further the Opposite Party No. 3 proceeded for tracheostomy with the patient's one colleague E.N.T surgeon.

18. The learned Counsel for the Opposite Parties vehemently argued that the Complaint was not maintainable before the State Commission. The first ground was that the services rendered by the hospital were on humanitarian grounds without any monetary gains. The hospital had neither demanded nor the Appellants made any payments to the hospital till date. Secondly, the Complainants received the insurance claim of Rs. 19,30,627/- as awarded by MACT, Ernakulum. Therefore, the Complainants are estoppeled to claim compensation under the CPA, 1986.

Medical Literature on 'ABC' Trauma Management:

19. To understand more about the management of trauma/ injuries due to high velocity accidents, we have gone through the Standard medical text books and literatures on the subject. The first priority in the care of all trauma patients is the affirmation of a patent airway to ensure adequate oxygenation and ventilation. The **ABCs of trauma resuscitation** begin with the airway evaluation, and effective airway management is imperative in the care of a patient with critical injury. Patients may require emergency tracheal intubation (ETI) for various reasons following injury including hypoxia, hypoventilation, or failure to maintain or protect the airway owing to altered mental status. However, the straightforward decision to intubate depends on multiple factors of the case. During the early phases of resuscitation, due to deteriorated clinical status of patient airway management is difficult. The decision to intubate may go well beyond a patient's ability to oxygenate or ventilate. Therefore, the decision is not only whether a patient needs intubation but also when and how to intubate. Delays in adequate airway management may have devastating consequences, and this is one of the more common causes of preventable death in both the pre hospital and the emergency department setting. In one study it revealed that even for patients that are initially stable, a delay in intubation is associated with increased mortality from 1.8% to 11.8%. In addition, ETI has the potential to cause secondary injury if performed inadequately or unsuccessfully by creating or exacerbating hypoxia or hypotension.

Advanced Trauma Life Support (ATLS) Protocol:

20. Since 1979, the Lincoln Medical Education Foundation, together with the University of Nebraska founded local courses aiming at teaching Advanced Trauma Life Support (ATLS) to doctors. It has been shown to be an effective teaching course in both developing and developed countries. Today ATLS is the internationally recognised standard for the initial assessment and management of serious injury. The systematic approach in the ATLS course increases speed and accuracy of resuscitation. The training imparted in identical format world-wide consists of:

Resuscitation and primary survey

A = Airway maintenance with Cervical spine protection

- Establish a clear airway **protecting the cervical spine at all times**. Definitive airway is established if the patient is unable to maintain integrity of airway.
- Cervical spine protection is vital and patient can lose his life due to spinal injuries if not from original trauma.

B = Breathing and Ventilation

High-flow oxygen through a mask is provided if patient is not intubated.

C = Circulation with Bleeding control

Blood loss is the main preventable cause of death after trauma. This is because even if the airway is maintained, severe haemorrhage results in loss of life.

D = Disability: Neurological examination

After A, B and C, a rapid neurological assessment is done to rule out head injuries, spinal injuries or paralysed limbs of organs.

X-RAYS are mandatory in high velocity accidents and must be done as soon as patient`s airway and blood volume is stabilised, X-rays recommended being:

- X-ray of Neck (Cervical spine)Lateral
- X-ray of Chest
- X-rays of Pelvic

Secondary survey

Once there is normalisation of vital signs, it is essential to conduct repeated head-to-toe examination with reassessment of vital signs and do further investigations as necessary. Once patient is stabilised further CT scans of neck, chest, abdomen and pelvis can be undertaken as necessary.

Discussion with ref. to Precedents and medical literature:

21. From the literature, it is evident that the treating doctors in the instant case failed to do the basic of ABC protocol for high velocity trauma management, thus it was their failure in the duty of care. In our view, the State Commission erred to observe the duty of doctors therein and merely holding it as an 'error of judgment', dismissed the Complaint and observed as below:

> "if there was an error of judgment in not resorting to tracheostomy earlier, the same cannot be treated as negligence on part of the opposite party doctors."

22. It is relevant to quote the Judgment of House of Lords/English Courts in ***Whitehouse vs. Jordan,***[1], which ruled that:

> "The true position that an error of judgment may or may not be negligent it depends on the nature of the error. If it is not one that would not have been made by a reasonable competent professional man professing to have the standards and type of skill that the defendant held himself out as having, and acting with ordinary care, then it is negligence, if on the other hand, it is an error if such a man, acting with ordinary care, might have made, than it is not negligence".

Thus, in our considered view, the instant case is not an "Error of Judgment" but the breach in duty of care from the doctors, who treated the patient. Resultantly, the patient died.

23. We further note that the treating doctors failed in their duties to act with reasonable degree of skill and knowledge. They have not exercised a reasonable degree of care to handle the emergency by adopting basics of ABC of trauma. This view dovetails from the judgment of Hon'ble Supreme Court in the case of **Dr. Laxman Balkrishan Joshi Vs Dr. Trimbak Bapu Godbole and Anr.** [2], it was observed as below:

"The duties which a doctor owes to his patient are clear. A person who holds himself out ready to give medical advice and treatment impliedly undertakes that he is possessed of skill and knowledge for the purpose. Such a person when consulted by a patient owes him certain duties, viz., a duty of care in deciding whether to undertake the case, a duty of care in deciding whether treatment to give or a duty of care in the administration of that treatment. A breach of any of those duties gives a right of action for negligence to the patient. The practitioner must bring to his task a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. Neither the very highest nor a very low degree of care and competence judged. In the light of the particular circumstances of each case is what the law requires. The above principle was again applied by this court in the case of **A.S. Mittal and Ors. vs. State of U.P. and Ors**. (AIR 1989 SC 1570). It observed "A mistake by a medical practitioner which no reasonably competent and a careful practitioner would have committed is a negligent one."

24. Thus, the doctors are liable for medical negligence, where they act carelessly, results an action in torts as held by Hon'ble Supreme Court in the case of **Spring Meadows Hospital v Harjyot Ahluwalia**[3]**,** their Lordships observed as follows:

> "Very often in a claim for compensation arising out of medical negligence a plea is taken that it is a case of bona fide mistake which under certain circumstances may be excusable, but a mistake which would tantamount to negligence cannot be pardoned. In the former case a court can accept that ordinary human fallibility precludes the liability while in the latter the conduct of the defendant is considered to have gone beyond the bounds of what is expected of the skill of a reasonably competent doctor…'

25. We necessarily looked into **ATLS protocols**, which were derived from extensive research in the U.S. to rapidly assess and give emergent treatment to victims of car crashes and ones especially involving fatalities. Further, it is also a fact borne from research that if there is a fatality or fatalities from a car crash at the scene of accident itself or a death *en route* to hospital, the risk of survivors who actually reach the hospital are at an increased risk of succumbing from similar injuries even if obvious, visible or otherwise. A high level of suspicion and constant surveillance of the survivor-victims needs to be done frequently and thoroughly investigated for any internal trauma which may not be apparent immediately and there is no procedure for dispensing with resuscitation as required, reassessment, head to toe examination and investigations followed by period of observation to ensure survivor survival and safety.

26. Merely because in the instant case, the victim - Dr. Sudha was conscious, coherent or vocal, this simply cannot deviate from the fact that even a simple radiograph of neck, chest and/or CT scan were not carried out. Further a head injury can also lead to brief periods of conscious lucid interval only to deteriorate later and can fool the inexperienced medical practitioner and hence there is need for vigilance and hence there is need for restrain to fully stabilise the patient, investigate the patient and only then take up for surgical intervention. The absence of clinical examination of the C-spine and radiographs or X-ray of the chest or X-ray of pelvis above is nowhere to be seen in the hospital notes particularly when a co-passenger has suffered fatality should be enough to raise the suspicion of any doctor to `very high` regarding likely mortality in the survivor-victims. It transpires that upon autopsy, it was discovered that there was a fracture of the C6 vertebrae. Without assessment of such an injury and without even a reasonable period of observation, it is seen that the maxillo-facial surgeon with undue alacrity attempted to undertake inter-dental wire fixation for fracture of the mandible and effectively shut access for easy or effective oro-tracheal intubation. Further there is no record as whether intranasal tracheal intubation apparatus or even a fibre-optic device was available or kept ready for any eventuality. Unfortunately, the secretions from the mouth and throat in absence of any suction mechanism caused aspiration into the air pipe and that despite making feeble and ill-trained attempts to obtain a `surgical airway` only made matters worse by further pooling of blood in the air-pipe. All these events appear ill-planned and ill-executed and complications ill-managed, eventually leading to aspiration, asphyxia leading to death of a person, who would have survived with systematic and expert management.

27. No doubt that interdental wiring is used to treat fractures of the mandible, and this is not a comment on choice of procedure. But it is clear that the procedure was undertaken without proper assessment of airway, risks to patient from Cervical spine injury and without even allowing stabilization of the patient and seems to be taken up with undue haste. Harm was certainly caused due to overenthusiastic interventions which should have been postponed to a suitable time. There is absence of effective medical notes to show if an Anaesthesiologist was available or even present at the time of the procedure.Thus it was **not a case of Error of Judgment, but a negligence**.

28. Based on the foregoing discussion, medical negligence is attributed upon the hospital and treating doctors therein. The quantum of compensation is subjective in nature and it is tough to decide on the quantum of compensation in the medical negligence cases. Different methods are applied to determine compensation. In fact, loss of dependency by its very nature is awarded for prospective or future loss. The deceased was a doctor left behind two minor children. From the record, it is evident that the Complainants received compensation from MACT also. In our view the compensation under MACT was against the negligent driving and under 3rd party insurance. It is entirely different from the compensation claimed against the medical negligence. The compensation under MV Act will not enable the doctor/hospital to commit mistake during the treatment of accident victim.

29. The act of omission is evident as the doctors working in KVM Hospital did not follow the basics of ***ABC of trauma*** by which one doctor lost her life. Therefore, we hold vicariously, the Hospital (Opposite Party No. 1) and Dr. Ravindran Nair - the Facio-maxillary Surgeon (Opposite Party No. 7) for breach in the duty of care. The Complainants have prayed compensation of Rs. 20 lakh before the State Commission in the year 2001. We are now in 2022, thus, in the ends of justice and considering the peculiarities of this case, lump-sum compensation of Rs. 30 lakh is just and proper. The Opposite Party No. 1 is directed to pay Rs. 25 lakh and the remaining Rs. 5 lakh shall be paid by the Opposite Party No. 7. The total amount shall be paid equally (Rs. 15

lakh each) to the Complainants Nos. 1 & 2. The entire amount shall be paid within 3 months from today, failing which, it shall carry 7% interest per annum, till its realization.

30. The Order of the State Commission is set aside and the instant Appeal is partly allowed. The Parties to bear their own costs.

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[1] [(1981)1 All ER 267]

[2] AIR 1969 SC 128

[3] (1998) 4 SCC 39

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

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DR. S.M. KANTIKAR
MEMBER