NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION
NEW DELHI

FIRST APPEAL NO. 375 OF 2015

(Against the Order dated 23/06/2014 in Complaint No. 455/1999 of the State Commission Maharashtra)

1. HARIDASAN PILLAI & ANR.
PRESENTLY RESIDING AT HARISH BHAVAN, ONATTIL KIZHAKETHIL, THATTARAMBALAM P.O., ANJILIPARA, MAVELIKKARA,
ALAPPUZHA-6901303
KERALA STATE
2. SMT. CHANDRIKA H. PILLAI
PRESENTLY RESIDING AT HARISH BHAVAN, ONATTIL KIZHAKETHIL, THATTARAMBALAM P.O., ANJILIPARA, MAVELIKKARA,
ALAPPUZHA-6901303
KERALA STATE .....Appellant(s)

Versus

1. NUCLEAR POWER CORPORATION OF INDIA & 3 ORS.
TARAPUR ATOMIC POWER STATION HOSPITAL, TAPS HOSPITAL, P.O. TAPP VIA BOISAR (W. RLY)
DIST. THANE-401504
MAHARASHTRA
2. MEDICAL SUPERINTENDENT
TAPS HOSPITA, P.O. TAPP VIA BOISAR (W. RLY)
DIST. THANE -401504
3. DR. SANCHDEV
C/O. TAPS HOSPITA, P.O. TAPP VIA BOISAR (W. RLY)
DIST. THANE-401504
4. DR. DEOLALIKAR (DEAD) THROUGH LRS., C/O. TAPS HOSPITAL,
C/O. TAPS HOSPITA, P.O. TAPP VIA BOISAR (W. RLY)
DIST. THANE-401504
5. DR. TANUJA DEOLALLKAR
- .....Respondent(s)

BEFORE:

HON'BLE MR. BINOY KUMAR,PRESIDING MEMBER

FOR THE APPELLANT : APPEARED AT THE TIME OF ARGUMENTS:
FOR THE APPELLANTS : MS. LAKSHMI N. KAIMAL, ADVOCATE
MR. RANJITH B. MARAR, ADVOCATE

FOR THE RESPONDENT : APPEARED AT THE TIME OF ARGUMENTS:
MR. SUMIT GOEL, ADVOCATE
MS. PRATYUSHA PRIYADARSHINI, ADVOCATE

MS. GARIMA KHANNA, ADVOCATE

Dated : 14 May 2024

ORDER

1. This First Appeal has been filed by the Appellants - Haridasan Pillai & his wife - Chandrika H. Pillai (in short, the "Complainants") against the Respondents – Tarapur Atomic Power Station Hospital (TAPS Hospital), its Medical Superintendent and two Doctors (in short, the Opposite Parties Nos. 1 to 4 respectively), challenging the impugned Order dated 23.06.2014 passed by the Maharashtra, State Consumer Disputes Redressal Commission, Mumbai (in short, the "State Commission") in CC/99/455, whereby the Complaint filed by the Complainants was dismissed.
2. The brief facts of the case are that on the complaint of high fever of their only son – Master Harish (since deceased) (in short, the "patient"), his parents / Complainants, on 12.07.1998 at 8.15pm, got him admitted in TAPS Hospital - Opposite Party No. 1, under C.H.S. facility, where he was checked by the duty doctor and blood and urine samples taken for investigation. It was alleged that noticing no improvement, the Complainants kept requesting Dr. Sachdev – the Opposite Party No. 3 as well as the Hospital Superintendent – the Opposite Party No. 2 to refer the patient to BARC Trombay Hospital, but it was refused, even though the patient was struggling for life. After getting Sonography test done from Palghar and informing that the patient had started becoming weak from 15.07.1998, eventually, Dr. Vachcharajani referred the patient on 16.07.1998 at 12.10 hrs to BARC Hospital. On the same day at 4pm, the Complainants admitted the patient to BARC Trombay Hospital, where, after examining the patient, the doctors found that the kidneys of the patient had stopped functioning and there was acute respiratory problem, but due to non-availability of the facilities, it referred the patient to Jaslok Hospital for specialized treatment. On the same day i.e. 16.07.1998 at around 7.30pm, the Complainants shifted the patient to Jaslok Hospital, where at about 6.10am on 17.07.1998, the patient ultimately died. Being aggrieved with the alleged gross medical negligence resulting in the death of their only son, the Complainants filed a Complaint before the State Commission seeking compensation to the tune of Rs. 16 lakh with interest at the rate of 18% p.a. from the date of filing of Complaint.
3. The Opposite Parties, in their reply, denied the allegations of negligence leveled against them during the treatment of the patient. It was stated that TAPS Hospital is run by the administration of TAPS, which is one of the units under Nuclear Power Corporation of India Ltd. (for short, NPCIL). It was further stated that the patient was admitted to the Hospital with high grade fever and bodyache and standard line of treatment was adopted. The patient was attended to by various qualified doctors, who treated the patient with all due required steps till the discharge of the patient from the Hospital on 16.07.1998. Necessary blood tests, pathological tests etc. were advised and done. The X-ray reports, pathological reports were normal. The urgent investigations with regard to the condition of the patient were advised, the reports of which suggested acute renal failure and impending Septicaemia, due to which the decision to refer the patient to the BARC Hospital, Mumbai was taken. The patient was observed to have developed Tachycardia & Tachypnoea. He was shifted to BARC Hospital in ambulance with a Doctor, a sister and other paramedical staff. It was further stated that the treatment availed by the patient was free of cost, except for a nominal amount as contribution,

provided by the employer to its employees and therefore, the Complaint is not maintainable. Also the Complaint is frivolous and vague, arising out of pure prejudice and ipsi-dixits of the Complainants and, therefore, deserves dismissal.

4. The State Commission, after hearing the arguments of the learned Counsel for both sides and after perusal of the record, dismissed the Complaint holding no negligence on the part of the Opposite Parties holding that the treatment was given as per medical protocol.
5. Being aggrieved, the Complainants filed the instant Revision Petition.
6. Heard the learned counsel for both the sides.
7. The learned counsel for the Appellant submitted that the patient was 16 years old and was admitted to TAPS Hospital on 12.07.1998 for fever. He was attended to by the Respondents Nos. 3 and 4. However, her condition worsened by 16.07.1998 and was referred to BARC, Trombay Hospital by evening of 16.07.1998. From there, he was referred once again on the same evening to Jaslok Hospital, Mumbai, where he was declared dead on 17.07.1998 in the morning. It was further submitted that the complete medical record was not provided by TAPS Hospital, in spite of requests. Necessary details were, therefore, not available with the Appellants / Complainants. He further cited the expert opinion of Dr. Achalraj U. Seth, which shows deficiency on the part of the hospital for not having properly treated the patient, be it in terms of malaria treatment or in terms of monitoring of fluids electrolytes, which would have prevented acute renal failure of the patient. He further submitted that the State Commission had erred in relying upon an expert opinion of Doctors constituted by the NPCIL under whose overall control the hospital functions. Finally, he submitted that when the condition was not improving after two days of treatment and on the other hand, in fact worsening, the patient should have been referred to a super specialty hospital and, therefore, his Appeal may be allowed.
8. The learned Counsel for the Respondent depending upon the expert opinion of the Doctors appointed by the NPCIL submitted that the State Commission has rightly based its decision on that opinion, which has not found any negligence on the part of the doctors and hospital. No blame can be laid on the doctors of TAPS Hospital as they did their best in the normal situation to treat the patient. He argued for dismissal of the First Appeal. He further submitted that the Respondent No. 4, Dr. Deolalikar has since expired, and, therefore, he need not be made a party in the Appeal as no Order against him has been passed by the State Commission.
9. I have carefully perused the voluminous record including the State Commission record and also heard the arguments of the learned Counsel for both sides at length.
10. The brief facts of the case is that the patient Master Harish, the only son of the Complainant / Appellant was admitted to the TAPS of NPCIL (a Govt. of India enterprise) on the evening of 12.07.1998 with the complaint of high fever and bodyache since last one day. Certain medicines were prescribed including chloroquin. The condition of the patient continued to be the same, but vomiting had started and spleen got enlarged. The condition of high fever continued coupled with both loose motion and vomiting as well as pain in abdomen. IV fluid was started. The condition continued to be the same despite administration of medicines as per the hospital record. The hospital noticed for the first time the patient not passing urine in the evening of 15.07.1998. Certain other medicines were prescribed including administration of Intravenous (IV) fluids. On 16.07.1998, when investigation was carried by way of blood tests, it was

noticed that the platelets had reduced substantively and the creatinine level had shot up. There was worsening of situation by late afternoon and on seeing the seriousness, the patient was referred to BARC Hospital, Mumbai, which, on seeing the patient immediately referred the patient to Jaslok Hospital, Mumbai as it was not competent to treat the patient. The patient died in the early hours of 17.07.1998. Thus, in all, within six days, the patient died on account of acute renal failure and the cause of death being septicemia with disseminated intravascular coagalopathy with acute renal failure. So, the patient died of acute renal failure with no known history of any disease.

11. Evidently and indisputably, the patient had malaria for which anti-malaria treatment was started by the hospital. It is also a fact that the anti-malarial drug causes vomiting and loose motion. Therefore, the first two to three days are not significant in a sense that the line of treatment was normal in the circumstance of the case and no negligence was shown by the doctors.
12. The situation changed after the third day when the condition of the patient was deteriorating very fast and that the patient was developing secondary conditions which the hospital and its Doctors either failed to notice or totally ignored the same. It is also a fact that after two days of hospitalization, the Complainant requested the hospital authorities to refer the patient to BARC Hospital, Mumbai. It is also a fact that TAPS Hospital is more like a big dispensary and it does not have a Critical Care facility. While not taking such decision on second day by TAPS, is understandable, but thereafter, on going through the history and on the record, not taking such decision is an issue which needs to be looked into closely and in my opinion is critical in deciding this Complaint. It would be worthwhile to go through the death summary report of Jaslok Hospital and Research Centre whether the patient was admitted in the late evening of 16.07.1998 and was declared dead in the early hours of 17.07.1998. This report is dated 04.08.1998 and is reproduced as under:-

"Mr. Harish Pillai is a 16 years old boy and was transferred to Jaslok Hospital from BARC Hospital on 16-07-98. He was in BARC Hospital for 5 days with complaints of fever, chills and decreased output for 3 days. He also complained of pain in the muscles of lower limbs for 2 days. He was treated there with antimalerial and magnamycin, but as his condition did not improve he was transferred here for further management. He denied history of diabetes, difficulty in passing urine ancle oedema or intake of nephrotoxic drugs. Physical examination on him showed pulse of 110 with B.P. of 110 with occasional crepitation. Lab reports on admission showed haemoglobin of 8.6. with leukocytosis and marked throimbocytopenia (21,000). BUN was 52 with creatinine 5.9. Notable future was high CPK with moderately high SGPT and bilirubin of 6.2.

In view of thrombocytopenia, patient was treated with high dose lasix, fluid restriction and also was given antibiotic therapy. In view of severe thrombocytopenia patient was treated conservatively.

Patient required ventilator support and later on developed severe bleeding from Nasal and oropharyngeal area. He was given transfusion also. At about 6.00 am. He suddenly developed cardiac arrest. Inspite of all measures patient could not be resseciated and declared expired on 17.07.98.

CAUSE OF DEATH: Septicemia with disseminated intravasculararcoagalopathy with acute renal failure.

13. I am placing my reliance on this report specifically because I have perused two expert opinions, one report produced as an affidavit of Dr. Achalraj U. Seth dated 24.04.2003 before the State Commission by the Complainants and the second being the report of the Committee of Doctors appointed by the NPCIL dated 05.12.1999. These reports have been duly considered by the State Commission, which finally relied upon, for its Orders, on the report of the Committee appointed by NPCIL. In both these reports, there is lack of clarity, which does not help in determining whether there has been a medical negligence or not. The official Committee has denied any negligence and has given opinion overlooking certain obvious omissions on the part of the hospital. The affidavit of Dr. Seth filed by the Complainants is, on the other hand, showed certain negligence on the part of the treating doctors and the hospital, the significant observation being the transfer of the patient to a better hospital on 14.07.1998 itself when the urine output started declining and stopped by 15.07.1998 and the patient continuing to have vomiting, loose motion and fever. The Jaslok report is significant because it has correctly noted in an impartial manner the sequence of events and thus more reliable. The significant observation has been that the Complainant was admitted in the hospital for five days with complaints of fever, chills and **decreased output for three days**. The third day would start definitely of 14/15.07.1998. When this has been noticed by the Doctor, from the hospital record, it is seen that they have totally ignored it and have continued with treatment for conditions other than this problem. I notice that on the one hand, IV fluid has been given and subsequently lasix has been given. These are the procedures to be adopted in a normal course. However, such procedure cannot be undertaken when it is observed that the urine output has either reduced or totally stopped on 15.07.1998.
14. The reduced urine output in a malarial situation is a clear indication of serious kidney problem and the Hospital should have shown promptness for the patient to be referred to a Super Specialty Hospital for further treatment where facility of dialysis / ventilator in an appropriate Nephrology ICU would have been available. Reduced output of urine is a sign of the patient having renal failure. Eventually when on 15.07.1998 the blood tests were conducted, it was found that the parameters indicating renal failures had already been on a very high side, including the level of creatinine and the reduction of platelets. Not having referred the patient even as late as 15.07.1998 was definitely a most negligent step taken by the Doctors and the Hospital as there would have been a possibility that if the patient had been put on a ventilatory support with dialysis, he would have recovered. It has to be borne in mind that the patient was very young and that he had no history of any disease whatsoever. Reduced urine output is a clear indication of a renal stress and should not have been allowed to have been handled by a hospital with limited facilities and no specialist Doctors. In this regard, I would like to cite the Order of the Hon'ble Supreme Court in **Arun Kumar Manglik vs. Chirayu Health and Medicare Pvt. Ltd. & Anr.**, (2019) 7 SCC 401, decided on 09.01.2019. In this case also, emphasis has been laid on careful monitoring of a patient. It has been observed as under:

23. The requirement of carefully monitoring a patient in such a situation is stipulated both by the guidelines of the World Health Organisation on which the appellant has placed reliance as well as in those incorporated by the Directorate of the National Vector Borne Diseases Control Programme in 2008.

24. The WHO guidelines indicate that Dengue is a 'systemic and dynamic disease' which usually consists of three phases i.e. febrile, critical and recovery. There had been a precipitous decline in the patient's platelet count the day she was admitted to the hospital. The WHO guidelines inter alia state as follows:

"2.1.2 Critical phase

-

Progressive leukopenia (3) followed by a rapid decrease in platelet count usually precedes plasma leakage. At this point patients without an increase in capillary permeability will improve, while those with increased capillary permeability may become worse as a result of lost plasma volume. The degree of plasma leakage varies. Pleural effusion and ascites may be clinically detectable depending on the degree of plasma leakage and the volume of fluid therapy. Hence chest x-ray and abdominal ultrasound can be useful tools for diagnoses. The degree of increase above the baseline haematocrit often reflects the severity of plasma leakage."

25. Clause 2.3.2.2 of the WHO guidelines deals with patients who should be referred for inhospital management (Group B).

"Patients may need to be admitted to a secondary health care centre for close observation, particularly as they approach the critical phase. These include patients with warning signs, those with co-existing conditions that may make dengue or its management more complicated (such as pregnancy, infancy, old age, obesity, diabetes mellitus, renal failure, chronic haemolytic diseases), and those with certain social circumstances (such as living alone, or living far from a health facility without reliable means of transport).

If the patient has dengue with warning signs, the action plan should be as follows:

• Obtain a reference haematocrit before fluid therapy. Give only isotonic solutions such as 0.9% saline, Ringer's lactate, or Hartmann's solution. Start with 5–7 ml/ kg/hour for 1–2 hours, then reduce to 3–5 ml/kg/hr for 2–4 hours, and then reduce to 2– 3 ml/kg/hr or less according to the clinical response (Textboxes H, J and K).

• Reassess the clinical status and repeat the haematocrit. If the haematocrit remains the same or rises only minimally, continue with the same rate (2–3 ml/kg/hr) for another 2–4 hours. If the vital signs are worsening and haematocrit is rising rapidly, increase the rate to 5–10 ml/kg/hour for 1–2 hours. Reassess the clinical status, repeat the haematocrit and review fluid infusion rates accordingly.

- *Give the minimum intravenous fluid volume required to maintain good perfusion and urine output of about 0.5 ml/kg/hr. Intravenous fluids are usually needed for only 24–48 hours. Reduce intravenous fluids gradually when the rate of plasma leakage decreases*

towards the end of the critical phase. This is indicated by urine output and/or oral fluid intake that is/are adequate, or haematocrit decreasing below the baseline value in a stable patient.

• Patients with warning signs should be monitored by health care providers until the period of risk is over. A detailed fluid balance should be maintained. Parameters that should be monitored include vital signs and peripheral perfusion (1–4 hourly until the patient is out of the critical phase), urine output (4–6 hourly), haematocrit (before and after fluid replacement, then 6–12 hourly), blood glucose, and other organ functions (such as renal profile, liver profile, coagulation profile, as indicated).

- *Patients should be monitored by health care providers for temperature pattern, volume of fluid intake and losses, urine output (volume and frequency), warning signs, haematocrit, and white blood cell and platelet counts (Textbox L). Other laboratory tests (such as liver and renal functions tests) can be done, depending on the clinical picture and the facilities of the hospital or health centre."*

….xxx….

28. The issue is not whether the patient had already entered a situation involving haemorrhagic fever or a dengue shock syndrome when she was admitted on the 12 morning of 15 November 2009. The real charge of medical negligence stems from the failure of the hospital to regularly monitor the blood parameters of the patient during the course of the day. Had this been done, there can be no manner of doubt that the hospital would have been alive to a situation that there was a decline progressively in the patient's condition which eventually led to cardiac arrest.

15. It is seen from the above that administration of certain drugs and intravenous fluid has to go simultaneously with monitoring of other parameters like blood (creatinine) and urine (sign of renal failure).
16. This problem of not diagnosing the seriousness of reduction in urine output was further compounded by the fact that even when the patient was referred to BARC Hospital, Mumbai, it should have been known by the Doctors in TAPS Hospital, being a sister concern, that facility for treatment of renal failure does not exist in BARC Hospital. It would have been the primary responsibility of the Superintendent of the Hospital to have taken this minimum precaution and care to find out where should the patient be referred to after coming to know about the renal failure. This shows that the hospital authority did not exercise due care in referring the patient to the proper hospital. In case of renal failure, time becomes an essence and therefore, this shows the lack of concern on the part of the hospital authorities.
17. These facts have been totally ignored in the State Commission. The State Commission has gone by the Expert opinion of NPCIL and on the simple assumption that there was no obvious negligence on the part of the hospital and that the patient was being attended to on a regular basis and that the hospital cannot be found fault with the patient developing acute renal failure. It has, at length, discussed about the grievance of the Complainants, who wrote a number of letters to various authorities and that there was such a Committee of experts formed who have stated that there has been no negligence. In this entire Order, the State Commission has missed this significant aspect of reduced

urine output. The Committee found that for reduced urine output and after coming to know of the creatinine levels, fluids were continued followed by Lasix injection for normal urine flow and more such injections continued and therefore all possible steps were taken.

18. I am absolutely confounded by the report of the expert Committee, which was headed by a Chief Engineer, NPCIL. For reduced urine flow even a Doctor with a normal competence would have understood the gravity of the situation. Administration of Lasix and IV fluid is not a solution when urine output is getting progressively reduced and creatinine level jumping. This should have been seen in the backdrop of the patient having the condition of malaria since last four days and who had not responded with all the multi malarial drugs and the drugs for reducing vomiting and loose motion including administration of powerful antibiotics. For not understanding this simple medical condition, in my opinion, is nothing short of serious medical negligence. It is not my contention that the Doctors should have given some other treatment, it is my contention that this hospital was just not equipped to handle such situation. The State Commission has missed the critical point. By the time the patient was referred to BARC Hospital on the evening of 16.07.1998, the patient had already crossed the stage of any recovery. The Expert Opinion of the Respondents is in my opinion, nothing more than covering up the mistake committed by TAPS hospital and its administration. In this case of ***Maharaja Agrasen Hospital & Ors. Vs. Master Rishabh Sharma & Ors.***, (2020) 6 SCC 501, decided on 16.12.2019, it was observed as under:

"It is well-settled that a court is not bound by the evidence of an expert, which is advisory in nature. The court must derive its own conclusions after carefully sifting through the medical records, and whether the standard protocol was followed in the treatment of the patient. The duty of an expert witness is to furnish the Court with the necessary scientific criteria for testing the accuracy of the conclusions, so as to enable the Court to form an independent opinion by the application of this criteria to the facts proved by the evidence of the case. Whether such evidence could be accepted or how much weight should be attached to it is for the court to decide."

19. The question to be now decided is who is basically now responsible for the death of the patient on account of medical negligence. The Complainant has included both the hospital and two doctors being Dr. Sachdev and Dr. Deolaikar. The learned Counsel for the Respondent submitted that Dr. Deolaikar has since expired and now no liability should be fixed on him. I am also not inclined to fix liability on Dr. Deolaikar, because he was one of the many doctors, who treated the patient. In my opinion, it was the collective negligence on the part of the hospital represented by its medical Superintendent. I hold the hospital responsible for medical negligence and for the death of the patient on the grounds of (a) not taking into cognizance the reduced urine output on the date in which it was first reported and (b) not referring the patient to a Super Specialty Hospital soon after it came to know of the reduced urine output in the circumstances of the case.

20. In this regard, I would like to cite the Order of the Hon'ble Supreme Court in ***Maharaja Agrasen Hospital & Ors. (supra),*** wherein, it was observed as under***:***

"12.4.21. It is well established that a hospital is vicariously liable for the acts of negligence committed by the doctors engaged or empanelled to provide medical care. 33 It is common experience that when a patient goes to a hospital, he/she goes there on account of the reputation of the hospital, and with the hope that due and proper care will be taken by the hospital authorities. 34 If the hospital fails to discharge their duties through their doctors, being employed on job basis or employed on contract basis, it is the hospital which has to justify the acts of commission or omission on behalf of their doctors."

21. In the Complaint, the Complainant has sought only an amount of Rs. 16 lakh as compensation. Though, this amount is very paltry, in view of the prayer made, compensation of Rs. 16 lakh is to be paid by the hospital along with a reasonable interest.
22. The Appeal is accordingly disposed of by partly allowing the Appeal and the Order of the State Commission is set aside. The Respondent No. 1 is directed to pay an amount of Rs. 16 lakhs along with interest @ 9% per annum from the date of death of the patient till realization to the Complainants within six weeks of this Order, failing which, the rate of interest shall be 12% per annum for the same period. Further, the Respondent No. 1 shall pay Rs. 1 lakh as cost of litigation to the Complainants within six weeks, failing which interest @ 9% per annum shall be paid from the date of this Order till realisation.

.....
BINOY KUMAR
PRESIDING MEMBER