NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION
NEW DELHI

CONSUMER CASE NO. 89 OF 2012

1. PARIKSHIT DALAL & ORS.
S/o. Mr. Anil Dalal, No. 1, Ahmed Sait Road,
FRAZER TOWN,
BANGLORE - 560 005.
2. SRI. SURESH J PATNE
S/o. Late Jagannath Patne,
FLAT 102, PLOT NO 38, 'BHOSALE SERENADE',
BHOSALE
NAGAR, PUNE - 411 005
3. SMT. MEENA S PATNE
W/o. Suresh J Patne,
FLAT 102, PLOT NO 38, ' BHOSALE SERENADE',
BHOSALE
NAGAR, PUNE - 411 005. .....Complainant(s)

Versus

1. SANTOSH HOSPITAL & 11 ORS. .....Opp.Party(s)
#6/1, Promenade Road, Behind Coles Park, Near Goodwill School
BANGALORE - 560 005.
2. DR. INDIRA RAO
W/o. M.V.R. Rao, B-310, Suryakiran Apartments,
42/1, NETAJI ROAD, FRAZER TOWN,
BANGALORE -5
3. DR. P. ASHOK
S/o. Paramashivan, 7,1st Cross,
AECS LAYOUT, SANJAYNAGAR,
BANGALORE
4. DR. S. BIKKAMCHAND
S/o. Late Sakkalchand, 5, Rukmini Colony,
AM ROAD CROSS,
BANGALORE - 42
5. DR. ANIL KUMAR SAKALECHA
S/o. Moongilal Sakalecha, 1295, 13th Cross, 2nd Stage,
INDIRANAGAR
BANGALORE
6. SMT. LALY VIJU,
W/o. Viju Varghese,
ST THOMAS POST, LINGARAJA PURA,
BANGALORE
7. SMT. VICTORIA PRAMOD
W/o. Pramod, No. 42/A, 3rd Cross, kanakadasa layout,
ST. THOMAS TOWN POST, LINGARAJA PURA,
BANGALORE

8. MR. MATHEW
S/o. Mallaiah, 123, Erappa Layout, Subbanapalya, Banaswadi,
BANGALORE
9. SMT. KRUPAMMA,
W/o. Naid, Res At. 101, N.C. Colony, Bore Bank
ROAD,
BANGALORE
10. DR. ADIL PASHA
S/o. Ansar Pasha, 9, Millers Road, Benson Town,
BANGALORE - 46.
11. DR. INAYATHULLA. M. SHARIEFF
S/o. Late K H Mehaboob Sherif, 27/1, 3rd Cross, Krishnamma Garden,
NEAR BENSON TOWN POST OFFICE,
BANGALORE.
12. SMT. JOYCE SAGAYANATHAN
W/o. Sagayanathan, R/o. 5A, 3rd Main Road, Rayappa Layout, Venkateshwaram,
ARABIC COLLEGE,
BANGALORE

BEFORE:

HON'BLE DR. S.M. KANTIKAR,PRESIDING MEMBER
HON'BLE MR. BINOY KUMAR,MEMBER

FOR THE COMPLAINANT :

Dated : 23 May 2023

ORDER

Appeared at the time of arguments

For the Complainant : Ms. M. Malika Chaudhuri, Advocate

with Mr. Parikshit Dalal, Complainant in person

For the Opp. Parties : Mr. G. N. Shenoy, Advocate

Pronounced on: 23rd May 2023

ORDER

Dr. S.M. KANTIKAR, PRESIDING MEMBER

Deaths due to anaphylactic shock are uncommon and it is a diagnosis based on findings which may not always be present and as such poses challenges for the forensic pathologist or an expert in reaching certainty with regard to the cause of death. A holistic view that all findings need to be considered in the approach to reach a definitive cause of death.

1. The present Complaint has been filed under Section 21(a)(i) of the Consumer Protection Act, 1986 (for short "the Act, 1986") by Parikshit Dalal & others (hereinafter to be referred as the 'Complainants') against Santosh Hospital & its 5 doctors (hereinafter to be referred as the 'Opposite Parties') seeking compensation amounting to Rs.24,91,30,000/- for causing death of wife and unborn child of the Complainant No. 1.

2. Facts of the Complaint:

2.1 The Complainant No. 1 - Parikshit Dalal and his wife Mrs. Kapali Patne (since deceased, hereinafter referred to as the 'patient"), on 13.04.2010, consulted Dr. Indira Rao (OP-2), the Sr. Gynecologist at Santosh Hospital (OP-1) during her first pregnancy. The OP-2, after examination, informed that the baby was large and advised the couple for Caesarean Section (LSCS) delivery. Accordingly, LSCS was fixed on 16.04.2010. The patient informed the OP-2 about her allergy to Sulpha drugs and also about her congenital (L5) birth defect. It was mentioned in her Ante Natal checkup (ANC) card.

2.2 On 16.04.2010, in the morning at around 6.30 am, the Complainant No. 1, his wife and their family members came to OP-1 Hospital. At around 8.00 a.m., the Anesthetist Dr. P. Ashok (OP-3) met the Complainant No. 1 and discussed whether General Anesthesia (GA) or Epidural Anesthesia should be given, as he was very worried about GA, which was not normally used for Caesarean Section. The OP-3 stated that as advised by OP-2, he will give GA. Thereafter again the Complainant-1 spoke to OP-2 about GA, who assured him that there would be no complications. She did not advise any pre-anesthetic tests. At 9.15 am, the patient was taken into Operation Theater (OT), at the same time, the OP-2 also entered the OT. At around 10.15 am, the Complainant-1 suddenly noticed a flurry of activities and all the senior doctors, staff from the hospital including the CMO Dr. Sharieff of Santosh Hospital rushed into the OT. At about 10.40 am, the OP-2 informed the Complainant-1 and his friend that the patient was given GA and one-in-a million patient may react violently to the drug. The OP-2 informed that due to severe '**Anaphylactic shock'** from Sodium Pentothal (anesthetic agent), the condition of the patient became very critical and the doctors were trying their level best to revive her and shifted to ICU. The Complainant-1 repeatedly enquired with OP-2 and OP-3 about the condition of his wife. The OP-2 expressed very slim chances of survival in her words as - 'She is as good as gone'. The OPs-2 & 3 had shown little concern and anxiety while monitoring the patient. It was further alleged that Dr. Indira Rao (OP- 2) was trying to selectively isolating herself from the situation as she told the Complainant that, "look, I have not even touched your wife".

2.3 The patient was taken to the ICU at around 11 a.m. and around 11.50 a.m., she and her unborn child were declared dead. Thereafter, the doctors and hospital authorities insisted the Complainant-1 to take away the dead body of his wife at the earliest. It was further alleged that the OP-2 did not assess the condition of the baby and failed to save the baby with the help of surgery.

2.4 The Complainant alleged strongly that his wife died in the O.T. itself. However, to cover-up their negligence, the doctors tried to show it as shifted to ICU. Therefore, the actual reading of monitors was not available on record. The ICU monitor showed zero reading, which itself confirms that the patient and unborn child were already expired in the O.T. at 11.30 a.m. The OP-2 made casual attempt to note Foetal Heart Sound (FHS) on the dead body and even the USG was actually done at 12.05 to 12.08 p.m., which was 15 minutes after the death.

2.5 The Complainant registered an FIR at Pulakeshinagar Police Station, Bangalore as UDR no. 15/10 u/s 174(3) of CrPC- Unnatural death on 16.04.2010 at around 4.30 p.m. The copies of the medical papers, seized by the police from the hospital, were handed over to the Complainant-1 on 23.04.2010. The cause of death mentioned in the intimation letter was ***"cardio respiratory arrest seconding to acute anaphylaxis reaction"***. The Post-Mortem (PM) was performed on 17.04.2010 and the copy of the preliminary report was handed over to the Complainant on 26.04.2010. The preliminary PM report recorded following findings:

a. Fracture of the Left Sacroiliac joint and plenty of clots into muscles in front of the joint.
b. Peritoneal cavity contained 1500 gms of clot and 200 ml of fluid blood.
c. The mesentery (mesocolon), transverse and left mesocolon were contused.

2.6 The viscera and blood were sent to forensic science lab for chemical analysis and to find anesthetic drugs, sedatives etc. and the organs were sent for histo-pathological examination (HPE). The HPE report received on 13.05.2010 showed a mesenteric, mesocolon hemorrhages and severe congestion. The FSL report received on 27.05.2010 revealed the anesthetic drug Thiopentone was not present in detectable limits. In the final PM report, the cause of death was given as ***'shock and hemorrhage as a result of the injury to the pelvis sustained'***.

2.7 Upon receipt of the preliminary PM report, noticing the injuries, a further FIR was lodged on 04.05.2010 and a case of medical negligence CR158/2010 under sections 304A, 315 and 201 of IPC was registered by Pulakeshinagar Police Station, Bangalore. The Complainant alleged that the hospital case sheet was fabricated, with numerous over writings and insertions, thus inconsistencies raised more suspicion on OPs. The BP was not recordable as early as 10.10 a.m. At many places the time of death was changed from 10.50 a.m. to 11.50 a.m. In July 2010 the police arrested OP-2 & OP-3 and four other medical staff and released on bail. The Crime Investigation Department (C.I.D), Karnataka took over the investigations in August 2010 and after 9 months of investigations filed a charge-sheet under sections 304A, 315, 201 r/w 34 of the IPC making OP-2, OP-3, & other accused staff. Further the above case has been committed to the Court of Session and is being tired in Fast Track Court No. 7 in Bangalore as SC No. 1544 of 2012. A petition under section 227 CrPC filed by the OPs was dismissed by the Session Court vide Order dated 24th November 2011. The said Order was challenged by the OPs in the Hon'ble High Court of Karnataka, which

was dismissed vide Order dated 03.10.2016. The Order of the Hon'ble High Court was further challenged by the OPs vide SLP NO 9332/16 before the Hon'ble Supreme Court, which vide Order dated 09.12.2016 upheld the criminal prosecution against OPs.

2.8 On 07.08.2010 the Complainant filed a Complaint in the Karnataka Medical Council (KMC) against OPs under professional misconduct and malpractice under Regulation. On 09.04.2012, he filed the Consumer Complaint before this Commission for alleged medical negligence and prayed total compensation of Rs.24,91,30,000/-.

3. **Defense:**

The Opposite Parties filed their written versions and respective evidences by the way of affidavits.

3.1 The OPs in their reply denied the allegations of negligence as the Complaint was filed with ulterior motive. They raised preliminary objections that instant complaint is premature, as the Complainants have filed Complaints before KMC and Criminal Complaint, which are pending. It will be contrary to Article 20(3) of the Constitution of India as no person shall be prosecuted twice for the same offence as under the Consumer Protection Act, 1986.

3.2 **Evidence on behalf of Hospital OP-1**

It was submitted that the OP-1 hospital is a tertiary health care institute, having state-of-art equipment and medical specialists. The infrastructure provided by OP-1 was never substandard nor were the medical and paramedical staff casual in their approach. There was no negligence or deficiency in the services rendered by the OP-1. The Complainants have not proved any specific allegations of an act of omission or commission of the Hospital and treating doctors.

3.3 **Evidence on behalf of OP-2- Dr. Indira Rao**

The OP-2 submitted that the patient told her about the allergy to sulfa drug and had spinal problem (back). Usually for the patient with spinal problem, the spinal or epidural anesthesia avoided. Therefore, General Anesthesia (GA) was preferred for elective LSCS. Accordingly, it was decided to perform elective LSCS on 16.04.2010. She submitted that after her clinical rounds, she went in OT at round 9:15 a.m. Dr. Adil Pasha - Paediatrician (OP-10), Dr. P. Ashok – Anesthetist (OP-3) were already present in OT. After scrubbing, OP-2 entered the OT to put on sterile gown and gloves. With the permission of Anesthetist, OP-2 started painting the abdomen with Povidone. The OP-3 noticed the appearance of allergic rashes which were increasing. The allergic reaction was treated by OP-3 –Dr. Ashok, he gave IV Efcorlin 200 mg intravenously. The OP-3 told to OP-2, not to proceed for surgery because he noticed bradycardia, hypotension and fall of oxygen saturation. It was diagnosed as severe Anaphylactic shock due to the anesthetic drug – Thiopentol sodium which occurred before the commencement of surgery.

3.4 **Evidence on behalf of OP-3- Dr. P. Ashok (Anesthetist)**

He submitted that the patient was posted for elective caesarean delivery on 16.04.2010. The patient was elderly primi with cord around the neck and possibly a big baby. The patient had some congenital spinal problem and had a history of sulfa drug allergy. He assured her that they do not use sulfa drugs during or after anesthesia. Pre-operative instructions to start IV fluids and Injection Rantac 1 amp. IV and Injection Emset 4 Mg IV were advised to be given at 08:30 am. He also spoke to the patient regarding GA.

3.4.1 On 16.04.2010 at about 09:15 a.m. the patient was shifted to the OT on the trolley. The patient was connected to the monitor with BP cuff and pulse oxymeter. The OP-3 came to the Major OT to administer GA at 10.05 a.m. After pre-oxygenation for about 5 minutes, the freshly prepared 2.5% Thiopentone sodium 250 mg was given in increasing dosages of 25 mg under observation for any untoward reaction. The full dose of Thiopentone was given followed by IV 100 mg of Suxamethonium. The patient was intubated with 7 size oro-tracheal tube without any difficulty and 100% oxygen was administered through the tube. Immediately the patient developed severe rashes over the chest and both the arms. He noticed bradycardia and hypotension. The findings were informed to Dr. Indira Rao who was ready after wash and also painted the abdomen with Povidone Iodine. Immediately hydrocortisone 200 Mg IV was given but there was no improvement in the BP and pulse rate. Rashes also increased and patient started to de-saturate in-spite of 100 % of oxygen with good ventilation of the lungs. The strong possibility of anaphylaxis due to thiopentone was considered.

3.4.2 Injection Atropine was given to combat bradycardia. Injection IV Adrenaline 1 Amp and 1 Amp SC given. Injection Hydrocortisone was repeated. In-spite of all these emergency drugs being given, the patient did not show any signs of improvement. There was further fall in blood pressure, which became very low. Immediately Dopamine infusion was started. Also Injection Noradrenaline and Dobutamine were administered and IV fluids were given at a very rapid rate to combat the peripheral vasodilation. Plasma expanders were also infused. The uterus was displaced manually to the left side to prevent any pressure on the vessels(aorta). The other consultants including one more anesthetist, physician and pediatrician were called to assist resuscitation. External cardiac massage was started. No LSCS surgery was commenced due to critical condition of the patient. At about 10:30 AM, the OP-2 informed the patient's husband about the critical condition of the patient. Knowing this, the patient's husband Mr. Parikshit Dalal called his uncle Dr. Vipul Kapadia, a Gynecologist in Ahmedabad. Meanwhile resuscitation was being continued, DC shock was given to combat tachyarrhythmia. Physician Mr. Quaisar Anwar shifted the patient to ICU at 10:40 AM with continuous ventilation on the Ambu bag, 100% oxygen through endotracheal tube. In the ICU the patient was connected to the ventilator and kept under monitoring. The resuscitative measures were continued by the ICU doctors, but in-spite of all attempts the patient succumbed at about 11:50 AM.

3.4.3 It was submitted that as per histopathology report, the patient had right ventricular dysplasia, which could be the reason for unsuccessful resuscitation. The anaphylactic reaction (Grade IV) led to patient pulseless and cardiac arrest.

3.5 Evidence by OP-4- Dr. S. Bikkamchand (Medical Director)

The OP-4 submitted as a Medical Director, he looks after administrative issues. It was the decision of Gynecologist and Anesthetist, intensivist to shift the patient to ICU for better management. Prime concern was to save the life of mother. Therefore, the team of doctors was concentrating on the mother and the resuscitation of cardiac arrest was continued for 45 mins to one hour. However, all the resuscitative measures failed and the family was informed about the death of the patient. Further, Police intimation slip was sent to Frazer Town police station to inform the death of the patient and after the preliminary investigations police took away hospital case sheet at 2.30 pm on the same day (10.04.2010). Therefore, there was no chance of fabrication of records. He further submitted that after a gap of 4 -5 months police seized the hard disc for OT, ICU monitors and Ultra Sound. Initially, the hard disk was sent for analysis to Hyderabad, therefore, there was no question of tampering or fabrication of the records. He further submitted that the OP-2 called Dr. Anil Kumar Saklecha to perform emergency USG of abdomen / pelvic scan to ascertain the viability of foetus and to prepare for emergency Cesarean to save the baby. However, Dr. Anil conducted USG in ICU which revealed non-viable foetus. Therefore, the patient's resuscitation was continued, but she could not survive and declared dead at 11.50 am. The CMO wrote a brief history, the time of death. The probable cause of death was mentioned as secondary to Anaphylaxis as confirmed by the treating doctors

3.6 Evidence of OP-10 - Dr. Adil Pasha (Pediatrician)

The OP-10 submitted that his role starts only after delivery of the baby, however, unfortunately, in the instant case, the baby was never delivered. He was one of the doctors assisting the resuscitating team in saving the life of the mother and the unborn. His involvement was purely on humanitarian grounds and medical ethics.

3.7 Evidence of OP-11 - Dr. M. K. Inayathulla Sharieff (CMO)

The OP-11 in his affidavit submitted that on 16.04.2010 at around 10.20 am, he got the intimation that there was an Emergency in OT. He was told by Dr. Ashok and Dr. Indira Rao that patient was posted for Elective Caesarian section under GA has suddenly developed Severe Anaphylactic reaction after giving IV pentothal. The patient, being actively resuscitated, needed to be shifted to ICU for further management. Accordingly he was asked to get ICU bed ready along with ventilator support, therefore, immediately; arranged ICU bed along with ventilator and the patient was shifted to ICU. He submitted that it was not his responsibility to maintain OT records, but the same was maintained by the OT in charge with well documented. He further submitted that neither hospital nor he was responsible for the delay in the settlement of the LIC claim. Later it was learned that the complainant received the full compensation from LIC. So, the allegation of the complainant putting them responsible for the delay was absurd.

4. A**rguments:**

We have heard the arguments from the learned Counsel for both the sides. Perused the entire material on record, *inter alia,* the expert opinions, KMC orders, the treatment details. The parties have filed their written arguments.

4.1 **Arguments on behalf of Complainant**

The learned Counsel for the Complainant reiterated the facts and chronology of events. The counsel further submitted that it was the grave reckless and severe carelessness of OPs that before the LSCS, the patient (pregnant lady) was dropped (fell) from O.T. table. The OPs to save their skin were creating concocted **story of anaphylaxis** that they have not touched the patient. The doctors before 10.30 a.m. itself inside the OT were built the records after the death of mother and the unborn child. He further brought our attention to the PM report done by the Forensic Expert Dr. Bheemappa Havanur. The C.I.D. on three different occasions sought clarification from Dr. Bheemappa Havanur with respect to 'Fracture', 'relationship of the fracture with Hemorrhagic shock' and 'so called rashes observed'. The Clarification was given as below:

a. That the fracture is ante mortem and not posts mortem.
b. A fall from the height of 3 to 4 ft. is the probable cause of the fracture of the Sacroiliac joint.
c. The Fracture sight is one of the primary sources of the blood loss.
d. The reddish spot observed may be due to fixation of PM stain.

4.1.1 The Complainants in their support filed Experts Opinions from Forensic Medicine Experts Dr. Ragavan and Dr. Selvakumar, the Gynecologist Dr. Behram Anklesaria- and the Committee of BMCRI headed by Dr. Satish Chandra. All the Experts have opined that the death was on account of **'shock and Hemorrhage as a result of the injury to the Pelvis sustained'.** He further argued that the PM findings revealed fracture of left Sacro-Iliac (SI) joint and 1,500 gms of blood clots and 200 ml of blood in the peritoneal cavity in the peritoneal cavity and there was mesenteric contusion. The medical record was seized by the investigating officer. The contention of OPs that the deceased suffered **'Anaphlactic Shock'.** The learned counsel further argued that the medical opinions filed in support of OPs by Dr. Quaisar Anwar, Dr. Manju Prakash and Dr. Umadevi failed to prove the theory of anaphylactic shock. The CFSL, Hyderabad report clearly affirms that OT Monitor readings, ICU Monitor and Digital copy of USG were deleted, thus, the OPs tried to destroy evidence and they indulged in unethical medical practices.

4.2 Arguments on behalf of Opposite Parties

The learned Counsel for the Opposite Parties reiterated their evidences. The role of OP-2 was she decided for elective Caesar operation. The Counsel submitted that the operation was decided to perform under General Anesthesia (GA) as the patient had history of PARS Fracture of L5-S1 segment. The GA was induced with IV Pentothal sodium injection, the patient immediately suffered severe anaphylactic reaction (Grade III)[1] showing as hypotension, hypoxia and bradycardia. The only contraindication to thiopentone is Acute Porphyria, though the patient gave history of sulpha drug allergy, thiopentone does not cause reactions in these patients. The worldwide incidents of anaphylaxis to thiopentone are about 1:30000[2]. Thiopentone is an ultra-short acting barbiturate and after IV bolus dose, the drug gets re-distributed to the muscle and fatty tissue within 5-10 minutes. Therefore, the drug was not detected in the FSL report[3]. Same was submitted by Dr. Havanoor before the KMC that Pentothal sodium was administered to the deceased. The Counsel further submitted that in the police panchnama, it was recorded that there were rashes all over the

body of the deceased. There are several causes for such generalized rashes, drug reaction was one of the most important causes. However, this finding was conspicuously missing in the PM Report.

4.2.1 The counsel further argued on the **PM Staining** that because of gravity the dependent parts of the dead body show PM Staining. Dr. Havanoor's finding was faint PM Staining on the back. He also mentioned about the confluence of reddish spots on the left side of the chest and also around lower front, lateral aspect of neck.

4.2.2 The learned counsel vehemently argued that it was Fictitious "Fall" Theory**.** At full term pregnancy the Sacro-Iliac (SI) joint is well buffered from all sides. The height of operation table is usually 3 ft. and if a fall from such a height, it was not possible to fracture the deeply seated SI joint which covered with thick muscles (gluteus maximus) and fatty tissue. In case of isolated SI joint fracture there will always be bleeding at the fracture site, however, in the instant case there was no bleeding noted at post mortem. The external muscles were spread and the psoas muscle situated internally in the pelvic cavity is contused. In the instant case there was no fracture of the neck of femur, acetabulum, the iliac crest and the symphysis pubis. A tougher bone cannot fractures when weaker bones stay intact. A post mortem X-ray would have been of immense value in such a situation. He submitted that at the time of PM X-ray of the pelvic girdle was deliberately not taken. It would have proved the "Fall" theory. Usually, in vehicular accidents high impact traumas the fracture SI joint occurs, but not in the cases of a fall from 3 feet height.

5. Observations:

The Complainants and the Opposite Parties have filed Expert opinions/Affidavits to support their case.

5.1 As per the PM Report issued by Dr. Havanoor, the cause of death of the patient was **'shock and Hemorrhage as a result of the injury to the Pelvis sustained'**. In the preliminary PM report, he mentioned about fracture of left SI joint and 1,500 gms of blood clots and 200 ml of blood in the peritoneal cavity. The mesentery was contused. We have perused the opinions on record filed by Dr. Behram Anklesaria and the two forensic experts viz. Dr. Selvakumar and Dr. Raghavan. Another report was issued by BMRCI Committee. In our considered view, the opinions are crucial to decide the instant case.

5.2 Expert Opinions on behalf of Complainants

5.2.1 Expert opinion of **Dr. Behram S. Anklesaria**

Dr. Anklesaria was Chairman of Indian College of Obstetrics and Gynecology having more than 25 yrs. teaching experience as a professor and HOD in NHL Medical College, Ahmedabad. He gave two opinions on 12.05.2010 and 23.08.2010 to CID Karnataka. Thereafter, he gave opinion on 15.03.2012. He has also deposed before KMC as an expert witness for the ongoing case. He gave opinion on the basis of medical record, preliminary and final PM report and other documents.

5.2.1.1 Opinion dated 12.05.2010 (Annexure-L3)

1. The fresh fracture seen in the PM report off the left Sacro iliac joint is not consistent with the cause of death given by the CMO of Santosh Hospital.
2. The massive hemorrhage (1.7 litres) seen in the PM report in the peritoneal cavity is unexplained.

5.2.1.2 Opinion dated 23.08.2010 (Annexure-L2)

1. The massive intraperitoneal haemorrhage is explained by the same trauma that led to the pelvic injury and the sacral fracture.
2. The final PM report clearly indicates that the intraperitoneal massive haemorrhage resulting from mesenteric injury was caused by some trauma that the patient experienced in the OT.

5.2.1.3 Opinion dated 15.03.2012 (Annexure-L1)

According to Dr. Anklesaria, he never came across a case of anaphylaxis to lead to fracture of SI joint and such massive internal bleeding. The patients L5-S1 defect was unrelated to fracture sustained in the operation theatre. According to him, presence of hemorrhagic in a full term patient, the only correct option for the surgeon is to treat is to immediately perform an exploratory anatomy to arrest the active bleeding which could have save life of mother and child. The mother's vital signs not being recorded or recordable, an immediate postmortem cesarean section within 15 minutes after death could have saved the life of unborn. Finally, he opined that from the PM report and other medical records, it was shock and hemorrhage as a result of injury to pelvis sustained was the actual cause of death anaphylactic shock as claimed by the hospital and the doctors.

5.2.2 Expert opinion of Dr. Selvakumar & Dr. Ragahvan

Vide dated 29.03.2012, both the forensic experts have opined that:

The cause of death was 'shock and hemorrhage as a result of injury to the pelvis sustained.' It was not due to anaphylactic shock. From the preliminary PM report there was fracture of left SI joint and blood into muscles in front of joint. It indicates fresh ante-mortem fracture. The other findings were 1.5 kg blood clots and 200 ml of blood in the peritoneal cavity. The mesentery, transverse and left mesocolon were contused. There was blood in and around perinephric tissue which all indicates a blunt trauma sustained on the left side of pelvis. In their opinion they have collaborated the blunt trauma with the histo-pathological findings as mesenteric hemorrhage, fat necrosis, hemorrhage and congestion. Regarding massive blood loss, the experts stated that the SI iliac joint region consists of internal and external iliac arteries, veins and their branches which got injured due to blunt trauma. They further commented on the finding in the preliminary PM report about confluence of reddish spots present around lower part of front and sides of the neck and left side of the chest. Those were petechial hemorrhagic spots due to prolonged hypoxic stage or as a result of sustained CPR. Even there was Laryngeal Edema was not seen which is an important PM finding in anaphylactic/drug reaction deaths.

5.2.3 Report of **Expert Committee constituted by Bangalore Medical College and Research Institute (BMCRI)**

In Cr/No.158/2010 U/s 340(A), 315, 201 IPC pertaining to Mrs. Kapali Patne (deceased herein), the expert panel of five experts was constituted. The opinion dated 30.11.2010 is reproduced as below:

- The Ultrasound (U/S) examination was done on the intra uterine foetus of Mrs. Kapali Patne on the 16th of April 2010. As per the records submitted, Mrs. Kapila Patne had been declared dead at 11.50 am on 16th April 2010.
- From the Ultrasound films (four films) enclosed, it is evident that the U/S examination was carried out on the intra uterine foetus at 12.05 prn.43 sec., 12.07 pm.47 sec., 12.08 pm.30 sec., and 12.08 pm 45 sec. The report of the performing Ultrasonologist with regards to the intra uterine foetal demise, is in order.
- Keeping the above mentioned facts in view, it is very evident that the said U/S examination had been done, after the maternal death had been declared at 11.50 am on 16th April, 2010.
- As per the records, Mrs. Kapali Patne had developed an anaphylactic reaction after the administration of the intravenous induction agent. The reaction had been immediately recognised and resuscitative measures had been instituted. The anaphylactic reactions are known tooccur after the administration of induction agents.
- After having gone through the records and the post mortem report, the fracture of the SI bone with a hematoma on the left side, can occur following a trauma. This can also cause hemorrhage.
- The presence of blood clots (1500 ml), haemo peritoneum (200 ml) contusion to the transverse colon and to the left mesocolon, and associated perinephric collection, can be due to trauma, and the cause of death due to hemorrhagic shock.
- Following a cardiac arrest of the mother, a post mortem caesarean section should be done within 4 to 5 minutes to save the intra uterine foetus. In this case, it has not been attempted.

5.3 Expert Opinions on behalf of OPs

Let us go through the four expert opinions filed in support of the Opposite Parties namely from Dr. Rajeev Naik, Dr. Umadevi, Dr. Manju Prakash & Dr. Quaisar Anwar.

5.3.1 Expert opinion of Dr. Rajeev Naik (Orthopedic surgeon)

Dr. Rajeev Naik had experience of 35 years and currently practicing Orthopaedics at Dr. B. R. Ambedkar Medical College Bangalore. He opined that :

“the displaced and unstable sacro-iliac fractures usually are a result of high velocity injuries, usually secondary to road traffic accidents or a fall from considerable height. In such cases apart from sacro-iliac joint fractures, the adjacent structures like urethra, bladder, pelvis, femur too would get involved. Isolated sacro-iliac joint fractures are rare, that too from a fall from 3 feet height which would not result in sudden death of the patient.”

5.3.2 **Expert Opinion of Dr. K. Uma Devi (Obstetrician and Gynecologist)**

Dr. K. Uma Devi a visiting Professor and senior Consultant Obstetrician and Gynecologist at MS Ramaiah Hospital Bengaluru studied the case record of the patient. In her opinion the antenatal records and the decision to do caesarean section based on the indication cephalopelvic disproportion at maturity of the baby is an accepted standard procedure. The decision about type of anaesthesia for the procedure depends on contraindications for a certain type, patient's condition and the combined decision of anaesthesiologist and obstetrician. As the patient had history of a spinal problem, the spinal or epidural route of anaesthesia was avoided. The Obstetrician did not proceed with the surgery waiting for the patient to recover from the shock. This is the standard agreed procedure in the operation theatres i.e. surgeon will not operate unless the anaesthetist instructs accordingly. According to her, the postmortem report did not correspond to the maternal anatomical parameters, and there are no established guidelines for performing a postmortem caesarean section. She relied upon Green-top Guideline No.56-January 2011 “Maternal collapse in Pregnancy and the Puerperium” and Guidelines from American college of Obstructions and Gynaecologist.

5.3.3 Expert Opinion of Dr. Manju Prakash, Forensic Expert

Dr. Manju Prakash is the Professor and HOD of Forensic Medicine at Aakash Institute of Medical Sciences, Devanhalli, Bangalore. According to him, the Expert Committee of Bowring & Lady Curzon Hospitals does not consist of Forensic Medicine to critically analyse and certify the findings of the Autopsy surgeon. The members were belonged to the same institution in which autopsy was performed and they were colleagues of autopsy surgeon. They had never scrutinized the findings but endorsed the final opinion based on autopsy findings without genuine attempts. He also commented on the expert opinion by Dr. Selvakumar that it does not touch upon the forensic medicine aspect at all, but goes into great detail to explain the anatomical relations in the region. None of the forensic aspects were discussed. He further opined that Dr. Srinivas Raghavan’s opinion was very similar to the opinion of Dr. Selvakumar, without discussion of new issues.

5.3.4 Expert Opinion of Dr. Radhika Dhanpai, Anesthesiologist She is Professor of Anaesthesiology and Critical Care, St. John's Medical College Hospital, Bangalore. In her affidavit stated that any drug can induce a life threatening anaphylactic reaction even in the absence of any risk factor in the patient's medical history. The documentation of anaphylaxis is often lacking because the cause and effect relationship is often hard to prove and because the diagnosis is not easy to make with the patient under anaesthesia. Anaphylaxis can present as Grade 1-5 with skin rashes, breathing difficulty or cardiovascular collapse and can be fatal.

According to her, in the instant case the patient was anesthetised with Inj. Thiopentone Sodium and Inj. Succinylcholine intravenously for administration of General Anaesthesia. Both these drugs are known to cause anaphylaxis, thiopentone 1:30,000 and Succinylcholine 1:2018. Thiopentone Sodium is redistributed from the blood into the tissues (muscle, fat) in 5-10 minutes and hence will not found in the blood after this period. Succinylcholine is metabolized by an enzyme, pseudo cholinesterase in the blood within 2-4 minutes of its administration.

5.4 The Complainant approached KMC on 07.08.2010. In pursuance to the Order of the Hon'ble High Court at Bangalore, the KMC appointed three qualified doctors the gynecologist, anesthetist and a pediatrician for the enquiry. The KMC, after hearing the parties, vide Order dated 12.09.2020 exonerated all the doctors.

6. **Discussion**

We gave our thoughtful consideration to the arguments on both the sides, carefully perused the entire records inter-alia the PM findings. We took references from standard medical books like Williams Obstetrics (14th edition), the Campbell's Orthopedics, Pelvic fractures and few research articles on fracture SI joint.

6.1 It is pertinent to note that the patient was full term and taken for elective LSCS on 16.04.2010. Admittedly, the patient suffered certain complications and died subsequently within short span of time. The say of Complainants was that the patient died due to fall from the operation table which sustained fracture of SI joint leading to hemorrhagic shock and death. Per contra the OPs contention that it was due to severe anaphylactic reaction to the anesthetic drug sodium pentathol, which subsequently led to cardiac arrest and death.

6.2 However, we are not convinced with the submission of the OPs about the anaphylactic reaction. The question before us that why there was massive blood clots and intra-peritoneal bleed, if it was an anaphylactic drug reaction. Such bleed could occur due to fall or any blunt trauma to the internal organs. We do not accept that anaphylactic reaction by any stretch of imagination will not cause such traumatic hemorrhage. At the full term pregnancy due increased vascularity in the venous plexus the pelvic bones of the woman are more vascular and fragile. Any trauma may lead to vascular injury and severe bleeding.

6.3 It is evident from the available medical records the OPs were trying to establish the story of anaphylaxis. The report of CFSL, Hyderabad clearly establishes that the OPs deleted the readings of OT Monitor, ICU Monitor and the Digital copy of USG. It was an attempt of OPs who tried to destroy the evidence. Thus, it was unethical practice.

6.4 As per the OPs, three congenital defects in the patient could have contributed to the death. The first defect was pars fracture L5-S1 which was detected in early 2008. The second defect was the right ventricular dysplasia which could affect right ventricle leads to thinning of ventricle. This causes right ventricular failure and sudden death. Third defect was presence of arcuate ligament remaining open to give a connection from thorax to kidney and perinephric areolar tissue and the base of transfer mesocolon to the muscles of pelvis. Therefore, the blood might have collected from the external cardiac muscles and fracture of 3 to 7 ribs. The blood flows down through open arcuate ligament towards postero superior surface of kidney only by areolar tissue and blood flows along aerolar tissue surrounding the left kidney. The OPs relied upon the decision of Hon'ble Supreme Court in **Jacob Mathew Vs. State of Punjab[4], Kusum Sharma & Ors. v. Batra Hospital and Medical Research Centre & Ors.[5]** The OPs stated that it was fictitious fall and fracture theory. The counsel for OP relied upon few medical literatures.

7. Medical Literature :

7.1 We have perused the standard textbooks on Obstetrics and Gynecology viz William's Obstetrics (20th ed) , Williams Gynecology (4th ed) Shaw's Textbook of Gynaecology (14th ed), and Grey's Human Anatomy(18th ed). The text books revealed the **pelvic vessels (pelvic vasculature)** play an important role in pelvic support. There is significant anatomic variation between individuals in branching pattern of internal iliac vessels. The pelvic vasculature is a high volume, high flow system with enormous expansive capabilities throughout reproductive life. The pelvic vasculature is supplied with an extensive network of collateral connections that provides a rich anastomotic communication between different major vessel systems.

7.2 During pregnancy, there occurs Hematological changes and increased vascularity in the pelvis. Both the plasma volume and the red cell mass increase throughout pregnancy. Plasma volume doubles by the end of the third trimester, however, in much higher proportion than the red blood cell mass increase. This results in dilutional anemia of pregnancy. The normal hemoglobin is 10-14 g/dl by the term. The liver becomes hyper-metabolic, increasing production of coagulation factors and fibrinogen. With this production, the patient is now more at risk for deep vein thrombosis and disseminated intravascular coagulation (DIC).

7.3 With respect to trauma during pregnancy, the literature revealed Trauma in pregnancy can ranges from mild, for example trauma associated with a single fall from standing height or hitting the abdomen on an object such as an open desk drawer, to major, for example trauma associated with penetrating injury or high force blunt motor vehicle accident. This activity reviews the evaluation and management of trauma in pregnancy and highlights the role of interprofessional team members in collaborating to provide well-coordinated care and enhance outcomes for affected patients and families.

Evaluation and Treatment of the Pelvic fractures during pregnancy are associated with increased maternal morbidity and mortality. One particularly significant physiologic change is that, in the third trimester, there is a relative maternal hypervolemia, and maternal blood loss of up to 1500 mL can occur before any signs of hypovolemia can be detected. Therefore, any suspicion of maternal blood loss should be treated vigorously and immediately, and, if necessary, application of external fixation for control of bleeding from pelvic injury should not be delayed. It must be emphasized that these measures are not relevant in the first trimester, during which almost no change in the maternal anatomical or physiologic parameters occurs. However, the mother's resuscitation and initial treatment should not be compromised because of the pregnancy. Treatment priorities for an injured pregnant patient remain the same as for the non-pregnant woman. Fetal death rates in cases of maternal pelvic fracture occur in 35% to 60% of cases. The pelvic fracture in itself is not an indication for termination of pregnancy, and the decision is usually based on other factors. It is a well-accepted principle that, for optimal outcomes for both mother and fetus, the mother should be assessed and resuscitated before the fetus. Usually, the worse the maternal injury, the higher the fetal risk, as reflected in parameters such as higher injury severity score 6-9, lower Glasgow Coma Scale(GCS) score, and presence of DIC. However, fracture severity does not always correlate directly with fetal demise probability. In a case of a severely injured mother

in the third trimester, with low chances for survival, a pre-mortem caesarean section should be considered in an attempt to save the fetus. Practically, this is not always possible, because of the mother's critical condition.

7.4 **Thiopental Sodium** anesthetic agent is a short acting depressant of central nervous system which induces hypnosis and anesthesia but not analgesia[6]. Thiopental[7] is an extremely short-lasting barbiturate that makes anaesthesia pleasant and smooth for the patient. When using the usual therapeutic doses, coming back into consciousness happens 15 min after administration. Thiopental has a straightforward dose-requiring oppressive effect on the myocardium, central nervous system, and to a lesser effect acts on the smooth muscle of blood vessels. It is used for narcosis in brief surgical operations.

A normal dose of sodium thiopental (usually 4–6 mg/kg) given to a pregnant woman for operative delivery rapidly makes her unconscious, but the foetus in utero remains conscious. However, larger or repeated doses can depress the baby's consciousness.

7.5 In the instant case the Obstetrician OP-2 was put on sterile gown and gloves and yet to start operation, but during painting of abdomen, the alleged incident occurred in the OT. We do not accept that, it was a case of severe anaphylactic shock due to Thiopental sodium. Based on the PM findings and expert opinions the death of patient was due to the hemorrhagic shock which could be only due to trauma inside the OT. Though even if we accept it was an anaphylactic reaction, but it is beyond our imagination that how the resuscitation will cause large amount of blood clots (1500 g) and blood in the pelvic cavity.

7.6 From the research article Anatomical **consequences of "open-book" pelvic ring disruption: a cadaver experimental study**[8]

Patients with pelvic fractures, there is frequently concomitant blood loss, even in closed fractures. Intra-abdominal bleeding up to 40% of cases, but there also may be intra-thoracic, retroperitoneal, or compartmental bleeding in such injuries. Within the pelvis, bleeding is usually caused by shearing of the venous plexus and can lead to hematomas holding up to 4L of blood. Posterior pelvic fractures may also result in an arterial injury to the superior gluteal artery, which constitutes a surgical emergency.

7.6.1 Anterior to Posterior Compression pelvic ring injuries

In anterior to posterior compression type pelvic injuries, ligamentous structures fail from an anterior to posterior direction. APC type pelvic ring injuries into 3 types in which the APC Type III injuries are defined as the disruption of both the anterior and posterior sacroiliac ligaments, including the posterior sacroiliac complex, the strongest ligaments in the body. APC III injuries have the highest rate of mortality, blood loss, and need for transfusion of all pelvic ring injuries. The venous plexus in the posterior pelvis accounts for the majority of hemorrhage associated with pelvic ring injuries. The corona mortis is an anastomosis between the obturator artery (a branch of the internal iliac artery) and the external iliac artery. Damage to the corona intra-operatively can quickly result in the expiration of the patient due to excessive blood loss within the pelvis.

7.7 The basic principles of trauma management apply to injured pregnant women, and therefore maternal resuscitation is the first priority under all conditions. Moreover, maternal condition has been found to be the main determinant of fetal outcome in trauma during pregnancy. It is a commonly accepted principle that the severity of the mother's injury directly affects the fate of the fetus. However, as pelvic fracture is only a single component of the blunt abdominal trauma sustained by the mother, fracture severity does not always correlate with the condition of the fetus. Most cases of pelvic fracture during pregnancy are not complicated and can be treated conservatively.

8 Law on medical negligence:

8.1 In **Jacob Mathew's** case (supra), the Hon'ble Supreme Court held that that, medical negligence is the breach of duty which one party owes to another. The duty can be in the form of an act or omission and it is referred to as the duty of care and due to the negligence of which it causes an injury to the person. Thus, it is the failure of medical practitioners to exercise certain acts or omission while discharging their duties with respect to their patients could not be saved.

8.2 The Hon'ble Supreme Court in **Smt. Savita Garg Vs. The Director, National heart Institute**[9] has held as below:-

> "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 the treating doctor or hospital. Therefore, in any case, the hospital is in a better position to disclose what care was taken or what medicine was administered to the patient. It is the duty of the hospital to satisfy that there was no lack of care or diligence. The hospitals are institutions, people expect better and efficient service, 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 and not impleading a particular doctor will not absolve the hospital of its responsibilities."

8.3 In the instant case, the death of patient and her foetus was due to the negligence of the hospital and the OP-3. However, prima facie we do not find any negligence of the OP-2 who did not start any operative procedure (Caesarean). Moreover, during resuscitation, the prime aim was to save the mother therefore the team of doctors were focused on resuscitation. In addition to trauma, umbilical was cord around the neck of foetus caused death. Therefore, the baby could not be saved; it was not a negligence of OP-2 or the team in OT. It is pertinent to note that the patient was under custody of doctors and the OT staff, but she sustained left SI joint fracture and suffered hemorrhagic shock resulted into death of the patient. As discussed above and from the PM findings, the death was not due to anaphylactic reaction. The OP-3 Anesthetist failed to establish why there was large amount of peritoneal / pelvic hemorrhage, whether it was due to anaphylactic reaction.

8.4 Considering the entirety, in our view the OP-1 hospital is vicariously liable for the negligent acts of its doctors or employees. We would like to rely upon the **Maharaja Agrasen Hospital and Ors. Vs. Master Rishabh Sharma and Ors**[10] case wherein Hon'ble Supreme Court observed:

> "11.4.17. 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. 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. 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."

8.5 Thus hospital (OP-1) cannot escape from its vicarious liability for the medical negligence that has been meted out in the present case. The hospital is required to compensate for the medical negligence and mental agony sustained by the patient's family members.

8.6 The **'Duty of Care'** towards the patient was clearly explained by the Hon'ble Supreme Court in **P.B. Desai vs State of Maharashtra & Anr**[11] case as below:

> "Once, it is found that there is 'duty to treat' there would be a corresponding 'duty to take care' upon the doctor qua/his patient. In certain context, the duty acquires ethical character and in certain other situations, a legal character. Whenever the principle of 'duty to take care' is founded on a contractual relationship, it acquires a legal character. Contextually speaking, legal 'duty to treat' may arise in a contractual relationship or governmental hospital or hospital located in a public sector undertaking. Ethical 'duty to treat' on the part of doctors is clearly covered by Code of Medical Ethics, 1972. Clause 10 of this Code deals with 'Obligation to the Sick' and Clause 13 cast obligation on the part of the doctors with the captioned "Patient must not be neglected".

In the instant case glaring deficiencies are visible from the hospital (OP-1). The Anesthetist and the assisting team in the OT have failed in their duty of care.

9. Compensation:

9.1 **I**n the catena of judgments of Hon'ble Supreme Court, laid down different methods to determine '**just and adequate compensation'**. The Hon'ble Supreme Court noted in **Sarla Verma vs. Delhi Transport Corporation case**[12] that:

> "The lack of uniformity and consistency in awarding compensation has been a matter of grave concern… If different tribunals calculate compensation differently on the same facts, the claimant, the litigant, the common man will be confused, perplexed, and bewildered. If there is significant divergence among tribunals in determining the quantum of compensation on similar facts, it will lead to dissatisfaction and distrust in the system."

It was further held that;

> "While it may not be possible to have mathematical precision or identical awards, in assessing compensation, same or similar facts should lead to awards in the same range. When the factors/inputs are the same, and the formula/legal principles are the same, consistency and uniformity, and not divergence and freakiness, should be the result of adjudication to arrive at just compensation."

9.2 The Hon'ble Supreme Court in **Malay Kumar Ganguly vs. Sukumar Mukherjee and Ors**[13] clearly mentioned that there were problems with using a strait-jacket formula for determining the quantum of compensation. It clarified about the basis of computing compensation under common law lies in the principle of '**restitutio in integrum'** which refers to ensuring that the person seeking damages due to a wrong committed to him/her is in the position that he/she would have been had the wrong not been committed. Thus the victim needs to be compensated for financial loss, future medical expenses and any suffering endured by the victim. By no stretch of imagination, the award shall not a paltry sum for gross negligence. It was held that there is no restriction that courts can award compensation only up to what is demanded by the complainant.

10. **Conclusion:**

10.1 Based on the foregoing discussion we determine 'medical negligence' and 'deficiency' on the part of the OP-1 hospital and the OP-3 anesthetist. The OP-3 conclusively failed to prove the theory of Sodium Pentothal anaphylaxis. It was traumatic injury to the SI joint of the full term pregnant woman who was inside the OT. The PM findings and the evidence/opinions of experts conclusively establish the death of patient and the foetus was due to fall in the OT and subsequently the hemorrhagic shock, but conspicuously the OP-3 portrayed it as Anaphylactic shock to the Pentothal. It was very unfortunate and sad to note that two precious lives were lost - the young Primigravida and also her fetus.

10.2 In view of the peculiarity of this case, to meet the ends of justice, we allow the lump-sum compensation of Rs. 1.6 Crore to be just and adequate. The OP-1 hospital shall pay Rs. 1.5 Crore and the OP-3 Anaesthetist shall pay Rs.10 lakh to the Complainants. We do not find either negligence or failure of duty of care from the Obstetrician, thus OP-2 is exonerated. We also allow Rs. 2 lakh towards the cost of litigation.

10.3 We may observe that, in case if the Complainant No.1, the husband of deceased Kapali Patne, got re-married; the entire amount shall be paid to the parents of the deceased Kapali Patne.

Order in entirety shall be complied by the OP-1 and 3 within 6 weeks from today, failing which, it shall carry the interest @ 7% per annum till its realisation.

The Complaint is partly allowed. There shall be no Order as to costs.

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[1] British Journal of Anesthesia Table 1 – Severity grade of allergic reactions and anaphylaxis during Anesthesia

[2] Drug Allergy – Brian A Baldo; Nighia H Pharm

[3] Millers Textbook of Anesthesia Seventh Edition

[4] 2005 (6) SCC 1

[5] (2010) 3 SCC 480

[6] Thiopentone - Mechanism, Indication, Contraindications, Dosing, Adverse Effect, Interaction, Hepatic Dose | Drug Index | Pediatric Oncall

[7] Synthesis of Essential Drugs,Elsevier,2006, 1 - General Anesthetics, R.S. Vardanyan, V.J. Hruby,

[8] Surg Radiol Anat. 2005 Dec;27(6):487-90

[9] IV (2004) CPJ 40 (SC)

[10] 2019 SCC OnLine SC 1658,

[11] (2013)15 SCC 481

[12] (2009) 6 SCC 121

[13] (2009) 9 SCC 221

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DR. S.M. KANTIKAR
PRESIDING MEMBER

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BINOY KUMAR
MEMBER