BEFORE THE TELANGANA STATE CONSUMER DISPUTES REDRESSAL COMMISSION:HYDERABAD

C.C.248/2013

Between :

1.K.Hari Prasad,
S/o.K.V.S.Rama Krishna,
Aged about 29 years, Indian,
Occ: Private service,
R/o.LIG 538, 1st floor,
KPHB Colony, Kukatpally,
Hyderabad – 500 072.

2. Baby K. Venkata Shanmuka Priya,
D/o.K.Hari Prasad,
Aged about 3 months, Indian,
Being minor, rep. by her father and
natural guardian K.Hari Prasad,
R/o.LIG 538, 1st Floor, KPHB Colony,
Kukatpally,
Hyderabad- 500 072. Complainants

And

1. Taraporewalla Nursing Home,
D.No.10-3-32/9/32,
Opp. Tagore Home Junior College,
East Maredpally,
Secunderabad-500 026.
Rep. by Dr.Shirin N .Taraporewalla.

2. Dr.Mrs.Shirin N Taraporewalla,
Taraporewalla Nursing Home,
D.No.10-3-32/9/32,
Opp. Tagore Home Junior College,
East Maredepally,
Secunderabad-500 026. …Opposite parties

Counsel for the Complainants : M/s.V.Gowrisankara Rao

Counsel for the opposite parties : M/s.D.Devender Rao

QUORUM:Hon'ble Smt.Meena Ramanathan,Incharge President
And
Hon'ble Sri V.V.Seshubabu, Member (Judicial).

MONDAY, THE FOURTH DAY OF MARCH,
TWO THOUSAND TWENTY FOUR.

Oral Order: (**Per Hon'ble Smt. Meena Ramanathan,**
Incharge President.).

*****

01). This is a complaint filed u/s.17(1)(a)(i) of C.P. Act alleging deficiency in service against the opposite parties and direct them:

i). to pay compensation of Rs.99,00,000/-
and
ii). to pay costs of Rs.50,000/-.

02). The brief facts of the complaint are as follows:

The marriage of the complainant no.1 took place on 15.7.2010 and his wife since conception of pregnancy took treatment with opposite party no.2 in opposite party no.1 Hospital at East Maredpally. On 10.8.2013, complainant's wife was admitted in opposite party no.1 hospital for her delivery and opposite party no.2 attended on the patient. The complainant's wife delivered a female baby by normal delivery on 11.8.2013 at 8.58 a.m. On the same day at about 9.20 a.m. she developed bleeding problem i.e. Post Portem Hemorrhage (PPH). Opposite party no.2 informed that the bleeding was minor and nothing to worry and also informed that hysterectomy may be needed as a last resort, for which, the complainant no.1 accepted. Complainant no.1 requested opposite party no.2 that he can fetch blood, if necessary or the patient may be shifted to any Super Specialty Hospital. Since he and his wife are software engineers and they are eligible for reimbursement upto Rs.7,00,000/- and Rs.2,00,000/- respectively from their employer i.e. Infosys Ltd.

On 11.8.2013 at about 10.20 a.m. on request of the opposite party no.2, to get blood as early as possible from the Blood Bank at Sunshine Hospitals, Paradise, Secunderabad, the complainant no.1 went to the said hospital within 10 minutes and requested to give 2 units of packed cells and 2 units of fresh frozen plasma and the hospital authorities took nearly 35 minutes time for grouping of the blood/matching of the blood and handed over packed cells by collecting Rs.5,200/-. The complainant no.1 rushed back to opposite parties by 11.25 a.m. where he was informed by opposite party no.2 that the pulse rate of the patient was very low due to excess bleeding and her condition was serious and there was no chances for recovery of the patient. The blood brought by complainant no.1 was not even transfused and the patient was declared dead at 11.45 a.m. on the same day.

It is submitted that the premature death of his wife occurred only due to lack of necessary care and skill exhibited by the opposite parties. As per the Antenatal Record, the expected date of delivery was 25.8.2013, but as per the advise of the opposite party no.2, the patient was admitted in the hospital on 10.8.2013. Opposite party no.1 hospital was not properly equipped with necessary infrastructure to meet the emergency and complicated cases and opposite party no.2 failed to properly visualize the situation of the patient after development of PPH and was negligent in not even conducting the grouping of the blood which was routine in nature and there was delay in summoning the blood immediately after development of PPH. Opposite party no.2 specifically instructed the complainant no.1 to get the blood from Sunshine Hospitals only, which is far from opposite party no.1 hospital, although there are about 10 blood banks within ½ km. of opposite party no.1 hospital. It is the case of the complainant that opposite party no.2 did not shift the patient to any other corporate hospital, though the complainant no.1 informed them that he is capable of bearing the necessary expenditure apart from reimbursement facility.

It is submitted that due to negligence of opposite parties in not properly treating and controlling the PPH of the patient, resulting in her premature death, not only amounts to deficiency in service but also amounts to unfair trade practice. Because of the pre-mature death of his wife, the complainant no.1 has been subjected to severe mental agony apart from irreparable financial loss and his minor baby girl i.e. complainant no.2 is subjected to permanent loss of her maternal love and affection apart from care which is irreplaceable. Hence alleging deficiency in service on the part of the opposite parties, the complainants filed this case seeking direction to the opposite parties to pay compensation of Rs.99,00,000/- and to pay costs of Rs.50,000/-.

03). Opposite parties filed their written version admitting the facts that the deceased patient consulted them for her pregnancy and she was admitted to their hospital for delivery and she had a normal delivery on 11.8.2013. The opposite parties clarified that the complainant no.1 was not present in the hospital at the

time of the delivery and blood was not made available inspite of seeking a request for blood and sample being made available to the attendants by 9.30 a.m. It is also clarified that the patient was not in a condition to be shifted to any other super specialty hospital until and unless she is stabilized. A mere perusal of Antenatal Card of the patient shows that the blood grouping was done many months prior to the admission of the patient into opposite party no.1 hospital for delivery and blood group as O+ve was clearly mentioned in the said Card. It is clarified that in order to avoid any risk factors in transfusion and other complications, they have specifically referred to Sunshine Hospital. It is further clarified that they have admitted the patient on 10.8.2013, though the expected date of delivery was 25.8.2013, since the liver function test of the patient done on 27.7.2013 showed alkaline phosphatase with itching all over body and she was diagnosed as having cholestatic jaundice and started on Actamarin Forte 1 b.d. (ursodeoxycholic acid) and in such situation the delivery is to be done at 38 weeks i.e. 15 days prior to expected date of delivery and hence the patient was asked to be get admitted on 10.8.2013 at night for induction of labour. The opposite parties submit that all the nursing homes do not need an attached blood bank and it is not mandatory nor required and also clarified that the opposite party no.1 hospital is fully equipped for obstetric emergencies with cardiac monitors/ defibrillators/central O2/pulse oximeters etc. Opposite party no.2 had properly visualized the situation of the patient after development of PPH and had initiated all the proper treatment measures immediately without any delay. It is clarified that complete step by step treatment of PPH was done with all possible injections and uterine massage etc. but the patient suffered uncontrolled Catastrophic Postpartum Hemorrhage which is known risk factor in delivery. The opposite parties submit that there is no negligence on the part of the opposite parties and the complaint is devoid of merits and is liable to be dismissed with exemplary costs.

04). Evidence affidavit of the complainant filed reiterating the facts stated in the complaint. On behalf of the opposite parties Evidence Affidavits in lieu of chief examination of opposite party

no.2 (RW.1), Dr.Usha Rani (RW.2) and Dr.Nandakumar Murari (RW.3) are filed, reiterating the facts as stated in written version. On behalf of the Complainant Exs.A1 to A17 are marked. On behalf of the opposite parties, Exs.B1 to B9 are marked .

Heard both sides. All the witnesses were subjected to cross examination.

05). In the light of allegations made in the complaint and the material available on record, the following points arise for consideration are :

i. Whether there is any deficiency in service or medical negligence on the part of the opposite parties?

ii. Whether the complainants are entitled to the reliefs as prayed for in the complaint.

06). <u>Point nos. i & ii</u> : It is the case of complainant no.1 that his wife started consulting opposite party no. 2 doctor in opposite party no.1 hospital, since the time she conceived. On 10.8.2013, his wife was admitted in opposite party no.1 hospital for her delivery and on 11.8.2013 at 8.58 am. she delivered a baby girl. It was a normal delivery. Subsequently, she developed PPH at about 9.20 a.m. on 11.8.2013 and complainant no.1 was informed that hysterectomy may be required, as a last resort. He even offered to procure the blood from the blood banks close by, but he was directed to the Blood Bank at Sunshine Hospital, Paradise, Secunderabad by opposite party no.2 . Tragically, his wife was declared dead at 11.45 am. on 11.8.2013 and the opposite party no.2 did not do the necessary blood transfusion as her chances of recovery was very slim.

07). The complainant no.1 has deposed in his evidence that the opposite parties did not shift his wife to a corporate hospital, where all the necessary facilities and the blood bank would be easily accessible. As per his deposition, he contends that PPH is not a fatal condition and timely care and skill was not exhibited to save his wife. He has supported his claim by filing Ex.A1 to A16. Ex.A1 is the Admission Record. Ex.A2 First Storage Information dt.16.8.2013 issued by Cryobanks International India Pvt.Ltd. Exs.A3 to A5 pertains to police complaints. Ex.A6 is complaint

filed before A.P.State Human Rights Commission. Ex.A7 is a representation dt.7.10.2013 of complainant no.1 to opposite parties . Ex.A8 is a reply given by opposite party no.2. Ex.A9 is the list of the blood banks near opposite party no.1 hospital. Ex.A10 is the complaint addressed to the Medical Council of India dt.13.9.2013. Ex.A11 is the report of ACP to the A.P. State Human Rights Commission. Ex.A12 is Discharge Card. Ex.A13 is the confirmation letter from Cryobanks International India Pvt. Ltd. Ex.A14 are the series of SMS online messages. Exs.A15 and A16 are the photographs of the new born baby and maternal grand mother of the new born baby. Ex.A17 is the order dt.3.2.2021 issued by Telangana State Medical Council.

08). Ex.A1 – pertains to the admission record of the patient. The patient was 32 years old and consent was taken for LSCS/TAH, blood investigation and grouping was already done.

On 11.8.2013 at about 8.58 am., a female child was delivered.

At 9.50 a.m. it is recorded that-"informed Dr.Usha Rani & Dr.Murari

BP was noted as 70/100.

At 10.34 a.m. – pulse absent, ECG leads attached, activity after cardiac massage seen.

Patient was declared dead at 11.45 a.m. by opposite party no.2 and Dr.Murari.

As per the evidence adduced by opposite party no.2 Doctor as RW1, she submits that the complainant no.1 was very aware of the complications in delivery and that the patient developed PPH immediately after delivery. As a routine, consent was taken for LSCS but consent for TAH was only taken at 10.20 a.m., after explaining to the complainant no.1 that it may be needed as a last resort. Blood grouping was done many months prior to admission and the patient's attendants lost valuable time in procuring the blood for transfusion from Sunshine Hospital by stating that cross matching was not done. In support of this, the opposite parties filed Exs.B5 (letter from Sunshine Hospital) and B6 (another letter from Sunshine Hospital stating that cross matching and issuance of blood took just 20 minutes.) .

09). Admittedly the complainant no.1's wife was admitted in opposite party no.1 hospital on 10.8.2013 and was attended to by opposite party no.2 doctor. On 11.8.2013 she developed PPH immediately after delivery. In her evidence as RW1, the opposite party no.2 doctor submits that 60% of the maternal deaths are caused by PPH. This is as per her submissions - a known factor for majority of cases for mortality and morbidity. At this juncture, we refer to the Ex.B2 – the admission record filed by opposite parties. the same exhibit has been discussed as Ex.A1. In this document, the patient's BP, post delivery was recorded as 90/60 (soon after delivery)and was only falling rapidly. When the first recording was so low, the opposite parties should have immediately reacted and taken serious note of the issue, instead only at 10.34, they attached the ECG leads. At 10.34 itself it is stated that "pulse absent". In this document, there is a complete absence of having asked the patient's attendants to procure the required blood for transfusion. The Discharge Card refers to the Stem Cell Collection by the Cryobanks International India Pvt. Ltd. - Ex.B4. It also refers to having informed Dr.Murari and Dr.Usha Rani to come for hysterectomy. Patient was shifted to OT at 9.50 a.m. Delivery occurred at 8.58 a.m. and the complainant has filed Ex.A15 and A16 being Photographs of the new born baby and the grandmother, not suspecting that the young mother was in any danger of losing her life. It is necessary to emphasize that if a patient has no attender then what is the duty of the nursing home/hospital to assist the patient to procure blood from a blood bank. Does no attender mean that treatment will be halted? or blood will not be immediately procured?

10). The Medical Literature filed by the complainants' counsel highlights the factors of prevention and management of Post Partum Hemorrhage. PPH occurs in women with no risk factor. So Physicians must be prepared to manage this condition at every delivery. Physical examination will suggest the diagnosis, and the etiology of hemorrhage determines the proper management. Hysterectomy should ultimately control hemorrhage. This is certainly within the knowledge and the capacity of the opposite

parties but they did not treat the hazard as severe and give it the immediate medical attention.

11). The opposite parties have filed the Medical Literature being **'Williams OBSTETRICS' 25th EDITION.** We have carefully perused the voluminous literature and refer to certain relevant portions :

- "**Risk Factors**: In many women with knowing risks, uterine atony can at least be anticipated well in advance of delivery."
- "**Evaluation and Management**: With immediate postpartum hemorrhage, careful inspection is done to exclude birth canal laceration. Because bleeding can be caused by retained placental fragments, inspection of the placenta after delivery should be routine".
- " **Bleeding Unresponsive to Uterotonic Agents**: If bleeding persists after initial measures for atony have been implemented, then the following management steps are performed immediately and simultaneously:

  1.Begin bimanual uterine compression, which is easily done and controls most cases of continuing hemorrhage (Fig.41-4). This technique is not simply fundal massage. The posterior uterine wall is massaged by one hand on the abdomen, while the other hand is made into a fist and placed into the vagina. This fist kneads the anterior uterine wall through the anterior vaginal wall and the uterus is also compressed between the two hands.

  FIGURE 41-4 Bimanual compression for uterine atony. The uterus is positioned with the fist of one hand in the anterior fornix pushing against the anterior wall, which is held in place by the other hand on the abdomen. The abdominal hand is also used for uterine massage.

  2. Immediately mobilize the emergent-care obstetrical team to the delivery room and call for whole blood or packed red cells.

3. Request urgent help from the anesthesia team.

4. Secure at least two large-bore intravenous catheters so that crystalloid with oxytocin can be continued simultaneously with blood products."

When these measures have been emphasized upon, the opposite party failed to mobilize the emergent care and urgent help from Anaesthesia team. Recognition of Obstetrical Hemorrhage severity is crucial to its management. It is also further referred in the literature provided by the opposite parties that in most institutions today whole blood is rarely available , thus most women with obstetrical hemorrhage and on going blood loss are given packed red cells and crysteloids. There is no explanation provided by the opposite parties as to why these measures which have been enunciated in the literature provided vide 'Williams OBSTETRICS' were not followed for the management of postpartum hemorrhage . We further emphasis by reproducing the following lines from the said literature:

- "The first step in the management is to establish good IV access, infuse IV normal saline rapidly, send a sample for blood tests and cross-match, and get additional assistance. A senior obstetrician, senior midwives, and nurses should be called in for help; the anesthetist and blood bank should be alerted."

12). The main defense of the opposite parties is that PPH is an uncontrollable catastrophic hemorrhage and cannot be imputed or linked as medical negligence. On the other hand, they have also stated that it accounts for 60% of maternal deaths. That being the case, should the opposite parties not be more cautious and alert in expecting complications during delivery?

13). PPH - Post Partum Bleeding or hemorrhage occurs due to poor contraction of uterus and symptoms include loss of lots of blood after child birth, increased heart rate etc. Blood pressure may drop and this condition can occur upto six weeks following delivery. Treatment and prevention is of importance and blood transfusion is very necessary. The opposite parties have not explained the treatment given nor have they explained why surgical repair was not immediately performed. If medical management fails, the surgery cannot be delayed. They stated that hysterectomy was needed but delayed it considerably.

14). In the evidence of RW.2 (Dr.Usha Rani) and RW.3 (Dr.Murari) – it is deposed that on 11.8.2013 they received a call at 9.50 a.m. and by the time they reached the hospital at 10.34 a.m. the patient's pulse was not felt and BP recorded was 60 systolic, Dopamine was started only then. The patient's BP even at 8.58 a.m. as per Ex.B2 was 90/60. Why was she not treated aggressively and the Obstetrician & Gynecologist Dr.Usha Rani and the Anaesthetist Dr.Murari not called immediately?

15). The protocol to manage post partum bleeding are surely specified and Nursing Homes dealing in this area of specialty should be equipped to respond faster and more skillfully. Failure on the part of the opposite parties is very visible and not having the skilled surgeon available has been a very heavy price to pay, by the complainant.

16). The opposite parties blame the attendants in wasting valuable time to procure the required blood for transfusion. Instead, the opposite party hospital could have been better equipped. When this is an anticipated emergency, a nursing home should have the necessary facility to manage the eventuality instead of blaming the attendants of wasting 35 minutes.

17). In the absence of timely and appropriate action, the young patient died because of PPH . In the developed world PPH is a largely preventable and manageable condition. It is pertinent to mention that the deceased was not suffering from any complications during her pregnancy. No such negative reference is made.

18). The tragic death of the young mother can never be sufficiently quantified monetarily and the loss of a mother's love for her child can never be replaced. The complainant has lost the companionship of his wife early in their married life. The complainant has pleaded that he and his wife were working as software engineers but has failed to provide the salary certificate or details, therefore, we can safely state that she was drawing a salary of Rs.20,000/- per month. For the injustice suffered on

account of the opposite parties' negligence, we rely on the judgment of the Hon'ble Supreme Court in Sarala Verma Case " a person in the age group of 31 to 35 years the applicable multiplier is 16". The same yardstick is applied as the age of the deceased is shown as 32 years.

As her age was only 32 years by the date of her death, there is every likelihood of enhancement of annual future income by another 50%. So, it can be taken as Rs.20,000/- + Rs.10,000/- = Rs.30,000/-, out which 30% shall be deducted towards the personal expenditure of the deceased and in such case, the annual contribution to the family can be taken as Rs.21,000/- x 12 = Rs.2,52,000/- . If the same is multiplied with 16 it comes to Rs.40,32,000/-.

The complainant is entitled for loss of consortium at Rs.1,00,000/- and the complainant no.2 is entitled for Rs.1,00,000/- for the loss of love and affection of her mother. They are also entitled for Rs.1,00,000/- towards loss of estate and Rs.25,000/- towards funeral expenses. So, altogether they are entitled for Rs.40,32,000/- + Rs.1,00,000/- + Rs.1,00,000/- + Rs.1,00,000/- + Rs.25,000/- = Rs.43,57,000/-.

19). In the result, complaint is allowed in part directing the opposite parties to pay to the complainants a sum of Rs.43,57,000/- with interest @ 7% p.a. from the date of complaint till the date of realization. We further direct that half of this amount must be placed in F.D. in the name of the young child i.e. complainant no.2 in any Nationalized Bank till she attains majority. The balance of the awarded amount is to be withdrawn by the complainant no.1.

Time for compliance is one month from the date of receipt of this order.

Sd/- Sd/-

I/c. PRESIDENT MEMBER (JUDICIAL)

Dated: 04.03.2024

Appendix of Evidence
Witnesses examined

For the Complainants	**For the opposite parties**
Evidence affidavit of complainant No.1filed.	**Evidence affidavits in lieu chief examination of OP2 (Rw1), Dr.Usha Rani (RW2) and Dr.Nanda Kumar Murari (R3) are filed.**

complainant no.1 (PW1) and opposite party no.2 (RW1) were cross examined.

Exhibits marked on behalf of the complainants:

Ex.A1 : Photostat copy of Admission Record dt.10.8.2013/ Case Sheet issued by opp. party no.1 Nursing Home.
Ex.A2 : Photostat copy of First Storage Information dt. 16.8.2013 issued by Cryobanks International India.
Ex.A3 : Original Letter (complaint) addressed by the complainant no.1 to the Deputy Commissioner of Police, Secunderabad.
Ex.A4 : Photostat copy of First Information Report No.117/2013 Dt.4.9.2013.
Ex.A5 : Photostat copy of Letter (Complaint) dt.15.8.2013 addressed by the complainant no.1 to Police Inspector, Police Station, Tukaramgate.
Ex.A6 : Photostat copy of Letter (Complaint) addressed by complainant no.1 to the Chairperson, A.P. State Human Rights Commission.
Ex.A7 : Photostat copy of Lr.dt. 07.10.2013 addressed by complainant no.1 to OP.2.
Ex.A8 : Photostat copy of Reply Lr. dt.12.10.2013 addressed by opposite party no.2 to the complainant no.1.
Ex.A9 : Photostat copy of List of Blood Banks surrounding opposite party no.1
Ex.A10 : Photostat copy of Lr.dt.13.9.2013 of Medical Council of India to The Registrar, Andhra Pradesh Medical Council, Hyd.
Ex.A11 : Photostat copy of Lr. from the O/o.Asst. Commissioner of Police, Gopalapuram Div., Sec'bad to the Secretary, APSHRC., Hyd.
Ex.A12 : Photostat copy of Discharge Card dt.12.8.2013 by opposite party no.1 Hospital and medical record.
Ex.A13 : Photostat copy of Lr.dt.24.9.2013 addressed by Cryobanks International India to the wife of complainant no.1.
Ex.A14 : Photocopies of Bunch of SMSs.
Ex.A15 : Photographs of new born baby i.e. complainant no.2
Ex.A16 : Photograph of maternal grand mother of the complainant no.2
Ex.A17 : Photostat copy of order issued by Telangana State Medical Council dt.3.2.2021.

Exhibits marked on behalf of the opposite parties:

Ex.B1: Photostat copy of Antenatal Record of wife of complainant no.1 issued by opp.party no.1

Ex.B2: Photostat copy of Admission Record/Case Sheet pertaining to wife of Complainant no.1, issued by opposite party no.1 Hospital.

Ex.B3: Photostat copy of Discharge Card issued by opposite party no.1 Hospital.

Ex.B4: Photocopy of Lr. from Cryobanks International India Pvt. Ltd. addressed to Opposite party no.2.

Ex.B5: Photocopy of Lr. dt.27.1.2014 of Sunshine Hospital.

Ex.B6: Photocopy of Lr. from CMO., Sunshine Hospital to opposite party no.2.

Ex.B7: Photocopy of Abstract from the Register of Sunshine Hospital Blood Bank.

Ex.B8: Photocopy of Request for Blood/components form of Sunshine Blood Bank.

Ex.B9: Photocopy of OP Bill cum Receipt dt.11.8.2013 issued by Sunshine Hospitals.

Sd/- Sd/-

I/c.PRESIDENT MEMBER (JUDICIAL)

Dated: 04.3.2024