



Case No. : WP(C)/73/2022

VERSUS

4:District Hospital
Serchhip
r/b the District Medical Superintendent
Serchhip
Mizoram

Advocate for the Respondent : Mrs. Linda L Fambawl, G.A., Mizoram

::: B E F O R E :::

HON'BLE MR. JUSTICE NELSON SAILO

Date of Hearing : 20.07.2023

Date of Judgment : 09.08.2023

JUDGMENT & ORDER (CAV)

Heard C. Tlanthianghlma, learned counsel for the petitioner and Mrs. Linda L. Fambawl, learned Govt. Advocate for all the respondents.

[2.] The petitioner has filed the instant Writ Petition praying for the following relief:-

“In the premises it is most humbly prayed that your Lordships may graciously be pleased to admit this petition, call for the records and issue rule calling upon the Respondents to show cause as to why they should not be directed to pay monetary compensation to the Petitioner as they are vicariously liable for the medical negligence act of the attending doctor & staffs of District Hospital Serchhip leading to the death of the Petitioner’s wife and his new born son as can be seen from Magisterial Enquiry Report dt.13/1/2022 and Departmental Enquiry Report dt.24/3/2022 and to pass any other order(s) as your Lordships may deem fit and proper.”

[3.] Brief facts of the case as projected by the petitioner is that the petitioner and the deceased Smt. Malsawmkimi were married on 31.10.2008 and out of their wedlock, a daughter and a son were born on 10.06.2009 and 09.04.2015 respectively.

Their daughter is however no more. Smt. Malsawmkimi before her marriage to the petitioner had one son who was born on 24.01.2004. After her marriage with the petitioner and after having two children, she became pregnant again and registered herself at Tlangpui Health Sub-Centre in Khawzawl district on 26.05.2021. She visited the Sub-Centre three times viz; 26.05.2021, 13.08.2021 and 08.11.2021 and according to the records entered, the Expected Date of Delivery (EDD) was 22.12.2021.

[4.] Smt. Malsawmkimi thereafter on 01.12.2021, went to the OPD in the District Hospital, Serchhip and around 10:50 AM, she was attended by Dr. Laltharzeli Fanai, a Gynecologist who did Ultra sound Sonography Test (USG) on her. According to the report of the USG, the EDD was 02.12.2021. The doctor therefore asked her to come again the next day i.e., 02.12.2021 and get herself admitted. She accordingly got herself admitted the next day and to induce labor, Cervi Prime Gel was applied on her. According to the Doctor, both the mother and the baby were found to be normal. However, as Smt. Malsawmkimi could not deliver the baby on 02.12.2022, Cervi Prime Gel was applied again the next day i.e., 03.12.2021. Ultimately on 03.12.2021, she delivered a baby boy at 8:30 PM weighing about 3.8 kilograms. The delivery was done by the nurse on duty but the baby did not show any signs of life. Smt. Malsawmkimi was accordingly informed about the status of the baby and later on at about 8:55 PM, she herself having developed some complication, the nurse on duty informed the Gynecologist. The Gynecologist came around 9:20 PM and she informed the District

Medical Superintendent about the condition of Smt. Malsawmkimi. At 10:40 PM, Smt. Malsawmkimi was declared dead. As per the Cause Report, death was said to be caused due to Post Partum Hemorrhage (excessive bleeding).

[5.] According to the petitioner, about one (1) month before the death of his baby and his wife, there was another incident in the District Hospital wherein, a baby boy born to one Smt. Vanlaldinpuii was too declared dead at the time of birth. Because of the said incidents, there was public outcry and the State Government in the Health & Family Welfare Department through its Secretary (respondent No. 2) vide order dated 09.12.2021 (Annexure - 9), ordered a magisterial enquiry to be conducted by the District Magistrate, Serchhip to enquire into the facts and circumstances leading to the death of three persons and to submit a report within 30 days. The terms of references is abstracted as under:-

“I. To look into the sequences of events between admission to the hospital and death of those 3(three) patients.

II. To bring out the role of those involved in the incidents including Nurses and Female Attendant on duty during the occurrence of the incidence.

III. To ascertain whether the incidents had taken place due to negligence and lapses on the part of the Doctors and Hospital Staff on duty.”

[6.] The District Magistrate accordingly conducted a magisterial enquiry and submitted his report on 30.01.2022 to the respondent No. 2 suggesting that in order to ascertain the propriety of the medical procedure followed, an independent team of doctors, from outside the district be formed. As suggested, an independent team of Doctors was constituted vide Notification dated 02.02.2022 (Annexure-11) by the respondent No. 2 to ascertain whether propriety of medical procedure was followed or otherwise in the incident leading to the death of three person at Serchhip District Hospital. The terms of reference is abstracted as below:-

“Terms of Reference:

- 1. To ascertain whether there is procedural lapse on medical treatment received by the patients.*
- 2. Level of Monitoring of the patient and details record of monitoring.*
- 3. Whether special care was given to the pregnant women based on their obstetric history.*
- 4. Are there any alternate medical procedures that could be undertaken to avoid such incident?*
- 5. Why cervi prime gel was used to induce labour for the second time to aggravate the patient's condition?*

The Team shall submit its report to Health & Family Welfare Department within 2 weeks from the date of issue of this notification."

[7.] As stipulated in the Notification dated 02.02.2022, the team of Doctors submitted their report on 02.02.2022 but according to the respondent authorities concerned, since the report did not bear the signature of the team of Doctors constituted, the report was resubmitted on 24.03.2022 (Annexure - 12) to the respondent No. 2. As per the report, enquiry was done on 18.02.2022 and it was observed that upon investigating the events leading to the maternal death, procedural lapse on the medical care given to the deceased patient was not found. The probable cause of the patient's deterioration was a concealed bleeding resulting in hypovolemic shock and which made it difficult for the attending nurse and doctor to act immediately. Considering the past obstetrical history with 5 abortions and only 1 living issue, and advanced age of 40 years in regard to obstetric, it was opined that the patient should have been advised to attend higher centre where operative (surgery) delivery can be performed 24/7. On the use of Cervi Prime gel, which is an uterine stimulant, that can cause uterine contraction and thereby dilating the cervix and mainly use for induction of labour (i.e ripening of cervix) and the action of which lasted for 4-6 hours, the gap between insertion was around 12 hours and therefore, the same will not cause hyperstimulation so as to aggravate the labour pain. Hence, using 2 times with a gap of 12 hours will not worsen the labour pain. The sudden deterioration of patient probably was due to hypovolemia resulting from silent

tear/rent in the lower part of uterus, the bleeding of which is mainly concealed and not revealed making it difficult to diagnose immediately. Although urgent, open laparotomy with subtotal hysterectomy might have saved the patient but due to non availability of the Anaesthetist who was out of station to attend IMA conference, and the patient's condition did not permit referral. Unfortunately the patient succumbed and died at 10:30pm on 03/12/2022. In regard to the stillbirth which was fresh stillbirth, the rent/tear in the uterine wall, just before delivery may have cut off the oxygen and blood supply which may have caused the fetus to die just before delivery.

[8.] Mr. C. Tlanthianghlina, learned counsel for the petitioner by drawing the attention of this Court to the observation made at paragraph Nos. 3 & 4 submits that although the report says that Smt. Malsawmkimi had five (5) abortions but in fact, she had four (4) abortions and the same has already been reflected in the beginning of the report under the column "Brief History". The team of Doctors observed that the patient should have been advised to attend higher center where surgery could be performed 24/7. He submits that considering her past obstetric history and advanced age, the attending Doctor at the OPD in the District Hospital, Serchhip ought to have not only informed her the risk of having a normal delivery but also advised her to attend higher center for caesarean surgery. The learned counsel submits that it is clear from the Enquiry report that it was due to the negligence of the attending Doctor and the nurses in the District Hospital that the petitioner not only lost his new born baby but also his wife. The learned counsel on the negligence of the Doctor and the

Hospital concerned submits that it is the responsibility of the State to adequately compensate the petitioner for the loss of the life of his new born son and his wife. The petitioner submitted a representation to the respondent No. 2 on 23.05.2022 asking appropriate compensation for the death of his wife and new born son due to the negligence of the Doctors and Staff of the District Hospital, Serchhip. However, the representation of the petitioner has been rejected by the State Government in the Health & Family Welfare Department, which was communicated to the petitioner on 16.06.2022 after the filing of the writ petition. The learned counsel for the petitioner submits that the manner in which the representation of the petitioner has been rejected is not at all acceptable to the petitioner and that the State Government being the employer of the Doctors and Staff of the District Hospital at Serchhip is liable to compensate the petitioner. In support of his submission, the learned counsel has relied upon the following authorities:-

(1) Judgment & Order dated 15.11.2019 passed by a Coordinate Bench of this Court in WP(C) No. 179/2016 (Moba Changkai -Vs- State of Nagaland & 8 Ors.)

(2) Judgment & Order dated 25.05.2021 passed by the Writ Appellate Court in W.A No. 31(K)/2019 (State of Nagaland & 7 Ors. -Vs- Moba Changkai & Anr.)

(3) Paschim Banga Khet Mazdoor Samity & Ors. -Vs- State of West Bengal & Anr., (1996) 4 SCC 37.

[9.] Mrs. Linda L. Fambawl, learned Govt. Advocate on the other hand by relying upon the affidavit-in-opposition filed by the State respondents on 18.11.2022 submits that Smt. Malsawmkimi registered herself at Tlangpui Health Sub-Centre which was manned by Health workers. She visited the Health Sub-Centre on three (3) occasions and although the petitioner claims that she had no health problems and that she had taken necessary precautions, including injections as was prescribed to her but from the record of the Sub-Centre, it can be seen that Smt. Malsawmkimi was suffering from Anaemia with Chronic Hypotension and that she was not sure of her last menstrual period. She submits that she is supposed to do USG to determine the EDD during her early pregnancy. The Anaemia suffered by Smt. Malsawmkimi as was detected in her first check-up was not corrected even when she went for the second check-up. As per Government protocol, she was supposed to attend her monthly Pradhan Mantri Surakshit Matruva Abhiyan (PMSMA) launched by the Ministry of Health & Welfare, Govt. of India programme. The programme provides a short comprehensive and quality antenatal care free of cost and universally to all pregnant women on the 9th of every month in either 2nd trimester or 3rd trimester where high risk patients are identified and they receive free blood investigation. Therefore, Smt. Malsawmkimi was not cautious about her pregnancy as can be seen from the records of the Sub-Centre.

[10.] The learned Govt. Advocate further submits that Smt. Malsawmkimi attended the OPD (Gynecology Department) at Serchhip District Hospital on 01.12.2021 alone

and that she was not accompanied by her sister as claimed. USG was conducted on this day as she was not sure about her last menstrual period to determine the EDD. She submits that ideally, USG should have been done in the 1st Trimester. Even though Smt. Malsawmkimi had three recurrent miscarriages, she delivered a male child by Normal Vaginal Delivery (NVD) in the year 2015 after her three miscarriages and therefore, she was rightful candidate for NVD and moreover, she had no absolute indication for Caesarean Section (C-Sec.). The learned Govt. Advocate submits that as per the protocol, NVD is usually conducted by Nursing staff and as they are fully trained and qualified to do so. The Doctors are usually informed when there are delivery complications and when instrumental delivery is required. Even in the instant case, when Smt. Malsawmkimi developed post delivery complications, she was immediately attended by the Doctors.

[11.] The learned Govt. Advocate further submits that as per the departmental enquiry report, the team of Doctors did not find any procedural lapse and the history of Smt. Malsawmkimi for having four (4) miscarriages and also her advanced age was not an absolute indication that C-Sec. should be performed. The view given on the enquiry report is only a retrospective assessment indicating that referring the patient to a higher centre might have been a better option. The learned Govt. Advocate submits that the cause of death of Smt. Malsawmkimi was Post Partum Hemorrhage, which she developed post delivery and it was not because of non-performance of C-Sec. Post Partum Hemorrhage cannot be anticipated and can be developed by any

patient who had undergone NVD or C-Sec. Every possible management was given to Smt. Malsawmkimi at the relevant time as permitted by the resource available and considering the fact that she had two life births through NVD, NVD was the plan for the last pregnancy. The absence of an anesthetist did not contribute in any manner for her untimely demise. Further, Smt. Malsawmkimi had also subscribed her signature in the consent form indicating that she was willing to have wider consultation. There was no duress for getting her consent in the consent form.

[12.] Referring to paragraph No. 13 of the counter affidavit, the learned Govt. Advocate further submits that Pelvic examination upon Smt. Malsawmkimi was conducted and the examination showed that her Pelvic was roomy and cervix was favourable for NVD and that prolonged labor was unlikely. She submits that there is only one (1) Gynecologist in the District Hospital take caring all the district population. In the present case as well, the lone Gynecologist was called by the Staff nurses on 8:55 PM and although she was not initially aware about the phone call as she was in the kitchen having dinner but she responded as soon as she came to know about the phone call. As per her advice, two wide bore i.v cannula, blood transfusion, uterine massage, tamponade, IV Fluid were given as per protocol for management of Post Partum Hemorrhage by the nurses on duty and the Doctor reached the labour room at 9:20 PM. The learned Govt. Advocate submits that despite all the attempts made by the Doctor and the Staff nurses of the Hospital by following the required protocol, Smt. Malsawmkimi was declared dead at 10:40 PM. The same being beyond the

control of the Doctor and the Staff nurses of the District Hospital, no medical negligence is attributable to them and as such, the claim for compensation made through the instant writ petition cannot be maintainable and the same should be dismissed. The learned Govt. Advocate also submits that the High Court in exercise of its extra ordinary powers under Article 226 of the Constitution of India is not the appropriate form for adjudicating medical negligence or otherwise which necessarily involves disputed questions of fact. As such, the writ petitioner should approach the competent forum with his claim for compensation for medical negligence. In this connection, the learned Govt. Advocate relies upon the decision of the High Court of Madras rendered on 08.06.2023 in WP(C) No. 14801/2017 & WMP No. 16048/2017 (*K. Mubeena Banu -Vs- Tamil Nadu Health & family Welfare Department & Ors.*).

[13.] Mr. C. Tlanthianghlina in reply invited the attention of this Court to the Health Sub-Centre record annexed as 'Annexure-5' of the writ petition where the date of last menstrual period of Smt. Malsawmkimi was recorded as 15.03.2021. He therefore submits that there is no substance in the contention made by the respondents in this regard. The learned counsel further submits that during her three visits to the Health Sub-Centre, Smt. Malsawmkimi was never informed about her having Anaemia with Chronic Hypotension. It was the duty of the Health Worker concerned to inform her about the same and to advice or give her proper treatment. The same having been not done, no blame can be put on her. The learned counsel also submits that as per the information received on an application made through RTI, PMSMA programme is

not implemented at the Sub-Centre level in Mizoram and therefore, the same was not available at Tlangpui Sub-Centre, where the petitioner and his wife resided. Therefore, there is no question of availing the benefit of the said Scheme.

[14.] I have heard the submissions made by the learned counsels for the rival parties and I have perused the materials available on record.

[15.] From the projection made by the petitioner and from the materials available on record, it is seen that a Magisterial Enquiry was ordered by the State Government in the Health & Family Welfare Department under the signature of the respondent No. 2 to enquire on the maternal death of Smt. Malsawmkimi and her new born child at District Hospital, Serchhip on 03.12.2021. Enquiry was also ordered to be conducted on the death of the new born child of one Smt. Vanlaldinpuii of Sialsir village on 31.10.2021 as well. Apart from the enquiry report in respect of the death of Smt. Malsawmkimi and her new born son, the enquiry report in respect of the other incident which was said to have occurred earlier is not known as there is nothing mentioned in this writ petition apart from the order of enquiry which says that it was the public complaint and public outcry in the social media which led to the direction for holding an enquiry. The conclusion of the Magisterial Enquiry conducted by the District Magistrate dated 13.01.2022 is abstracted below:

“Brief summary of the Observations/Findings:

- 1. The patient was having the history of 3 abortions and one pre term.*

Dr. Laltharzeli Fanai stated that the patient while on admission opted for the NVD. The doctor has stated in her written explanation that informed written consent for NVD was taken on 2.12.2021 at 10:50 A.M. However, this is a general written consent which does not specifically mention about NVD or C-Sec.

2. After the first failed inducement of labor on 2.12.2021 upon application of cervi prime gel, the attendant claimed that they requested for C-Sec on 3.12.2021. The doctor denied the claim made by the attendant. It is evident that there is a clear contradiction in between the claims made by the attendant of Pi Malsawmkimi and the doctor and Hospital staff with respect to the request for Caesarean Section. Moreover, there is no evidence of written consent for NVD given by the patient or the attendant at that time.

3. The delivery was done by the staff nurse and was not attended by the doctor. The Doctor was called by the staff nurse at 8:55 PM and the doctor reached the spot and attended the patient at 9:20 PM.

4. Upon perusal of the statements and random statements taken from the previous cases of deliveries at the District Hospital, there is preponderance of possibility that the hospital staff, at some times, behave

rudely and not in a professional manner with the patients.

5. On the point of enquiry of indulgence in any kind of intoxicating substance by the doctors or the staff, there is no evidence to prove this.

6. In order to ascertain the propriety of the medical procedure followed, the undersigned is of the opinion that an independent team of doctors, from outside the district, may be formed."

[16.] Therefore as opined, a team of doctors was appointed and given the task of making a further enquiry through Notification dated 02.02.2022. The team of Doctors submitted their report on 02.02.2022 but according to the respondent authorities concerned, since the report does not bear the signature of the team of Doctors constituted, the report was resubmitted on 24.03.2022 (Annexure - 12) to the respondent No. 2. The contents of the enquiry report is abstracted as below:-

"DEPARTMENTAL ENQUIRY REGARDING MATERNAL DEATH

DATE OF ENQUIRY : 18/2/2022

*NAME : MALSAWMKIMI, 40 years
w/o ZOTHANKIMA
Tlangpui, Serchhip District*

DATE OF ADMISSION : 02/12/2021 @ 10:50 am

DIED ON : 03/12/2022 @ 10:30 pm at District Hospital, Serchhip

BRIEF HISTORY

Mrs. Malsawmkimi, 40 yrs old woman with previous 2 living children and a history of 4 abortions, with no recorded antenatal check-up, came for check-up at District Hospital, Serchhip on 01/12/2022 at OPD. She was attended and seen by Dr. Laltharzeli Fanai, MS (Obst & Gynae) at OPD on the same day. On ultrasound it was diagnosed to be a single live intrauterine pregnancy, term pregnancy with no obvious anomaly and Grade III placenta in cephalic presentation and EDD on 02/12/2021. Patient was advised admission.

Patient turned up on 02/12/2021 at District Hospital Serchhip. Patient was given induction of labour with Cerviprime Gel at 12:05 pm. On the day of induction, both the mother and baby were doing fine with no untoward events.

During the time in Labour room, condition of mother and baby were monitored and found to be stable.

Since there was no progress in labour, Doctor advised for another induction on 03/12/2021. Cerviprime Gel was applied again on 11:45am on 03/12/2021. The labour Progress was monitored and patient delivered at District Hospital, Serchhip at 8:35 on 03/12/2021, followed by placental delivery at 8:40pm. At this time, the mother was conscious, oriented, but the baby was stillbirth with no sign of life (Fresh stillbirth) at the time of delivery.

Soon after delivery, the patient's condition was deteriorating, nurses informed the Doctor on call. The Doctor attended the patient and suspected to be a case of Rupture Uterus, with hemorrhage (concealed). Measures were taken to resuscitate the patient and control bleeding with blood transfusion. Uterotonics, Vaginal packing, ligating descending cervical artery was also attempted, and patient to be prepared for possible Hysterectomy. But in spite of all the measures, the patient goes into irreversible hypovolemic shock and eventually died at 11:40pm, 3/12/2021.

OBSERVATION

- 1. After investigating the events leading to the maternal death, we did not find and procedural lapse on the medical care given to the deceased patient.*
- 2. Details of patient monitoring is enclosed in the photocopy of the patient's life. The probable cause of the patients deterioration which is a concealed bleeding resulting in hypovolemic shock makes it difficult for attending nurse and doctor to act immediately.*
- 3&4. Considering the past obstetrical history with 5 abortions and only 1 living issue, and advance age (40 years) in regards to obstetric, the patient should have been advised to attend higher centre – where operative (surgery) delivery can be performed 24/7.*

5. On using cerviprime gel, which is an uterine stimulant, that can cause uterine contraction and thereby dilating the cervix and mainly use for induction of labour (i.e ripening of cervix) and the action of which lasted for 4-6 hours, the gap between insertion is around 12 hours, which will not cause hyperstimulation so as to aggravate the labour pain, and hence using 2 times with a gap of 12 hours will not worsen the labour pain.

The sudden deterioration of patient which probably due to hypovolemia resulting from silent tear/rent in the lower part of uterus, the bleeding of which is mainly concealed and not revealed which makes it difficult to diagnose immediately and although urgent, open laparotomy with subtotal hysterectomy might have saved the patient. But due to non availability of Anaesthetist doctor who was out of station to attend IMA conference, and the patient's condition did not permit referral.

Unfortunately the patient succumbed and died at 10:30pm on 03/12/2022.

In regard to the stillbirth which was fresh stillbirth, the rent/tear in the uterine wall, just before delivery may have cut off the oxygen and blood supply which may have caused the fetus to die just before delivery."

[17.] From what has been projected, it is seen that the petitioner and his late wife out of their marriage have a daughter and a son born on 10.06.2009 and 09.04.2015 respectively. According to the petitioner, only the son survives and is living with him.

The late wife of the petitioner had one son born on 24.01.2004. As per the Labour Record, the late wife of the petitioner had a normal delivery of a male child in the year 2004. Thereafter, in the year 2009, 2012 and 2014, she had undergone abortion after being pregnant for three (3) months. In the year 2015, she had a normal delivery and delivered a male child. Again in the year 2016, she underwent abortion after being pregnant for six (6) months. Although it is contended by the respondents that for the last pregnancy when the petitioner's late wife came to the District Hospital on 01.12.2021, she was not aware about the date of her last menstrual period but the fact remains that she had visited Tlangpui Health Sub-Center on three (3) occasions i.e., 26.05.2021, 13.08.2021 and 08.11.2021 and as per the record maintained by the Health Sub-Center, the date of her last menstrual period was 15.03.2021 and the EDD was recorded as 22.12.2021. Despite this, the respondents have contended that since the petitioner's wife was not aware of this date, upon her visiting the Gynecologist OPD on 01.12.2021, USG was done on 01.12.2021 and as per the indication in the ultra sound machine, the EDD was 02.12.2021. She was therefore advised to get herself admitted on the next day i.e., 02.12.2021. It is a common knowledge that EDD is generally calculated from the date of the last menstrual period of a pregnant woman when she gets herself checked up at the initial stage of pregnancy. In the present case as well, as per the record maintained by the Health Sub-Centre, the date of last menstrual period of Smt. Malsawmkimi was 15.03.2021 and accordingly, the EDD was calculated as 22.12.2021. However, on 01.12.2021 when she visited Gynae

OPD, the Gynecologist performed USG to examine the baby and in doing so, she found no abnormality in the baby and as indicated by the Ultrasound machine, she accepted 01.12.2021 as the EDD, which was the next day. It can be seen that there is a difference of 20 days between the EDD calculated by the Ultrasound machine and what was calculated in the Health Sub-Centre by taking into account the last menstrual date of Smt. Malsawmkimi. In absence of an expert opinion on the subject, the Court has limitations but one wonders whether the EDD shown by the Ultrasound machine at the very fag end of the pregnancy can be considered to be accurate, particularly when a different date i.e., 22.12.2021 (20 days beyond the detected EDD) has already been recorded in the Health Sub-Centre records on the basis of the last menstrual period of the person concerned. If there is any discrepancy in the calculation of the EDD, the question which arises is whether Smt. Malsawmkimi was induced labour for delivery of the child through NVD prematurely or in other words, much before she had shown any signs of going into labour naturally. Nevertheless, as was advised to her by the Doctor, Smt. Malsawmkimi got herself admitted on 02.12.2021 at 10:50 AM and it is said that after she was counseled, she opted for NVD and had also given her consent for it. However, there are no materials on record to show that the petitioner's wife had given written consent for NVD in particular. The only signature given by her is against a format which is general in nature, stating that she agrees to be treated by the District Hospital, Serchhip as may be necessary. In other words, it is only a general written consent and does not specifically mentioned

about NVD or C-Sec. The same is also the observation and findings of the District Magistrate, Serchhip who had conducted the Magisterial Enquiry. Although it is contended by the Doctor concerned and by the Hospital staff that the wife of the petitioner had opted for NVD but there are also materials to show that she had opted for C-Sec which can be seen from the statements given by Smt. Rammuni, who was her sister and attendant at the relevant time.

[18.] According to Smt. Rammuni, when the wife of the petitioner could not deliver even after applying Cervi Prime Gel on 02.12.2021, when the Doctor came visiting on 03.12.2021 at around 11:00 AM, the petitioner's wife asked for C-Sec and she also verbally supported her request. But the Doctor responded that the Anesthetist was not in station and she as well as the nurse on duty persuaded them to go for NVD saying that physical activity will not be hampered after delivery. Therefore, on 03.12.2021, Cervi Prime Gel was again applied on the petitioner's wife. According to Smt. Rammuni, before the Doctor came visiting, the wife of the petitioner told her that if they apply Cervi Prime Gel again, she will not be able to endure the pain anymore. Since the District Magistrate, Serchhip could not give his opinion and findings on the propriety of the medical procedure followed, he suggested that an independent team of Doctors from outside the District may be formed. As such, an independent team of Doctors was formed while providing the term of reference vide Notification dated 02.02.2022. As per the observation recorded by the independent team of Doctors, they did not find any procedural lapse on the medical care given to

the petitioner's wife. Upon going through the details of the patient monitoring from the patient file, the probable cause of the patient's deterioration according to them was a concealed bleeding resulting in hypovolemic shock which makes it difficult for the attending nurse and doctor to act immediately. While it cannot be ascertained for sure as to whether the petitioner's wife had requested for C-Sec when she was examined on 01.12.2021 or after the application of Cervi Prime Gel on 03.12.2021 and further, as to whether NVD was possible and advisable for her or C-Sec. was required but according to the independent team of Doctors in their observation, considering the past obstetrical history with 5 (4) abortions and only one living issue and also the advanced age (40 years) of Smt. Malsawmkimi in regard to obstetric, she should have been advised to attend higher center, where operative (surgery) delivery can be performed 24/7. In other words, according to the independent team of doctors in view of the past history of Smt. Malsawmkimi, she ought to have been referred to higher center. However, the fact remains that Smt. Malsawmkimi was advised to get herself admitted for NVD on 02.12.2021. What followed after she was admitted in the District Hospital, Serchhip can be seen from the Labour Record of the Hospital. The record contains the obstetric history of Smt. Malsawmkimi and the date and time of her admission to the District Hospital. Cervi Prime Gel was applied to her on 01.12.2021 at 12:05 PM. On 03.12.2021, Cervi Prime Gel was again applied on 11:45 AM and besides this, some injection was given to her. At 8:30 PM, she delivered a stillbirth male child weighing 3.8 kgs. At around 8:40 PM, 1^o perineal tear was repaired with

Catgut 2-0. She developed Atonic PPH with traumatic PPH. The nurses on duty informed the Gynecologist on 8:55 PM where after, the Gynecologist attended her at 9:20 PM, after about 25 minutes on being informed. Smt. Malsawmkimi was said to have cervical friable, which was attempted to be repaired with Catgut. However, the same could not be repaired due to friability and there was oozing of dark colored blood. Vaginal tight packing was done and blood was transfused. The oozing of blood continued and inspite of all interventions, the patient collapsed and died at 10:40 PM.

[19.] From the Labour Record of the Hospital under the heading 'Delivery Note', it is seen that on 03.12.2021 labour began at 3 PM and the time of full dilation was recorded as 7:00 PM. The time of delivery of the baby was 8:35 PM while the time of delivery of Placenta was 8:40 PM. Although the observation of the independent team of Doctors is that the sudden deterioration of the patient was probably due to hypovolemia resulting from silent tear in the lower part of uterus, the bleeding of which is mainly concealed and difficult to diagnosed, the Labour Record otherwise shows that the patient had 1^o perineal tear, which was attempted to be repaired with Catgut but the oozing of the blood continued. Therefore, it is not a case that the deterioration of the patient was on account of undetected silent tear in the lower part of her uterus. In fact, as per the Labour Record, the Perineal Tear and the oozing of blood was noticed and the nurses attending the patient tried to repair the same but since the patient developed Atonic PPH and Traumatic PPH, the Gynecologist was informed on 8:55 PM and the Gynecologist came at 9:20 PM. Since the time of

delivery of the stillborn child at 8:30 PM, the nurses on duty and Doctor who came eventually on being informed, could not control the bleeding until the patient collapsed and died at 10:40 PM. The independent team of Doctors in their observation had also recorded that in the event of such bleeding, urgent open laparotomy with subtotal hysterectomy might save the patient. But again due to non availability of an Anesthetist, who was out of station, the patient condition did not permit referral.

[20.] From a careful perusal of the Magisterial Enquiry report and also the report and observation of the independent team of Doctors, some degree of negligence is attributable to the attending nurses and Doctors of the Hospital. Considering the past and medical history of Smt. Malsawmkimi, due care and proper monitoring ought to have been done, particularly in view of the non-availability of an Anesthetist in station at the relevant time in case of emergency. More care ought to have been taken in view of the fact that there was another incident of death of a new born child on 31.10.2021, just over a month back.

[21.] In regard to the stillbirth of the male child of the petitioner and his late wife, the independent team of Doctors in their observation and report have opined that the rent/tear in the uterine wall, just before delivery might have cut off the oxygen and blood supply which may have caused the fetus to die just before delivery. According to the State respondents, for NVD, the nurses in Government Hospitals are trained to make the delivery. While the same may be practiced, the fact remains that Smt. Malsawmkimi was induced labour by applying Cervi Prime Gel at 12:05 PM on

02.12.2021 but despite that she could not deliver the child throughout the night and when the Doctor came visiting the next day at around 11:00 AM, despite the claim that she had asked for C-Sec, the Doctor and nurses on duty persuaded NVD and Cervi Prime Gel was again applied at 11:45 AM on 03.12.2021. Finally, it was only at 8:30 PM that Smt. Malsawmkimi delivered the male child, which was found to be stillborn. Going back to the sequence of events, Smt. Malsawmkimi was examined by the Gynecologist when she came to the Gynae OPD of Serchhip District Hospital on 01.12.2021 where USG was done on her. According to the records available, no abnormality was noticed on the baby and in fact, the team of Doctors constituted by the State Government in their report recorded– *'On Ultrasound it was diagnosed to be a single live intrauterine pregnancy, term pregnancy with not obvious anomaly and Grade III placenta in cephalic presentation and EDD on 02.12.2021. Patient was advised admission.'* Therefore, the baby was alive and kicking inside the womb of Smt. Malsawmkimi on 01.12.2021. From the stand taken by the respondents, she was being monitored carefully and was under the care of the nurses of the Hospital on duty, who were trained to carry out NVD. The Enquiry Report of the team of Doctors also stated that the labour progress was monitored and the patient delivered the baby at 8:35 PM on 03.12.2021 followed by placental delivery at 8:40 PM. However, the baby was said to show no signs of life at the time of delivery. The claim for having monitored the labour progress while delivering a still born baby is only contradictory. If there indeed was constant monitoring of the labour progress, it is not understood as to how the

baby could have been found to have no signs of life immediately on delivery. The team of Doctors in their report had no answer except to suggest that the rent/tear in the uterine wall, just before delivery may have been the cause. However, with the amount of care and monitoring said to have been done after inducing Cervi Prime Gel upon Smt. Malsawmkimi twice, it cannot be an occasion for delivering a still born baby. From the manner in which the events took place and considering the medical history of Smt. Malsawmkimi, not only the nurses on duty ought to have been more careful but the Doctor concerned also ought to have closely monitored her condition. Therefore, there is clearly some element of negligence on the part of those who attended Smt. Malsawmkimi i.e., the attending nurses and the Doctor concerned.

[22.] The Apex Court in *Maharaja Agrasen Hospital & Ors. -Vs- Master Rishabh Sharma & Ors.*, (2020) 6 SCC 501, in the given facts of that case observed that it is a well settled position that Court is not bound by the evidence of an expert which is advisory in nature and the Court may derive its own conclusions after carefully sifting through the medical records, and whether the standard protocol was followed in the treatment of the patient. In the facts of that case, it was contended that Retinopathy of Prematurity (ROP) was not conducted by the Doctors of the hospital concerned resulting in the blindness of the baby concerned for life. The family of the baby on approaching the National Commission by filing a complaint under Section 21 of the Consumer Protection Act, 1986 were awarded compensation after a finding was made that the authorities of the Hospital were guilty of negligence resulting in deficiency in

service. The verdict on being challenged before the Supreme Court by the Hospital authorities was dismissed and at the same time, the appeal filed by the family of the baby seeking enhancement of the compensation amount was allowed. The Apex Court at paragraph Nos. 12.4.1 and 12.4.21 held as follows:-

“12.4.1. Medical negligence comprises of the following constituents:

- (1) *A legal duty to exercise due care on the part of the medical professional;*
- (2) *failure to inform the patient of the risk involved;*
- (3) *the patient suffers damage as a consequence of the undisclosed risk by the medical professional;*
- (4) *if the risk had been disclosed, the patient would have avoided the injury;*
- (5) *breach of the said duty would give rise to an actionable claim of negligence.*

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. 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.”

[23.] In the present case as well, the District Hospital at Serchhip is a Government Hospital and the Doctors, Nurses and Staff employed in the hospital are the employees of the Government. Therefore, the Government being the employer will be vicariously liable for the acts of negligence committed by the Doctors, Nurses and Staff of the Hospital.

[24.] The Apex Court again in *Paschim Banga Khet Mazdoor Samity & Ors. -Vs- State of West Bengal & Anr., (1996) 4 SCC 37*, in the given facts of that case held that for the failure and denial of treatment of the patient concerned at various Government Hospitals, which were approached even though the condition of the patient was very serious requiring immediate medical attention amounted to denial of his right guaranteed under Article 21 of the Constitution of India. The relevant portion of the observation of the Apex Court at paragraph No. 9 of the said judgment may be abstracted below:-

“9. The Constitution envisages the establishment of a welfare State at the federal level as well as the State level. In a welfare State the primary duty of the Government is to secure the welfare of the people. Providing adequate medical facilities for the people is an essential part of the obligations undertaken by the Government in a welfare State. The Government discharges this obligation by running hospitals and

health centres which provide medical care to the person seeking to avail of those facilities. Article 21 imposes an obligation on the State to safeguard the right to life of every person. Preservation of human life is thus of paramount importance. The government hospitals run by the State and the medical officers employed therein are duty-bound to extend medical assistance for preserving human life. Failure on the part of a government hospital to provide timely medical treatment to a person in need of such treatment results in violation of his right to life guaranteed under Article 21."

[25.] The Constitutional Courts in a claim of compensation, such as the present case has in a catena of decisions including the case of *Moba Changkai -Vs- State of Nagaland & 8 Ors. WP(C) No. 179/2016* and *Sambara Sabar -Vs- State of Odisha & Ors. WP(C) No. 11860/2015* held that under the public law remedy as a palliative measure, Court may award appropriate compensation and that the compensation awarded will be in addition to the claim for damages or compensation under the private law remedy. Therefore, having regard to the sequence of events leading to the death of Smt. Malsawmkimi and the new born child and the circumstances attributable to the Doctors and Nurses working in the hospital concerned, this Court is of the considered view that the State respondents should pay the petitioner a sum of Rs. 5 lakhs for the death of Smt. Malsawmkimi and her still born baby. It is ordered accordingly.

[26.] The amount awarded should be deposited before the Registry of this Court within a period of eight (8) weeks from the date of receipt of a certified copy of this

Order failing which, the amount shall carry interest @ 6% p.a. till the amount is fully paid.

[27.] The petitioner is said to be living with his son Joshua Lalramdinthara, aged about 7/8 years at Tlangpui village in the District of Khawzawl and therefore, for the welfare of Joshua Lalramdinthara, out of the sum of Rs. 5 lakhs awarded, a sum of Rs. 3 lakhs shall be kept in a fixed deposit in a nationalized bank, renewable at regular intervals and the amount deposited along with all the interest accrued therein can only be withdrawn after Joshua Lalramdinthara attains the age of majority. A photo copy of the initial fixed deposit receipt and the subsequent receipts renewing the fixed deposit shall be submitted before the Registry until Joshua Lalramdinthara attains majority. Registry shall maintain the fixed deposit receipts submitted by the petitioner and in the event the same is not deposited regularly and in a timely manner, the Registry shall bring the matter to the notice of the Court. It is also made clear that the amount of compensation awarded is as a pallative measure under the public law remedy and the same will not debar the petitioner from claiming any further compensation for damages or for deficiency of service before the appropriate forum.

[28.] With the above observations and directions, the writ petition stands disposed of. No cost.

JUDGE

Comparing Assistant