

W.P.(MD).No.5530 of 2022

BEFORE THE MADURAI BENCH OF MADRAS HIGH COURT

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Reserved on:
04.04.2025

Pronounced on:
22.05.2025

Coram

THE HON'BLE MR JUSTICE V. LAKSHMINARAYANAN

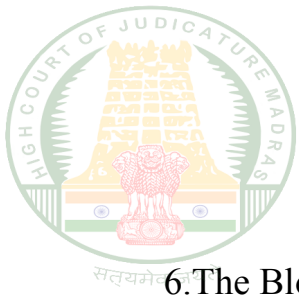
Writ Petition (MD) No.5530 of 2022 &
WMP(MD).Nos.4476 & 4477 of 2022

Murugambal

... Petitioner

-Versus-

- 1.The Principal Secretary to Government,
Health and Family Welfare Department,
Secretariat,
Chennai – 600 009.
- 2.The Special Secretary to Government,
Public (HR) Department,
Secretariat,
Chennai – 600 009.
- 3.The Director of Public Health and Preventive Medicine,
No.359, DMS Building,
Anna Salai, Teynampet,
Chennai – 600 018.
- 4.The Deputy Director of Health Service,
O/o.Deputy Director of Health Service,
Kovilpatti,
Thoothukudi District.
- 5.The District Collector,
District Collector Office,
Thoothukudi District.



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6.The Block Medical Officer,
Government Primary Health Centre,
Kadambur,
Thoothukudi District.

7.The Assistant Surgeon,
Government Primary Health Centre,
Kadambur, Thoothukudi District.

8.The Auxiliary nurse Midwife,
Government Primary Health Centre,
Kadambur, Thoothukudi District.

9.The Staff Nurse,
Government Primary Health Centre,
Kadambur, Thoothukudi District.

10.The Village Health Nurse,
Government Primary Health Centre,
Kadambur, Thoothukudi District.

... Respondents

Writ Petition filed under Article 226 of the Constitution of India seeking to issue a Writ of Mandamus directing the respondents No.1 to 5 to pay a just and reasonable compensation to the sum of Rs.50,00,000/- for the negligent pregnancy treatment of the respondents No.6 to 10 led to the death of petitioner's daughter namely Kavitha and death of the still born boy baby based on the petitioner's representation dated 18.02.2022 & 10.03.2022 within a stipulated time that may be fixed by this court.

For Petitioner : Mr.S.Sukumar

*For Respondents : Mr.M.Ajmalkhan, AAG
1 to 4 & 6 to 10 Assisted by
Mr.A.Kannan, AGP*



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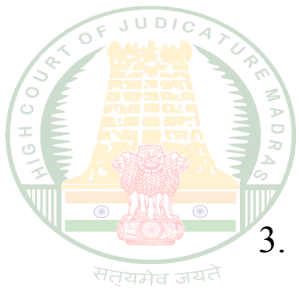
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ORDER

The petitioner seeks a Writ of Mandamus directing Respondents Nos. 1 to 5 to pay just and reasonable compensation to the tune of Rs. 50,00,000/- for the negligent pregnancy treatment by Respondent Nos. 6 to 10, which led to the death of the petitioner's daughter, namely Kavitha, and the stillbirth of a male child, based on the petitioner's representations dated 18.02.2022 and 10.03.2022.

Case of the petitioner

2. The petitioner, Murugammal, is the mother of the deceased, Kavitha. Kavitha was married to Ramki, a daily wage labourer residing in Soolamangalam, Thanjavur District. The marriage took place on 22.02.2021. Kavitha conceived soon after her marriage and underwent routine antenatal checkups at the Government Rasa Mirasuthar Hospital, Thanjavur. She was assigned RCH ID No. 133009242569, and her expected date of delivery was 15.02.2022. She received her first dose of Covishield vaccine on 07.12.2021, during her seventh month of pregnancy.



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3. On 12.02.2022, at around 5:00 a.m., Kavitha experienced continuous labour pain. The petitioner and her daughter proceeded to the Kadambur Primary Health Centre (PHC) at approximately 10:00 a.m. on the same day. At the PHC, the 6th and 7th respondents, who were the attending medical personnel, informed them that the fetus was positioned correctly for normal delivery and advised that Kavitha be admitted and monitored for a day.

4. Kavitha's husband arrived at the PHC at around 5:00 p.m. on 12.02.2022. Later that night, viz. on 13.02.2022, at around 2:00 a.m., Kavitha experienced intensified labour pain. Despite the critical condition, and though 7th respondent was available “on call”, the attending nurse for reasons unfathomable, did not call the doctor. The delivery was attended only by the nurse, nurse’s husband, and a hospital assistant, without the supervision of a qualified medical officer. Kavitha delivered a stillborn male child at approximately 2:40 a.m. on 13.02.2022.

5. Following the delivery, Kavitha's condition rapidly deteriorated due to continuous bleeding as a result of a medical condition termed PPH (post partem haemorrhage). Postpartum haemorrhage (PPH) is severe or excessive bleeding after childbirth. It is a serious, potentially life-threatening condition, because of



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which, one can lose large amounts of blood very quickly. It causes a sharp drop in the blood pressure, which can restrict blood flow to the heart, brain and other organs. Even at this stage, the doctor was not called upon to attend on Kavitha. The nurse attempted to address the situation. At 2.29 am, she called the ambulance service and shifted Kavitha to the District Government Hospital at Tirunelveli. The ambulance arrived at the hospital at around 3.45 am. Despite the attempts of the doctors at Tirunelveli to resuscitate Kavitha, she passed away at 4:30 a.m. No post-mortem examination was conducted. The final rites were carried out at Soolamangalam, Thanjavur District.

6. When the petitioner attempted to lodge a complaint against the concerned medical staff at the PHC, the Inspector of Police, Kadambur Police Station, refused to register an FIR. A representation was submitted online by the petitioner on 18.02.2022, and only a CSR bearing the number 74/2022 was issued. No further investigation or FIR followed. The petitioner approached the District Collector, Thoothukudi, on 10.03.2022, seeking justice and for initiation of action against the negligent government medical officers. However, no effective steps were taken by the respondents.

7. The petitioner states that the Block Medical Officer at PHC,

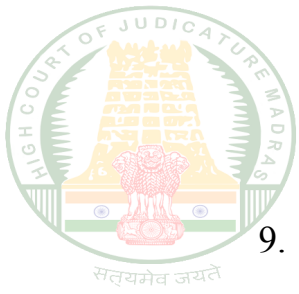


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Kadambur was absent during the critical time of delivery, leading to the death of Kavitha, and of her child. The duty doctor was also not present at the time of delivery, depriving Kavitha of necessary medical care during the crucial moments. Respondent Nos. 8 to 10 failed to perform a cesarean section even though Kavitha's condition was critical, and required immediate surgical intervention. They did not provide prompt and essential medical treatment to Kavitha, despite her worsening condition.

8. Respondent nos. 8 to 10 neglected their responsibility to refer Kavitha to higher-level medical facilities, such as the Government Medical College Hospital at Tirunelveli, Government Hospital Thoothukudi, or Kovilpatti, after recognizing her critical condition. Their unwillingness to take such prompt and essential action not only shows their negligence, but also proves their marked recklessness towards human life. The failure of Respondent nos. 8 to 10 to take the care expected of them- at the time of critical deliveries such as the one in this case- is the sole reason for the death of Kavitha and the stillbirth of her male child. Hence, the respondents 1 to 6 are vicariously liable. Therefore, this writ petition seeking the aforesaid reliefs.

Averments in the counter affidavit filed by the 4th Respondent



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9. The 4th respondent in the counter affidavit, submitted on behalf of itself and Respondents 1, 3, and 6 - 10, has stated that the deceased, Kavitha, was identified as a high-risk antenatal patient due to critically low haemoglobin levels in her early stages of pregnancy. She was accordingly referred and admitted to the Government Raja Mirasuthar Hospital, Thanjavur, where she received timely treatment including blood transfusions. Subsequent improvements in her clinical condition and haemoglobin levels were well documented, and she continued to receive antenatal care from both sub-centres and government facilities.

10. Contrary to the petitioner's allegations, the deceased did not maintain consistent antenatal consultations at the tertiary hospital but appeared intermittently. However, even during her brief registration at the Primary Health Centre (PHC), Kadambur, she was adequately monitored and her vitals were routinely assessed. Her haemoglobin level as of 09.02.2022 was recorded at 11.7 g/dl, ruling out anaemia as a prevailing risk factor at the time of delivery.

11. On 12.02.2022, the deceased was admitted at PHC, Kadambur for observation as her expected date of delivery was approaching. She was

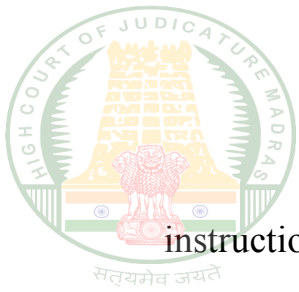


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reviewed by the medical officer during duty hours and monitored by trained nursing staff during the night. When the labour commenced, she was appropriately shifted to the labour ward, and an episiotomy was performed as per standard obstetric guidance to facilitate delivery. The delivery was complicated by poor maternal effort, and the neonate was stillborn with signs suggestive of meconium aspiration. The Block Medical Officer was informed by the night duty staff nurse regarding the stillbirth on 13.02.2022.

12. Upon delivery, postpartum complications ensued. The staff nurse on duty, in response to deteriorating clinical signs, promptly contacted emergency services and initiated transfer of the deceased to Tirunelveli Medical College Hospital. The deceased was accompanied in the 108 Ambulance with all necessary care, including intravenous fluids and oxygen. Her vitals remained stable during transit and upon arrival at the referral hospital.

13. The attending nurse held valid registration and had completed requisite professional training in obstetric management. Under prevailing government orders and departmental guidelines, trained staff nurses and auxiliary nurse midwives are duly empowered to conduct deliveries in primary health centres, with medical officers available on call after duty hours. The duty doctor at PHC, Kadambur was available on call and had provided prior



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instructions for management.

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14. The absence of two assistant surgeons at PHC, Kadambur was due to one pursuing postgraduate studies and the other having been transferred, with sanctioned approval. The sole assistant surgeon on duty had discharged her responsibilities during working hours, and remained available for emergency contact thereafter, in conformity with G.O. (Ms) No. 339 dated 14.10.2009.

15. The maternal death and stillbirth were discussed under the institutional maternal death review framework established by the Government of Tamil Nadu. The findings acknowledged the timely and appropriate response from the healthcare personnel. Any suggestions of negligence are unfounded in light of the medical documentation and the series of actions taken in real time to save both mother and child.

16. Finally, the petitioner and the deceased had not adhered consistently to medical advice and referral instructions during the course of the pregnancy. This contributed significantly to the clinical challenges faced during the labour process. Despite this, the medical team took every measure to stabilise and save the deceased, and her child.



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WEB COPY Averments in the counter affidavit filed by the 7th respondent

17. It is the case of the 7th Respondent that Kavitha was consistently and adequately treated for anaemia from her initial antenatal registration at 7 weeks. Throughout her entire pregnancy term, she was regularly monitored under the PICME system. Iron and folic acid supplementation, iron sucrose injections, and two packed cell transfusions were administered when clinically indicated. At the time of her final antenatal check-up on 09.02.2022, her haemoglobin level was 11.7 g/dl—indicative of a non-anaemic status. This confirms adherence to the established clinical protocols in anaemia detection and correction. There were no further clinical symptoms suggestive of persistent anaemia post-treatment.

18. The delivery process adhered to is accepted by the usually followed obstetric practices. Though her estimated date of delivery was 15.02.2022, she was admitted to the Kadambur PHC upon experiencing labour pains on 12.02.2022. Labour progressed naturally but was prolonged due to poor maternal effort. An episiotomy was performed to facilitate delivery. Following the delivery of a stillborn infant, the patient experienced Uterine atony. However, in this case, uterine atony led to postpartum haemorrhage (PPH). To



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manage the bleeding, standard uterotonic agents, including Oxytocin, were promptly administered. Despite all emergency protocols being followed, the patient's condition necessitated immediate referral to the Tirunelveli Medical College Hospital.

19. Upon the onset of PPH, the staff nurse promptly initiated emergency management and referred the patient to Tirunelveli Medical College Hospital via 108 Ambulance equipped with IV fluids, syntocinon, and oxygen support. The patient was accompanied by qualified personnel and transported without delay to a tertiary care centre, arriving at the said centre within approximately 60 minutes. This evidences due diligence and prompt action in a critical situation.

20. The attending staff nurse, Tmt. M. Vanitha, is a Registered Nurse and Midwife, trained in the Government Medical College and appointed through the Medical Recruitment Board. She had conducted numerous deliveries, including high-risk cases, and had undergone skill-based training in managing obstetric emergencies, including PPH. Under G.O.(Ms) No. 396/1999 and G.O. (Ms) No. 152/2006, staff nurses are authorized to conduct deliveries at PHCs, with doctors available on-call beyond regular hours.



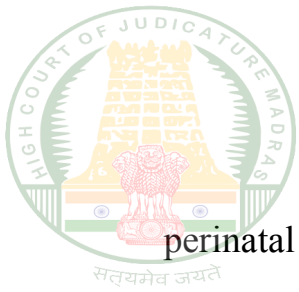
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21. The staffing pattern and operational protocols at Primary Health Centres in Tamil Nadu, as notified in G.O.(Ms) No. 339/2009, permit 24x7 delivery services to be conducted by trained nurses with the support of medical officers on call. On the relevant date, the duty medical officer was available and had instructed for continuous monitoring. No deviation from prescribed duties occurred.

22. The patient was subjected to regular foetal monitoring, including doppler scans and anomaly scans, confirming foetal well-being. Post-abdominal injury at 32 weeks, she was referred to the Government Hospital for expert opinion and no abnormality was detected. At subsequent visits, foetal movement and heart rate were within normal range, evidencing no dereliction in follow-up or investigation.

23. The unfortunate outcome was the result of an unpredictable obstetric complication—atonic PPH—which is recognized in clinical literature as a leading cause of maternal mortality, often occurring without identifiable antecedents or risk indicators. All reasonable medical care and diligence were exercised by the Government healthcare staff. The occurrence of maternal and



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perinatal mortality in this case was tragic, but not attributable to the negligence or dereliction of duty of the medical staff as due medical protocols were observed in both the antenatal and intrapartum periods.

Arguments of the parties

24. This Court heard Mr.S. Sukumar, learned Counsel for the petitioner and Mr.Ajmal Khan learned Additional Advocate General assisted by Mr.A.Kannan, learned Additional Government Pleader, for the respondents.

25. Mr. S. Sukumar, Counsel for the petitioner submitted as follows:

(i) The petitioner's deceased daughter suffered a preventable stillbirth and maternal death, due to gross medical negligence of respondents 8 to 10. The delivery was conducted in the absence of a qualified medical officer, and despite evident signs of labour distress, the attending nurse failed to summon appropriate medical assistance. The absence of both the Block Medical Officer and the duty doctor during the critical period of delivery constitutes a serious lapse of professional duty.

(ii) The failure to perform an emergency caesarean section, coupled with inadequate management of postpartum haemorrhage (PPH) and the delay in referring the patient to a tertiary care facility, establish negligence on the part



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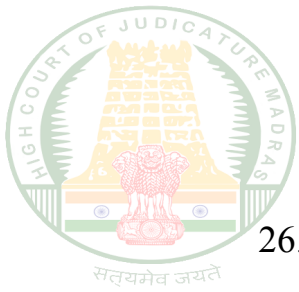
of the medical staff at the PHC, Kadambur. This directly contributed to the fatal outcome. Despite representations to the police and district administration, no effective legal action was initiated, thereby impeding the petitioner's access to timely remedy and justice.

(iii) He placed reliance on the decision of the Supreme Court in ***Parmanand Katara v. Union of India, [(1989) 4 SCC 286]***, wherein it was held that the preservation of human life is of paramount importance and that timely medical intervention is a fundamental right under Article 21 of the Constitution.

(iv) A further reliance was placed on the judgment rendered by the Madurai Bench of the Madras High Court in ***Director of Primary Health Centre v. Thangapandi, [2016 SCC OnLine Mad 17460]***, wherein the Court reaffirmed the State's obligation to ensure that the medical institutions uphold minimum standard of care, particularly in rural and primary health settings.

(v) On the strength of these precedents, the Counsel submitted that the State is vicariously liable for the systemic failure and medical negligence of Respondents 6 to 10, which led to the demise of Kavitha and the stillbirth of her child.

Submissions on behalf of the respondents



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26. Mr. Ajmal Khan, Additional Advocate General assisted by

Mr.A.Kannan learned AGP for the respondents submitted as follows:

(i) No dereliction of duty occurred. The delivery was conducted within the scope of prescribed authority and training.

(ii) Appropriate escalation and emergency protocols were followed. The unfortunate outcome was due to clinical complications beyond anticipation or control of the medical staff at the PHC, Kadambur.

(iii) The petitioner and the deceased further contributed to the fatal outcome by not adhering to the routine medical advice rendered during antenatal checkups, weakening the claim of institutional fault.

(iv) The “Bolam test”, which has been approved by the Supreme Court in **Jacob Mathew v. State of Punjab, [(2005) 6 SCC 1]**, places significant weight on the opinion of a doctor’s peer within his/her speciality. If a doctor's actions are supported by the opinion of another independent and responsible doctor specializing in the same field of medicine wherein the negligence is alleged to have taken place, then such actions are generally considered not negligent.

(v) The standard of care expected while applying the said test is that of an ordinary skilled man exercising and professing that special skill. A doctor is not expected to possess the highest expert skill, but it is sufficient if he/she



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exercises the ordinary skill of an ordinary competent man working in the concerned field of medicine.

(vi) Reliance was also placed on the judgments of the Supreme Court in *Martin F. D'Souza v. Mohd. Ishfaq*, [(2009) 3 SCC 1], and *S.K. Jhunjhunwala v. Dhanwanti Kaur*, [(2019) 2 SCC 282] to reiterate the aforesaid submissions on the Bolam test.

Hence, the learned Additional Advocate General pleads for dismissal of the writ petition.

27. I heard both sides, perused the affidavits and medical documents filed by them, and analysed the answers made to the technical queries posed by the Court.

Discussion

28. Before this Court enters into the merits of the case, certain fundamentals must be borne in mind while dealing with cases alleging medical negligence. Under Article 226 of the Constitution of India, the High Courts have the power to grant compensatory damages against governmental institutions as well as against doctors who are manning such institutions for having failed in the performance of their duties towards patients. Whatever be the forum chosen by the aggrieved person, three tests must be applied before



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arriving at a conclusion. They are:

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- (i) Whether there was a duty to take care of the person who had placed herself/himself in the hands of the medical practitioner or nurse;
- (ii) Whether there has been a breach in the performance of such duty; and
- (iii) Whether the breach has resulted in consequential loss or harm to the patient concerned.

29. It is the case of the petitioner that Respondents 1 to 5 are vicariously responsible and hence, liable for the medical negligence of Respondents 6 to 10, which resulted in the death of her daughter, Kavitha, and the stillbirth of her grandchild.

30. Negligence, as time and again opined by the Supreme Court and this Court, in a plethora of authorities, can be viewed as the failure to exercise reasonable care that a man of ordinary prudence would so exercise in a given situation, or the failure to act in accordance with the standards that a reasonable man would adopt in a particular situation. In this case, prior to determining the vicarious liability of Respondents 1 to 5, first, it must be ascertained whether the actions of Respondents 6 to 10 constitute negligence. This is to say that the factual circumstances leading to the death of the deceased Kavitha and her

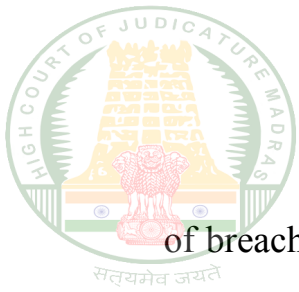


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child must be evaluated and viewed from the shoes of a doctor/nurse specialising in obstetrics. This alone would aid the Court in understanding if the events leading to the untimely death of the petitioner's daughter and grandchild are beyond the scope of care that ought to be exercised by the medical professionals practicing in that field.

31. While undertaking such an evaluation, the Court must remember that, in cases where medical negligence is alleged, there are two kinds of care that are expected of the medical professionals. The first kind of care is “statutory care”. The Government, at regular intervals, issues orders and guidelines imposing certain unbreachable duties on medical professionals, in an attempt to monitor their actions and to ensure the well-being of the people seeking medical help. The second kind of care is “medical care”. The study and practice of medicine prescribe a certain course of action to be undertaken by the doctors to ensure proper treatment of the patients. The doctors, therefore, are under an obligation to perform the duties and observe the standards imposed on them by both the government and medicine.

32. In the case of breach of statutory duty, the Court is adept at determining the negligence of the medical professionals. However, in the case



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of breach of the duty that the study and practice of medicine impose, the Court must apply the “Bolitho test” to ascertain whether the actions of the medical practitioners are logical and approved by the medical fraternity specializing in the same field. As to what is “Bolitho test” will be seen later.

33. Before delving into the factual matrix and legal questions arising in the present case concerning alleged medical negligence, it is imperative to first understand certain medical terms and concepts that are central to the issues under consideration. The comprehension of these terms is essential not only for contextual clarity, but also for an accurate assessment of the medical procedures and decisions undertaken during the course of treatment.

(a) Fetus, usually written as Foetus, refers to an unborn vertebrate, especially a developing human from usually two months after conception to birth

(b) Partograph training is a specialized course that teaches how to use a partograph, a graphical tool for tracking the progress of labour in real-time. It helps in identifying abnormal labour patterns, such as prolonged labour, and assists in making timely decisions to prevent complications.

(c) Episiotomy, also known as perineotomy, is a planned surgical incision of the perineum to augment the second stage of labour. When the



crowning of the baby occurs—that is, when the presenting part of the head of the baby is visible—an episiotomy is performed to widen the gap and expedite labour. It is administered to facilitate delivery.

(d) Uterine atony—a condition in which the uterus fails to contract effectively after the placenta is delivered. Normally, uterine contractions play a critical role in minimizing blood loss by constricting the blood vessels at the site of placental separation.

(e) Meconium Aspiration, Meconium- the first stool of a newborn, can be released into the amniotic fluid before or during labor. When inhaled into the lungs around the time of delivery, this mixture of meconium and amniotic fluid can lead to meconium aspiration syndrome, a serious respiratory condition in newborns.

Bearing these principles in mind, the Court now proceeds to assess the factual matrix of the case and the authorities relating to medical negligence:

A. Death of the mother:

34. The Court must first analyse the factual circumstances that led to the death of the mother to ascertain the propriety of the actions of the Respondent medical professionals. Here, certain events in particular assume relevance: the facts relating to the absence of a medical practitioner during the time of



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delivery, labour monitoring, referral to another hospital, postpartum hemorrhage management, and involvement of non-medical personnel at the labour ward, loom large.

a. **Absence of medical officer during the time of delivery**

35. It is not in dispute that Kavitha started experiencing labour pain in the early morning of 12.02.2022. She was admitted to the PHC, Kadambur on the same day, pursuant to the advice and assurance of the 6th and 7th Respondents that the fetus had been correctly positioned for normal delivery. The next day, viz. on 13.02.2022, at around 1 a.m., the membrane of Kavitha ruptured, and by 2 a.m., she was fully dilated. At the time of delivery, Kavitha was attended only by the nurse and the hospital assistant. Under G.O.(Ms) No. 396/1999 and G.O.(Ms) No. 152/2006, though staff nurses are authorized to conduct deliveries at PHCs, they are not solely permitted to conduct the delivery without the presence of the doctors. In case the delivery takes place beyond the regular hours, the staff nurses are permitted to manage the delivery along with the doctors available on-call.

36. In this case, the delivery had commenced beyond the regular hours, namely at 1 a.m., when the membrane ruptured. The petitioner had maintained



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that the medical officer was not available at the time of the delivery. Though a stray statement is found in the counter affidavit of the 4th Respondent that the duty doctor and the assistant surgeon were available on-call and had given due instructions to the nurse during the regular hours to monitor Kavitha, there are no records to show that they were present at the time of delivery and had attempted the available and medically feasible options to manage the delivery. The telephonic instructions of the duty doctor cannot substitute for the presence of the said doctor. This shows that the very delivery had taken place in a manner contrary to G.O.(Ms) No. 396/1999 and G.O.(Ms) No. 152/2006.

37. The Block Medical Officer, Government Primary Health Centre, Kadambur while stating that staff nurses are trained to conduct deliveries, adds that if staff nurse faces difficulty in conducting delivery, the medical officer will be called for conducting the delivery by the duty staff nurse. Though he states that the delivery of Kavitha was uneventful, the fact that the fetus which was normal, while in the womb suffered from Meconium aspiration at the time of delivery and it was not attended to, resulting in its death shows that Kavitha's pregnancy was not and cannot be treated as an uneventful one.

38. When the staffing pattern and operational protocols at Primary



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Health Centres in Tamil Nadu, as notified in G.O.(Ms) No. 339/2009, permit

24x7 delivery services to be conducted by trained nurses with the support of medical officers on-call, the non-communication of the details of commencement of the delivery and the difficulties associated with it by the nurse to the medical officer available on-call shows non-observance of the minimum care expected of the nurse, thereby constituting gross negligence on her part.

39. The fact that the nurse was properly qualified and was trained to perform normal deliveries, and that the delivery happened well beyond the regular working hours of the PHC cannot replace the experience and expertise of doctors and warrant the non-requisition of timely emergency medical assistance. Kavitha's case as the records reveal was not a normal one. She had been treated as anaemic at the famous Government Raja Mirasudhar hospital. 'On call' duty implies that in case a nurse encounters a medical emergency, she would have to summon a Doctor, who on attending the call would rush to treat the patient. Kavitha, as pointed out above, has already come to notice by the Doctors for specialised treatment. Apart from the usual iron supplement and folic acid given at the time of pregnancy, Kavitha had underwent two blood transfusions, while being treated at Thanjavur. The failure on part of the nurse



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to call the Doctor to assist her in the surgery reflects the first aspect of negligence.

b. Improper labour management

40. Further, while answering the query posed by this Court as to how the nurse handled and managed the PPH, the respondents have submitted that at 2.29 a.m., the nurse had called the 108 Ambulance for referral due to poor maternal efforts during the “head on perineum” phase. The calling of the ambulance when the fetal head was approaching or was on the perineum indicates that the nurse had deducted the possibility of a difficult labour that was beyond her control and expertise. This is because measuring the distance between the fetal head and perineum can help predict the mode of delivery and inform clinical decisions regarding labour management. The nurse, the respondents claim, was trained to detect such issues. This shows that the nurse had detected the possibility of difficult labour at 2.29 a.m. and had called the ambulance. Yet, she did not call the Doctor, who was available near-by.

41. Though it was contended by the Respondents that the transfer to the Government Hospital, Tirunelveli was felt necessary due to lack of adequate maternal efforts, the very choice of the nurse to transfer the patient signifies that the delivery had reached a point that was beyond the management of the

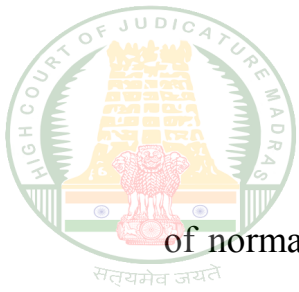


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nurse, and the presence of the medical officer at such a time could have facilitated the performance of an emergency caesarean section to take out the baby.

42. It should also be remembered that the counter affidavit filed by the 7th Respondent highlights that the nurse had underwent “partograph” training. This training is designed to equip healthcare professionals with the necessary skills to monitor and manage labour efficiently. The training focuses on the assessment of key parameters, including cervical dilation, fetal heart rate, and the descent of the baby, thus aiding the early detection of potential risks, and allowing for appropriate medical interventions. Partograph, being a helpful tool, in detecting abnormal labour patterns and the nurse having undergone partograph training reveal that she had deducted the possibility of unmanageable complications and difficulties. However, it was only at 2.29 a.m. when she called the ambulance for transferring Kavitha to the Tirunelveli Medical College Hospital. Despite the same, the “On call” doctor was not informed.

43. The nurse, being aware that the labour was complicated and was one beyond her ability or control, proceeded with episiotomy as done in the cases



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of normal delivery. Though the nurses are trained and empowered to conduct delivery in the presence of doctors, neither law nor medicine empowers them to exercise the judgment of the doctor while deciding the mode of birth, especially after coming to know the issues associated with the labour. This clearly shows that the nurse had acted in a reckless manner, without observing the medical care that she ought to have observed. This situation could have been avoided or better handled- and even an emergency caesarean section could have been performed- if she had requested the timely assistance of a duty doctor available on-call.

c. Delay in referral and unviable escalation

44. Kavitha's labour began at 9.00 a.m. on 12.02.2022 and continued to progress throughout the day. The membranes ruptured at 1.00 a.m. and full dilation happened at 2.00 a.m. on 13.02.2022. This shows that Kavitha underwent labour for a span of nearly 17 hours. Prolonged labour is often characterized by a delay in cervical dilation or the inability of the baby to descend through the birth canal, both of which can lead to serious complications.

45. Despite prolonged labour, the ambulance was only called at 2.29



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a.m., well after full dilation and rupture of membranes, when the fetal head was on the perineum. The ambulance reached Kadambur at 2.50 a.m. and departed from the Government PHC at 3:05 a.m.

46. At this juncture, it should also be noted that even after discerning that the labour would be a complicated one at 2.29 a.m., the nurse has opted to transfer Kavitha from PHC, Kadambur to Tirunelveli Medical College Hospital, both of which are about 44 kms apart. Though the delivery was complicated, and the escalation itself was delayed, instead of requesting the presence of the physically proximate on-call duty doctor or assistant surgeon, the nurse had preferred to transfer the deceased Kavitha to a medical institution that was 44 kms away.

47. The counter affidavit filed by the Medical Officer indicates that it took approximately 60 minutes for the ambulance to arrive at the Tirunelveli Medical College Hospital. In cases of prolonged labour and escalation during crucial moments like the “head on perineum” phase, the decision to make the pregnant woman traverse a distance of 44 kms for 60 minutes when the duty doctor and assistant surgeon were available on-call indicates the improper discharge of duty and negligence of the nurse.



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WEB C d. Insufficient exercise of care to manage PPH

48. It should also be noted that the ambulance arrived at the scene at 2.50 a.m., after the birth of the child, when the petitioner's daughter was undergoing PPH. The ambulance was not alerted to handle the situation of PPH but was called upon to transfer Kavitha from the PHC, Kadambur to Tirunelveli Medical College Hospital, Tirunelveli to manage the difficult labour. This shows that the haemorrhage, a consequence of the delivery, that was known to be beyond the managing capacity of the nurse- yet was attempted to be addressed by her, without the assistance of a Doctor.

49. Though the Respondents have contended, while answering the queries posed to them, that the reason for PPH could have been uterine atonicity and have maintained that the reasons for 2/3rd of PPH remain unknown, the difficult labour and the consequential PPH could have been effectively handled if the duty doctor and assistant surgeon available on-call were present at the time of delivery. The non-communication of the completion of dilation and the on-set of difficult delivery by the nurse to the duty doctor has worsened the entire process, thereby evidencing her negligence and failure of her duty to take care of the deceased Kavitha .



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50. Further, when Kavitha was transported from Kadambur to Tirunelveli, she was shifted without the nurse suturing the episiotomy wound. The wound was dressed only with a plug to prevent bleeding. When the deceased Kavitha was already suffering from PPH and was being made to travel a distance of 44 kms, the mere covering of the episiotomy wound with a plug did not even meet the minimum standard of medical care expected of the nurse who had undergone all the requisite obstetric training. No trained nurse, nay even, a person of ordinary prudence, would engage in such a life-threatening deed. It is akin to applying a band aid to a deep & seriously bleeding cut injury.

51. Even after PPH was noted, the ambulance did not depart from the PHC until 3.05 a.m. It took another 60 minutes for the ambulance to traverse the distance of 44 kms and arrive at the Tirunelveli Government Hospital. This delay in transferring the patient had worsened the condition, as uterine atony and excessive bleeding require prompt intervention to prevent life-threatening consequences.

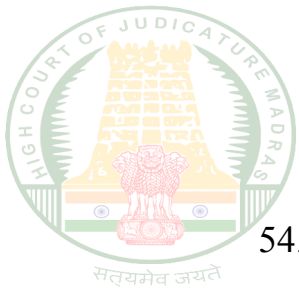
52. Further, in the 7th respondent's affidavit, it is detailed that the



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concerned nurse underwent various training programs, with specific information provided regarding the name, date, duration, and location of each training since 2020. It is mentioned that the nurse took PPH training on **20.04.2022**. However, the tragic event in question occurred on **13.02.2022**, which was nearly two months prior to this training. This shows that the nurse, who had not yet received specific training to treat PPH at the time of the incident, was expected to manage a critical condition such as postpartum hemorrhage. This further strengthens the petitioner's assertions of gross medical negligence.

53. These dates reveal that on the date on which the unfortunate occurrence took place, the nurse who handled the situation was not competent to deal with it. Kavitha had placed herself in the hands of Ms. Vanitha for a safe delivery. By virtue of that relationship, the latter owed a duty to take care of the former. This duty included acting within the scope of expertise and not indulging in adventurism. A life of an individual is too precious to be gambled on such exercises; this is more so in the case of a medical nurse.



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54. The nurse had attempted to treat an affliction over which she neither had competence, nor ability, nor training. It will be relevant to recall here that even if a person is an expert in the Indian form of medicine, he is treated but as a quack, when it comes to the allopathic form. When the nurse had not been given training in PPH, she ought not to have dabbled in the same. She should have immediately called the concerned doctor ,who is in charge of the PHC. That doctor would have been in a position to take a call whether to shift the patient immediately or to proceed further with the treatment at Kadambur. This too is a fatal breach of the duty to take care. The petitioner had specifically averred that she and her and her son-in-law (Kavitha's husband) had called upon the nurse to give the number of the Doctor, so that they would call the Doctor for assistance. Unfortunately, this aspect too has not been followed. Even if one were to condone the act of the nurse in not calling the Doctor on her own, it is beyond once imagination as to why she did not permit the patient's attender to call the Doctor.

55. Even if I were to apply the Bolam test, as to be discussed later, it does not satisfy the requirement of law. This is not a situation of a false sense of complacency, where a competent person takes a laid-back attitude which results in damage. In the present case, the nurse was not competent in PPH and



attempted to treat it. An incompetent person treating an affliction which requires expertise also falls within the domain of negligence.

56. The affidavit of Dr. Pamila also reveals that Kavitha was brought to the Government Hospital, Tirunelveli, at her final and most critical moments. Despite the application of resuscitative methods, the patient could not be revived. Dr. Pamila has also affirmed that by the time the patient arrived, her condition had deteriorated to a point where the scope for effective intervention was extremely limited. This is clear from the following averments in her additional affidavit : -

I attended the patient at 04:20am and on investigation, I found the following observations : -

“Patient is unconscious – not responding to painful stimuli – no spontaneous respiration – gasping – severely anaemic – pupils dilated – CVS heart sounds muffled – RP bilateral crepitation present, gasping – no spontaneous respiration...”

57. The medical records reveal that Kavitha’s hemoglobin (Hb) level was 11.7 g/dL as per the report dated 09.02.2022. However, upon her admission to the Government Hospital, Tirunelveli, following delivery, her Hb level had precipitously declined to 5.6 g/dL, clearly indicating extensive blood loss. In



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situations of acute hemorrhage, the failure to administer fluid resuscitation without delay critically impairs the body's ability to deliver oxygen and essential nutrients to vital organs, resulting in hypovolemic shock. This condition, characterized by inadequate tissue perfusion, leads to progressive organ dysfunction and, if not promptly managed, culminates in life-threatening complications or death. The loss of circulating blood volume—whether due to haemorrhage or fluid depletion—necessitates immediate replenishment; the absence of which severely compromises cellular oxygenation and results in multiple organ failure and mortality.

58. It is not in dispute that Kavitha had lost substantial fluids during the time of pregnancy and was suffering from PPH. In situations, where blood products are unavailable, intravenous (IV) fluids are administered as an alternative to maintain circulatory volume and support hemodynamic stability. This approach is recognized in established medical literature, including Bailey & Love's Short Practice of Surgery, which discusses the management of shock and haemorrhage and acknowledges the role of IV fluids as a temporary substitute in the absence of transfusion resources. There is absolutely no record to show either Ms. Vanitha or during the travel from Kadambur to Tirunelveli, Kavitha was administered with IV.



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59. The nurse who attended to the labour undoubtedly had the last clear chance to prevent the death of Kavitha by offering timely intimation to the doctor and withholding herself from performing a procedure that was not approved by the doctors. Her inefficiency coupled with her lack of training in treating conditions such as PPH have further worsened the situation.

e. Inappropriate involvement of non-medical personnel at the time of delivery

60. The Petitioner's affidavit at Paragraph 6 mentions that the nurse, along with her husband and one hospital assistant, attended to the delivery on 13.02.2022. This raises a question as to what role the nurse's husband had in the labour room. Unless he is a medical professional, his involvement in a medical procedure is unusual and has to be considered inappropriate. This issue was neither addressed nor denied in the counter affidavit filed by the Respondents. It remains unclear as to why the nurse's husband was present inside the labour ward, especially when Kavitha was in her active labour.

61. According to the press release issued by the Press Information Bureau, Government of India, Ministry of Health and Family Welfare dated



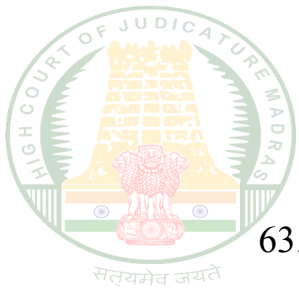
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25.02.2016, the Health Ministry allows certain birth companions to be present

during the delivery in public health facilities. These companions can be a female relative- who must have preferably undergone the labour process- or the husband of the woman in labour (husbands are allowed in facilities where privacy protocols are followed in the labour room). The birthing companions are the only non-medical personnel permitted inside the labour room at the time of delivery. The Ministry does not permit the presence of the husband of a nurse inside the labour room at the time of delivery.

62. The presence of an unauthorized non-medical person in such a critical and sensitive environment raises concerns about adherence to medical protocols and the appropriateness of his involvement in the delivery process. It is a well-established principle of law that averments which are not specifically traversed are deemed to be admitted. The Respondents have not addressed the reason for the presence of the nurse's husband inside the labour room when Kavitha was undergoing labour. The absence of any categorical denial on this material fact amounts to an admission as held by the Supreme Court in *Bharat Sanchar Nigam Limited v. Abhishek Shukla & Another*, (2009) 5 SCC 368. thereby lending further credibility to the petitioner's version of events.

f. Dereliction of duty by the medical officer and assistant surgeon



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63. In the counter affidavit filed by the 4th Respondent, it has been alleged that the Petitioner and the deceased had not adhered consistently to medical advice and referral instructions during the course of the pregnancy. This, in the opinion of the 4th Respondent, contributed significantly to the clinical challenges faced during the labour process.

64. Kavitha was admitted in PHC, Kadambur in the morning of 12.02.2022. If the non-adherence to the medical advice during the course of the pregnancy had the potential to complicate the labour process, the failure of the 6th and 7th Respondents to enquire about and monitor the labour beyond the regular hours, despite knowing the complications associated with, it reflects their dereliction of duty and non-exercise of the ordinary care.

65. Therefore, the dereliction of duty and the failure to exercise ordinary care by the 6th and 7th Respondents while managing the labour of Kavitha exacerbated the difficult labour, and led to her eventual death.

66. A conjoint reading of the above-narrated events indicates that Respondents 6 to 10 had failed to exercise the care that is mandated both by law and medicine, thereby contributing to the untimely and tragic death of Kavitha.



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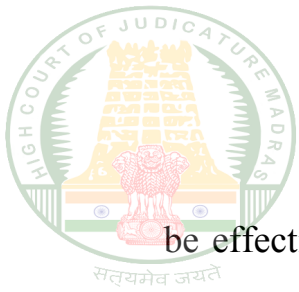
B. Death of the child:

67. Now that the Court has made an inference, after evaluating the relevant circumstances, that the death of Kavitha occurred as a result of the non-exercise of reasonable care (both as mandated in law and medicine) and dereliction of duty by Respondents 6 to 10, the Court must next proceed to assess the circumstances leading to the death of the child to determine whether the actions of the said Respondents had any bearing to the same.

a. Signs of foetal distress and treatment of meconium aspiration

68. As discussed earlier, Kavitha was fully dilated at 2.00 a.m on 13.02.2022. Considering the timeline and the details provided by the Block Medical Officer in her counter affidavit, it is evident that the fetus had a heartbeat at 2.00 a.m. with a fetal heart rate (FHR) of 146 bpm and showed no signs of fetal distress. This clearly indicates that the fetus was alive and stable just moments before birth.

69. However, at 2.29 a.m., the nurse called the ambulance to transfer the petitioner to the Tirunelveli Medical College Hospital. This, as previously pointed out, indicates that the labour had reached a point wherein it could not

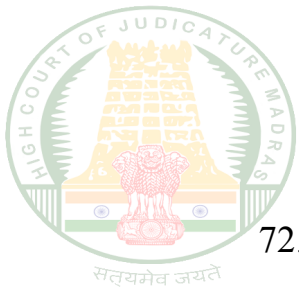


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be effectively managed by the nurse herself. Despite the same, an episiotomy was performed by her, and the child was stillborn at 2.40 a.m. displaying signs of meconium aspiration.

70. The fact that the fetus was born displaying signs of meconium aspiration shows that the fetus had undergone distress. The fetus had a normal at 2.00 a.m. This means that the fetus must have undergone distress during the period between 2.00 a.m. and 2.29 a.m., when the ambulance was called to transfer Kavitha from PHC, Kadambur to Tirunelveli Medical College Hospital. This could have been deducted and treated if the nurse had performed her duty of monitoring the heartbeat of the fetus after the beginning of the descent of the fetal head at 2.00 a.m. Further, the nurse had undergone partograph training and there is a good possibility that the nurse could have called the ambulance after noticing the abnormalities as in meconium stain and heart rate.

71. However, there is nothing on record to show that the attending nurse had taken any proactive measures within her ambit of care and control to address this situation of fetal distress such as administering oxygen, etc.



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72. Even then, the nurse had not informed the on-call doctor regarding the situation. Meconium aspiration is deducted with the meconium stain.

Meconium stain is revealed during the process of delivery. A nurse who is supposed to have been trained in performing deliveries, could have easily deducted it. Yet, no corrective steps were taken to prevent the child from aspiration. She merely alerted the ambulance for transferring the mother and child to Tirunelveli Medical College Hospital, a medical institution 44 kms away from PHC, Kadambur. Nevertheless, she had not undertaken the measures necessary to prepare the mother and the child for the transfer. Rather, she had proceeded with episiotomy before the ambulance could arrive.

73. There are no records to show that the episiotomy was sanctioned by the medical officer, on the appraisal of the material facts. In these exigent cases of fetal distress, the appropriateness of episiotomy is a medical decision that must be taken by the doctor managing the delivery. The discretion and the decision of the nurse, despite her training and education, cannot replace the medical knowledge, experience and expertise of a doctor. These unilateral and unapproved decisions at the time of dealing with fetal distress could be dangerous and shows lack of reasonable care.



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74. Further, even after the baby was stillborn displaying signs of meconium aspiration, there are no records to show that the attending nurse had attempted an established and recommended method of tracheal suctioning or any other accepted neonatal resuscitation procedures. The nurse, having undergone training required to manage labour, should have performed neonatal resuscitation procedures to save the child. However, in this case, there are no records to establish that the neonatal resuscitation procedures were at least attempted, evidencing lapse in professional care and medical negligence.

75. A closer scrutiny of the afore-discussed chain of events reveals that both fetal distress and its consequent meconium aspiration, leading to the death of the child, were not treated with ordinary professional care.

C.The standard to determine medical negligence-
the shift from Bolam to Bolitho:

76. The principles governing medical negligence have undergone significant development since the foundational decision in ***Bolam v. Friern Hospital Management Committee, [(1957) 1 WLR 582]***.



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77. In ***Bolam v. Friern Hospital Management Committee***, [(1957) 1 **WLR 582**], McNair J articulated the standard of care required of medical professionals. The Court held:

“Pg. 587 ... It is just a question of expression. I myself would prefer to put it this way, that he is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art.”

78. This principle, now known as the ***Bolam Test***, establishes that while assessing whether a medical professional has breached their duty of care, the question is not whether the court would have acted differently, but whether the professional’s actions were in accordance with a practice accepted by a responsible body of medical men specializing in the field of medicine wherein the negligence is alleged to have occurred.

79. The judgment emphasized that a medical practitioner cannot be held negligent merely because there exists a body of opinion that would have acted differently, so long as the practice adopted is deemed acceptable by a



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competent and responsible group within the profession.

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80. This test has been approved by the Supreme Court in **Jacob Mathew v. State of Punjab**, [(2005) 6 SCC], wherein the Court placed significant weight on the opinion of a doctor's peer within his/her speciality. However, it should be noted that the principle of law laid down in the **Bolam** case was clarified by the House of Lords later. In **Bolitho v. City and Hackney Health Authority**, [(1998) A.C. 232], the House of Lords revisited and clarified the principle established in **Bolam** case. Lord Browne-Wilkinson in the Bolitho case opined:

“Pg. 241 ...the court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of opinion that the defendant's treatment or diagnosis accorded with sound medical practice. In the Bolam case itself, McNair J. [1957] 1 W.L.R. 583, 587 stated that the defendant had to have acted in accordance with the practice accepted as proper by a “responsible body of medical men.” Later, at p. 588, he referred to “a standard of practice recognised as proper by a competent reasonable body of opinion.” Again, in the passage which I have cited from Maynard's case [1984] 1 W.L.R. 634, 639, Lord Scarman refers to a “respectable” body of professional opinion. The use.



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of these adjectives — responsible, reasonable and respectable.
— all show that the court has to be satisfied that the exponents
of the body of opinion relied upon can demonstrate that such
opinion has a logical basis. In particular in cases involving, as
they so often do, the weighing of risks against benefits, the judge
before accepting a body of opinion as being responsible,
reasonable or respectable, will need to be satisfied that, in
forming their views, the experts have directed their minds to the
question of comparative risks and benefits and have reached a
defensible conclusion on the matter.”

81. Thus, **Bolitho case** clarified and stressed upon "logical analysis", confirming that expert medical opinion must withstand rational scrutiny. The Court retains the authority to reject medical opinion if it is not reasonable or responsible, even if it is widely held. This decision refined the Bolam test by ensuring that professional practices must not only be widely accepted but must also be logically defensible.

82. The shift from **Bolam** to **Bolitho** thus marks a movement away from a purely deferential approach to medical expertise, toward a more balanced standard in which judicial oversight plays a critical role. While courts continue to respect the complexities of medical judgment, **Bolitho** affirms that such



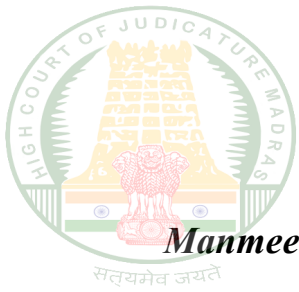
W.P.(MD).No.5530 of 2022

judgments must be defensible in logic and not merely protected by tradition or convention.

83. The reasoning expressed in the ***Bolitho case*** were accepted and adopted by the Supreme Court in ***Arun Kumar Manglik v. Chirayu Health & Medicare (P) Ltd., [(2019) 7 SCC 40]***. Dr. Justice D. Y. Chandrachud (as his Lordship then was) speaking for the bench held:

“In the practice of medicine, there could be varying approaches to treatment. There can be a genuine difference of opinion. However, while adopting a course of treatment, the medical professional must ensure that it is not unreasonable. The threshold to prove unreasonableness is set with due regard to the risks associated with medical treatment and the conditions under which medical professionals function. This is to avoid a situation where doctors resort to “defensive medicine” to avoid claims of negligence, often to the detriment of the patient. Hence, in a specific case where unreasonableness in professional conduct has been proven with regard to the circumstances of that case, a professional cannot escape liability for medical evidence merely by relying on a body of professional opinion.”

84. It will be relevant to refer two cases here. ***Deep Nursing Home V.***



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Manmeet Singh Mattewal, (2012) 3 CPJ 154 (NC) and Sabita v. SHreepad and Ors, MANU/CF/0789/2015. In both these cases, when complicated

deliveries were performed by the nurses, in the absence of the doctors, the Courts held that negligence stood proved and the institutions to be answerable to the claims of the petitioner.

85. In the present case, apart from the breach of statutory standard that mandates the presence of a doctor at the time of delivery, none of the actions of the attending nurse, as outlined in the previous paragraphs, could be considered reasonable. Though the Respondents, in the counter affidavits and arguments, contend that the actions of the attending nurse fall within the medically accepted standards and practices, when the actions are evaluated in the light:-

- (i) of prolonged labour,
- (ii) non-intimation of the commencement of delivery to the doctor and assistant surgeon available on-call,
- (iii) the performance of unapproved and unadvised episiotomy after deducting the complications involved in the delivery process,
- (iv) improper management of fetal distress,
- (v) poor handling of PPH,
- (vii) transfer of the mother and child to a tertiary centre 44 kms away



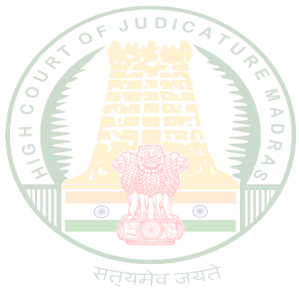
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during the critical time, and non-performance to neonatal resuscitation to treat meconium aspiration,

(viii) the risk and the detrimental factors associated with the actions of the attending nurse, and

(ix) outweighs the apparent benefits. It points to negligence and this court accordingly concludes so.

86. No man of ordinary reason and logic would endorse the propriety of the methods of delivery management undertaken by the attending nurse despite the same being approved by the 4th Respondent. The measures undertaken by the nurse to manage the delivery of Kavitha clearly fall below the standard of care expected by law and medicine. Her dereliction of duty and disregard towards the established statutory and medical standards during the time of delivery, upon the stillbirth of a male child, and while managing PPH, coupled with the inaction of Respondents 6 and 7, have significantly contributed to the death of the petitioner's daughter and her grandchild. Therefore, it is reasonable to conclude that the actions of Respondents 6 to 10 constitute medical negligence.



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D.Vicarious liability of Respondents 1 to 5:

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87. The aforesaid paragraphs lead to the conclusion that the death of Kavitha and her child happened on account of negligence in action, and in inaction of respondents 6 to 10. The petitioner wants respondents 1 to 5 to be held liable on account of the aforesaid aspects. This foundational principle is embedded in the latin maxim “*qui facit per alium facit per se*”. The meaning of this latin maxim is that he who acts through another, acts himself, hence, the master is liable for the negligence of his agent. Kavitha throughout her pregnancy had visited only Governmental Institutions for her treatment. Initially, she underwent her treatment at the Government Raja Mirasudhar Hospital in Thanjavur. As is the practice in this part of the country, a pregnant lady is usually sent to her maternal home. Consequently, Kavitha placed herself in the hands of those managing an operating the PHC at Kadambur.

88. Since the actions of Respondents 6 to 10 constitute medical negligence, the Respondents 1 to 5, being persons having effective control and authority over the actions of Respondents 6 to 10, are vicariously responsible for the death of the petitioner’s daughter and the stillbirth of the male child, and hence are liable to compensate the petitioner for her loss in accordance with the principle of “*respondeat superior*”.



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89. The PHC was established by first respondent and is under the control and supervision of Respondents 2 to 5. The paths of respondents 6 to 10 would not have crossed Kavitha, if not, for the PHC. Therefore, any mishaps / accidents that takes place during the course of the treatment, would hold the persons or authorities who established the PHC responsible. Hence, I conclude respondents 1 to 5 are answerable to the Writ Petitioner for the negligence / inaction of respondents 6 to 10.

AMOUNT OF COMPENSATION

90. Having held that the respondents 1 to 5 are vicariously liable for the negligence of the respondents 6 to 10, I now have to turn to the quantum of compensation.

91. The Supreme court in **Balaram Prasad v. Kunal Saha and Ors, 2014 (1) SCC 384** had rejected, across the board application of the principle of multiplier method used in motor accidents cases for grant of compensation. The relevant portion is extracted hereunder :-

A careful reading of the above cases shows that this Court is skeptical about using a strait jacket multiplier method for determining the quantum of compensation in



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medical negligence claims. On the contrary, this Court mentions various instances where the Court chose to deviate from the standard multiplier method to avoid over-compensation and also relied upon the quantum of multiplicand to choose the appropriate multiplier. Therefore, submission made in this regard by the claimant is well founded and based on sound logic and is reasonable as the National Commission or this Court requires to determine just, fair and reasonable compensation on the basis of the income that was being earned by the deceased at the time of her death and other related claims on account of death of the wife of the claimant...”

Following this judgment, I have to see what would be reasonable, just and fair compensation payable to the heirs of Kavitha.

92. The Hon'ble Mr. Justice N. Paul Vasantha Kumar (as his lordship then was) had award a sum of Rs. 200,000/- towards the death of a child in **S. Mary v. Union of India and Ors, W.P. 25697 of 2012** dated 08.02.2013. Giving room for the decade that has passed by, I award a sum of Rs. 3,00,000/- as compensation for the death of the child.

93. In far as the death of Kavitha is concerned, she was a graduate aged about 24 years. Therefore, I am of the opinion that if Rs. 12,00,000/- is



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awarded, it would be just and fair in the circumstances of the case. The respondents 1 to 5 shall pay a sum of Rs.15,00,000/- to the petitioner. The respondents are at liberty to recover this amount from respondents 6 to 10, after due enquiry.

94. The claim for Rs.50,00,000/- is rejected. The writ petition is partly allowed in the above terms. The respondents shall pay a sum of Rs.15,00,000/- to the petitioner together with costs of Rs.25,000/-. The amount awarded together with costs shall be paid to the petitioner within a period of four weeks from today.

22.05.2025

nl

Index : yes / no
Neutral Citation : yes / no
Speaking / Non Speaking Order



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To

- 1.The Principal Secretary to Government,
Health and Family Welfare Department,
Secretariat, Chennai – 600 009.
- 2.The Special Secretary to Government,
Public (HR) Department,
Secretariat, Chennai – 600 009.
- 3.The Director of Public Health and Preventive Medicine,
No.359, DMS Building,
Anna Salai, Teynampet,
Chennai – 600 018.
- 4.The Deputy Director of Health Service,
O/o.Deputy Director of Health Service,
Kovilpatti, Thoothukudi District.
- 5.The District Collector,
District Collector Office,
Thoothukudi District.
- 6.The Block Medical Officer,
Government Primary Health Centre,
Kadambur, Thoothukudi District.
- 7.The Assistant Surgeon,

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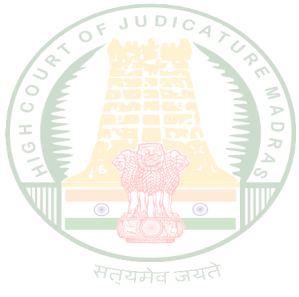
Government Primary Health Centre,
Kadambur, Thoothukudi District.

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8.The Auxiliary nurse Midwife,
Government Primary Health Centre,
Kadambur, Thoothukudi District.

9.The Staff Nurse,
Government Primary Health Centre,
Kadambur, Thoothukudi District.

10.The Village Health Nurse,
Government Primary Health Centre,
Kadambur, Thoothukudi District.



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V.LAKSHMINARAYANAN, J.
nl

Pre-delivery order in
W.P.(MD).No.5530 of 2022

22.05.2025