



2025:DHC:10466



* **IN THE HIGH COURT OF DELHI AT NEW DELHI**

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Reserved on: 08th August, 2025

Pronounced on: 26th November, 2025

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CRL.A.1157/2025

THE STATE

Govt. of NCT of Delhi

Through its Standing Counsel (Crl.)

.....Petitioner

Through: Mr. Utkarsh, APP for the State with
SI Amit Bhardwaj, P.S. Najafgarh.

versus

1.INDER SINGH

S/o Karam Singh

R/o Lot No.1 & 2, Vinobha Enclave,
Near CRPF Camp, Jharoda Kalan,
Najafgarh, Delhi.

2. JAGJEET KAUR

W/o Inder Singh

R/o Lot No.1 & 2, Vinobha Enclave,
Near CRPF Camp, Jharoda Kalan,
Najafgarh, Delhi.

3. SHIVRAJ

S/o Yugraj

R/o 662A, Gaushala Road,
Najafgarh, Delhi.

4. DR. VANDANA SINGH

W/o Sh. Gyan Pratap Sisodia

R/o H. No.286, Sector-6,
Bahadurgarh, Haryana.

.....Respondents

Through: Mr. Dharam Raj Ohlan, Mr. Krishan
Kant Kaushik, Mr. ParovOhlan,
Mr.Ritesh and Mr. Mohit, Advocates
for R-2 &R-3.



CORAM:

HON'BLE MS. JUSTICE NEENA BANSAL KRISHNA

J U D G M E N T

NEENA BANSAL KRISHNA, J.

1. Criminal Appeal under Section 378(3) of the Code of Criminal Procedure, 1973 (*hereinafter referred to as 'Cr.P.C.'*) has been filed on behalf of the **Petitioner/State** challenging the Order dated 16.01.2020 learned CMM, Delhi, whereby the **Respondents have been acquitted** under Section 304A of the Indian Penal Code, 1860 (*hereinafter referred to as "IPC"*) and Sections 13(4A)/15(3) of the Indian Medical Council Act, 1956 (*hereinafter referred to as "IMC Act"*) in FIR No.804/2005 registered at P.S. Najafgarh, Delhi.

2. The **case of the Prosecution** is that Complainant/Satish Kumar filed a Complaint wherein he stated that on **12.08.2005**, he took his pregnant wife Smt. Reeta (*'the deceased'*) to nearby Delhi Clinic, where she gave birth to a daughter at about 02:30 PM. She remained admitted in the Clinic for about one hour and during this period, Respondent No.1/Dr. Inder Singh (*since deceased*) and his wife, Respondent No.2/Ms. Jagjeet Kaur continued some treatment on her and when her condition got serious, Dr. Inder Singh, on his own, at about **04:00 PM**, **shifted her along with Glucose bottle, to Gobhania Nirog Dham Hospital ('Gobhania Hospital')**. There she was kept under observations of Respondent No.3/Dr. Shivraj (*since deceased*) for about 1.5 hours. Dr. Inder Singh remained present there throughout this period.

3. On the same day, at about **05:45 PM**, the Complainant was informed by Gobhania Hospital that his wife's condition is not well and it as not



improving. Dr. Shivraj along with the Complainant, one Driver, an Employee of Gobhania Hospital and Complainant's Mother, took his Smt. Reeta to DDU Hospital. On reaching the Emergency of DDU Hospital at about **06:30 PM, Doctors declared Smt. Reeta, as brought dead.** The Complainant brought his wife to his house and informed the Police and on his statement, FIR was registered.

4. On **13.08.2005, the body of the deceased was shifted to mortuary of DDU Hospital to conduct the post-mortem.** On the same day, the statements of Dr. Shivraj, Dr. Vandana, Mr. Ashok Kumar and Mr. Deepak Sharma, Dr. Inder Singh, Dr. Jagjeet Kaur and relatives of the deceased, i.e. her mother, mother-in-law and uncle were recorded by IO/SI Balwan Singh. During the inquiry, Certificates of Registration and Degrees of the Respondents, were collected.

5. On the request of SI Sandeep Sharma, a Medical Board for post-mortem of the deceased was constituted. **The post-mortem was conducted on 17.08.2005.** However, before giving the final opinion, the Board of Doctors sought certain information from the IO.

6. Thereafter, the **Board of Doctors gave its 'subsequent opinion' on 31.08.2005** (comprising of Dr. SK Khanna, Dr. MK Wahi and Dr. S. Daka) and suggested to obtain an opinion of specialist in Obstetrics and Gynaecology in regard to the negligence of doctors.

7. **Another Medical Board, headed by Dr. S. Batra (included Dr. U. Manaktala and Dr. Rewa Tripathi) was constituted, who gave detailed Report on 28.10.2005,** wherein it was opined that the doctors at both the Hospitals, i.e. Delhi Clinic and Gobhania Nirog Dham, were negligent in treatment of deceased Smt. Reeta, resulting in her death.



8. After completion of investigations, **Chargesheet under Section 304A IPC was filed on 07.11.2007** against four accused persons / Respondents herein.
9. During trial, **Respondent No.3/Dr. Shivraj expired on 16.07.2016** and proceedings against him were abated *vide* Order dated 03.09.2018.
10. The Prosecution, in support of its case, examined following **14 witnesses**.
11. **PW-1/Satish Kumar** is the Complainant, who has deposed about the entire incident in terms of his Complaint Ex.PW1/A.
12. **PW-10/Smt. Kamlesh Kumari** is the mother-in-law of the deceased Smt. Reeta (*the deceased*) who deposed regarding the incident on the same lines as PW-1, her son.
13. **PW-3/Dr. S. K. Khanna**, Director Professor, Maulana Azad Medical College along with PW-5/Dr. M. K. Wahi and Dr. S. Daka had conducted the post-mortem of the deceased Reeta on 17.08.2005 and Post-Mortem Report is Ex.PW-3/A.
14. **PW-4/Dr. Usha Manaktala**, **PW-5/Dr. M. K. Wahi** and **PW-8/Dr. Swaraj Batra** were the members of Medical Board, gave its *Report on 31.08.2005, Ex. PW3/C* and opined that “*Death in this case was due to haemorrhage and shock consequent upon placenta being retained in the uterus after delivery*”. However, it stated that before giving any final opinion in regard to cause of death, an opinion of specialist in Obstetrics and Gynaecology in regard to the negligence of doctors, be obtained. Subsequently, they gave an opinion *vide* their Report dated 28.10.2005, Ex.PW-4/A (comprising of Dr. S. Batra, Dr. U. Manaktala, Dr. R. Tripathi) that doctors at both the Hospitals were negligent.



15. **PW-2/HC Ramesh** registered the FIR No.0804/2005 which is Ex.PW-2/A.
16. **PW-6/HC Chandan Singh** had taken the photographs of the deceased, which are Ex.PW-3/1 to 8.
17. **PW-9/Surender Kumar**, Clerk MDU Rohtak, produced the qualification records of Dr. Inder Singh and Dr. Jagjeet Kaur and deposed that they had cleared BAMS Examination in the year 1985, which are collectively Ex.PW-9/1 (OSR).
18. **PW-11/SI Balwan Singh (Retired)**, was the first IO, who conducted the initial investigations. He along with PW-3/HC Jitender Singh, on receiving DD No.49A on 12.08.2005, had gone to the house of the Complainant at *Sainik Enclave, Part II, Delhi*, where IO recorded the Statement of Complainant Satish Kumar, Ex.PW1/A. Again on 17.08.2005, they went to DDU Hospital, and thereafter to LNJP Hospital. On his request, Medical Board constituting of Dr. Wahi, Batra and Daka conducted the post-mortem of Petitioner's wife Smt. Reeta on the request of SI Sandeep Sharma on 17.08.2005. A sealed parcel containing Viscera was handed over by the Doctors, which was deposited in P.S. Malkhana. The dead body was handed over *vide* Handing Over Memo Ex.PW-3/A.
19. **PW-12/SI Hansraj** is the MHC(M) with whom the case property was deposited.
20. **PW-13/SI Sandeep Sharma** was the second IO of the present case. He deposed regarding Application, Ex.PW13/A for constituting Medical Board for conducting the post-mortem of the deceased, collection of the PM Report, sending the exhibits to CFSL and getting the present FIR registered.



He also deposed regarding the arrest of the accused persons, namely Smt. Jagjit Kaur, Inder Singh, Shivraj Gobhania *vide* memos, Ex.PW-13/E-G.

21. **PW-14/Inspector Johny Anto** is the last IO, who arrested the accused (Dr. Vandana) *vide* memo, Ex.PW-14/A and also filed the Chargesheet.

22. Another Medical Board, headed by **Dr. S. Batra** with Dr. U. Manaktala and Dr. R. Tripathi as members, was constituted, which gave the Report dated 28.10.2005, wherein it was opined that ***both the Hospitals, i.e. Delhi Clinic and Gobhania Nirog Dham, were negligent in treatment of deceased Smt. Reeta, resulting in her death.***

23. Statements of the three accused were recorded under **Section 313 Cr.P.C.**, wherein they denied the entire incriminating evidence put to them and claimed that they have been falsely implicated and did not lead any evidence in defence.

24. **Accused Dr. Inder Singh in his statement under Section 313 Cr.P.C.** had denied all the incriminating evidence and explained that he was the owner of Delhi Clinic, Najafgarh. On 12.08.2005, the patient, Smt. Reeta was brought for check-up. Prior to that, she had never taken the treatment at their hospital. On checking, he found that she was having labour pain. He was informed by her husband, Complainant Satish Kumar that they had gone to RTRM Hospital, Jaffarpur for delivery, but they had some quarrel with the staff and therefore, they left the RTRM Hospital. Complainant had brought his wife to his Clinic as they were neighbours.

25. **Dr. Inder Singh** informed the Complainant that they were not equipped to conduct deliveries at their clinic, on which, Complainant told him to keep an eye on patient, while he arranges a vehicle to shift her to some other hospital. However, the husband was gone, the water bag of the



patient burst and water started coming out of her vagina and within half an hour, she delivered the baby girl normally. However, the placenta did not expel within half an hour, which should have happened in a normal delivery. He again told the family members of the deceased to shift her to a higher centre like RTRM, but they declined to go there, on account of the quarrel. DDU Hospital was at great distance and therefore, she could not be referred there, as her condition was deteriorating. The family members of the deceased requested Dr. Inder Singh to arrange some other private clinic. He talked to some other Hospital, but Gynae Doctor was not available. Dr. Shivraj, owner of Gobhania Nirog Dham informed that Gynae Doctor was available and the patient may be brought to their hospital. They hired the van and shifted the deceased to Gobhania Nirog Dham. He accompanied the patient and she was safely shifted to Gobhania Nirog Dham, where she was taken into the operation theatre; he remained there for about half an hour and thereafter left. He stated that the patient was never admitted in their hospital nor were they charged for the same. *He further asserted that there was no negligence on their part.*

26. **Dr. Jagjeet Kaur** in her statement under Section 313 Cr.P.C. denied all the incriminating evidence and stated that she was the wife of the owner of Delhi Clinic, Najafgarh. She reiterated the same facts as was stated by Dr. Inder Singh.

27. **Dr. Vandana**, in her statement under Section 313 Cr.P.C., denied all the incriminating evidence and stated that she was going to Gobhania Nirog Dham, owned by Dr. Shivraj for learning purpose. On the day of incident Dr. Shivraj told her that a post-deliver patient has been received in the Hospital, and on his asking she informed Dr. Geeta Jain, in-charge of Gynae



Department in Gobhania Hospital from the mobile of Dr. Shivraj, as she did not have any mobile phone at that time. Dr. Geeta Jain asked her to check the BP and pulse of the patient and inform her. After checking, pulse was found to be very low, about which she informed Dr. Geeta Jain, who told her to get the patient referred to some higher Hospital. She accordingly, informed Dr. Shivraj and left the Hospital.

28. ***Learned CMM*** considered the entire evidence and concluded that no medical negligence was proved against the Respondents / Doctors and they all were ***acquitted vide Judgment dated 16.01.2020.***

29. *Aggrieved by the said acquittal, Petitioner / State has filed present Appeal.*

30. During pendency of this Appeal, ***Dr. Inder Singh expired on 03.12.2022***, as per his Death Certificate dated 07.12.2022.

31. The **grounds of challenge** are that PW-1/Satish Kumar, the Complainant, *husband of deceased* has improved his versions given before the Court from the statement given to the Police. He, in his statement under Section 161 Cr.P.C. had stated that he had taken his wife to Delhi Clinic for check-up, whereas he deposed in the Court that he had admitted his wife in Delhi Clinic. PW-1/Satish Kumar had deposed essentially on similar lines, as his Complaint. PW-10 Smt. Kamlesh Kumari, mother of the Complainant has corroborated the testimony of PW-1.

32. PW-1/Satish Kumar further stated that Respondent No.4/Dr. Vandana Singh informed him that some cotton and one scissors were left in the person of the deceased, however, nothing was found in post-mortem.

33. In regard to the negligence of the Doctors, Medical Board opinion was taken in view of judgment of Hon'ble Supreme Court of India in the



case of Jacob Mathew vs. State of Punjab &Anr., (2005) 6 SCC 1 (CRL.A.Nos.144-145/2004) dated 05.08.2005, where it was observed that *opinion of specialist in Obstetrics and Gynaecology* may be sought regarding negligence of doctors.

34. It is asserted that the learned Trial Court has not appreciated and has totally ignored the Report of Medical Board. On the Letter of DCP South, another Medical Board consisting of *Dr. S. Barta*, Doctor Professors HOD Gynae Obstetrics MAMC, *Dr. Usha Manaktala* and *Dr. R. Tripathi* was constituted, wherein it was opined, “*It appears that the delivery was normal but after the delivery placenta was retained and there was heavy bleeding (post-partum haemorrhage) for 2-3 hours after deliver and no steps were taken by the Doctors for removal of placenta and control of bleeding. No blood transfusion was given. These omissions amount to negligence in our opinion. By the time patient was taken to DDU Hospital, it was too late. No records appear to have been maintained pertaining to management of patient at either Delhi Clinic or Gobhania Nirog Dham*”.

35. It was concluded that “*both the Hospitals, i.e. Delhi Clinic and Gobhania Nirog Dham were negligence in treatment of deceased, which resulted in her death.*”

36. PW-4/Dr. Usha Manaktala, who was the member of the Medical Board, had stated that the post-mortem was conducted on 17.08.2005, while the deceased had expired on 12.08.2025. The opinion was given by the Medical Board that no remedial measures were taken by the Doctors after the placenta could not come out, is given on the basis of the record as supplied by the IO and not on the basis of post-mortem report of the



deceased. It also establishes the negligence of the Doctors resulting in the demise of Smt. Reeta.

37. Learned Trial Court has failed to appreciate that *Accused Nos.1 and 2 (Dr. Inder Singh and Dr. Shivraj, who both are dead)* did not take any remedial measure such as drip and drug etc, while shifting the deceased. In case the placenta was not coming out and causing continuous bleeding, remedial measures were essential as stated by PW-4/Dr. Usha Manaktala and absence of resorting to such measures, constitutes negligence on the part of the accused persons. It is further asserted that the evidence of the Prosecution Witnesses, has not been appreciated in the right perspective.

38. It has not been appreciated that in *Tarun Thakore vs. Dr. Nashir M. Shroff*, OP No.215/2000 dated 24.09.2002, National Commission had made observations about the duties of the Doctors towards the patients. One of the duties of the Doctor is of care in deciding what treatment is to be given and also to take care in the administration of treatment. Breach of these duties, may lead to an action for negligence by the patient.

39. The grave lapses were committed by the accused persons, which constituted negligence, but has wrongly been ignored by the learned Trial Court. **The alleged negligent acts are as under:**

(i) *while shifting the patient Accused Nos.1 & 2 did not take remedial measures such as drip, drug etc., which were necessary, as testimony of PW-4 Dr. Usha Manaktala;*

(ii) *if the placenta did not come out in 30 minutes, then surgery is required. The child was delivered at around 02:30 PM, while she was*



shifted at 03:30 PM, *whereas she should have been shifted at 03:00 PM to other Hospital for surgery;*

(iii) Dr. Jagjeet Kaur was qualified as BAMC Exam. (learner) and was not registered in Delhi and *she was not entitled to practice in Delhi;*

(iv) Dr. Vandana Singh was qualified from Russia and was required to pass screening test for being registered as medical practitioner at Delhi and despite this fact she had given treatment to the deceased;

(v) In case *Delhi Clinic was not equipped for delivery*, there was no reason for it to keep the deceased in the Clinic before delivery for about 1.5 hours and shift her to Gobhania Nirog Dham, after unwanted delay.

40. Reference is made to Bhalchandra @ Bapu and Another vs. State of Maharashtra, AIR 1968 SC 1319, wherein the Apex Court opined that ***criminal negligence*** is the gross and culpable neglect or failure to exercise that reasonable and proper care and precaution to guard against injury either to the public generally or to an individual in particular, which having regard to all the circumstances out of which the charge has arisen, it was the imperative duty of the accused person to have adopted.

41. Furthermore, the testimony of all other Prosecution Witnesses were consistent but had only natural variations, which did not go to the root of the prosecution's case and could not have been made a ground for acquittal of the accused person.



42. Reliance is placed on Raj Kumar Singh @ Raju vs. State of Rajasthan, (2013) 8 SCR 599, wherein the Apex Court observed that the Court must not attach undue importance to minor discrepancies, rather must consider broad spectrum of prosecution evidence. Reliance is also placed on Yogesh Singh vs. Mahabeer Singh & Ors., 2017 (1) JCC 63 (SC).

43. Learned Trial Court has failed to appreciate that the principle of vicarious liability is based on a Latin maxim “*qui facit per alium facit per se*”, which describes that the one who acts through another, acts in his or her own interest. The patient only requires diligent and proper care; if any of the staff/Doctor of the Hospital is negligent in the performance of their prescribed work, it is the Hospital which will be held liable for the negligent conduct, even of borrowed Doctors for specific performance of certain operations.

44. Reliance is placed on Aparna Dutt vs. Apollo Hospital Enterprises Ltd., (2002) ACJ 954 (Madras HC) and V. Kishan Rao vs. Nikhil Super Speciality Hospital, Civil Appeal No.2641/2010 (arising out of SLP (C) No.15084/2009) decided on 08.03.2010.

45. Learned Trial Court has failed to appreciate that this is a case of *res ipsa loquitor* (*thing speaks for itself*) and the Plaintiff was entitled to compensation.

46. *It is therefore, submitted that impugned Judgment of Acquittal dated 16.01.2020 of learned CMM be set aside and the Respondents be convicted.*

47. **Learned counsel for the Respondents** has contended that there is no treatment record available, wherein any complication was noted and that though Dr. Jasjeet Kaur and Dr. Vandana were present in their respective Hospitals, but had no role in the treatment of the deceased. The main



treating Doctors were *Dr. Inder Singh and Dr. Shivraj*, who have both expired.

48. It is submitted that *Dr. Vandana Singh* was only a trainee and there is no evidence on record that she had given any treatment to the deceased.

49. Furthermore, there are material contradictions in his statements PW-1/Satish Kumar and PW-10/Kamlesh Kumari, *Mother-in-Law of deceased*, in regard to taking the deceased to Delhi Clinic. While PW-1 stated that deceased was taken around 11:00 AM, PW-10 claimed it to be 08-09:00 AM.

50. Even otherwise, from the explanations given by the Respondents in their respective statements under Section 313 Cr.P.C., it is abundantly clear that there was no negligence on the part of any of the Doctors.

51. *In the end, it is submitted that the learned Trial Court has rightly appreciated the evidence and has acquitted the Respondents.*

Submission heard and record perused.

52. It is indeed an unfortunate case, where a young girl aged about 26 years died during delivery of the child. While normal delivery of a girl child took place at 02:30 PM on 12.08.2005, but Smt. Reeta (deceased) suffered from post-partum complications, which eventually led to her death at about 05:45 PM.

53. At the outset, before delving into the facts of the case, it is pertinent to take note of the definition of **Negligence, which** as per the definition in **Black's Law Dictionary** read as under:

“Negligence per se-conduct, whether of action or omission, which may be declared and treated as negligence without



*any argument or proof as to the particular surrounding circumstances, either because it is in violation of a statute or valid municipal ordinance, or because it is so palpably opposed to the dictates of **common prudence** that it can be said without hesitation or doubt that no careful person would have been guilty of it. As a general rule, the **violation of a public duty**, enjoined by law for the protection of person or property, so constitute.”*

54. In this context, reference be also made to the observations made by the Apex Court in the case of Jacob Mathew, (supra) wherein it was observed that *to prosecute a medical professional for negligence under criminal law, it must be shown that the **accused did something or failed to do something which in the given facts and circumstances no medical professional in his ordinary sense and prudence would have done or failed to do.***

55. Following Jacob Mathew, (supra), the Apex Court in Kusum Sharma vs. Batra Hospital, (2010) 3 SCC 480 laid down the following **principles that are to be considered while determining the charge of medical negligence:**

I. *Negligence is the breach of a duty exercised by omission to do something which a reasonable man, guided by those considerations which ordinarily regulate the conduct of human affairs, would do, or doing something which a prudent and reasonable man would not do.*

...

III. *The medical professional is expected to bring a **reasonable degree of skill and knowledge and must exercise a reasonable degree of care.** Neither the very highest nor a very low degree of care and competence judged in the light of the particular circumstances of each case is what the law requires.*



IV. A medical practitioner would be liable only where his conduct fell below that of the standards of a reasonably competent practitioner in his field.

...

VI. The medical professional is often called upon to adopt a procedure which involves higher element of risk, but which he honestly believes as providing greater chances of success for the patient rather than a procedure involving lesser risk but higher chances of failure. Just because a professional looking to the gravity of illness has taken higher element of risk to redeem the patient out of his/her suffering which did not yield the desired result may not amount to negligence.

VII. Negligence cannot be attributed to a doctor so long as he performs his duties with reasonable skill and competence. Merely because the doctor chooses one course of action in preference to the other one available, he would not be liable if the course of action chosen by him was acceptable to the medical profession.

...

IX. It is our bounden duty and obligation of the civil society to ensure that the medical professionals are not unnecessarily harassed or humiliated so that they can perform their professional duties without fear and apprehension.

...

XI. The medical professionals are entitled to get protection so long as they perform their duties with reasonable skill and competence and in the interest of the patients. The interest and welfare of the patients have to be paramount for the medical professionals.

90. In our considered view, the aforementioned principles must be kept in view while deciding the cases of medical negligence. We should not be understood to have held that doctors can never be prosecuted for medical negligence. As long as the doctors have performed their duties and exercised an ordinary degree of professional skill and competence, they cannot be held guilty of medical negligence. It is imperative that the doctors must be able to perform their professional duties with free mind."

56. Thus, to constitute medical negligence, the circumstances must clearly establish the three essential components i.e. '**duty**', '**breach**', and '**resulting damage**'.



57. The **duty** arises when a medical professional undertakes treatment, obliging him to act with that *degree of care, skill, and prudence* which a reasonably competent practitioner in the field would exercise in similar circumstances. A **Breach** occurs when the medical professional *either lacked the skill he professed to possess, or, having the requisite skill, failed to exercise it with reasonable competence*, such that no medical professional acting with ordinary sense and judgment would have so acted or omitted to act. The **Damage** must be the direct consequence of such breach.

58. Thus, *unless these three elements co-exist, a doctor who has performed his duties with ordinary skill and prudence cannot be fastened with liability for medical negligence.* **On these parameters, the case of the Prosecution may now be considered.**

Liability of Dr. Inder Singh and Dr. Jagjeet Kaur of Delhi Clinic:-

59. At the outset, it has to be noted that Dr. Inder Singh is BAMS, registered in Delhi and his wife Dr. Jagjeet Kaur was also a qualified BAMS Doctor from MDU, Haryana though not registered in Delhi. Their qualifications clearly show that *they were not qualified to do any complicated surgery*, but could only assist in normal deliveries. It emerges from the testimony of the Complainant, that the deceased Smt. Reeta was taken by her husband/Complainant Satish Kumar, who was accompanied by PW-10/Kamlesh Kumari (*his mother*) to Delhi Clinic for the first time at about 11:45 AM, which was owned by Dr. Inder Singh for check-up. She was found to be under labour pain. There is also *nothing on record to show that there was any suspected complication* and thus, deceased was taken to Delhi Clinic considering it to be a case of normal delivery.



60. Pertinently, *there is no medical record produced to show that the deceased had been visiting this Delhi Clinic during her pregnancy or her follow-up check-ups.* This gives credence to the defence of the Respondents that the deceased was not a regular visiting patient and had been merely taken to the Clinic which was in the neighbourhood, as it was expected to be a case of normal delivery.

61. It has further emerged from the testimony of PW-1/Satish Kumar and his mother PW-10/Kamlesh Kumari that normal delivery of a girl child took place at 02:30 PM. However, subsequent thereto, *complication developed* as there was no automatic expulsion of placenta which should have happened within half an hour of delivery. As per the testimony of PW-1, he was informed about the complication and that she was required to be shifted to another Hospital.

62. Here, the distinction between *inadvertent mis-judgment* and *actionable negligence*, becomes crucial.

63. It has emerged from the Prosecution evidence that the Complainant and his wife had walked into the Delhi Clinic as it was expected to be a normal delivery, which indeed happened at 2:30 PM. *Dr. Inder Singh who was In-charge, did whatever best he could in the given circumstances, considering that he was not qualified to undertake any surgery.* In his own estimation, he waited for the expulsion of the placenta, which generally happens in normal delivery cases. Moreover, he followed the Protocol in administering the Drip and even accompanied the patient to Gobhania Nirog Dham, after ascertaining that it was equipped to deal with the emergency. It had also been explained in the statement under Section 313 Cr.P.C. that the patient was not taken to DDU Hospital as it was at a great distance.



64. In any case, he is already dead and the Appeal already stands abated against him.

65. In so far as **Dr. Jagjeet Kaur**, is concerned, there is not an iota of evidence against the respondent Dr. Jagjeet Kaur, who merely was present in the Clinic. The Prosecution has not been able to produce any evidence whatsoever including that of Complainant that she was handling the case of the deceased of there was any kind of negligence on her part.

66. The question of her not being registered in Delhi, to practice, would have been relevant if it was shown that she was in any manner, responsible for the treatment of the deceased. Mere presence in the Clinic, without any averment of her being a treating Doctor, cannot attach any culpability to her. She has been rightly, acquitted by the Id. Trial Court.

Liability of Dr. Shivraj and Dr. Vandana at Gobhania Nirog Dham:-

67. PW-1/the Complainant himself has stated that at about 03:45 PM, it was informed by Dr. Inder Singh that the deceased is required to be shifted to another Hospital, as the placenta had not expelled. The arrangements were made by him and Smt. Reeta was shifted to Gobhania Nirog Dham. He further stated that Dr. Inder Singh had accompanied them in the van with a drip and his wife was admitted in Gobhania Nirog Dham. The factum of admission is corroborated by the Admission Form, Ex.PW-1/D and is also a fact admitted by the Complainant as well as his mother, PW-10/Kamlesh Kumari.

68. PW-1/Satish Kumar has deposed that at Gobhania Nirog Dham they met Dr. Vandana, who after preliminary examination of his wife, told that she was serious case, as the bleeding was heavy. She was provided Oxygen



and treated till 05:30 PM. Treatment was being given by Dr. Vandana and Dr. Shivraj and three-four nurses. He was physically present and was seeing the treatment being given to his wife. At about 05:30 PM, his wife spoke to him and said she was having a breathing problem and told him to take care of the child. He then realised that her condition was very critical and she may lose her life after few minutes. However, Doctors told her that she is still alive and there is nothing to be worried. *He was also told by Dr. Vandana that some cotton and one scissors have been left inside the body of his wife.* At the instance of Dr. Shivraj, she was shifted to DDU Hospital in a private van of Gobhania Nirog Dham along with the Compounder, Complainant and his mother.

69. They left at about ***05:45 PM and reached DDU Hospital in half an hour, during their journey to DDU***, wife did not speak anything and as per his statement, she had already died after having travelled a distance of about half a kilometre from Gobhania Nirog Dham. He further deposed that as per common knowledge, the case of delivery was critical as the placenta did not get removed in time. At DDU Hospital, his wife was declared *brought dead*.

70. From the testimony of PW-1, it emerges that, *Dr. Shivraj*, who was present in Gobhania Nirog Dham, gave whatever possible treatment he could and also put the deceased on Oxygen. However, be as it may, Dr. Shivraj died during the course of trial and the proceedings stood abated against him.

71. The allegations against Dr. Vandana are that she was not qualified to practice in India. During investigations, qualification documents of the Doctors had been collected by the IO, which showed that Dr. Vandana had taken a *Degree in General Medicine from Russian Federation vide*



Certificate dated 24.06.2003. As per Rule, she was required to undergo training and pass qualifying examination to become eligible to treat patient. She in her statement under Section 313 Cr.P.C., had explained that she being a trainee at Gobhania Nirog Dham, had merely taken the BP and Pulse of patient Smt. Reeta, which was found to be very low and she had accordingly informed Dr. Geeta Jain, In-Charge Gynaecologist.

72. From the statement of Dr. Vandana under Section 281/313 Cr.P.C., it emerges that Dr. Geeta Jain, In-Charge Gynaecologist was not present in Gobhania Nirog Dham and on her instructions, she had taken BP and Pulse of the patient, which was found to be very low. Dr. Geeta Jain, being informed, advised them to immediately shift the patient to a higher Hospital. *No evidence has emerged from the testimony of PW-1 to show that Dr. Vandana administered any critical treatment to his wife, during the time she was in Gobhania Nirog Dham.*

73. In the entire evidence led by the Prosecution, there is not an iota of evidence to suggest that *Dr. Vandana was in fact the treating Doctor or that she was In-Charge* and responsible for the treatment given to the deceased. No negligence on her part has been established by the Prosecution.

74. **To conclude,** from the Prosecution Evidence, the best, which emerges is that Dr. Inder Singh was In-Charge of Delhi Clinic, where the patient was taken and normal delivery took place. Likewise, Dr. Shivraj was In-Charge of Gobhania Nirog Dham and responsible for the patient being brought to his clinic. Dr. Jagjeet Kaur and Dr. Vandana may have been present in their respective Hospitals as support persons, but they both were neither the treating Doctors nor In-charge or responsible for the treatment that was



meted out to the deceased. *There is no culpability of Dr. Jagjeet Kaur and Dr. Vandana brought out from the entire Prosecution Evidence.*

Other evidence for assessing liability of the doctors:-

75. Reference may also be made to the **Post-Mortem Report** and the **opinion of the Medical Board** about the cause of death.

76. The **Post-Mortem was conducted on 17.08.2005 by PW-3/Dr. S. K. Khanna and PW-5/Dr. MK Wahi and Dr. S. Daka**. PW-3 and PW-5, both in their respective testimony proved the Post-Mortem Report as Ex.PW-3/A. They both admitted that before giving any opinion regarding the cause of death, request was made to provide the complete Medical Records. Letter dated 18.08.2005, Ex.PW-3/B was accordingly written by Dr. S. K. Khanna (PW-3) to the SHO, P.S. Najafgarh.

77. It is evident that the **opinion of the Medical Board, Ex.PW-4/A given vide Report dated 28.10.2005 by PW-8/Dr. Swaraj Batra, PW-4/Dr. Usha Manaktala and Dr. Rewa Tripathi**, which read as under:

1. *Cause of death appears to be postpartum haemorrhage following normal vaginal delivery.*
2. *It appears patient received sub optimum management at both places. No uterotonic drugs, blood or surgical intervention were utilised.*
3. *Precious time was wasted during transporting the patient from one place to another and PPH can be fatal if not managed actively on emergency basis. Pre delivery medical status of patient is not documented on record which could also have bearing on outcome.*
4. *No records appear to have been maintained pertaining to management of patient at either Delhi Clinic or GobhaniaNirog Dham.*
5. *We agree with the report of medical board under the Chairmanship of Dr. S.K. Khanna of MAMC. However,*



doctors at both clinics appear to be responsible for mismanagement and negligence cannot be excluded.

78. **PW-4/Dr. Usha Manaktala** in a question to specify cases wherein the placenta can remain inside the uterus for more than half an hour, had explained that there can be **three conditions of retained placenta**, which are:

- (a)** *it is separated but did not come out due to abnormal uterine contract;*
- (b)** *it is attached with wall of uterus but did not separate and can be easily removed under anaesthesia; and*
- (c)** *Adherent placenta (accreta i.e. placenta entering into muscular layer of the uterus, increta i.e. placenta having entered the full thickness of muscle of uterus and percreta i.e. placenta coming out of the wall of uterus and entering any other organ) which cannot be removed easily even under anaesthesia and can cause severe postpartum haemorrhage.*

79. **PW-4** had further deposed that ***since it was a high-risk case, as such the proper diagnosis should be made there before delivery*** and patient should be managed by a senior Obstetrician and Anaesthetic and patient should have been referred in the higher territory centre, where blood and operation were available. The diagnosis of Adherent placenta should have been made in ante natal period and the patient should have been referred to a senior Hospital.

80. **PW-4** further admitted that the Medical Board had opined that no uterotonic, blood or surgical utero or surgical intervention was utilised in the



present case, as there was no medical record provided. The Board also opined that precious time was wasted in transporting the patient from one place to another and PPH can be fatal, if not managed actively on the emergency basis, as the patient was sent to Nirog Dham instead of higher qualified Hospital like DDU, where facility of blood and operation were available.

81. **PW-8/Dr. Swaraj Batra**, who has also headed the Medical Board, gave subsequent opinion that the cause of death appears to be Post-partum Haemorrhage (PPH) following normal vaginal delivery. He also stated that because no record had been maintained, pertaining to the management of the patient, he could not state whether the patient was optimally managed at either Delhi Clinic or Gobhania Nirog Dham.

82. He further admitted that he had not personal knowledge regarding wastage of time and it has been so stated only on the basis of Post-Mortem Report. He further explained that in case of placenta no coming out, the decision for immediate transfer of patient and also for pursuing further remedial measures i.e. drip, drug etc. or calling the expert in the panel should have been undertaken.

83. The significant aspect, which emerges from the testimony of Prosecution Witnesses as well as subsequent opinion, is that the *cause of death was non-expulsion of placenta after normal delivery*. Rest, the Medical Board has given its opinion that there was waste of precious time in transporting the patient and that Doctors of both Hospitals appeared to be responsible for management; and negligence cannot be excluded. However, from their testimony, it is evident that there were no medical records available, from where such inference could have been drawn. Moreover, the



assertion that Gobhania Nirog Dham was not equipped for surgery, is not based on any evidence as it has emerged that it had an Operation Theatre and also had a Gynaecologist attached to the Hospital. Such opinion about the alleged negligence, is essentially, conjectural and not based on any documents.

84. *Another significant aspect* is that it was admittedly a normal delivery. PW-4/Dr. Usha Manaktala had explained that one of the causes for non-expulsion of placenta may be that it is attached to the wall of uterus and does not separate, but can be easily removed under Anaesthesia. In this context, it is pertinent to refer to the Post-Mortem Report, Ex.PW-3/A, wherein it has been clearly noted that on opening the uterine cavity, placenta was found attached in upper part of uterus. *It could be detached easily. A few blood clots were present in the uterine wound.*

85. From this Medical Report, it is evident that it was a case *where the placenta being attached, which can be easily removed through anaesthesia. Pertinently, it was not a case of adherent placenta, which is a critical condition and requires immediate surgical intervention.*

86. Dr. Inder Singh at Delhi Clinic admittedly was not a qualified Doctor for conducting any surgical intervention and realising the situation getting complicated, he not only put the drip but also accompanied the Complainant and patient to Gobhania Nirog Dham for further management, on being informed that the said hospital had requisite arrangement.

87. From the evidence of the Prosecution, it further emerges that Gobhania Nirog Dham was equipped but Dr. Geeta Jain, the Gynaecologist was not present in the Hospital and finding the condition to be critical, patient was forwarded to DDU Hospital, but she died *en route*. It is evident



that there cannot be any negligence attributed to the Doctors, who tried to manage the situation to the best of their capacity. It may be a case of mis-judgement, but definitely, not a case of negligence.

88. Furthermore, no negligence whatsoever can be attributed to Dr. Jagjeet Kaur and Dr. Vandana, as already discussed. There was no intrusive procedure conducted by them, and there is no evidence to indicate that any such operation was carried out by them. Any 'dereliction', if at all, could only be attributed to Dr. Inder Singh of Delhi Clinic and Dr. Shivraj of Gobhania Nirog Dham, but both of them have since passed away.

Conclusion:-

89. In the light of aforesaid discussion, it is hereby held that learned CMM has rightly acquitted the Respondents.

90. There is no merit in the present Appeal, which is hereby **dismissed** along with pending Applications.

(NEENA BANSAL KRISHNA)
JUDGE

NOVEMBER 26, 2025/R