IN THE STATE CONSUMER DISPUTES REDRESSAL COMMISSION MIZORAM : AIZAWL

SCC No.1 of 2024

1. Shri Zaithankima
H/o Smt. Malsawmkimi (L)
R/o Tlangpui, Khawzawl District,
Mizoram

2. (Minor)
S/o Smt. Malsawmkimi (L)
Represented by his father Sh. Zaithankima
R/o Tlangpui, Khawzawl District, Mizoram

Versus

1. The State of Mizoram
Represented by the Chief Secretary to the Govt. of Mizoram
Aizawl.

2. The Secretary to the Govt. of Mizoram
Health & Family Welfare Department
Aizawl, Mizoram

3. The Principal Director
Health & Family Welfare Department
Govt. of Mizoram
Aizawl, Mizoram

4. District Hospital, Serchhip
Represented by the District Medical Superintendent
Serchhip, Mizoram

BEFORE :

HON'BLE MR. LALHMINGMAWIA, INTERIM PRESIDENT
HON'BLE MR. C. LALRINKIMA, MEMBER
HON'BLE MRS. P.C. VANLALREMRUATI, FEMALE MEMBER

For the Complainants : Mr. C. Tlanthianghlima, Advocate
For the Respondents : 1. Mr. B. Lalramenga, Advocate
2. Mr.Vanlaltanpuia, Proxy Counsel of Mr. B. Lalramenga, Advocate

Date of Pronouncement **: 20.11.2025**

JUDGEMENT & ORDER

1. The complaint was filed by Shri Zaithankima h/o Malsawmkimi (L), resident of Tlangpui, Khawzawl District, Mizoram under Section 47 of the Consumer Protection Act, 2019 against the State of Mizoram represented by the Chief Secretary to the Government of Mizoram and 3 Ors. The Complainant filed the complaint against

medical negligence and deficiency in service leading to the maternal death of Smt. Malsawmkimi w/o Shri Zaithankima, and a new born baby at District Hospital Serchhip on 03.12.2021.The Complainant prayed for awarding the amount of ₹1,20,00,000/- (Rupees one crore twenty lakhs only) along with interest @9% per annum till payment is made as pecuniary and non-pecuniary damages along with punitive damages and compensation for medical negligence and deficiency in service.

2. The deceased Smt. Malsawmkimi on being pregnant and near expected date of delivery approached the Serchhip District Hospital (herein after referred to as the District Hospital) and got herself checked up in OPD on 01.12.2021 and she was counselled for Normal Vaginal Delivery (NVD). The deceased was admitted in the District Hospital on 02.12.2021 at 10:50 a.m. On the day of her admission, Cervi Prime Gel was applied to induce labour for Normal Vaginal Delivery (NVD) and her condition as well as the baby were found to be stable. No delivery happened on 02.12.2021, Cervi prime gel was applied on her again on 03.12.2021 at 11:45 a.m. and the deceased Malsawmkimi delivered a baby boy weighing 3.8 kg at 8:30 p.m., however, the baby showed no sign of life at the time of birth. The deceased developed post-delivery complications soon after, the nurse on duty informed the Gynaecologist at 8:55 p.m. The Gynaecologist attended the patient at 9:20 p.m. and informed the District Medical Superintendent (herein after referred to as DMS) about the critical maternal condition of the deceased. The DMS and the Gynaecologist attended the deceased, but she was declared dead at 10:40 p.m. and recorded the cause of death as Post Partum Haemorrhage. Before the deceased Malsawmkimi approach the District Hospital, she had register herself inHealth Sub-Centre, Tlangpui Village on 26.05.2021, 13.08.2021 and 18.11.2021.As per the photocopy of the ANTENATAL CARE Card, the deceased had last menstrual period on 15.03.2021 and the expected date of delivery was 22.12.2021. The deceased had 4 spontaneous abortions/miscarriages and 3 living issues.

3. Consequent upon the death of Smt. Malsawmkimi and her newborn child, public outcry in social media and complaints prompted the Government of Mizoram to institute a Magisterial Enquiry by Mr. Kumar Abhishek, IAS, District Magistrate, Serchhip, Serchhip District, Mizoram.Brief Summary of the Observations/Findings are:

(a) The patient was having history of 3 abortions and one pre term. Dr. Laltharzeli Fanai stated that the patient while on admission opted for theNVD. The doctor has stated in her written explanation that informed writtenconsent for NVD was taken on 02.12.2021 at 10:50 AM. However, this is ageneral written consent which does not specifically mention about NVD or C-Sec.

(b) After the first failed inducement of labour on 02.12.2021 upon application of cervi prime gel, the attendant claimed that they requested for C-Sec on 03.12.2021. The doctor denied the claim made by the attendant. It is evident that there is a clear contradiction in between the claims made by the attendant of Pi Malsawmkimi and the doctor and Hospital Staff with respect to the request for Caesarean Section. Moreover, there is no evidence of written consent for NVD given by the patient or the attendant at that time.

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

(d) Upon perusal of the statements and random statements taken from the previous cases of deliveries at the District Hospital, there is preponderance of possibility that the hospital staff, at some times, behave rudely and not in a professional manner with the patients.

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

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

4. As per the recommendation of the report of the Magisterial Enquiry, the Government of Mizoram instituted an independent Team of Doctors to ascertain whether a propriety of medical procedure is followed or otherwise in the incident leading to the maternal death of Smt. Malsawmkimi of Tlangpui Village and her newborn child and the death of the newborn child of Pi Vanlaldinpuii of Sialsir Village in District Hospital, Serchhip with the following Terms of Reference:

(1) To ascertain whether there is any procedural lapse on medical treatment received by the patients.

(2) Level of Monitoring of the patient and details record of monitoring.

(3) Whether special care was given to the pregnant women based on their obstetric history.

(4) Are there any alternate medical procedures that could be undertaken to avoid such incident?

(5) Why a cervi prime gel was used to induce labour for the second time to aggravate the patient's condition?

OBSERVATION

(1) After investigating the events leading to the maternal death, we did not find anyprocedural lapse on the medical care given to the deceased patient.

(2) Details of patient monitoring is enclosed in the photocopy of the patient's file. Theprobable cause of the patient deterioration which is a concealed bleeding resultingin hypovolemic shock makes it difficult for attending nurse and doctor to actimmediately.

(3) Considering the past obstetrical history with 5abortions and only 1 living issue,and advance age (40 years) in regards to obstetric, the patient should have beenadvised to attend higher centre - where operative (surgery) delivery can beperformed 24/7.

(4) On using cerviprime gel, which is a uterine stimulant, that can cause uterinecontraction and thereby dilating the cervix and mainly use for induction of labour (i.e. ripening of cervix) and the action of which lasted for 4-6 hours. The gap betweeninsertion is around 12 hours, which will not cause hyperstimulation so as toaggravate the labour pain, and hence using 2 times with a gap of 12 hours will notworsen the labour pain.

The sudden deterioration of patient which probably due to **hypovolemiaresulting from silent tear/rent in the lower part of uterus, the bleeding of which ismainly concealed and not revealed which makes it difficult to diagnose immediatelyand although urgent, open laparotomy with subtotal hysterectomy might have savedthe patient.But due to non-availability of Anaesthetist doctor who was out of stationto attend IMA conference, and the patient's condition did not permit referral.**Unfortunately, the patient succumbed and died at 10:30pm on 03/12/2022.

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

5. Aggrieved with the loss of a wife and a new born baby, the Complainant Shri Zaithankima filed a Writ Petition (C) with the Gauhati High Court (High Court of Assam, Nagaland, Mizoram and Arunachal Pradesh) against the State of Mizoram represented by the Chief Secretary to the Govt. of Mizoram, Aizawl & 3 Ors. The Hon'ble High Court delivered a Judgement and Order (CAV) on 09.08.2023in Case No.WP(C)/73/2022 held that there is clearly some element of negligence on the part of those who attended Smt. Malsawmkimi i.e., the attending nurses and the Doctor concern. It also held that the Government being the employer is vicariously liable for the acts of negligence committed by the Doctors, Nurses and Staff of the District Hospital, Serchhip, Mizoram. The Hon'ble High Court awarded ₹5 lakhs to the Petitioner as a palliative measure under the public law remedy and added that the same will not debar the petitioner from claiming any further compensation for damages or for deficiency of service before the appropriate forum.

6. Being aggrieved for losing the loved ones and a newborn baby, the deceased husband filed a Consumer Complaint under Section 47 of the Consumer Protection Act,

2019. In his complaint, the Complainant affirmed that the deceased Malsawmkimi and himself were lawfully wedded in accordance with Mizo Christian Custom on 31.10.2008. The deceased Smt. Malsawmkimi had one child born on 24.01.2004before her marriage to the Complainant No.1. They had two issues out of their wedlock born on 10.06.2009 and 09.04.2015. The Complainant No.1 is engaging in manual works to earn their living and continue to do so even after the demise of his wife to sustain their living. The Complainant No.2 is living with his uncle (the Complainant No.1's younger brother) who are living in Aizawl, Mizoram to have a better education than their own village.

7. The Complainant in his submission stated that the deceased Smt. Malsawmkimi, 40 years of age on being pregnanthad registered herself at Health Sub-Centre, Tlangpui Village managed by Health Worker(s) on 26.05.2021 bearing registration No.5. She had regular check up at the Sub-Centre on 26.05.2021, 13.08.2021 and on 08.11.2021. Being in a remote village, the deceased did her best to take all necessary precautions and injections prescribed to her. No complication or problem was reported in the Antenatal Visits records. The deceased already had 4 spontaneous abortions/miscarriage and 3 living issues attended the OPD at the District Hospital, Serchhip, Mizoram on 01.12.2021. accompanied by her sister. The District Medical Superintendent reported that she was counselled for Normal Vaginal Delivery (NVD) and was admitted on 02.12.2021 at 10:50 a.m. by Dr. Laltharzeli Fanai, Gynaecologist of District Hospital, Serchhip. The condition of the deceased and her baby were found to be stable, Cervi Prime Gel was applied on her to induce labour for NVD on the day of admission. Since no delivery on 02.12.2021, Cervi Prime Gel was again applied on her the next day i.e. 03.12.2021 and she had delivered a male child at 8:30 p.m. The newborn baby was weighing 3.8 kg, but the baby did not show any signs of life at birth. The nurse on duty Smt. Melody Zoremsangi informed the Gynaecologist at 8:55 p.m. as the deceased developed post-delivery complications. The Gynaecologist attended the patient at 9:20 p.m. and informed the DMS about the critical maternal condition, the deceased was attended both by them. However, she was declared dead at 10:40 p.m. The direct cause of death was recorded as Post Partum Haemorrhage. There was, in the recent past on 31.10.2021, the newborn son of Smt. Vanlaldinpuii of Sialsir Village was declared dead at the same hospital. There were numerous complaints and public outcry in social media about the negligence and lapses committed by the Doctors & Hospital Staff of the District Hospital, Serchhip. As such the Opposite Parties instituted Magisterial Enquiry and an Independent Team of Doctors to look into the circumstances leading to the maternal and infant death.

8. The Complainant prayed for the following reliefs:

(i) For an order declaring that the maternal death of Smt. Malsawmkimi and her newborn son at the District Hospital, Serchhip on 03.12.2021 was due to deficiency in service and negligence on the part of the Opposite Parties;

(ii) For an order declaring that the Complainants are entitled to award of compensation as damages from the Opposite Parties for the medical negligence and deficiency in service in looking after the deceased Smt. Malsawmkimi and her newborn son;

(iii) For an order directing the Opposite Parties to pay a sum of ₹1,20,00,000/- (Rupees one crore twenty lakhs only) along with interest @ 9% p.a. as pecuniary and non-pecuniary damages along with punitive damages and compensation for the medical negligence and deficiency in service leading to the maternal death of Smt. Malsawmkimi and her newborn son till payment is made in full to the Complainants;

(iv) For any other relief (s) as this Commission may deem fit and proper;

(v) For cost of the Complainant.

9. On behalf of the Opposite Parties, the Respondent No.3,Dr. Vanlalsawma, the Principal Director, Health & Family Welfare Department, Govt. of Mizoram, Aizawl, Mizoram submitted written statement objecting the allegation of the Complainants. The OPs submitted that the present complaint is liable to be dismissed *in limine* as the same is barred by limitation. Referring to the proviso to sub-section (2) Section 69 of the Consumer Protection Act, 2019, this complaint is to be dismissed at the threshold on the ground of limitation. Moreover, it is illegal and wrong to extend its jurisdiction by this Hon'ble State Commission to entertain this instantcomplaint underSection 47 of the Consumer Protection Act, 2019 and the complaint is liable to be dismissed without further proceeding.The Opposite Parties further submitted their objection that:

(1) As per the record being maintained in the Hospital, the Obstetric Record of Malsawmkimi (L) are –

2004 - Normal Vaginal Delivery (NVD) – Full term delivery -Male/(Alive)

2009 - Abortion at 3 months

2012 - Abortion at 3 months

2014 - Abortion at 3 months

2015 - Normal Vaginal Delivery (NVD) - Full term delivery, Male(Alive)

2016 - Abortion/? Preterm delivery at 6 months

2021 - Present pregnancy.

(2) The Complainant No.1's deceased wife Malsawmkimi record in the Health Sub-Centre showed –

At 1st visit	*- Weight -51 kg*	*BP-80/50 mm hg*	*Hb-9gm%.*
At 2nd visit	*- Weight -53 kg*	*BP-80/50 mm hg*	*Hb-9gm%.*
At 3rd visit	*- Weight -58 kg*	*BP-100/60 mm hg*	*Hb-10gm%.*

This clearly indicates that the patient Malsawmkimi (L) was suffering from *Anaemia with Chronic Hypotension,* and she was not sure of her last menstrual period while she is supposed to take ultrasound to determine expected date of delivery in early pregnancy. *Anaemia* is not corrected from 1st check-up to2nd check-up. As per the Government protocol, she was supposed to attend PMSMA (Pradhan Mantri Surakshik Matriva Abhiyan) launched by MoHFW, Govt. of India Programme. The program aims to provide assured, comprehensive and quality antenatal care free of cost, universally to all pregnant women on the 9th of every month in either 2nmd trimester or 3rd trimester where high risk patients are identified and received free blood investigation. This clearly shows that Malsawmkimi (L) was not cautious about her pregnancy, saying she had no problem during pregnancy and the Sub-Centre records say otherwise.

(2) That during her pregnancy on 01.12.2021, Malsawmkimi (L)attendedGynae OPD in Serchhip District Hospital at Serchhip, Mizoramalone and she was not accompanied by her sister as claimed by theComplainants. On this particular day, an Ultrasound was conducted onMalsawmkimi (L) as she was not sure of her last menstrual period todetermine her expected date of delivery which should have been done inthe first trimester ideally. Even though she had three recurrentmiscarriages, she delivered a male child by Normal Vaginal Delivery (NVD)in the year 2015 after her 3 miscarriages so she was a rightful candidatefor Normal Vaginal Delivery (NVD) and she had no absolute indication forCaesarean Section.

(3) That there is only one Gynaecologist in Serchhip District cateringall thedistrict population. As per protocol, Normal Vaginal Delivery (NVD)is usually conducted by Nursing staff as they are fully trained andqualified to perform Normal Vaginal Delivery and Mid Wifery. Doctors areinformed usually when there are delivery complication and wheninstrumental delivery is required.

(4) That as per Gynaecologist's statement, Malsawmkimi (L) wasexplained the risks and benefits of Normal Vaginal Delivery (NVD) andCaesarean Section in her own language. The Ultrasound examination wasconducted on 1stDecember, 2021 as she was not aware of her expecteddate of delivery and the Ultrasound report showed that her ExpectedDate of Delivery (EDD) was between 2nd – 5th December, 2021.Malsawmkimi (L) opted for vaginal delivery as she already had twoprevious normal vaginal deliveries. One (1) being after 3

recurrentMiscarriages and she is a rightful candidate to undergo Normal VaginalDelivery (NVD).

(5) That the claim made by the Complainants requesting CaesareanSection is neither heard nor known to/by the Gynaecologist and NursingStaffs. On the day of her admission, Late Malsawmkimi's vitals werenormal, her history and maternal age merely is not an indication forCaesarean Section. Hence, she was expected to have an ability to bemanaged in the District Hospital. Post-delivery complication was notanticipated and there was no absolute indication for referral to higherCentre at the time of admission and consent for further managementwas taken at the time of admission.

(6) That as per the Department Enquiry Report, the Team did notfind any procedural lapse on the medical case given to the deceasedpatient. Late Malsawmkimi's history of four (4) Miscarriages and advanced age is not an absolute indication for Caesarean Section and itdoes not imply that surgery should be performed. It is a retrospectiveassessment and referring to higher Centre might be a better option. Thecause of death was Post-Partum Haemorrhage (PPH) which she developedpost-delivery and not because Caesarean Section was not performed.Post-Partum Haemorrhage (PPH) can be developed by any patient(Caesarean Section or Normal Vaginal Delivery) and was neveranticipated. Like what the Departmental Enquiry Report had stated,every possible management was given to the patient at that time as theresource permitted. At the time of admission, Malsawmkimi (L) did notpresent any conditions/signs which could not be managed at DistrictHospital at that time. As such, she was not referred to the higher Centre.The patient already had two (2) live births which were both NormalVaginal Deliveries. So, Normal Vaginal Deliveries was the plan for her in this pregnancy. In fact, the absence of anaesthetist does not contribute to any reason for her untimely demise. There was no lack of care and caution on the part of theattending Doctor and staffs, which could be seen from the followingsequence of events –

(a) The patient Malsawmkimi (L) came on her first check up in theGynae OPD on 01.12.2021 and was admitted on 02.12.2021 as perher request.

(b) The Ultrasound was conducted for her on emergency basis by theGynaecologist after OPD as she came only on her late stage ofpregnancy and she was not aware of her date of delivery.

(c) The patient reported in Gynae Ward on the next day following heradmission (i.e. 02.12.2022) on her request.

(d) Full examination of Blood Pressure, Pulse Rate, Fetal Heart Sound,Per Abdominal examination, Pelvic examination was done on thisday.

(e) On the day of admission –

Per Abdomen (P/A) - Fetal Heart Sound (FHS) - 146/min
Per Vaginal (P/V) - Os-2cm
Cx (Cervix) - Px (Partially) effaced
Membrane -(+)
Station -High up

(f) Induction of labour was done with Cerviprime Gel.

(g) The Patient Could not achieve active labour.

(h) The Patient was in Latent Labour at the time of admission.

(i) Induction of Labour was repeated on the next day i.e., 3.12.2022at 11:30 AM, and she achieved active labour at 4:00 PM.

(j) Partogram (Graphical Information about the progress of labour) wasplotted as soon as she progresses into Active Labour, she achieved fulldilation at 7:30 PM and was taken for delivery. Throughout herlabour pain she was accompanied by Female Attendant and Nurse.

(k) Delivery was conducted by qualified Nurse. Doctor was informed asSoon as she developed post-delivery complication, treatment wasstarted immediately as advised by the Gynaecologist over phonebefore she even reached the Hospital.

(l) District Medical Superintendent was also informed and he attendedimmediately.

(m) The condition of the patient worsened very rapidly unlike usualpost-partum Haemorrhage (could be due to associated conditionslike DIC(Disseminated Intravascular Coagulation).

Note: Blood sample collected from patient on 3/12/2021 is stillpreserved and does not show Sign of clotting.

(n) The patient was collapsed while she was prepared to be takeninside Operation Theatre for exploration.

(7) That during such period, the Anaesthetistwas on authorizedCasual Leave from 2nd to 3rdDecember, 2021 for IMA Conference, Aizawl.Moreover, not Performing Caesarean Section is not the direct leadingcause of the Post-Partum Haemorrhage and the death of the patient, Itwas not done as there was the indication and not due to non-availabilityof the Anaesthetist. Hence, it is the humble submission of the OPs that theattending Doctors and Staff cannot be held negligence against theunfortunate demise of Malsawmkimi (L). There is no proof of evidence that the outcome would have been different on the patient if surgery was performed.

(8) That according to Smt. Melody Zoremsangi, Staff Nurse whoconducted delivery, she did not admit in front of Magisterial Inquiry thatthere was no Post-Partum Haemorrhage, rather she mentioned that thePost-Partum Haemorrhage she witnessed was different from the Post-Partum Haemorrhage she experienced before. As normally practised inMizoram, Normal Delivery is conducted by Nurses as they are qualifiedand trained in conducting in Normal Delivery and Mid-Wifery and adoctor is informed and attended only when there is complication in theprocess. There is only one Gynaecologist in the District Hospital atSerchhip catering all the District Population. Moreover, Pelvic examinationshows that late Malsawmkimi's Pelvic was roomy and Cervix wasfavourable and hence, Difficult Vaginal delivery and prolonged labour wasunlikely.

(9) The Doctor was called by Staff Nurses at 8:55 PM. However, shewas not aware of her phone call as she was in the kitchen having herdinner and her phone was charging in the bedroom. She responded aftera few attempts. All necessary immediate intervention required wereinitiated as per the Doctor's advice which started from 9:10 PM as perNurses' record over phone and necessary instructions viz. two wide borei.v. cannula, Blood Transfusion, uterine massage/tamponade, IV Fluidwere given as per protocol for management of Post-PartumHaemorrhage to Nurses on duty and she reached the Labour Room at9:20 PM.

(10) The OPs submitted that payment of Rs.5 lakh to the ComplainantNo.1 as per the Hon'ble High Court's Judgment & Orderdated09.08.2023 passed in WP(C) No. 73 of 2022 does not mean that the OPsherein admitted to the negligence, liability and deficiency in service onthe unfortunate demise of Malsawmkimi (L). In fact, as stated by theHon'ble High Court, awarding of Rs. 5 lakh in favour of the Petitioner inWP(C) No. 73 of 2022 as a palliative measure only under the public lawand it does not imply/indicate that the Hon'ble High Court confirmed thenegligence and deficiency in service on the part of the OPs;

as suchallegation on medical negligence needs to be proved by taking anevidence as per law in the proceeding like the present ConsumerComplaintwhereintheComplainantsclaimingforcompensation under the private law. Hence, the Complainants cannottake any advantage of the said Judgment & Order dated 09.08.2023passed in WP(C) No. 73 of 2022 in the present claim which they aremaking in this Consumer Complaint.

(11) The OPs submit in this regard that there is no iota of reason asto why Section 47 of the Consumer Protection Act, 2019 should beinvoked by the Complainants, inasmuch as, there is no goods or servicesexceeding Rs. 1 Crore paid as consideration by the Complainants to theOPS. In view of this, there can be no 'deficiency' in service betweenMalsawmkimi (L) or the Complainants and the OPs herein. As a result,the present Consumer Complaint is liable to be rejected outright.

(12) As submitted above, there can be no cause ofaction in the present case in favour of the Complainants. Even onassuming for a moment but not admitting that there is such cause ofaction as alleged by the Complainants, the present Complaint shouldhave been presented within a period of two years from the date of thecause of action. However, the present Complaint has been filed only inthe month of February, 2024 which was beyond the period of limitation.The Complainants, although took the ground of exclusion of the limitation during the Covid-19 pandemic by the Hon'ble Apex Court, are still obligated to explain the delay and the reason thereof as to why the present Complaint is liable to be rejected and dismissed.

10. In the course of the proceedings, the Ops learned counsel Mr. B. Lalramenga propounded the question of law for not filing the complaint within 2 years as per the limitation provision in terms of Section 69 of the Consumer Protection Act, 2019 since the cause of action happened in 03.12.2021 whereas the present complaint was filed on 26.02.2024 without condonation application. In absence of a member who is having judicial background in the State Commission, the learned counsel put forward the question of law in regard to limitation. Both the learned counsels submitted arguments in writing. The Complainant's counsel Mr. C. Tlanthianghlima relied his arguments for filing the complaint after 2 years from the cause of action happened on the Hon'ble Apex Court order dated 10.01.2022 in **"In Re: Cognizance for Extension of Limitation" Suo Motu Writ Petition (C) No. 3 of 2020**whereby the period from 15.02.2020 till 28.02.2022 was excluded for the purposes of limitation as may be prescribed under any general or special laws in respect of all judicial or quasi-judicial proceedings. The learned counsel of the Opposite Parties argued that the Complainants

failed to file any separate application for condonation of delay in filing the present complaint by taking the ground of the exemption/exclusion of the limitation period during Covid-19 or other ground(s) which the Complainants may deem appropriate. The OPs counsel also quoted Section 5 of the Limitation Act, 1963 which says, "*An appeal or any application, other than an application under any of the provisions of Order XXI of the Code of Civil Procedure, 1908, may be admitted after the prescribed period, if the appellant or the applicant satisfies the Court that he had sufficient cause for not preferring the appeal or making the application within such period.*" It is argued that it is obligatory for the Complainants to show sufficient cause as to why they could not file the complaint within the period of 2 years by filing separate application for condonation of delay. However, the Complainants did not file any application for condonation of delay as per Section 5 of the Limitation Act, 1963. The OPs counsel relied on the order of the National Consumer Disputes Redressal Commission dated 07.11.2023 on **Ireo Pvt. Ltd. vs Sujeet Jha & Anr** in Review Application No.350 of 2023.

11. On perusal of the submissions of both the counsels, we do not find any complex question of law regarding limitation period which may be prompting this Commission to refer the matter to the National Commission in absence of the President and Member with judicial background in the State Commission. The Order of the Hon'ble Supreme Court in Suo Motu Writ Petition (C) No. 3 of 2020 (Supra) is cleared about the excluded period and no complexity found. The cause of action happened on 03.12.2021 during the excluded period from 15.02.2020 till 28.02.2022; this complaint was filed on 26.02.2024 well in time whereby deducting the excluded period. Moreover, Section 12 of the **Consumer Protection (Consumer Commission Procedure) Regulation, 2020** provided that, *"....does not have a member with judicial background and any complex question of law arises and there is no precedent to decide the law point..."* The order of the Hon'ble Supreme Court in "In Re: Cognizance for Extension of Limitation" Suo Motu Writ Petition (C) No. 3 of 2020" (supra) is very cleared.We have allowed the complaint to proceed on.

12. On proceeding further, both the learned counsels submitted proposals for framing issues. We had frame issues base on the proposal submitted by the respective counsels as under:

1. Whether the complaint is maintainable or the cause of action in favour of the complainant and against the opposite party.
2. Whether the complainant suffered from any undisclosed disease during her pregnancy as per her antenatal visits record.

3. Whether the complainant's doctor and staffs of the District Hospital, Serchhip had committed negligence and deficiency in taking care of the deceased Malsawmkimi.

4. Whether a Gynaecologist was present at the time of delivery of the baby.

5. Whether the complainants are entitled to the relief(s) claimed. If so, to what extent.

13. For the lone witness of the Complainants, the Complainant No.1 Shri Zaithankima himself stand for witness and he was crossed examined by Mr. B. Lalramenga, learned counsel for the Opposite Parties.The Complainant submitted an I.A. registered as I.A. No.2 of 2025 in SCC No.1 of 2024 for exhibiting thecomplaint petition and signatures of the Complainant No.1 and was allowed by this Commission. The Opposite Parties produced five witnesses. The witness No.1 is Smt. Melody Zoremsangi, Serchhip who was on duty in a night shift in the District Hospital, Serchhip. The Opposite Parties produced Dr. Laltharzeli Fanai, MS Obstetrics and Gynaecologist who was working as Gynaecologist in the District Hospital, Serchhip at the relevant time as their witness No.2. Witness No. of 3 of the OPs, Dr. Lalnunhlima Khiangte, Pathologist (DCP) who was working in the District Hospital, Serchhip at the relevant time was produced. The OPs' witness No.3 was in-charge of District Medical Superintendent since the DMS was on leave during the relevant period.Witness No.4 of the OPs Dr. ZD Lalmuanawma, who is serving as current District Medical Superintendent of the District Hospital, Serchhip. The OPs also produced witness No.5 Mr. Lalnunfela s/o Khiangthuama, who works as a Health Worker at Tlangpui Sub-Centre – Health and Welness Centre (SC-HWC) from 2019 till date.All the OPs witnesses except No.5 were crossed examined by the Complainant's counsel and re-examined by the OP's counsel whenever necessary. However, the counsel of the Complainants declined to Cross Examine witness No.5 of the OPs andby order of this Commission dated 03.11.2025,evidences were supposedly closedand final hearing was reserved on for 13.11.2025after submission of brief or full written arguments on 10.11.2025.

14. We have perused the documents on record. We also heard arguments of the learned counsel Mr. C. Tlanthianghlima on behalf of the Complainants andMr. Vanlaltanpuia proxy learned counsel of Mr. B. Lalramenga on behalf of the Respondents. We also perused their submissions in the written arguments. The learned counsel of the Complainants argued that:

(1) The deceased Smt. Malsawmkimi on being pregnant registered herself at Health Sub-Centre, Tlangpui on 26.05.2021 and she had regular checkups at the Sub-Centre. She had complied with and had taken all necessary precautions and

injections prescribed to her and she had no problem during her pregnancy as can be seen from her antenatal visits record. The deceased had Smt. Malsawmkimi (40 Years) already had 4 spontaneous abortions/miscarriage, and 3 living issues. She had attended the OPD at District Hospital on 01.12.2021, she was counselled forNormal Vaginal Delivery (NVD). In absence of the Anaesthetist in station to arrange Caesarean Section (C-Sec), the Nurse persuaded her to go for NVD by saying that physical activity will not be hampered after delivery as the patient will have to engage in manual agricultural works later on. She was admitted in the hospital on 02.12.2021 at 10:50 a.m. by the Gynaecologist of District Hospital, Serchhip. On the day ofadmission, Cervi Prime Gel was applied on her to induce the labour forNormal Vaginal Delivery (NVD) and her condition as wellas thecondition of the baby was found to be stable. Since there was nodelivery on the night of 02.12.2021, Cervi Prime Gel was again applied onthe next day, i.e., 03.12.2021 and delivered a male child 3.8 kgs at 8.30 p.m., but the baby did notshow any signs of life at the time of birth. During the delivery, theGynaecologist was not present. As the patient developed post-deliverycomplications, the nurse on duty informed the Gynaecologist at 8:55 PM.The Gynaecologist attended the patient at 9:20 p.m. and informed theDistrict Medical Superintendent (DMS) about the critical maternalcondition. She was declared dead at 10:40 p.m. The learned counsel based his arguments on the report of the Magisterial Enquiry Report of the Serchhip District Magistrate, Serchhip, Mizoram.

(2) The learned counsel of the Complainants further argued that as per the Departmental Enquiry Report that no procedural lapse was found on the medical care given to the deceased patient, however, considering the past obstetrical history with 5 abortions and only 1 living issues and advance age (40 years), she should have been advised to attend higher centre where operative (surgery) delivery can be performed 24/7. It is an established principle of law that a doctor is not guilty of negligence if he/she has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art. However, in the instant case, the attending doctor & staffs had committed negligence thereby causing deficiency in service by considerably failing to act in accordance with the practice accepted. They had negligently failed to take into consideration the obstetrical history as well as her advance age by advising her to attend higher centre where operative (surgery) delivery can be performed 24/7 even though they were well aware that surgery (C-Sec) could not be performed at the District Hospital, Serchhip during that period as the Anaesthetist was not in station. It is a well-established law that a hospital is

vicariously liable for the acts of negligence committed by the doctors engaged or empanelled to provide medical care. Hence, it can be safely concluded that the Respondents are fully responsible for the tragic death of the deceased Smt. Malsawmkimi and her newborn son who had died at birth.

(3) The Complainant's counsel further submitted that the Hon'ble Gauhati High Court, Aizawl Bench inwrit petition No. W.P.(C) No.73/2022 filed by the Complainant directed the Respondents herein to pay ₹5.00 lakhs to the Complainant No.1 as compensation under public law remedy. At the same time, the Hon'ble High Court granted liberty to the Complainant No.1 herein for claiming further compensation for damages or deficiency of service before the appropriate forum. Thereafter, the Respondents having admitted their negligence, liability and deficiency in service had complied with the Judgement & Order dated 09.08.2023 as can be seen from the letter address to the Registrar, Gauhati Hight Court, Aizawl Bench.

(4) The Complainant stated that his deceased wife had no problem and taken necessary precautions, viz. injection prescribed to her.

(5) In regard to the issues framed, the learned counsel submitted as under in the written arguments that:

Issue No.1: *Whether the complaint is maintainable or the cause of action in favour of the complainant and against the Opposite Party.*

With regard to the present issue, the Respondents haveraised strong objections against the maintainability of the presentComplaint. Hearing on maintainability was conducted on 03.02.2025wherein the Ld. Counsels for both the parties were heard at length andthe Ld. Counsels had thereafter submitted their respective submissionsin writing on 11.03.2025. Consequently, this Hon'ble Commission videOrder dt.02.04.2025 maintained the complaint and had proceeded withthe case. Further, a plain reading of paras No.14 & 15 of the Complaint(Ext C- 16) clearly shows that the complaint is maintainable and there iscause of action in favour of the Complainants and against the Oppositeparties. Hence, this issue needs to be decided in favour of theComplainants.

Issue No.2 : *Whether the Complainant suffered from any undisclosed disease during her pregnancy as per her antenatalvisits record.*

The Complainant No.1 Shri Zaithankima in Para 3 of his Examination-In-Chief had deposed as follows:

"3. On being pregnant, my wife registered herself at HealthSub-Centre, Tlangpui Village on 26.05.2021 bearingRegistration No.5. She had regular check up at the Sub-Centre under the Health Worker(s) on 26.05.2021, 13.08.2021and on 08.11.2021. She had complied and had taken allnecessary precautions and injections prescribed to her andshe had no problem during her pregnancy as can be seenfrom her antenatal visits record."

He exhibited the Registration Card, i.e., the antenatal visits record ofSmt.Malsawmkimi (L) at the Sub-Centre as Ext. C- 5. He further statedin Para 9 of his Cross-examination that his wife Smt.Malsawmkimi had nohealth problem or any complaint when she was admitted in theDistrict Hospital, Serchhip for delivery of baby.

Further, Dr.Laltharzeli Fanai (OP Witness No.2) in Para 7 of her cross-examination had deposed as under:

"7. It is a fact that there are no complications developed bySmt. Malsawmkimi when I admitted her."

The deposition of Dr.Laltharzeli Fanai (OP Witness No.2) was alsocorroborated by Shri Lalnunfela (OP Witness No.5) who in Paras No.3&4 of his Examination-In-Chief stated that Smt. Malsawmkimi had no complaints orproblems during her visit to the Sub-Centre. This clearlyproves that the deceased Smt. Malsawmkimi did not have any complaints nor suffered from any undisclosed disease during her pregnancy. In other words, the deceased Smt. Malsawmkimi did not have any undisclosed disease during her pregnancy as per her antenatal visitsrecord. Hence, this issue is to be decided in favour of the Complainants.

Issue No.3 : *Whether the complainant's doctor andstaffs of theDistrict Hospital, Serchhip had committed negligence anddeficiency in taking care for the deceased Malsawmkimi.*

With regards to the present issue, the Complainants hadproved the negligence and deficiency in taking care of the deceasedMalsawmkimi in two folds.

Firstly, the Complainant No.1 Shri Zaithankima byreproducing the relevant abstract of the Departmental Enquiry Report(Ext.C-12) in Para No.8 of his Examination-in-Chief had mentionedthat the doctor and staffs of the District Hospital, Serchhip hadcommitted negligence and deficiency in taking care of his

deceasedwife. The relevant Observation made by the Departmental EnquiryReport (Ext.C-12) which was relied by the Complainants Witness No.1may be reproduced below:

> *"3.84. Considering the past obstetrical history with 5abortions and only 1 living issue and advance age (40 years)in regards to obstetric, the patient should have been advised to attend higher centre - where operative (surgery) delivery can be performed 24/7."*

In this Connection, it is pertinent to rely on the cross-examination ofSmt.Melody Zoremsangi (OP Witness No.1): (*extract*)

> *"9. It is a fact that considering the advanced age and Obstetrical history of Smt. Malsawmkimi (L), her case is of complex pregnancy case.*
>
> *10. It is a fact that the case of Smt. Malsawmkimi (L) being Complex pregnancy case, she should be given more attention and care....*
>
> *11. It is a fact that there is no discussion or consultation made between me and the Gynaecologist to prepare the patient, Smt. Malsawmkimi (L) for NVD.*
>
> *26. I admit Para 3 & 4 of the Observation made by the Departmental Enquiry (Exbt.C-12) "*

Further, Dr.Laltharzeli Fanai (OP Witness No.2) in her cross-examinationhad deposed as under:(*extract*)

> *"10. It is a fact that it is normal practice to refer patients to attend higher medical centre in case if there is any emergency or any complex complications which cannot be treated in the District Hospital.*
>
> *32. I admit Para 3 & 4 of the Observation made in the Departmental Enquiry Report."*

It is submitted that both the OPs Witnesses No.1 & 2admitted the fact that the patient should have been advised to attendhigher centre where surgery could be performed 24/7 considering herhistory and advanced age. In fact. the OPs Witness No.1 Smt.MelodyZoremsangi admitted that the case of Smt.Malsawmkimi (L) is a complexpregnancy case and she should be given more care and attention.Further, Dr.Laltharzeli Fanai also stated in Para No.10 of her cross-examination that *it is normal practice to refer patients to attend highermedical centre in case if there is any emergency or any complexcomplications which cannot be treated in the District Hospital.* However,she had failed to refer the patient to attend higher medical centre

considering her complex pregnancy case and her explanation given inParas No.17 & 19 of her cross-examination is self-contradictory withPara No.32 of her cross-examination. It is an established principle of lawthat a doctor is not guilty of negligence if he/she has acted in accordance with a practice accepted as proper by a responsible body ofmedical men skilled in that particular art. However, in the instant case,the attending doctor & staffs had committed negligence by considerablyfailing to act in accordance with the practice accepted as proper as theyhad negligently failed to take into consideration the obstetrical history aswell as her advance age by advising her to attend higher centre whereoperative (surgery) delivery can be performed 24/7 even though theywere well aware that surgery (C-Sec) could not be performed at DistrictHospital, Serchhip during that period as the Anaesthetist was not instation. In other words, in the absence of an Anaesthetist who is essentialin performing surgery (C-Sec), the patient should have been advised toattend higher centre as rightly pointed out by the independent Team ofDoctorsin their Departmental Enquiry Report dt.24.03.2022, and the saidnot being done, a case of negligence/deficiency in service on the part ofthe attending doctor and staffs had been proved.

Secondly, both the OPs Witnesses No.1 & 2 knew that theAnaesthetist was on leave during this period. The fact that surgery wasnot performed on the patient/deceased could be attributed to theabsence of the Anaesthetist. In this connection, it is submitted that theAnaesthetist had availed leave and no negligence was attributed to her,but the fact that the Gynaecologist had admitted the patient to undergoNVD fully knowing her complex conditions and her failure to consider theabsence of the Anaesthetist is pure negligence on her part.

In this connection, the OP Witness No.1 Smt. MelodyZoremsangi in Para No.12 of her cross-examination stated that she knewthat *the Anaesthetist at District Hospital, Serchhip was on leave during this period.*She further admitted in Paras No.13 & 23 of her cross-examination that surgery could not be performed in the absence of anAnaesthetist and the sole reason why surgery was not performed onSmt.Malsawmkimi was due to the absence of an Anaesthetist. Therelevant cross-examination of the OP Witness No.1 Smt.MelodyZoremsangi may be reproduced below

> *"12. I know that the Anaesthetist at District Hospital, Serchhipwas on leave during this period.*

13. I know that Caesarean Section or any surgical operationcannot be conducted in the absence of an Anaesthetist.

23. It Is correct to suggest that Smt. Malsawmkimi could not be operated in the OT solely due to the absence of the Anaesthetistduring this period.

27. Even though I deny the suggestion that the life ofSmt.Malsawmkimi (L) could have been saved if surgery wasperformed after she had developed complications, however, I opined that she could have been saved if she was prepared forCaesarean Section at the time of her admission."

Similarly, the OP Witness No.2 Dr.Laltharzeli Fanai in Para No.11 had deposed as below:

"11. It is a fact that I know that the Anaesthetist was onleave during this period."

OP Witness No.2 Dr.Laltharzeli Fanai in Para No.12 of her cross-examination further stated that *they used to perform life-saving operation in case of emergency.* She further stated in Para No. 13 of hercross-examination that *the presence of an Anaesthetist is not always compulsory at the time of performing life-saving operation,* however, in Para No.14 of her cross-examination, she stated that *life-saving operation was not performed on the deceased.* Therefore, negligence and deficiency in taking care of the deceased patient is clearly established even on this ground alone. Hence, this issue needs todecided in favour of the Complainants and against the Opposite Parties.

Issue No.4*: Whether a Gynaecologist was present at the time ofdelivery of the baby.*

Regarding the present issue, the Complainants' lone Witness Sh.Zaithankima in Para 4 of his Examination-In-Chief had stated that as per his knowledge and information, a Gynaecologist was not present at the time of delivery, He exhibited the Magisterial Enquiry ReportExt.C-10 wherein the Magisterial Enquiry Report had clearly mentionedin Point No.3 of his Observations/Findings that *the delivery was done by the staff nurse and was not attended by the doctor.*

In fact, a plain reading of Paras No.3 - 5 of the Examination-in-Chief of Smt.Melody Zoremsangi (OP Witness No.1) clearly showsthat she was the one who had delivered the baby of the deceasedSmt.Malsawmkimi and the Gynaecologist was not present at the time ofdelivery. Further, ParaNo.11 of the

Examination-in-Chief ofDr.Laltharzeli Fanai (OP Witness No.2) confirms that she was notpresent at the time of delivery. Hence, this issue needs no furtherdiscussion.

Issue No.5: *Whether the complainants are entitled to relief (s) claimed if so, to what extent.*

It is well-established principle that a hospital is vicariouslyliable for the acts of negligence committed by the doctors engaged orempanelled to provide medical care. In the present case, monetarycompensation to the Complainants will be the only effective remedy toheal their wounds as they were caused non-pecuniary damages notlimited to hardships, discomfort, disappointment, frustration and mentalstress in life. Moreover, the multifarious services rendered by thedeceasedto her husband and minor son cannot be ruled out. TheHon'ble Supreme Court in the case of **Arvind Kumar Pandey & Ors. Vs Girish Pandey & Anr.** reported in **(2025) 2 SCC 145** held thatthe role of a homemaker is as important as that of a family memberwhose income is tangible as a source of livelihood for the family. Theactivities performed by a home-maker, if counted one by one, there will hardly be any doubt that the contribution of a home-maker is of a highorder and invaluable. In fact, it is difficult to assess such a contributionin monetary terms. In this connection, it is submitted that even thoughthe deceased Smt.Malsawmkimi did not have any govt. job or regularmonthly income, her role and contribution made to her husband and sonis invaluable. In view of the above facts and circumstances and onperusal of the evidence adduced by the witnesses and Issues No.1 – 4being decided in favour of the Complainants, the Complainants are entitled to the reliefs claimed. Hence, Issue No.5 is to be decided infavour of the Complainants.

15. The learned counsel of the Opposite Parties filed Written Arguments for the final hearing and contended that:

(1) Smt. Malsawmkimi (L) was suffering from *Anaemia with Chronic Hypotension*, and she was not sure of her last menstrual period whileshe is supposed to take ultra-sound to determine expected date of delivery inearly pregnancy*. Anaemia* is not corrected from 1st check-up to 2nd check-up.As per the Government Protocol, she was supposed to attend PMSMA(Pradhan Mantri Surakshik Matriva Abhivan) launched by MOHFW, Govt. ofIndia Programme. The program aims to provide assured, comprehensive andquality antenatal care free of cost, universally to all pregnant women on the9th of every month in either 2nd trimester or 3rd trimester where high riskpatients are identified and received free blood investigation. This clearlyshows that Malsawmkimi (L) was not

cautious about her pregnancy, sayingshe had no problem during her pregnancy; and her Sub-Centre records sayotherwise. Even though she had three recurrent Miscarriages she delivered amale child by Normal Vaginal Delivery (NVD) in the year 2015 after her 3Miscarriages so she was a rightful candidate for Normal Vaginal Delivery(NVD) and she had no absolute indication for Caesarean Section. As perprotocol, Normal Vaginal Delivery (NVD) is usually conducted by Nursing staffas they are fully trained and qualified to perform Normal Vaginal Delivery andMid Wifery. Doctors are informed usually when there aredelivery complications and when instrumental delivery is required. The Ultrasound examination wasconducted on 1st December, 2021 as Smt. Malsawmkimi (L) was not aware ofher expected date of delivery and the Ultrasound report showed that herExpected Date of Delivery (EDD) was between 2nd- 5th December, 2021. Smt.Malsawmkimi (L) opted for vaginal delivery as she already had two previousnormal vaginal deliveries. One (1) being after 3 recurrent Miscarriages andshe is a rightful candidate to undergo Normal Vaginal Delivery (NVD).

(2) The Opposite Parties further contended that the claim made by the Complainants requesting Caesarean Section is neither heard nor known to/by the Gynaecologist and Nursing Staffs. On the day of her admission, Late Smt. Malsawmkimivitals were normal, her history and maternal age merely is not an indication or Caesarean Section. Hence, she was expected to have an ability to be managedin the District Hospital. Post-delivery complication was not anticipated and there was no absolute indication for referral to higher Centre at the time of admission and consent for further management taken at the time of admission. As per the Department Enquiry Report, the Team did not find any procedural lapse on the medical case given to the deceased patient. Late Malsawmkimi's history of four (4) Miscarriages andadvanced age is not an absolute indication for Caesarean Section and it doesnot imply that surgery should be performed. It is a retrospective assessmentand referring to higher Centre might be a better option. The cause of death was Post-Partum Haemorrhage (PPH) which she developed post-delivery andnot because Caesarean Section was not performed. Post-Partum Haemorrhage(PPH) can be developed by any patient (Caesarean Section or Normal VaginalDelivery) and was never anticipated. Like what the Departmental EnquiryReport had stated, every possible management was given to the patient atthat time as the resource permitted. At the time of admission, Smt.Malsawmkimi (L) did not present any conditions/signs which could not bemanaged at District Hospital at that time. As such, she was not referred to thehigher Centre. The patient already had two (2) live births which were bothNormal Vaginal Deliveries. Hence, Normal Vaginal

Deliveries was the plan forher in this pregnancy. In fact, the absence of anaesthetist does not contributeto any reason for her untimely demise.

(3) It is the stand of the Opposite Parties that there is nomedical negligence on their part for the untimely demise of Smt. Malsawmkimi(L) and as such, they are not liable to pay any compensation to theComplainants.

(4) During the proceeding which was drawn in this Hon'ble StateCommission, the Complainant No.1 produced his sole evidence and theOpposite Parties produced 5 (five) Witnesses. The points for determination in the instant case would be *'Whetherthe Opposite Parties had committed any medical negligence and deficiency inservice against the deceased Smt. Malsawmkimi'* and *'If the opposite Partiescommitted such medical negligence and deficiency in service against Smt.Malsawmkimi (L), whether they are liable to pay any compensation to theComplainants and to what extent'.*

(5) The learned counsel for the Opposite Partiesargues that there is no medical negligence and deficiency in servicecommitted by the Opposite Parties against the deceased Smt. Malsawmkimi. The question of payment of any compensation to the Complainantsdoes not arise. The Opposite Parties put forth the following points for arguments as under:–

(i) That the Complainants failed to prove that the deceased Smt.Malsawmkimihad been charged by the Opposite Parties for her admission tothe District Hospital, Serchhip. In fact, the District Hospital, Serchhip is aGovernment's Hospital and as such, unless the Complainants could not provethat the alleged service rendered upon Smt. Malsawmkimi (L) was not free orcharge, there can be no deficiency in service. In his cross-examination atParagraph No.3, the Complainant No.1 deposed as, *"It is a fact that while mywife,Malsawmkimi (4) was admitted in the District Hospital, Serchhip we did not pay any medical charges like private hospital."*At any event, on assumingbut not admitting that 'service' had been rendered to the said deceased, thereİs no deficiency at all in that respect. Besides, as it can be seen from theavailable records and also from the evidences adduced during the proceeding,there is no reason to say that the concerned Doctor(s)/staff of the DistrictHospital, Serchhip had committed the medical negligence against the saidSmt. Malsawmkimi (L). As a result, the instant Consumer Complaint should bedismissed as it cannot fall within the purview of the Consumer Protection Act,2019, particularly by reading Section 2(11) & (42) of the same Act of 2019.

(ii) That there is no iota of reason as to why Section 47 of the ConsumerProtection Act, 2019 should be invoked by the Complainants, inasmuch as,there is no goods or services exceeding Rs. 1 Crore paid as consideration bythe Complainants to the Opposite Parties. As a result, the present ConsumerComplaint is liable to be rejected outright.

(iii) That the evidences on record have clearly revealed that there is nonegligenceon the part of the staff of the District Hospital, Serchhip in lookingafter Smt. Malsawmkimi (L) while she was admitted to the said Hospital. TheOpposite Parties' Witness No.2 (Dr. Laltharzeli Fanai) had stated in herExamination-in-Chief as to how she had attended Smt. Malsawmkimi (L) with care and caution. Paragraph Nos. 7- 13 of her Examination-in-Chief maykindly be looked into as such depositions portrayed that there was nonegligence on the said Doctor/Gynaecologist.The evidences on record squarely showed that the condition of Smt. Malsawmkimi (L) was good andshe was seen by the Medical experts to be fit and able to deliver her baby inNormal Vaginal Delivery and no Caesarean Section would be required.However, it was due to the sudden unanticipated complications which happened to Smt. Malsawmkimi (L) after she delivered her baby that she hadlost her blood too much thereby causing her untimely demise in the said Hospital. In this regard, the said Witness No.2 for the Opposite Partiesdeposed as, "*...despite the possible intervention done the patient Malsawmkimi (L) could not be revived and was declared dead at 10:40 p.m. due to Disseminated Intravascular Coagulopathy (DIC) leading to Post-PartumHaemorrhage (PPH).*" (Paragraph No. 13 of her Examination-in-Chief). ThisWitness also deposed in Paragraph Nos. 14, 15, 17 & 18 in her Examination-in-Chief that DIC which caused uncontrolled bleeding could further bringmulti-organ failure which needs such treatment requiring specialized blood components. Since no such special treatment was available in the District Hospital, Serchhip District and inasmuch as the complications due to DIChappened suddenly without any expectation, there was no chance to saveSmt. Malsawmkimi (L) from her untimely demise. The evidences of thisWitness No.2 (Medical Expert) for the Opposite Parties were not rebutted in her cross-examination.

In order to support the evidences of the said Witness No.2 for theOpposite Parties, the Witness No.3 for the Opposite Parties who is the Doctor(Medical Expert) who took the charge of the Medical

Superintendent at thetime of the incident had also deposed in Paragraph Nos. 3& 4 of hisExamination-in-Chief that when he was called by the said Witness No.2 on thenight of 03.12.2021 informing him about the critical condition of Smt.Malsawmkimi (L), he rushed to the Hospital and he observed that she wasattended and closely monitored by the said Gynaecologist and the Nurses.However, despite all the efforts given, Smt. Malsawmkimi (L) could not besaved. This Medical Expert i.e., Witness No.3 for the Opposite Parties deposedin Paragraph No. 5 of his Examination-in-Chief as, *"That my observation inthis regard is that the Patient collapsed and died too quickly for the amount ofblood she appeared to lose.In my years of experience, patients who lose asmall amount of blood can usually be saved with IV fluids and bloodtransfusions. In this specific case, despite all medical interventions, the Patient namely late Malsawmkimi's death was unusually sudden."*The said WitnessNo.3 further deposed in Examination-in-Chief at Paragraph No.6 that as theyfound the unusual case of Smt. Malsawmkimi (L), the Blood Bank LabTechnician was asked to take the blood sample of Smt. Malsawmkimi (L) forcross-matching after the said patient died. Then, it was found that the bloodsample of the deceased could not clot and it was haemolyzed (the red bloodcells had broken down). The said blood sample was preserved at the District,Hospital, Serchhip and the blood sample of the deceased still could not clot,as the human blood should normally clot after a short interval. It was opinedby the said Witness No.3 that late Malsawmkimi's death was caused byDisseminated Intravascular Coagulopathy (DIC) leading to Post-PartumHaemorrhage (PPH).

The said blood sample of Smt. Malsawmkimi (L) was also physicallythe same as Exhibit D-16. The Witness No.4 for the Opposite Parties who is holding the post of theDistrict Medical Superintendent, District Hospital, Serchhip also deposed thatthe blood sample of Smt. Malsawmkimi (L) which was well preserved in thesaid Hospital was sent to Aizawl for production in this Hon'ble StateCommission.

These evidences of the said Witnesses of the Opposite Parties hadclearly indicated the fact that the condition of Smt. Malsawmkimi (L) post herdelivery of her baby had suddenly become worsened due to the said DICwhich could not be controlled nor saved from her untimely death. Therefore,this further shows that there is neither medical negligence nor

deficiency inservice on the part of the concerned staff of the District Hospital, Serchhip.

(iv) That the evidences of the Witness No.5 for the Opposite Parties whichwasnot rebutted at all as no cross-examination was done against him hadclearly revealed that the said Smt. Malsawmkimi (L) had attended Tlangpui SC-HWC during her period of pregnancy and she had nocomplaint/problem in her pregnancy duringher medical check-ups. Eventhe Witness No.2 i.e., Gynaecologist and the Nurse (Witness No.1 for theOpposite Parties) deposed that no risk or medical complication/problem wasseen in Smt. Malsawmkimi (L) while she was admitted to the said Hospital forher delivery and that was why she was found to be fit for NVD, particularly bytaking into account of her previous deliveries of babies by way of NVD. Infact, the Complainant No.1 in his cross-examination at Paragraph No.6 statedas. *"It is a fact that my wife, Malsawmkimi (L) did not make any complaint regarding her health problem in the Tlangpui Health Sub-Centre during theperiod of her check-up."* He also deposed in Paragraph No.7 of his cross-examination as, *"It is a fact that I neither saw nor knew anything to indicatethe ill-health or any medical problem in my deceased wife during the time of her pregnancy".*He further deposed in Paragraph No.9 of his cross-examination *"It is a fact that even when my wife was admitted in the District Hospital, Serchhip for delivery of a baby, she had no health problem or any complaint in that regard".*

This Shows that there was no chance for the concerned staff of theDistrict Hospital, Serchhip to ascertain or anticipate the complicated conditionof Smt. Malsawmkimi (L) which happened suddenly after she delivered herbaby. As such, the Complainants' allegation against the Opposite Parties formedical negligence is baseless and is not proved at all.

(v) That lastly but not the least, it may further be submitted that paymentof ₹5.00 lakh to the Complainant No.1 as per the Hon'ble High Court'sJudgment & Order dated 09.08.2023 passed in WP(C) No. 73 of 2022 doesnot mean that the Opposite Parties admitted to the negligence, liability anddeficiency in service on the unfortunate demise of Smt. Malsawmkimi (L). Infact, as stated by the Hon'ble High Court, awarding of ₹5.00 lakh in favour ofthe Petitioner in WP(C) No. 73 of 2022 as a palliative measure only under thepublic law and it does not imply/indicate that the Hon'ble High CourtConfirmed the negligence and deficiency in

service on the part of the OppositeParties; as such allegation on medical negligence needs to be proved bytaking an evidence as per law in the proceeding like the present ConsumerComplaint wherein the present Complainants are claiming for compensationunder the private law. Hence, the Complainants cannot take any advantage ofthe said Judgment & Order dated 09.08.2023 passed in WP(C) No. 73 of 2022in the present claim which they are making in this Consumer Complaint.

(vi) That in any view of the matter, the Consumer Complaint is liable todismissed and rejected.

(6) The following citation (Judgment of the Hon'ble Supreme Court ie. Nivedita Singh vs Dr. Asha Bharti & Ors. reported in (2022) 16 SSC 724 also held that if a patient availed of any service free of charge from a government hospital, such patient/person would be outside the purviewSection 2(1)(o) of the Consumer Protection Act, 1986 which now fallsSection 2(42) of the Consumer Protection Act, 2019 inasmuch as there is no 'deficiency in service' in such matter. Therefore, it is the similar case thatComplainants had also admitted to the fact that the alleged service rendered to Smt. Malsawmkimi (L) by the District Hospital, Serchhip was also free of charge and hence, there can be no question of deficiency in service which further means that the Complainants cannot make the present Consumer Complaint.

16. In regard to the issues No.1 framed by this Commission, the Complainants placetheir reliant on the **Hon'ble Apex Court's** Judgement in **Indian Medical Association vs V.P. Shantha in (1995) 6 SCC 651**wherein it was held that:

"55. On the basis of the above discussion, we arrive at the following conclusions:(1) Service rendered to a patient by a medical practitioner (except where the doctor rendersservice free of charge to every patient or under a contract of personal service), by way ofconsultation, diagnosis and treatment, both medicinal and surgical, would fall within theambit of 'service' as defined in Section 2(1)(o) of the Act.

(2) The fact that medical practitioners belong to the medical profession and are subject to thedisciplinary control of the Medical Council of India and/or State Medical Councils constitutedunder the provisions of the Indian Medical Council Act would not exclude the servicesrendered by them from the ambit of the Act.

(5) Service rendered free of charge by a medical practitioner attached to a hospital/nursinghome or a medical officer employed in a hospital/nursing home where such services arerendered free of charge to everybody, would not be 'service' as defined in Section 2(1)(o) ofthe Act. The payment of a token amount for registration purpose only at the hospital/nursinghome would not alter the position.

(9) Service rendered at a government hospital/ health centre/ dispensary where no chargewhatsoever is made from any person availing of the services and all patients (rich and poor)are given free service — is outside the purview of the expression 'service' as defined inSection 2(1)(o) of the Act. The payment of a token amount for registration purpose only at thehospital/nursing home would not alter the position.

(10) Service rendered at a government hospital/health centre/dispensary where services arerendered on payment of charges and also rendered free of charge to other persons availing ofsuch services would fall within the ambit of the expression 'service' as defined in Section 2(1)(o) of the Act, irrespective of the fact that the service is rendered free of charge to personswho do not pay for such service. Free service would also be 'service' and the recipient a'consumer' under the Act.

17. The learned counsel of Opposite Parties contended that there is no iota of reason as to why Section 47 of the ConsumerProtection Act, 2019 should be invoked by the Complainants, inasmuch as,there is no goods or services exceeding Rs. 1 Crore paid as consideration bythe Complainants to the Opposite Parties. The OPs further contended that the present complaint is outside the purview of the Consumer Protection Act as held by the **Hon'ble Supreme Court in Nivedita Singh vs Dr. Asha Bharti (supra)**that**:**

"....a medical officer who is employed in a hospital renders service on behalf of the hospital administration and if the service as rendered by the Hospital does not fall within the ambit of 2(1)(o) of the Act being free of charge, the same service cannot be treated as service under Section 2(1)(o) for the reasons that it has been rendered by medical officer in the hospital who receives salary for the employment in the hospital. It was thus concluded that the services rendered by employee-medical officer to such a person would therefore continue to be service rendered free of charge and would be outside the purview of Section 2(1)(o) of the Act."

The Complainant No.1 in his cross-examination deposed that "*"It is a fact that while my wife, Malsawmkimi (4) was admitted in the District Hospital, Serchhip we did not pay any medical charges like private hospital."*

18. The counsel of the Complainant objecting to the arguments of the OPs stating that the initial objection of the OPs was the question in absence of members having judicial background in regard law of limitation,there was ample opportunities to have objected the complaint at the initial stage for its maintainability in Consumer Commission, it is not in the best interest of justice to bring that up at the fag end of the case.

19. We have also place our reliance on Hon'ble Apex Court's Judgement in Indian Medical Association vs V.P. Shantha (supra) that *"(10) Service rendered at a*

Government hospital/health centre/dispensary where servicesare rendered on payment of charges and also rendered free of charge to other personsavailing such services would fall within the ambit of the expression 'service' as definedin Section 2(1) (o) of the Act irrespective of the fact that the service is rendered free ofcharge to persons who do not pay for such service. Free service would also be "service"and the recipient a "consumer" under the Act.(11) Service rendered by a medical practitioner or hospital/nursing home cannot beregarded as service rendered free of charge, if the person availing the service has taken aninsurance policy for medical care whereunder the charges for consultation, diagnosis andmedical treatment are borne by the insurance company and such service would fall withinthe ambit of 'service' as defined inSection 2(1) (o) of the Act." In this context, the Mizoram Government is implementing Mizoram Health Care Scheme, *A Health Insurance Scheme implemented by theMizoram State Health Care Society*at the relevant time. The services rendered by the District Hospital, Serchhip is hard to believe that all the services rendered to all their patients are free of charges. The Complainant produced a receipt for RAgT charges collected by the District Hospital as indicator for all charges are not free of charge. At the same time, when an insurance scheme is in operation at the hospital, all the services of the Doctors, Nurses and other employees may not be totally free of charge even when the salaries are paid the State Government. The Health & Family Welfare Department, Government of Mizoram displays in their website https://health.mizoram.gov.in/page/machines-rateMachines rate - Machine & Investigation rates etc. at Civil Hospital, Aizawl are on display as under:

Pay Cabin @ Rs. 600/-

Sl.No.	Particulars	Out Door	Indoor
1	X-Ray		
	Hand, Elbow, Shoulder, Humerous, Forearm	Rs. 20.00	Free
	Pelvis, Abdomen, Skull etc	Rs. 30.00	Free
	Chest	Rs. 35.00	Free
	Ba Swallow	Rs. 50.00	Free
	Ba Enema	Rs.140.00	Free
	Ba meal	Rs.120.00	Free
	Lumber, Thorasic Spine	Rs. 60.00	Free
	IVU	Rs.140.00	Free
2	ECG	Rs. 50.00	Rs. 50.00
3	Ultrasound	Rs.150.00	Rs.100.00
4	Endoscopy	Rs.150.00	Rs.100.00
5	Echo	Rs.250.00	Rs.250.00
6	EEG	Rs.300.00	Rs 250.00
7	PFT	Rs.300.00	Rs.250.00
8	TMT	Rs.500.00	Rs.500.00
9	Dialysis	Rs.600.00	Rs.600.00
10	Holter ECG	Rs.500.00	Rs.500.00
11	CT Scan		

Head	Rs.700.00
Chest, Abdomen	Rs.1000.00

(BPL & AAY Family = Free)

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20. In careful consideration of the above, the District Hospital, Serchhip, Mizoram is also under the Government of Mizoram and the Health & Family Welfare Department, Govt. of Mizoram is the controlling authority. We believe that the District Hospital, Serchhip did not provide entirely free service for their patients which cannot be entirely different from the Civil Hospital, Aizawl which is under the control of the Health & Family Welfare Department, Mizoram. Hence, we allowed the Consumer Case No. 1 of 2024.

21. Before we analyse the case further, it is important to revisit the Hon'ble Supreme Court guidelines on Medical Negligence arising out of **Jacob Mathew vs State of Punjab & Anr. (2005) 6 SCC 1.** Some portion of the guidelines laid down that:

> (1) Negligence is the breach of a duty caused by omission to do something whicha reasonable manguided by those considerations which ordinarily regulate the conduct of human affairs would do, ordoing something which a prudent and reasonable man would not do. The definition of negligence asgiven in Law of Torts, Ratanlal & Dhirajlal (edited by Justice G.P. Singh), referred to hereinabove,holds good. Negligence becomes actionable on account of injury resulting from the act or omissionamounting to negligence attributable to the person sued. The essential components of negligenceare three: 'duty', 'breach' and 'resulting damage'.
>
> (2) Negligence in the context of medical profession necessarily calls for a treatment with adifference. To infer rashness or negligence on the part of a professional, in particular a doctor,additional considerations apply. A case of occupational negligence is different from one ofprofessional negligence. A simple lack of care, an error of judgment or an accident, is not proof ofnegligence on the part of a medical professional. So long as a doctor follows a practice acceptable tothe medical profession of that day, he cannot be held liable for negligence merely because a betteralternative course or method of treatment was also available or simply because a more skilled doctorwould not have chosen to follow or resort to that practice or procedure which the accused followed.When it comes to the failure of taking precautions what has to be seen is whether those precautionswere taken which the ordinary experience of men has found to be sufficient; a failure to use specialor extraordinary precautions which might have prevented the particular happening cannot be thestandard for judging the alleged negligence. So also, the standard of care, while assessing thepractice as adopted, is judged in the light of knowledge available at the time of the incident, and notat the date of trial. Similarly, when the charge of negligence arises out of failure to use someparticular equipment, the charge would fail if the equipment was not generally available at thatparticular time

(that is, the time of the incident) at which it is suggested it should have been used.

(8) Res ipsa loquitur is only a rule of evidence and operates in the domain of civil law specially in cases of torts and helps in determining the onus of proof in actions relating to negligence. It cannot be pressed in service for determining per se the liability for negligence within the domain of criminal law. Res ipsa loquitur has, if at all, a limited application in trial on a charge of criminal negligence.

22. **The Hon'ble Apex Court** also held in **Kusum Sharma & Others *Vs.*Batra Hospital & Medical Research Centre & OrsCIVIL APPEAL NO.1385 OF 2001**thatwhile deciding whether themedical professional is guilty of medical negligence followingwell known principles must be kept in view:-

I. Negligence is the breach of a duty exercised byomission to do something which a reasonableman, guided by those considerations whichordinarily regulate the conduct of humanaffairs, would do, or doing something which aprudent and reasonable man would not do.

II. Negligence is an essential ingredient of theoffence. The negligence to be established bythe prosecution must be culpable or gross andnot the negligence merely based upon an errorof judgment.

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

IV. A medical practitioner would be liable onlywhere his conduct fell below that of thestandards of a reasonably competentpractitioner in his field.

V. In the realm of diagnosis and treatment thereis scope for genuine difference of opinion andone professional doctor is clearly not negligentmerely because his conclusion differs fromthat of other professional doctor.

VI. The medical professional is often called uponto adopt a procedure which involves higherelement of risk, but which he honestly believesas providing greater chances of success for thepatient rather than a procedure involvinglesser risk but higher chances of failure. Justbecause a professional looking to the gravity ofillness has taken higher element of risk toredeem the patient out of his/her sufferingwhich did not yield the desired result may notamount to negligence.

VII. Negligence cannot be attributed to a doctor solong as he performs his duties with reasonableskill and competence. Merely because thedoctor chooses one course of action inpreference to the other one available, he wouldnot be liable if the course of action chosen byhim was acceptable to the medical profession.

VIII. It would not be conducive to the efficiency ofthe medical profession if no Doctor couldadminister medicine without a halter roundhis neck.

IX. It is our bounden duty and obligation of thecivil society to ensure that the medicalprofessionals are not unnecessary harassed orhumiliated so that they can perform theirprofessional duties without fear andapprehension.

X. The medical practitioners at times also have to besaved from such a class of complainants who usecriminal process as a tool for pressurizing themedical professionals/hospitals particularly privatehospitals or clinics for extracting uncalled forcompensation. Such malicious proceedings deserveto be discarded against the medical practitioners.

XI. The medical professionals are entitled to getprotection so long as they perform their duties withreasonable skill and competence and in the interestof the patients. The interest and welfare of thepatients have to be paramount for the medicalprofessionals.

23. The Hon'ble Apex Court in the case of **Arun Kumar Manglik Vs. Chirayu Health and Medical Care Private Limited and Anr.(2019) 7 SCC 401** held that:

"A three-Judge Bench of this Court in ***Laxman Balkirshna Joshi vs. Trimbak Bapu Godbole*** stipulated that the standard to be applied by a medical practitioner must be of a "reasonable degree of care" –

> *"11. The duties which a doctor owes to his patient are clear. A person who holds himself out ready to give medical advice and treatment impliedly undertakes that he is possessed of skill and knowledge for the purpose. Such a person when consulted by a patient owes him certain duties viz. a duty of care in deciding whether to undertake the case, a duty of care in deciding what treatment to give or a duty of care in the administration of that treatment. A breach of any of those duties gives a right of action for negligence to the patient.* ***The practitioner must bring to his task 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*** *(cf. Halsbury's Laws of England,* 3rd Edn., *Vol.26 p.14)"*

24. The learned counsel of the Opposite Parties is relying on the **Hon'ble Apex Court Judgement** in the case of **Neeraj Sud & Anr. Vs. Jaswinder Singh (Minor) & Anr.Civil Appeal No. 272 of 2012**held that:

"14. It is well recognized that actionable negligence in context of medical profession involves three constituents (i) duty to exercise due care; (ii) breach of duty and (iii) consequential damage. However, a simple lack of care, an error of judgement or an accident is not sufficient proof of negligence on part of the medical professional so long as the doctor follows the acceptable practice of the medical profession in discharge of his duties. He cannot be held liable for negligence merely because a better alternative treatment or course of treatment

was available or that more skilled doctors were there who could have administered better treatment.

"15. A medical professional may be held liable for negligence only when he is not possessed with the requisite qualification or skill or when he fails to exercise reasonable skill which he possesses in giving treatment..."

"16. When reasonable care, expected of the medical professional is extended or rendered to the patient unless contrary is proved, it would not be a case for actionable negligence. In a celebrated and very often cited decision in *Bolam v. Friern Hospital Management Committee (Queen's Bench Division),* it was observed that a doctor is not negligent if he is acting in accordance with the acceptable norms of practice unless there is evidence of a medical body of skilled persons in the field opining that the accepted principles/procedure were not followed. The test so laid down popularly came to be known as Bolam's test and stands approved by the Supreme Court in *Jacob Mathews v. State of Punjab.* If we apply the same in the present case, we would find that Dr. Neeraj Sood was a competent and a skilled doctor possessing requisite qualification to perform PTOSIS surgery and to administer the requisite treatment and that he had followed the accepted mode of practice in performing the surgery and that there was no material to establish any overt act or omission to prove negligence on his part. As stated earlier, no evidence was adduced to prove that he had not exercised sufficient care or has failed to exercise due skill in performing the surgery."

"18. In other words, simply for the reason that the patient has not responded favourably to the surgery or treatment administered by a doctor or that the surgery has failed, the doctor cannot be held liable for medical negligence straightway by applying the doctrine of *Res Ipsa Loquitor* unless it is established by evidence that the doctor failed to exercise the due skill possessed by him in discharging of his duties."

25. **The Hon'ble Apex Court** in the case of **CPL Ashish Kumar Chauhan (Retired) vs. Commanding Officer and Ors. (2023) 15 SCC 152** held that:

"(iii) The law on negligence

67. In India, medical negligence is said to have been established by an aggrieved plaintiff or complainant when it is shown that the doctor or medical professional was in want of, or did not fulfil the standard of care required of her or him, as such professional, reasonably skilled with the science available at the relevant time. In other words, a doctor is not negligent if what he has done would be endorsed by a responsible body of medical opinion in the relevant speciality at the material time. This test is known as the Bolam test and has gained widespread acceptance and application in Indian jurisprudence. It finds resonance in several decisions. Recently, in Arun Kumar Mangalik v Chirayu Health and Medicare Ltd., this court outlined that though Bolam has been the bulwark principle in deciding medical (and professional negligence) cases, it

must adapt and be in tune with the pronouncements relating to Article 21 of the Constitution and the right to health in general:

"41. Our law must take into account advances in medical science and ensure that a patient-centric approach is adopted. The standard of care as enunciated in the Bolam case must evolve in consonance with its subsequent interpretation by English and Indian Courts."

26. On careful perusal of documents on records and hearing the oral arguments, the contention of the Opposite Parties that the deceased Smt. Malsawmkimi was suffering from *Anaemia with Chronic Hypotension,* and not sure of her last menstrual period while she is supposed to take ultrasound to determine the expected date of delivery in early pregnancy. Dr. Laltharzeli Fanai in her statement also mentioned in Magisterial Enquiry that the patient did not know her last menstrual cycle. The deceased is a villager, who were living in Tlangpui Village which is about 100 km from Serchhip where she succumbed to the delivery of her baby. It was absurd to take ultrasound to determine the expected date of delivery which none of the Health Worker or Doctor advised them to do so. Moreover, the deceased patient could not be expected to know from the Antenatal Visit record if she had **anaemia**or any other disease unless informed by the medically qualified person including the Health Worker(s) in the Health Sub-Centre**.**Assuming the deceased Smt.Malsawmkimi had anaemia as per the objection of the OPs as in para 9(2) above, **the blood sample of the deceased was taken only after the patient Smt. Malsawmkimi died.**No sign of intending to take corrective measure to treat anaemia problem was found in the action of the treating doctors and nurses in the District Hospital, Serchhip.In the light of the Hon'ble Apex court stipulation in***Laxman Balkirshna Joshi vs. Trimbak Bapu Godbole***(supra), the treating doctor did not undertake reasonable due to care owed to the patient. It is the responsibility of the treating doctor to inform the patient that she had suffered from anaemia and needed to be corrected.There is no way that the patient herself could prescribed medicine to correct anaemia, it is absurd to expect to do so in absence of prescription from qualified medical practitioner, let alone had known it or not. The course of treatment should have been prescribed by the treating Gynaecologist at least or referred to the concerned doctor if she had really suffered from *Anaemia with Chronic Hypotension*.

27. Moreover, the last menstrual period was recorded in the Antenatal Care registration card/visit records of the deceased that:

PREGNANCY RECORD

Date of last menstrual period – 15.3.21

Expected Date of Delivery – 22.12.21

Thestatement of Dr. Laltharzeli Fanai in the Magisterial Enquiry that the patient did not know her last menstrual cycle whereas the Antenatal visit records showed that the last menstrual period was 15.03.2021and the expected date of delivery was 22.12.2021. The treating doctor undermined the record in hand.The treating doctor despite knowing that the patient was suffering from *Anaemia with Chronic Hypotension* allowed to apply *cervi prime gel* on the patient for induction of labour to have NVD on 02.12.2021 instead of correcting the anaemia before delivery while the actual expected date of delivery was 22.12.2021 from her last menstrual period. From the submissionof the OPs in their Objection to the Complaint submitted by Dr. Vanlalsawma present itself the evidence that the deceased Malsawmkimi was suffering from *Anaemia with Chronic Hypotension* based on the Antenatal visit report. It is established that the evidence from the submission of the OPs representative Dr. Vanlalsawma that the doctor failed to exercise the due skill possessed by the treating doctor in discharging of her medical duties.The treating doctor totally ignored the record in the Antenatal Care card and allowed to proceed for force deliverybased on USGdone alone on 01.12.2021 by applying cervi prime gel on the deceased before the actual expected date of delivery from her last menstrual cycle.TheDistrict Hospital, Serchhip is deficient and negligent in treating the deceased Malsawmkimileading to maternal death.

28. Not attending PMSMA (Pradhan Mantri Surakshik Matriva Abhiyan) launched by MoHFW, Govt. of India Programme by the deceased has been the weakest defence against the complaint. In a reply to the information sought under RTI Act, 2005 by the counsel of the Complainants, Directorate of Health Services, Government of Mizoram informed on 13.02.2023 that,"**PMSMA is not implemented at Tlangpui Sub-Centres. As the scheme is not implemented at their level, health workers are not given training for implementation. But they may give awareness to the community about the service availability in the nearest Government Hospital. It may be noted that routine ANC check-up for pregnant women is done at Sub-Centre level (not PMSMA service).”**The RTI information further admitted that, "....**no Free Clinic was organised by the State Government to implement PMSMA at Tlangpui Sub-centre during the year 2021 due to Covid 19 pandemic.”** It is a fit case that the Respondents took a wrong turn showing their deficiency and negligence.

29. The Witness No.1 of the Opposite Parties Smt. Melody Zoremsangi deposed in her cross-examination that, *"1. I worked as a substitute Staff Nurse in place of the regular nurses at the District Hospital, Serchhip from the year 2011 till December 2021. During the period, I worked under MSACS and I am not a regular employee of District*

Hospital, Serchhip and I did my duty as a nurse as and when requested by the regular nurses". In her Re-examination by the counsel for the OPs, she clarified that *"1. With respect to Para No.1 of my Cross-Examination, I would like to clarify that my post under MSACS is also a staff Nurse, and although my duty as a Staff Nurse under MSACS and as a substitute staff Nurse at the District Hospital, Serchhip is not the same, I have necessary qualification for both the duties."* The deposition of the Witness No.1 of the OPs confirmed that she is only a substitute nurse in place of the regular nurse.Sheis working in MSACS (Mizoram State AIDS Control Society); she is qualified or not; no cogent reason was put forth by the Opposite Parties being the State Government to treat and care patients in the District Hospital, Serchhip. To aggravate the matter, the substitute nurse was on duty without the supervision of Gynaecologist in the labour room. This also shows the failure of the District Hospital, Serchhip administratively thereby allowing the unauthorised personnel to treat and care patients breaching the Government regulations.The District Hospital, Serchhip was severely disarrayto allow to employ substitute nurse in place of regular staff nurse for treating patients. In all likelihood, the District Hospital, Serchhip isin the hands of unauthorised personnel.The State Government of Mizoram is vicariously liable for whatever the Witness No.1 of the OPs Smt. Melody Zoremsangi did, good or bad, in treating patients in the District Hospital, Serchhip.

30. The contention of the Opposite Parties in para 15 (2) above, we are of the view that the decision whether to undertake Caesarean Section on the patient or not has to be taken by the attending doctor. The attending doctor ought to advise the patient by taking into consideration the condition of the patient. In this case, the patient is advance age (40 years) with 4 miscarriages may not be absolute indication for caesarean section, but for a prudent doctor with utmost care probably would have suggested without the request of the patient. Moreover, before resorting to forcing labour NVD, it would be prudent to have more investigation apart from doing USG. The treating doctor who herself is a female would have probably opted to have caesarean section had she been in the shoes of the deceased. It looks as if the treating doctor had in mind to have NVD only in absence of the Anaesthetist.

31. In the light of the above, this Commission is of the considered view that the District Hospital, Serchhip is negligent and deficient in the following counts: -

(1) The deceased patient Smt. Malsawmkimi approached the District Hospital, Serchhip with Anaemia with Chronic Hypotension during her pregnancy unknown to her which was evident from the Antenatal Visit records of the Sub-Centre as per para (ii) of the written statement of Respondent No.3 Dr. Vanlalsawma on

behalf of the Opposite Parties. The treating doctor took no action to correct the anaemia suffered by the deceased even after admission in the District Hospital.

(2) The Opposite Parties alleged that the deceased Smt. Malsawmkimi did not know her last menstrual period to established the expected date of delivery. The Antenatal Visit Card clearly mentioned the date of her last menstrual period as 15.03.2021 and expected date of delivery as 22.12.2021. The treating doctor ignored the record in Antenatal Care card and attempting to force Normal Vaginal Delivery on 02.12.2021 and 03.12.2021 by applying Cervi Prime Gel leading to maternal complication and death.

(3) Despite the deceased patient had history of four spontaneous abortions/miscarriages, no careful examination and investigation was done on the deceased Smt. Malsawmkimi before or after admission as to whether she was a fit case of Caesarean or NVD. Whether or not C-Sec may be a choice, but health condition of the patient would determine. Absence of the Anaesthetist did not warrant to force NVD before the expected date of delivery.

(4) No complication developed at the time of admission as per the statement of the treating Gynaecologist. However, the deceased patient Smt. Malsawmkimi developed complication on delivery of a newborn baby and died on 03.12.2021 at 10:40 p.m. due to Post Partum Haemorrhage. By order of the DMS, Blood sample collected from deceased patient on 04.12.2021 possibly for a plausible defence.

(5) The District Hospital, Serchhipengaged a substitute nurse and the substitute nurse is attending the deceased patient without supervision of the treating doctor while the deceased patient was in labour and at the time of delivery. The District Hospital was lapse in engaging unauthorised personnelto attend to the deceased patient at the critical moment alone.

(6) Upon perusing all the statements and facts of the case, it is evident that there is a clear contradiction in between the claims made by the attendant of Smt. Malsawmkimi (L) and the Doctor and nurses of the hospital. Contradiction can also be found in the submission of Dr. Vanlalsawma as in (1) and Dr. Laltharzeli Fanai about the health conditions of the deceased patient as in (4).

32. The Hon'ble Gauhati High Court (High Court of Assam, Nagaland, Mizoram and Arunachal Pradesh) in Case No.WP(C)/73/2022 (supra) for the instant parties held that:

"20. From a careful perusal of the Magisterial Enquiry report and also the report and observation of the independent team of Doctors, some degree of negligence

is attributable to the attending nurses and Doctors of the Hospital. Considering the past and medical history of Smt. Malsawmkimi, due care and proper monitoring ought to have been done, particularly in view of the non-availability of an Anaesthetist in station at the relevant time in case of emergency. More care ought to have been taken in view of the fact that there was another incident of death of a new born child on 31.10.2021, just over a month back."

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

33. Having regard to the events leading to the death of Smt. Malsawmkimi and her newborn baby we have concurred with the views of the Hon'ble Gauhati High Court in case No.WP(C)/73/2022 (supra) of the instant parties.

34. **The Hon'ble Apex Court in (2005) 2 SCC 145 Arvind Kumar Pandey & Ors. Vs. Girish Pandey and Anr.** held that:

> "6. Assuming that the deceased was not employed, it cannot be disputed that she was a homemaker. Her direct and indirect monthly income, in no circumstances, could be less than the wages admissible to a dailywager in the State of Uttarakhand under the Minimum Wages Act."

Therefore, compensation for the death of Smt. Malsawmkimi in the District Hospital, Serchhip should be paid by the Government of Mizoram at least the minimum wage. Smt. Malsawmkimi was 40 years of age when the unfortunate incidents happened. Assuming that she will be able to work till the age of 60 years of age when she reaches the retirement age as for the Government employees.The Opposite Parties should pay compensation amounting to₹26,20,800calculate at current minimum wage rate of ₹420 per day, 26 working days in a month for 20 years to the Complainants. In addition to the above, the loss of newborn baby could not be left unattended. Losing a mother by

her two young children was hard enough, the husband also losta wife and a newborn baby. We, therefore, allowed additional compensation amounting to ₹25,00,000 to be paid to the Complainants as punitive damagealong with litigation cost amounting to ₹1,00,000 shall also be borne by the Respondents.Failure to make payment within 60 days from the date of this judgement and order, 9% per annum will be added from the total amount till payment.

35. The case is disposed of.

Sd/-
(LALHMINGMAWIA)
INTERIM PRESIDENT

Sd/-
(C.LALRINKIMA)
MEMBER

Sd/-
(P.C.VANLALREMRUATI)
FEMALE MEMBER