**IN THE NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION AT NEW DELHI**

**RESERVED ON: 09.09.2024**
**PRONOUNCED ON: 28.02.2025**

**CONSUMER COMPLAINT NO. 2644 OF 2017**

WITH

IA/9174/2023 (Condonation of delay),
IA/19403/2019 (Directions)

1 Jaita Mitra Basu,
W/o Late Partha Pratim Basu,
residing at 1/3B, Nilmoni Mitra Row,
Kolkatta-700002.

2 Srimoyee Basu
daughter of Late Partha Pratim Basu,
residing at 1/3B, Nilmoni Mitra Row,
Kolkatta-700002. … Complainants

**Versus**

1 Dr. Anirban Chatterjee,
residing at 279, Olabibitaola First Bye Lane,
Madirtala, Howrah, Pin: 711102.

2 Nightingale Diagnostic & Medicare Centre Private Limited,
11, Shakespeare Sarani, Kolkata-700071. … Opposite Parties

**BEFORE:**
**HON'BLE MR. SUBHASH CHANDRA, PRESIDING MEMBER**
**HON'BLE AVM J. RAJENDRA, AVSM VSM (Retd.), MEMBER**

For the Complainants : Mr. Alok Saxena, Advocate
Mr. Saksham T., Advocate

For the Opposite Parties : Dr. Anirben Chatterjee, in person OP-1
Mr. Vikas Nautiyal, Advocate for Mr. Srijan Nayak for OP-2

**JUDGMENT**

**AVM J. RAJENDRA, AVSM VSM (Retd.), MEMBER**

1. The present Consumer Complaint has been filed under Section 21 of the Consumer Protection Act, 1986 (for short "the Act") against the Opposite Parties seeking to direct the OPs:

***"a. Pass an order directing the opposite parties nos. 1 and 2 to make payment of a sum of Rs. 20,41,64,575/- in favour of the complainant no. 2, jointly and severally.***

***b. Costs and incidentals of the instant proceeding be paid in favour of the complainants by the opposite parties;***

***c. Pass such other order or orders and/or direction or directions as this Commission may deem fit and proper."***

2. Brief facts of the case, as per the Complainants, are that Complainant 2, a minor of 2 years of age, was experiencing swelling in the right gluteal region since 2000. Initially, the lump was small, barely visible, and painless. Over time, various doctors were consulted, and they opined that it was likely a case of neurofibroma, assuring there was no cause for concern. By 2011, the lump had begun to increase in size and occasionally became painful, prompting the parents seeking her further evaluation. They consulted Dr. G Venugopal, a Senior Consultant at Institute of Neurosciences, Kolkata who recommended an FNAC test. The FNAC test, conducted in September 2014, suggested a probable diagnosis of angiolipoma. Based on this, Dr. Venugopal advised consulting a surgeon. On 21.05.2015, Complainant 2's parents consulted Dr. Pradeep Sen, a surgeon, who advised an MRI of the right pelvis. The MRI conducted on 22.05.2015, indicated the need for further evaluation. Subsequently, they approached Dr. Anirban Chatterjee, a vascular surgeon, who reviewed the medical history and noted a progressively enlarging soft tissue lesion in the right buttock and upper thigh. He recommended further tests, including

a CT angiography and certain blood tests. On 15.06.2015, CT angiography revealed Arterio-Venous Malformation (AVM) in the right buttock. After review of the reports Dr Chatterjee, recommended a surgical procedure known as vascular embolization. He estimated that the surgery would last about five hours and cost Rs.2,00,000/-. The procedure was scheduled on 16.09.2015, at Nightingale Hospital. After the surgery on 16.09.2015, Dr. Chatterjee informed the parents post-surgery that while the embolization was performed successfully, a small amount of glue had accidentally slipped into the main artery of the right leg. He assured them that the issue was minor and would not adversely affect the patient's health. He advised a minor follow-up procedure the next day to address the issue.

3. On 17.09.2015, the follow-up procedure was conducted, and Dr. Chatterjee claimed that 95% of the blood circulation was restored. However, on 18.09.2015, he informed the parents that circulation of blood to the right leg had stopped, and there were signs of gangrene. Dr. Chatterjee suggested transferring Complainant 2 to Sir Ganga Ram Hospital, Delhi for specialized treatment by Dr. VS Bedi. The complainants promptly arranged for her transfer to Delhi. Upon admission at Sir Ganga Ram Hospital on 19.09.2015, doctors found significant deterioration in her right lower limb, including black discoloration, swelling and loss of pulse. A CT angiography confirmed

that the condition had worsened, necessitating the amputation of her right leg above the knee to prevent further complications. Following consultations, her right leg was disarticulated on 22.09.2015. She also developed pneumothorax, which required immediate treatment. Despite being discharged on 13.11.2015, she required repeated hospitalizations for wound healing and follow-ups, incurring significant medical expenses. To regain mobility, they purchased a prosthetic leg from Otto Bock Healthcare for Rs. 7,25,000/- as per experts advice. A disability certificate dated 25.11.2016 confirms that she sustained 90% permanent disability and severe emotional, financial and physical burden on Complainant No. 2 and her family, mandating lifelong care. It is the Complainants case that failure to explore alternative scope of treatments, such as bypass surgery, compounded the situation. The unnecessary procedure performed on 17.09.2015 allowed gangrene to develop, ultimately necessitating the amputation. Alleging medical negligence and deficiency in service, on part of the Opposite Parties (OPs), they prayed for compensation for the loss of career prospects, physical and mental agony, medical expenses, litigation costs etc.

4. Upon notice, the complaint was forcefully resisted by the OPs by filing their Written Statement. OP-1 contended that that Arteriovenous Malformation Embolization (AVM embolization) inherently carried the risk of non-target embolization, wherein the embolic agent might enter

unintended blood vessels. While the likelihood of complications remained minimal, the risk increased with the complexity of the AVM. The Complainant had duly signed a high-risk consent form acknowledging these risks. It was contended that they failed to disclose their prior consultations with Dr. Venugopal, Dr. Pradeep Sen, and other medical professionals, thereby suppressing crucial medical history that could have aided in more comprehensive evaluation of the patient's condition. OP-1 denied charging any professional fees for the procedure, asserting that the Complainants did not qualify as "consumers" under the Consumer Protection Act. It is the further contention of OP-1 that he was unaware of the Complainants' prior medical/ surgical consultations on 21.05.2015. He maintained that the Complainants been informed that intervention was not mandatory, as the indications were relative rather than absolute. It was denied that OP-1 recommended Nightingale Hospital for the procedure, as it was the Complainants who independently chose the hospital based as per their financial considerations. He also denied assuring them of minor surgery the following day. He contended that all necessary medical measures were undertaken and that clinical records evidenced the restoration and normalization of blood flow. He asserted his extensive experience in vascular interventions, having practiced for over 15 years and performed numerous AVM embolization procedures. He

submitted that AVM management fell within the overlapping domains of vascular surgeons, plastic surgeons, and angiologists, and that haematologists are not routinely involved unless a known haematological condition existed, which was not the case here. Accordingly, no haematologist was consulted. It was further contended that OP-1 had considered the opinion of cardiothoracic surgeon Dr. Susan Mukherjee, who confirmed that a bypass procedure was not a viable option. This was duly communicated to the Complainant's parents. He denied allegations that he claimed blood circulation had stopped despite the procedure, clarifying that thrombosis had compromised circulation in the right leg of the patient. He contended that clinical notes were the best evidence and submitted copies of relevant medical records. He emphasized that he personally facilitated the patient's transfer to Sir Ganga Ram Hospital, engaged with Dr. VS Bedi, coordinated with airline authorities for urgent transfer, and arranged an ambulance upon arrival in Delhi. He asserted that these efforts demonstrated his commitment and denied allegations of negligence. He maintained that he remained at Nightingale Hospital with the patient, except for a few hours at night. He denied independently suggesting any doctor, clarifying that upon inquiry from Complainant No. 1 and that he merely referred to Dr. Vimal Someswar, who then recommended Dr. VS Bedi. He contended that

he could not be held responsible for the lack of medical facilities in the region and that the decision to seek treatment in another state was solely made by them. OP-1 denied that his fees were included in the hospital bill and asserted that he had not charged any amount for the procedure, as evidenced by the bill breakup. He contended that allegations related to Sir Ganga Ram Hospital and its doctors were beyond his knowledge. He refuted claims of glue slippage or medical negligence, emphasizing that utmost care had been taken and that medical outcomes were not always predictable. He contended that any delay in treatment was attributable to Complainants, who suppressed past medical history and attempted to misuse legal proceedings for financial gain. OP-1 asserted that embolization of congenital vascular malformations was inherently complex and risky, citing medical literature to substantiate that complications such as glue spillage and reflux were well-documented risks. As per him, AVMs are progressive conditions that often required surgical intervention, despite risks involved. He contended that standard medical guidelines were adhered to and maintained that surgical bypass was not a recognized treatment. OP-1 rejected claims that medical records were withheld, asserting that all relevant documents were provided. He denied all allegations of negligence or deficiency in service and asserted that he exercised due diligence in his professional capacity.

5. OP-2 contended that the Complainant was not maintainable as it was barred by limitation and bad for non-joinder of necessary parties. It was averred that there was no complaint against OP-2 in rendering medical support. OP-2 asserted that no claim for compensation was made out against it and sought the complaint to be dismissed.

6. The Complainant had filed rejoinder to the Written Statement filed by the Opposite Parties and reiterated the facts of the complaint.

7. In evidence, the Complainants submitted FNAC Report dated 03.09.2014 (Annexure A), Current Medication dated 21.5.2015 (Annexure B), Dept of Radiology CT Scan dated 17.6.2015 (Annexure C), Report of the examination of Blood dated 3.9.2015 (Annexure D), Medical report of Ms. Subhanji Basu dated 13,6.2015 (Annexure E), Admit authorization letter 18.9.2015 (Annexure F), Transfer Summary dated 16.9.2015 (Annexure G), Receipt dated 16.9.2015(Annexure H), Copy of CT Report dated 19.9.2015 (Annexure I), Copy of discharge summary report dated 13.11.2015 (Annexure J), Copy of ECG dated 22.1.2016 (Annexure K), Copy dated bill 02.01.2016 (Annexure L), Copy of Tax Invoice dated 28.5.2016 (Annexure M), Copy Of disability certificate dated 25.11.2016 (Annexure N), Copy of place of treatment dated 19.9.2015 (Annexure O), Copy Of medical information sheet dated 16.9.2015 (Annexure P), Copy of mark-sheet in the name of Subhangi Basu (Annexure Q), Copy of I.D. Proof (Annexure R).

8. OP-1 filed his evidence affidavit and relied on various publications made by reputed medical institutions and published in Vascular Surgery, Intervention Radiology and Gastroenterology Journals (Exhibit- A), copies of High Risk Consent form and clinical notes (Exhibit- B), Manual of 1981 (Exhibit- C), Publications declaring that Physical disability won't prevent deserving candidate from becoming doctor (Exhibit- D) and Copy of the Request Letter dated 18.09.2018 and their reply thereto (Exhibit E). To support his contentions, OP-1 submitted additional medical literature in evidence for understanding of Arterio-Venous Malformation (AVM) and its Endovascular Embolization using NBCA (N-Butyl Cyanoacrylate) Glue, its outcomes, complications and possible causes. These included Evaluation and Management of Congenital Peripheral Arteriovenous Malformations, Case Report-Full recovery after Non-target Cerebral embolization of N-Butyl-Cyanoacrylate occurred during emergency treatment of a facial arteriovenous malformation, Acute mesenteric vein thrombosis after glue of gastric varices- a case report, Non-Target Embolization of the Glans Penis during Prostatic Artery Embolization, Fatal Non-target Embolization via an Intra fibroid Arterio Venous Fistula during Uterine Fibroid Embolization, Characterization of N-Butyl-Cyanoacrylate (NBCA) Glue Polymerization for Embolization of Brain AVMs. OP-2 also filed evidence affidavit and denied the allegations levied against it.

9. The learned counsels for the complainant reiterated the facts and background of the complaint and vehemently argued that the present disabled condition of Complainant No.2 was only because of the medical negligence caused during her operation where some portion of the glue slipped into the main artery which ultimately resulted in causing 90% disability to her. They referred to AIIMS medical report dated 29.02.2024 which stated that concentration/proportion of glue used during the procedure could vary and the proportions used during the procedure were within the prescribed limited (both 1:2 and 2:1 could be used, depending on the DSA findings). This decision was best taken by the treating doctor. He argued that it was the discretion of the treating doctor and the amount and ratio was to be decided depending on the DSA finding. In this regard, the learned counsel argued that OP-1 failed to answer the question as to how and why, the said amount and ratio of glue (2:1) was utilised for surgery of the Complainant No.2. It was argued that had OP-1 been more vigilant towards the care of the complainants during the procedure, a lower amount and ratio would have been used by him thereby saving her from most unfortunate and regrettable 90% disability that had been caused to her now due to the direct actions of OP-1. He sought that the complaint against the OPs be allowed.

10. On the other hand, the learned Counsel for OP-1 reiterated that the Complainants had malicious intention to create prejudices by making contradicting submissions on oath. He argued that there exist significant contradictions in the complaint and the rejoinder. The facts of the minor's operation on 12.09.2015 had been distorted, revealing inconsistencies in both submissions. Both the surgeon and the anaesthetist involved in the case never charged any fees for their services, highlighting their dedication to patient care. The pre-medical history was not disclosed to OP-1 during the first visit, and the discharge notes and CDs provided by OP-2 were handed over to Dr. VS Bedi at Sir Ganga Ram Hospital, which raised serious questions about their intent. Complainants provided their consent and were fully informed and aware of the procedural implications. Also, OP-1 submitted a collection of publications to refute the allegations of gross negligence and illustrate the complexities involved in AVM process. The claims that OP-1 failed to adhere to contemporary medical guidelines for managing non-target embolization were entirely false. Assertions of the need for a surgical bypass were refuted. Further, it was argued that the complainant had significantly misinterpreted the ratio of Lipidol to glue. The ratio was stated as 2:1 (Lipidol to glue) but was incorrectly characterized as hyper concentrated glue. Iodized Oil Lipidol is, in fact, commonly mixed with N-BCA glue at ratios ranging

from 1:1 to 1:4 (oil to glue). Even medical literature did not support using a thrombectomy catheter in prothrombotic state since it affected only a small area of the thrombus. No medical literature specified the involvement of a radiologist or haematologist in managing AVMs.

11. The learned counsel for OP-2 contended that the complaint was not maintainable as it was barred by limitation and suffered from non-joinder of parties. Ms. Subhangi Basu was admitted on 16.09.2015 and discharged on 18.09.2015 under the direct care of Dr. Anirban Chatterjee, who was not a regular consultant of OP-2. She was diagnosed with Arterio Venous Malformation (AVM) by OP-1 and, after the procedure, developed vascular complications in her right leg. On OP-1's advice, she was shifted to another hospital. Prior to admission, she was under OP-1's treatment at other hospitals, where necessary investigations were done. OP-2 merely provided the Cath Lab, OT, hospital bed and nursing care, while OP-1 conducted the procedure. OP-1 had long dissociated himself from OP-2 and there is no complaint regarding the medical support between 16.09.2015 and 18.09.2015. Thereafter, she received treatment at other hospital, where OP-2 had no role. The original discharge summary, transfer summary, and procedure CD had been handed over to the concerned party. OP-2 retained no backup. It was thus asserted that OP-2 could not be held liable for any deficiency in service.

12. We have examined the pleadings and associated documents placed on record and rendered thoughtful consideration to the arguments advanced by the learned Counsel for both the Parties.

13. It is admitted position that Complainant 2, a minor, had the history of experiencing swelling in the right gluteal region since 2000. Over the years, various doctors were consulted, and the condition was initially diagnosed as neurofibroma. In 2014, an FNAC test suggested a probable diagnosis of angiolipoma, leading to further consultations. On 16.09.2015, she underwent an embolization procedure at Nightingale Hospital under OP-1, a vascular surgeon. During the procedure, admittedly, a small amount of NBCA (N-Butyl Cyanoacrylate) Glue used in the process accidentally slipped and entered the main artery of her right leg. OP-1 informed this to the parents and assured them that this issue was minor in nature and could be resolved through a follow-up procedure, which was performed on the next day i.e. 17.09.2015. However, by 18.09.2015, blood circulation to her right leg ceased, leading to development of gangrene. Complainant No. 2 was then transferred to Sir Ganga Ram Hospital, where further evaluations confirmed that the condition of right leg had deteriorated, ultimately necessitating an amputation above the knee on 22.09.2015. Following the surgery, Complainant No. 2 sustained 90% permanent disability, requiring lifelong medical care and the use of a prosthetic limb.

14. The main issue to be determined is whether OPs were negligent in performing the embolization procedure and whether this negligence resulted slippage of N-Butyl Cyanoacrylate Glue entering into the artery of her right leg leading to stoppage of blood flow and amputation of her right leg? Additionally, the issue involves determining whether OPs failed to explore alternative treatments, such as bypass surgery, and whether OPs are liable for medical negligence and deficiency in service, making them liable to pay compensation to the Complainants?

15. It is the Complainants contention that OP-1 had acted in grossly negligent manner during the embolization procedure on 16.09.2015 by allowing NBCA Glue, a chemical, to enter into the main artery, which led to severe medical complications, development of gangrene and resulted in amputation of her right leg on 22.09.2015. OP-1 failed to exercise due caution in determining appropriate concentration and ratio of NBCA Glue used, which, if adjusted properly, could have prevented the severe adverse consequences that ensued. They alleged that OP-1 did not explore alternative treatments, such as bypass surgery, which could mitigate the damage. OP-1 misrepresented the severity of the situation post-surgery, giving them false assurances on 17.09.2015 that blood circulation was restored while, in fact the condition worsened by 18.09.2015, resulting in onset of gangrene and the eventual consequence of amputation.

16. In defence, OP-1 argued that AVM embolization is an inherently high-risk procedure, and non-target embolization complication is a known risk, which had been disclosed to the Complainants through a high-risk consent form signed before the procedure. The glue ratio was within medical standards and supported by scientific literature. As per OP-1 alternative treatments like bypass surgery were not viable, as confirmed by cardiothoracic surgeon Dr. Susan Mukherjee. The medical protocols necessary were followed. He denied any medical negligence and asserted misrepresentation of facts.

17. An Arteriovenous Malformation (AVM) is stated to be an abnormal tangle of blood vessels that causes problems with the connections between the arteries and veins. AVMs often occur in the spinal cord and in the brain but can develop elsewhere in the body. Majorly, three surgical options viz. conventional surgery, endovascular embolization and radiosurgery are used to treat AVMs. The treatment choice depends largely on the size and location of an AVM. Endovascular embolization and radiosurgery are less invasive than conventional surgery and offer safer treatment options for some AVMs located deep inside the brain. In the present case, Embolization was used, which involves guiding a catheter though an artery until the tip reaches the site of the AVM. The surgeon then injects a substance such as fast-drying glue-like substances, fibered titanium coils, or tiny balloons that

travel through blood vessels and create an artificial blood clot in the centre of the AVM. Since embolization usually does not remove or obliterate the AVM, it is generally used as a complement to surgery or radiosurgery to reduce blood flow through the AVM and make surgery safer. The contentions and the record reveal that the complainants had signed a High-Risk Consent form dated 16.09.2015 acknowledging the risks and consequences associated with AVM embolization under general/spinal anaesthesia. However, information details provided does not have any mention the risk of “leakage on the glue” and the likely implications. It is the specific assertion of the OPs that the main risks of AVM embolization is 'non-target' embolization. This happens when the embolic agent passes into the wrong blood vessels at the time of delivery with or without causing problems in this blood vessel. Even if some material passes into the wrong vessel, there is an even smaller chance that it may cause problems. This risk varies in each individual patient and depends on number of factors. The injected glue cannot be precisely controlled and Non-target inadvertent embolization is possible. Embolic agent migration past the target lesion due to delayed polymerization is a well-described complication during AVM embolization where blockage venous outflow increases the risk of haemorrhage.

18. At this point we would like to refer to the Report of the Medical Board constituted at AIIMS for expert opinion vide order dated 24.07.2023 and 12.09.2019 of this Commission. The findings of the said report dated 26.02.2024 are reproduced as below:

- ***"1 The procedure undertaken for the treatment was justified. Endovascular glue embolization is the standard treatment of arteriovenous malformations.***
- ***High-risk consent had been taken prior to the procedure, where the patient and the parents appear to have agreed to the risk of the fatal outcome/future morbidity (Exhibit B).***
- ***The concentration/proportion of glue used during the procedure can vary and the proportions used during the procedure were within the prescribed limits (both 1:2 and 2:1 can be used, depending on the DSA findings). This decision is best taken by the treating doctor based on the flow dynamics of the corresponding vessels.***
- ***The total volume of glue used during the procedure (0.5mL x 2) is within the expected range.***
- ***The complication encountered is described in the literature and can be encountered even if the procedure is done with due diligence.***
- ***The risk of non-target embolization during these procedures has been documented multiple times in medical literature.***
- ***The complication was identified immediately and thereafter adequate corrective measures were taken including endovascular revascularization, support from Cardiovascular surgery and a Haematologist.***
- ***A Haematologist is not usually required as standby during such procedures and the encountered complication was rare and unanticipated.***
- ***The use of heparin to prevent further clots and the use of Tenecteplase to lyse the already formed clots, appears rational. Heparin is routinely administered to prevent potential procedure-related clots.***
- ***The prothrombotic state was treated with blood thinners (injection fondaparinux); however, did not get better with this medication. Even when the patient was shifted to Delhi, the prothrombotic state continued even after the amputation surgery. This required further amputation.***

- ***It appears that the standard of care treatment was administered at all steps during the management.***
- ***<u>The decision to withhold surgical bypass appears appropriate since there was no good distal flow</u>."***

19. Towards appropriately considering the aspect of allegation of medical negligence, which is the mainstay in the matter, the contentious aspects of medical care can be broadly categorized into three categories:

(a) Diagnosis: means medical condition/status of the patient;
(b) Advice: treatment options reasonable alternatives and risk attending on various options; and
(c) Treatment.

20. The material difference between these aspects of medical care lies in the degree of passivity on the part of the patient. The diagnosis and treatment are in the domain of doctor and the patient is a passive participant. When advice is being given to the patient, the patient assumes an active role. Then doctors' function is to empower and enable the patient to make a decision by giving him/ her relevant, sufficient and material information. The patient must make choices and decisions. The patient must be informed about the options for treatment, its consequences, risks and benefits. Why a doctor thinks particular treatment necessary and appropriate for the patient. The prognosis and what may happen if treatment is delayed or not given. Failing to furnish correct sufficient information when obtaining consent may be a breach of duty of care. It amounts to

negligence, failure to inform the patient. The patient must be given a reasonable amount of time to consider the information to make a decision. The allowing of cooling off period is for the purpose of giving time to think over the decision or take advice so that a patient does not feel pressurised or rushed to sign. On the day of surgery, the patient may be under strain, mental stress or under influence of the pre-procedure drugs which may hamper his decision-making ability. The doctor performing any procedure must obtain the patient's consent. No one else can consent on behalf of the competent adult. The consent should be properly documented and preferably witnessed as such consent is legally more acceptable. The video recording of the informed consent process may also be done with prior consent of the patient.

21. Now, we would like to discuss with regard to the "Bolam Test", which was articulated in 1957. At that point of time emphasis was not on the principle of autonomy rather on the principle of beneficence. The doctor was considered to be the best person and the patient was kept in dark with regard to the risks and alternative treatment relating to the illness. Now there is a seismic shift in medical ethics and societal attitude towards the practice of medicine. Also, the Medical Council framed statutory regulations regarding professional conduct, etiquette and ethics. This warrants legal tests to adjudicate

the advice aspect of doctor patient relationship. The MCI Regulations as amended up to date clearly stipulate the need to respect the patient's autonomy and doctor's obligation to adequately inform the patient for self-determination. Nature of the patient doctor relationship has to be examined in the light of education and access to the knowledge of ordinary citizens. In the light of these facts and statutory provisions, the "Bolam Test" can no longer be applied to a doctor's advice to his patient, unless it complies with the statutory provisions. The information given to the patient has to be examined from the patient's perspective. The information disclosed is not limited to risk-related inputs. It should include doctor's diagnosis of the patient's condition, the prognosis of that condition with and without medical treatment, the nature of proposed medical treatment and the risks associated with it, the alternative to the proposed medical treatment, advantages and risks of the said treatment and the proposed treatment. The doctor must ensure that information given is "in terms and at a pace that allows the patient to assimilate it, thereby enabling the patient to make informed decision".

22. Instances, where withholding of information is justified, are:

> "(a) **Waiver situation:** is when the patient expressly indicate that he does not want to receive further information about the proposed treatment or the alternative treatment.

(b) **Medical emergency:** when life-saving treatment is required and the patient temporarily lacks decision-making capacity. The "Bolam test" would continue to apply.

(c) **Therapeutic privileges:** when the patient has mental capacity, his decision-making capabilities are impaired to an appreciable degree such that doctor reasonably believes that the very act of giving particular information would cause the patient serious physical or mental harm. For example, the patient with anxiety disorder."

23. As regards the material issue whether before undergoing surgery, the patient or her parents were informed about the possible risks and complications and their informed consent was taken, it is true that every operation, as small as it may be, carries wide range of risks from the most insignificant to the most serious, may lead to fatal complications. Discussing all complications with the patient and attending relatives is a necessity, so that she may make up her mind for surgery. Before commencing a treatment or procedure, an 'Informed Consent' is required to be obtained satisfy the following conditions:

*"The consenting party i.e. the patient or his/her family members must be aware of the nature and extent of complications and risks of the surgery. The consenting party must have understood the nature and extent of the complications and risks and the consenting party or his/her family members must have consented to the harm and assumed risk. Comprehensive explanation of the possible complications and risks and the extent of entire procedure and transaction, inclusive of all its consequences, must be explained to the patient or his/her family members."*

24. In ***Samira Kohli Vs. Dr. Prabha Manchanda & Anr 1(2008) CPJ 56 (SC)***, the Hon'ble Supreme Court has extensively dealt with the concept of consent to be taken from the patient or his family members. It was held that patient has an inviolable right in regard to his body and he has right to decide whether or not he should undergo the particular treatment or surgery. The Hon'ble Supreme Court held that unless the procedure is necessary in order to save the life or preserve the health of the patient and it would be unreasonable to delay the further procedure until the patient regains consciousness and takes decision, a doctor cannot perform such procedure without the consent of the patient. Identical view was taken by the U.K. Supreme Court in "*Montgomery (Appellant) v.* Lanarkshire Health Board (Respondent) (Scotland)" Hilary Term [2015] UKSC 11 on appeal from: [2013] CSIH 3; [2010] CSIH 104, wherein also the concept of the informed consent has been emphasized.

25. As regards duty of medical care, Hon'ble Supreme Court in **Dr. Laxman Balakrishna Joshi Vs Dr Trimbak Babu Godbole** (2013)15 SCC 481 has held that a person who holds himself out ready to give medical advice and treatment impliedly undertakes that he is possessed of skill and knowledge for that purpose:

1. He owes a duty of care in deciding whether to undertake the case.
2. He owes a duty of care in deciding what treatment to give and,
3. He owes a duty of care in the administration of that treatment.

26. Breach of any of these duties gives right of action for negligence to the patient. This means that when a medical professional, who possesses a certain degree of skill and knowledge, decides to treat a patient, he is duty bound to treat him/her with a reasonable degree of skill, care, and knowledge. Failure to act in accordance with the medical standards in vogue and failure to exercise due care and diligence are generally deemed to constitute medical negligence.

27. In **P.B. Desai vs State of Maharashtra & Anr [2013] 11 S.C.R. 863** the 'Duty of Care' towards the patient is explained as below:

> "Once, it is found that there is 'duty to treat' there would be a corresponding 'duty to take care' upon the doctor qua/his patient. In certain context, the duty acquires ethical character and in certain other situations, a legal character. Whenever the principle of 'duty to take care' is founded on a contractual relationship, it acquires a legal character. Contextually speaking, legal 'duty to treat' may arise in a contractual relationship or governmental hospital or hospital located in a public sector undertaking. Ethical 'duty to treat' on the part of doctors is clearly covered by Code of Medical Ethics, 1972. Clause 10 of this Code deals with 'Obligation to the Sick' and Clause 13 cast obligation on the part of the doctors with the captioned "Patient must not be neglected".

28. In **Jacob Mathew vs. State of Punjab**, (2005) 6 SCC 1, decided on 05.08.2005, Hon'ble Supreme Court while laying down the elements of medical negligence observed that:

> "48. (2) Negligence in the context of medical profession necessarily calls for a treatment with a difference. 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 the one of professional negligence. A simple lack of care, an error of judgment or an accident, is not proof of

negligence on the part of a medical professional. So long as a doctor follows a practice acceptable to the medical profession of that day, he cannot be held liable for negligence merely because a better alternative course or method of treatment was also available or simply because a more skilled doctor would 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 precautions were taken which the ordinary experience of men has found to be sufficient; a failure to use special or extraordinary precautions which might have prevented the particular happening cannot be the standard for judging the alleged negligence. So also, the standard of care, while assessing the practice as adopted, is judged in the light of the knowledge available at the time of the incident, and not at the date of trial. Similarly, when the charge of negligence arises out of failure to use some particular equipment, the charge would fail if the equipment was not generally available at that particular time (that is, the time of the incident) at which it is suggested it should have been used."

"At least three weighty considerations can be pointed out which any forum trying the issue of medical negligence in any jurisdiction must keep in mind. These are: (i) that legal and disciplinary procedures should be properly founded on firm, moral and scientific grounds; (ii) that patients will be better served if the real causes of harm are properly identified and appropriately acted upon; and (iii) that many incidents involve a contribution from more than one person, and the tendency is to blame the last identifiable element in the chain of causation with the person holding the 'smoking gun'."

"According to Charlesworth & Percy on Negligence (Tenth Edition, 2001), in current forensic speech, negligence has three meanings. They are: (i) a state of mind, in which it is opposed to intention; (ii) careless conduct; and (iii) the breach of duty to take care that is imposed by either common or statute law. All three meanings are applicable in different circumstances but any one of them does not necessarily exclude the other meanings. (Para 1.01) The essential components of negligence, as recognized, are three: "duty", "breach" and "resulting damage", that is to say:-

1. the existence of a duty to take care, which is owed by the defendant to the complainant;
2. the failure to attain that standard of care, prescribed by the law, thereby committing a breach of such duty; and

3. damage, which is both causally connected with such breach and recognized by the law, has been suffered by the complainant. (Para 1.23) If the claimant satisfies the court on the evidence that these three ingredients are made out, the defendant should be held liable in negligence."

29. In the case in question, it is undisputed that Complainant 2, a minor of 2 years of age, was noticed to be experiencing swelling in the right gluteal region in the year 2000. Initially, the lump was small, barely visible and painless. Over time, the parents consulted various doctors who opined that it was likely to be neurofibroma and assured them of no cause for concern. By 2011, the lump had begun to grow and occasionally became painful, prompting them to seek further evaluation. They consulted Dr G Venugopal, a Senior Consultant at Institute of Neurosciences, Kolkata who recommended an FNAC test. The FNAC test held in September 2014, suggested a probable diagnosis of angiolipoma and Dr. Venugopal advised them to consult a surgeon. On 21.05.2015, they consulted Dr. Pradeep Sen, a surgeon, who advised an MRI of right pelvis. The MRI on 22.05.2015 indicated the need for further evaluation. They consulted Dr. Anirban Chatterjee, a vascular surgeon, who reviewed the medical history and noted a progressively enlarging soft tissue lesion in the right buttock and upper thigh. He recommended further tests, including a CT angiography and blood tests. The CT angiography on 15.06.2015 revealed Arterio-Venous Malformation (AVM) in the right buttock and Dr Chatterjee, recommended a surgical procedure known as vascular embolization.

The surgery was done on 16.09.2015 at Nightingale Hospital. After the surgery, Dr. Chatterjee informed them that while the embolization was successful, a small amount of NBCA Glue had accidentally slipped into the main artery of the right leg. He assured them that the issue was minor and would not adversely affect the patient's health and advised a minor follow-up procedure the next day. On 17.09.2015, the follow-up procedure was done, and Dr. Chatterjee told them that 95% of the blood circulation was restored. However, on 18.09.2015, he informed them that blood circulation to the right leg had stopped, and there were signs of gangrene. He suggested transferring her to Sir Ganga Ram Hospital, Delhi for treatment. When she was admitted at Ganga Ram Hospital on 19.09.2015, the doctors found significant deterioration in her right lower limb, including black discoloration, swelling and loss of pulse. CT angiography confirmed her critical condition, necessitating the amputation of her right leg above the knee to prevent further complications. On 22.09.2015 her right leg was disarticulated. She had also developed pneumothorax, which required immediate treatment. Even after being discharged on 13.11.2015, she required repeated hospitalizations and follow-ups, incurring significant medical expenses. To regain mobility, she purchased a prosthetic leg for Rs. 7,25,000/-, as per expert advice. She was also issued with a Disability Certificate on 25.11.2016 confirming 90% permanent disability.

30. On the other hand it is the contention of the OPs that the medical diagnosis and prescription of AVM were correct. The AVM inherently carried the risk of non-target embolization, wherein the embolic agent might enter unintended blood vessels. While the likelihood of complications remained minimal, the risk increased with the complexity of the AVM. The Complainant had duly signed a high-risk consent form acknowledging these risks. They failed to disclose their consultations with Dr. Venugopal, Dr. Pradeep Sen, and others and thus suppressed the crucial medical history of her condition. OP-1 denied charging any professional fees and that his fees was not included in the hospital bill. OP-1 also denied assuring them of minor surgery the following day and contended that all necessary medical measures were undertaken and the clinical records evidenced the restoration and normalization of blood flow. He asserted his extensive experience in such surgeries for over 15 years. He refuted that he misinformed the parents about her condition. He facilitated her transfer to Ganga Ram Hospital, engaged with Dr. VS Bedi, coordinated with airlines for urgent transfer and admission. He refuted claims of glue slippage or medical negligence and emphasised that utmost care was taken and that the medical outcome is not always predictable. He asserted that embolization of congenital vascular malformations is inherently complex and risky, citing medical literature to substantiate that complications such as glue

spillage and reflux were well-documented risks. AVMs are progressive conditions that often required surgical intervention, despite risks involved. He contended that standard medical guidelines were adhered to and maintained that surgical bypass was not a recognized treatment, as confirmed by cardiovascular surgeons. He denied all allegations of negligence or deficiency in service and asserted that he exercised due diligence in his professional capacity.

31. With respect to the accuracy of the diagnosis, the standard of care during surgery and the appropriateness of treatment provided to the patient, there have been specific allegations and vigorous resistance to the same by OPs bringing details of treatment given to the patient. It is undisputed that, the patient unfortunately lost her right leg till above the knee. It is the OPs contention that the complications arose during the surgery on 16.09.2015 by OP-1 at OP-2 Nightingale Hospital when N-Butyl Cyanoacrylate Glue accidentally slipped into the main artery of her right leg, impacting the blood supply to the right leg. This was noticed and a follow up procedure was performed on 17.09.2015. On 18.09.2015, it was revealed that the blood circulation to the right leg had stopped, and there was swelling and loss of pulse and gangrene developed. The patient was then transferred to Sir Ganga Ram Hospital for specialized treatment on 19.09.2015 with indications of significant deterioration in her right lower limb, including

black discoloration. A CT angiography confirmed the condition, her right leg above the knee had to be amputated to prevent further complications on 22.09.2015. OPs refuted the claims of glue slippage was due to medical negligence, emphasizing that utmost care had been taken and that medical outcomes were not always predictable. The delay in the matter, if any, was attributable to the parents, who suppressed past medical history and attempted to misuse legal proceedings for financial gain. OP-1 asserted that embolization of congenital vascular malformations was inherently complex and risky, citing medical literature to substantiate that complications such as glue spillage and reflux were well-documented risks.

32. Notwithstanding the said assertions of OPs, if the implications of the surgery are as contended by the OPs, the risk at which the patient was ought to have been even more particularly notified to her and/or her parents prior to obtaining their consent for surgery. This is specifically material considering the fact that the patient and parents approached OPs with the history for Arterio-Venous Malformation, which is a medical condition that developed over a period of time and had scope for deferment of surgery till the parents and the patient completely understand the implications of surgery and then render an informed consent.

33. In the case in question, the High Risk Consent Form with respect to the AVM embolization surgery dated 16.09.2015 is placed on record. This is a printed format with the information given, explanation made, possible risks during the surgical procedures, anesthetic procedures, medications and pre-existing and current medical conditions. It also indicates the consent of the possibility of unforeseen conditions arising. Therefore, it is unclear as to whether the said High Risk due to which the patient in fact lost her leg, was informed to them at that stage at all. Therefore, this Consent cannot be termed as an informed consent for accepting such High Risk, as contended by OPs.

34. Pertinently further, it is the assertion of the Complainants that after the surgery, the patient had developed “Gangrene” in the right leg due to blockage of blood flow. The blood flow occasioned due to slippage of glue during the surgery, which could not be effectively addressed and, as a consequence, the right leg of the patient had to be amputated till above the knee. The OPs refuted the allegations of medical negligence and contended that the slippage of N-Butyl Cyanoacrylate Glue could occur in such cases. As per OPs, the parents of the patient have been well informed of the risks involved and they are responsible for the delay in approaching OPs and supressing the consultations they previously made.

35. The above persistent contentions of OPs mainly reflected that the said high risk of AVM is inherent in the surgery in question performed by the OPs on the patient. If that is the case, it was even more incumbent upon the OPs to specifically raise these queries with the patient/ Complainant and the case sheet should have been made accordingly. Based on the determination of risk involved, the patient/ Complainant ought to have been explained the degree of risk and then consent should have been obtained. Further, after obtaining such informed consent, adequate preparations also ought to have been made for the clinical procedures, depending on the risk assessment. No such action as stated is placed on record, other than allegation that the parents of the Complainant have delayed the treatment, and the patient had to be urgently shifted to Ganga Ram Hospital in Delhi in very critical condition where her right leg was amputated. Clearly, the parents have been continuously following up her medical diagnosis at each stage and only based on the medical evaluation and advice, they approached OPs. As regards the allegation of the parents hiding the details of medical consultations, clearly, there is no reason for any parent to hide such details of consultations. It was in fact incumbent upon the medical professionals who possess the requisite knowledge to specifically elicit these details, which has not been done. Therefore, the consent obtained in the present case and the assertions made by

the OPs in defence are of limited consequence. If the surgery entailed High Risk as asserted by OPs, it was even more imperative for the OPs to elicit the necessary responses with specific questions with respect to the medical history and associated conditions of patient to determine her risk potential and take necessary preventive measures as well as effective measures to deal with the situation of handling such subsequent conditions. This was not done and, after the slippage of the chemical Glue into the artery and the blood flow was blocked, the patient had to be urgently shifted to Ganga Ram Hospital in Delhi in very critical condition, where her right leg was amputated.

36. Hon'ble Supreme Court in **Neeraj Sud & Anr. v. Jaswinder Singh (Minor) & Anr.** (2024 LiveLaw (SC) 863), decided on 25.10.2024, 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 judgment 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 the treatment. None of the above two essential conditions for establishing negligence stand satisfied in

the case at hand as no evidence was brought on record to prove that Dr. Neeraj Sud had not exercised due diligence, care or skill which he possessed in operating the patient and giving treatment to him."

37. In **M.A Biviji v. Sunita & Ors.** (2023 LiveLaw (SC) 931, decided on 29.10.2023, Hon'ble Supreme Court observed that:

"38. To hold a medical practitioner liable for negligence, a higher threshold limit must be met. This is to ensure that these doctors are focused on deciding the best course of treatment as per their assessment rather than being concerned about possible persecution or harassment that they may be subjected to in high-risk medical situations. Therefore, to safeguard these medical practitioners and to ensure that they are able to freely discharge their medical duty, a higher proof of burden must be fulfilled by the complainant. The complainant should be able to prove a breach of duty and the subsequent injury being attributable to the aforesaid breach as well, in order to hold a doctor liable for medical negligence. On the other hand, doctors need to establish that they had followed reasonable standards of medical practice."

"54. At this stage, we may benefit by adverting to what the renowned author and surgeon Dr. Atul Gawande had to say on medical treatment. He said "*We look for medicine to be an orderly field of knowledge and procedure. But it is not. It is an imperfect science, an enterprise of constantly changing knowledge, uncertain information, fallible individuals, and at the same time lives on the line. There is science in what we do, yes, but also habit, intuition, and sometimes plain old guessing. The gap between what we know and what we aim for persists. And this gap complicates everything we do*."

55. The above observation by Dr. Atul Gawande aptly describes the situation here. This is a classic case of human fallibility where the doctors tried to do the best for the patient as per their expertise and emerging situations. However, the desired results could not be achieved. Looking at the line of treatment in the present matter, it cannot be said with certainty that it was a case of medical negligence."

38. In **Jacob Mathew vs. State of Punjab**, (2005) 6 SCC 1, decided on 05.08.2005, Hon'ble Supreme Court while laying down the elements of medical negligence also observed that:

> "11. Deterioration of the condition of the patient post-surgery is not necessarily indicative or suggestive of the fact that the surgery performed or the treatment given to the patient was not proper or inappropriate or that there was some negligence in administering the same. In case of surgery or such treatment it is not necessary that in every case the condition of the patient would improve and the surgery is successful to the satisfaction of the patient. It is very much possible that in some rare cases complications of such nature arise but that by itself does not establish any actionable negligence on part of the medical expert."
>
> "18. In other words, simply for the reason that the patient has not responded favourably to the surgery or the 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."

39. The contention of the OP-1 that he had not received any fees for the treatment of the patient in question and, in the absence of any consideration, she does not constitute a consumer is also untenable as, clearly, the parents of the child paid the fees to the Hospital and that itself constitutes the consideration with respect to OP-1 as well.

40. In view of the foregoing deliberations and the decisions of the Hon'ble Supreme Court, the negligence and deficiency in service on the part of the OPs is manifest.

41. Now, towards determining the compensation payable by the OPs to the Complainants, the law established by the Hon'ble Supreme Court in catena of judgments provides for award of just and fair compensation to address the consequences suffered by an individual in such cases where negligence is manifest.

42. In **Alfred Benedict & Anr. v. Manipal Hospital, Bangalore & Anr.**, (2015) 11 SCC 423, decided on 11.08.2014, while determining the quantum of compensation in a case of amputation of arm of a baby, who had developed gangrene due to wrongful administration of IV fluid, the Hon'ble Supreme Court held that:

> ***"10. We have heard the learned counsel for the parties and have gone through the finding recorded by the State Commission as also the National Commission. We do not find any reason to differ with the finding that it was only because of the negligence on the part of the Hospital that the two years' child developed gangrene resulting into amputation of her right arm.***
>
> ***11. However, taking into consideration the sufferings of the girl child, who is now 13 years of age, in our opinion the compensation awarded by the Commission is on a lower side. The learned counsel appearing for the complainant submitted that every year she has to incur battery charges for the artificial limb, which costs Rs 80,000 annually. There cannot be any dispute that the girl will have to suffer throughout her life and has to live with artificial limb. Not only she would have to face difficulty in her education but would have also to face problem in getting herself married. Although the sufferings, agony and pain, which the girl child will carry cannot be compensated in terms of money, but, in our view, a compensation of Rs 20,00,000 (Rupees twenty lakhs only) will be just and reasonable in order to meet the problems being faced by her and also to meet future troubles that will arise in her life.***

***12. With the aforesaid reason, we allow the appeal filed by the complainants being civil appeal arising out of SLP (C) No. 35632 of 2013 by enhancing the compensation to Rs 20,00,000 (Rupees twenty lakhs only), which shall carry simple interest of 9% per annum from the date of this order. It may be made clear that out of the total compensation, a sum of Rs 10 lakhs shall be deposited in a long-term fixed deposit in a nationalised bank so that this amount along with interest that may accrue, shall take care of her future needs. The balance Rs 10 lakhs shall be utilised by investing Rs 5 lakhs in a short-term fixed deposit in a nationalised bank so that this amount along with the accrued interest will take care of her needs in near future. The rest Rs 5 lakhs may be spent for her further medical treatment."***

43. In **Shoda Devi v. DDU/Ripon Hospital, Shimla & Ors**., (2019) 14 SCC 357, decided on 07.03.2019, the Hon'ble Supreme Court enhanced the compensation in a case of amputation of arm of the complainant and observed as below:

***"15.2. We are constrained to observe that the National Commission, even after appreciating the troubles and trauma as also disablement and disadvantage suffered by the appellant, had been too restrictive in award of compensation. Ordinarily, the general damages towards pain and suffering as also loss of amenities of life deserve to be considered uniformly for the human beings and the award of compensation cannot go restrictive when the victim is coming from a poor and rural background; rather, in a given case like that of the appellant, such a background of the victim may guide the adjudicatory process towards reasonably higher amount of compensation (of course, after having regard to all the attending circumstances).***

***15.3. Such granting of reasonability higher amount of compensation in the present case appears necessary to serve dual purposes: one, to provide some succour and support to the appellant against the hardship and disadvantage due to amputation of right arm; and second, to send the message to the professionals that their responsiveness and diligence has to be equi-balanced for all their consumers and all the human***

***beings deserve to be treated with equal respect and sensitivity. We are impelled to make these observations in the context of an uncomfortable fact indicated on record that when the appellant was writhing in pain, she was not immediately attended at and was snubbed with the retort that "the people from hilly areas make unnecessary noise". Such remarks, obviously, added insult to the injury and were least expected of the professionals on public duties.***

***15.4. Apart from the above, when the appellant is shown to be a poor lady from rural background, her contribution in ensuring the family meeting both ends also deserves due consideration. With her disablement and reduced contribution, the amount of compensation ought to be of such level as to provide relief in reasonable monetary terms to the appellant and to her family.***

***16. For what has been discussed and observed hereinabove and in the given set of facts any circumstances, we are of the view that the appellant deserves to be allowed further an amount of Rs 10,00,000 towards compensation, over and above the amount awarded by the State Commission and the National Commission. Having regard to the quantum of enhancement being allowed herein, it is also considered proper to grant three months' time to the respondents to make the requisite payment and else, to bear the burden of interest.***

***17. Accordingly, this appeal is allowed. The appellant is awarded further an amount of Rs 10,00,000 (Rupees ten lakhs) towards compensation, over and above the amount awarded by the State Commission and the National Commission. The respondents shall make the requisite payment within 3 months from today failing which, the enhanced amount of compensation shall carry interest at the rate of 6% per annum from the date of filing of the complaint before the State Commission."***

44. In **Charan Singh v. Healing Touch Hospital**, (2000) 7 SCC 668, decided on 20.09.2000, the Hon'ble Supreme Court has held that:

***"12. While quantifying damages, Consumer Forums are required to make an attempt to serve the ends of justice so that compensation is awarded, in an established case, which not only serves the purpose of recompensing the individual, but which also at the same time, aims to bring about a qualitative***

***change in the attitude of the service provider. Indeed, calculation of damages depends on the facts and circumstances of each case. No hard and fast rule can be laid down for universal application. While awarding compensation, a Consumer Forum has to take into account all relevant factors and assess compensation on the basis of accepted legal principles, on moderation. It is for the consumer forum to grant compensation to the extent it finds it reasonable, fair and proper in the facts and circumstances of a given case according to the established judicial standards where the claimant is able to establish his charge.***

***13. It is not merely the alleged harm or mental pain, agony or physical discomfort, loss of salary and emoluments etc. suffered by the appellant which is in issue — it is also the quality of conduct committed by the respondents upon which attention is required to be founded in a case of proven negligence.***

45. In the present case, undisputedly the patient who of 17 years at the time of surgery, lost her right leg till above knee and thus left permanently disabled. The negligence in performing the AVM Surgery by the OP is manifest and she is otherwise in healthy condition. Without doubt, the unexpected consequence of amputation of her leg has resulted in severely impacting on her self-esteem, employability as well as living her life with dignity. She was issued with a Certificate by RG Kar Medical C. Hospital, Kolkata dated 25.11.2016 declaring that she suffered 90% permanent disability. The patient who suffered the consequences is a girl child and thus the implications are even more profound. The Complainants stated to have incurred Rs.2,00,000 towards the surgery itself and spent Rs.7,25,000/- for prosthetic leg, which needs regular replacement. Therefore, there is certainly a need

to compensate her for the pain, suffering and loss of future prospects, gainful employment, settlement and trauma and enable her to live her life with reasonable security and dignity. With due regard to the foregoing, we consider it appropriate to award a lumpsum compensation of Rs. 75 Lakhs to be paid jointly and severally by the OPs to the Complainants, within a period of one month from the date of this order. In the event of delay beyond one month, the OPs are also liable to pay simple interest @ 12% per annum on Rs.75 Lakhs till the date of final payment.

46. With due regard to the entire facts and circumstances of the case, the OPs are also directed to pay Rs. 50,000/- to the Complainants as costs of litigation.

47. With these directions, CC No. 2644 of 2017 is disposed of.

48. All pending Applications, if any, are also disposed of accordingly.

**……**
**(SUBHASH CHANDRA)**
**PRESIDING MEMBER**

**……**
**(AVM J. RAJENDRA AVSM VSM (Retd.))**
**MEMBER**

/Hitaishee