IN THE HIGH COURT OF ORISSA, CUTTACK

CRIMINAL REVISION NO. 758 of 2013

From the order dated 23.02.2013 of the S.D.J.M., Bolangir passed in G.R. Case No. 447 of 2013.

Dr. Subas Chandra Dash …… Petitioner

-Versus-

State of Orissa …… Opp. Party

For Petitioner: - Mr. Trilochan Nanda
K. Dash

For State of Odisha - Mr. Deepak Kumar Pani
Addl. Standing Counsel

P R E S E N T:

THE HONOURABLE MR. JUSTICE S.K. SAHOO

Date of Hearing: 19.12.2016 Date of Judgment: 27.02.2017

S. K. Sahoo, J. "We have not lost faith, but we have transferred it from God to medical profession."

- George Bernard Shaw

A common man treats the doctor as 'Dhanvantari'. He has tremendous amount of confidence on the doctor. The comforting and reassuring words of the doctor are very powerful and sometimes it creates miracle for the patients and strengthen

them to fight from within. That is why the doctors should shoulder their responsibility with all care and caution, rise to the occasion, believe in hard work and discipline and behave with all sensibility not thinking only of their Everestian interest of amassing huge wealth burying larger collective interest of common men which would strengthen the patient-doctor relationship.

The petitioner Dr. Subas Chandra Dash has filed this revision petition challenging the impugned order dated 23.02.2013 passed by the learned S.D.J.M., Bolangir in G.R. Case No. 447 of 2013 arising out of Bolagir Town P.S. Case No.170 of 2012 in taking cognizance of offence under section 304 Part-II of the Indian Penal Code and issuance of process against him.

2. One Susanta Kumar Thakur filed a complaint petition before the learned S.D.J.M., Bolangir on 11.05.2012 against the petitioner and another Dr. Narayan Thanapati, on the basis of which I.C.C. Case No.34 of 2012 was registered.

The prosecution case as per the complaint petition is that the complainant admitted his wife Rajeswari Thakur (hereafter 'the deceased') for delivery in Women's Care Nursing Home, Manoharpur on 24.03.2012 at about 8.00 a.m. which

belonged to the petitioner who after check up of the deceased told that she was in normal condition. The petitioner placed one tablet inside the vagina of the deceased as a result of which there was heavy vaginal watery discharge and she also felt severe pain. After some time, the petitioner gave one saline and injection and told that the deceased would be alright within fifteen minutes. Then the petitioner used hand gloves and though forceps tried to pull out the baby from the womb of the deceased, as a result of which there was profuse bleeding due to rupture of uterus. After sometime, the petitioner referred the deceased in a serious condition to District Headquarters Hospital, Bolangir by arranging one vehicle. It is the further case of the complainant that the health condition of the deceased deteriorated when she was admitted in the District Headquarters Hospital, Bolangir. The referral slip issued by the petitioner was produced by the complainant before Dr. Narayan Thanapati who was the gynaecologist in the said hospital. It is further stated that even at the Government Hospital, the deceased was not treated properly by Dr. Thanapati till 10.00 p.m. and for the negligent treatment of the petitioner and Dr. Thanapati, the deceased as well as the baby in the unborn condition died. Dr. Thanapati asked the complainant to take the dead body of the

deceased immediately from the hospital. The mental condition of the complainant was not good for which he took the dead body of his wife from the hospital to Sundargarh and with the help of the in-laws' family members of the complainant, the dead body was cremated.

3. The matter was reported in Town Police Station, Bolangir on 27.03.2012 but no action was taken for which the complaint petition was filed. The learned S.D.J.M., Bolangir sent the complaint petition to the Inspector in Charge, Town Police Station, Bolangir under section 156(3) of Cr.P.C. to treat it as F.I.R. and to investigate the case. Accordingly, Bolangir Town P.S. Case No.170 of 2012 was registered on 22.06.2012 under sections 304 and 201 of the Indian Penal Code against the petitioner and Dr. Narayan Tahanapati.

During course of investigation, the Investigating Officer examined the complainant, seized the original treatment papers of the deceased in the Nursing Home of the petitioner on different dates so also the sonography test report on the production by the complainant. The bed head ticket of the deceased regarding her admission at D.H.H., Bolangir and her treatment papers at D.H.H., Bolangir were also seized. The

investigating officer examined the witnesses and visited the Women's Care Nursing Home.

During examination of the witnesses, he found that the deceased Rajeswari Thakur was admitted in Women's Care Nursing Home of the petitioner on 24.03.2012 at 8.00 a.m. and then she was admitted at D.H.H., Bolangir on the same day at 7.30 p.m. in a critical condition with profuse bleeding due to rupture of uterus. The investigating officer sent requisition to the CDMO, D.H.H, Bolangir to form a team of doctors and to enquire regarding the alleged negligence in the treatment by the petitioner as well as Dr. Narayan Thanapati of D.H.H., Bolangir. The investigating officer seized the original certificate of registration under section 19(1) of PNDT Act,1994, renewal of registration to establish/maintain a clinical establishment valid from 28.04.2009 to 27.04.2011 in original, application for renewal of Women's Care Nursing Home, Manoharpur in original dated 17.02.2012, degree of M.D. (O & G), registration of M.B.B.S. and M.D. in original on production by the petitioner which were left in the zima of the petitioner under proper zimanama after keeping the xerox copy of the documents. The investigating officer received the enquiry report of CDMO, D.H.H., Bolangir wherein it is indicated Dr. Thanapati applied

adequate professional scheme and timely intervention in managing the patient and in spite of all possible treatment given by Dr. Thanapati, the deceased expired. However the team of doctors could not give any definite opinion regarding the role played by the petitioner in the treatment of the deceased and suggested for further investigation.

During course of investigation, after examining the witnesses and also verifying the documents, the investigating officer came to the conclusion that the deceased died due to the act of the petitioner who was the owner of Women's Care Nursing Home who though had no intention of causing death of the deceased but had sufficient knowledge that such bodily injury i.e. rupture of uterus caused due to pulling out the unborn baby forcefully by means of forceps was enough to accelerate the death and cause death in ordinary course of nature. It was further concluded that the petitioner was responsible for the death of the baby in the womb of the deceased since no proper remedies and treatment was given to pull out the baby from the mother's womb while alive. The investigating officer sent a query to CDMO, Bolangir regarding inquiry to be conducted by team of doctors as to whether there was adequate facility and infrastructure available for the treatment of such type of cases

as the deceased suffered. The query report was received which indicated that only normal delivery can be performed in the Women's Care Nursing Home. The investigating officer was of the opinion that the petitioner knowingly kept the deceased in the Nursing Home with assurance to the complainant for normal delivery. Despite repeated approach of the complainant, the petitioner did not advise him to take the deceased to D.H.H., Bolangir rather he pulled the unborn baby by means of forceps forcibly causing rupture of her uterus, as a result of which there was profuse bleeding and the condition of the deceased became serious and at the last moment, when the petitioner failed to make successful delivery, he arranged a vehicle and sent the deceased to D.H.H., Bolangir and such omission and commission of the petitioner in the treatment of the deceased resulted in her death along with the unborn baby.

After receipt of the order of the Superintendent of Police, Bolangir, charge sheet was submitted against the petitioner on 31.02.2013 under section 304 of the Indian Penal Code.

4. The learned Magistrate on a perusal of the chargesheet, case diary and other connected papers being prima facie satisfied regarding the commission of offence under section

304 Part-II of the Indian Penal Code, took cognizance of such offence and issued process against the petitioner which is impugned in the case.

5. Mr. Trilochan Nanda, learned counsel for the petitioner contended that the impugned order is illegal, unjust and improper and has been passed in a mechanical manner without application of mind. According to Mr. Nanda, on a bare perusal of the First Information Report, charge sheet, statements of the witnesses recorded under section 161 of Cr.P.C., inquiry report submitted by the CDMO, Bolangir and other materials available on record, no case under section 304 Part-II of the Indian Penal Code is made out and therefore, the impugned order of cognizance is not sustainable in the eye of law. It is further contended that the petitioner has been charge sheeted with an ulterior motive while another doctor i.e., Dr. Thanapati has been exonerated by the police. He further emphasized that when no post mortem has been conducted on the dead body of the deceased to ascertain the truth of the accusation, the prosecution case that the deceased suffered from internal injury and rupture of uterus at Women's Care Nursing Home cannot be accepted. He further contended that the CDMO, Bolangir along with a team of doctors enquired about the alleged negligence

and treatment by the petitioner which was conducted on the request of the Investigating Officer and the inquiry report revealed that the deceased was not admitted as an indoor patient in Women's Care Nursing Home rather the OPD register of the said Nursing Home revealed the name of the deceased in sl. No.477 dated 24.03.2012. It is contended that when the deceased was brought to the Nursing Home, she was diagnosed as a case of Abruptio Placentae causing concealed hemorrhage and the condition of the deceased was very low for which one vial of ceftriaxone injection was administered intravenously and she was referred to D.H.H., Bolangir. It is contended that unless this Court exercises its revisional jurisdiction and quash the impugned order, there would be miscarriage of justice. The learned counsel for the petitioner in support of his contention that there was no medical negligence, placed reliance in the cases of **Jacob Mathew -Vrs.- State of Punjab reported in (2005) 32 Orissa Criminal Reports (SC) 175**, **Dr. Suresh Gupta -Vrs.- N.C.T. of Delhi reported in (2004) 29 Orissa Criminal Reports (SC) 38**, **Mahadev Prasad Kaushik -Vrs.- State of U.P. reported in (2008) 41 Orissa Criminal Reports (SC) 825**, **A.S.V Narayanan Rao -Vrs.- Ratnamala and another reported in (2013) 56 Orissa Criminal**

Reports (SC) 789 and **Kusum Sharma -Vrs.- Batra Hospital and Medical Research Centre reported in A.I.R. 2010 S.C. 1050**.

6. Mr. Deepak Kumar Pani, learned Addl. Standing counsel on the other hand placed the 161 Cr.P.C. statements of the complainant Susanta Kumar Thakur and other witnessees so also of Dr. Narayan Thanapati. The learned counsel for the State further placed the enquiry report which indicates that the cause of death was shock and bleeding due to rupture of uterus. He placed the report of the CDMO, Bolangir which indicates that only normal delivery could have been performed in the Nursing Home of the petitioner. It is contended by the learned counsel that the statements of the complainant, Dr. Narayan Thanapati and other witnesses and the surrounding circumstances clearly indicates that there was an attempt to pull out the unborn baby from the womb of the deceased by using forceps for which there was rupture of uterus and heavy bleeding as reasonable care was not taken. The learned counsel for the State further submitted that the manner in which everything was done by the petitioner in his private Nursing Home clearly makes out the ingredients of offence and the points raised by the learned counsel for the petitioner can be taken note of during course of trial but not at

this stage and therefore, the revision petition should be dismissed.

7. There are certain undisputed facts which are as follows:-

(i) the petitioner was having degree of M.D. (Obstetrics and Gynecology).

(ii) Director of Medical Education and Training, Odisha, Bhubaneswar issued certificate of renewal of registration of the Nursing Home of the petitioner for a period of two years from 28.04.2011 to 27.04.2013 under the Odisha Clinical Establishments (Control and Regulation) Act, 1990 and Odisha Clinical Establishments (Control and Regulation) Rules, 1994 and Orissa Clinical Establishment (Control and Regulation) Amendment Rules, 2006.

(iii) the report of the Chief District Medical Officer, Bolangir dated 07.11.2012 indicates that only normal delivery can be performed in the Women's Care Nursing Home which was having only two beds.

(iv) the enquiry report of a team of doctors which was submitted by the CDMO, Bolangir before the Inspector in Charge, Town Police Station, Bolangir indicates that so far as the petitioner is concerned, there are contradictory statements of the

witnesses relating to time of attending the clinic and whether the patient was admitted as indoor patient or not, mode of treatment and nature of intervention given, times spent in the Nursing Home, type of bleeding (concealed or visible) and identification of the driver and vehicle used for transportation of patient and therefore, it was indicated that no definite opinion can be given regarding the role of the petitioner in the treatment of the deceased.

8. The learned counsel for the petitioner contended that the deceased was brought to the Nursing Home in the evening hours around 6.00 p.m. on 24.03.2012 and she was never treated as an indoor patient that would be clear from the OPD register and after one vial of ceftriaxone injection was administered intravenously, she was referred to D.H.H., Bolangir. The statements of the complainant Susanta Kumar Thakur and other witnesses on the other hand indicate that the deceased was in the hospital since morning at about 8.00 a.m. on 24.03.2012 and petitioner placed one tablet inside the vagina of the deceased at about 3.00 p.m. as a result of which there was heavy vaginal watery discharge and she also felt severe pain and at about 4.30 p.m., the petitioner gave one saline and injection to the deceased but the pain subsisted. It further

reveals that at about 6.45 p.m. again the petitioner checked the deceased using gloves and told that the deceased would be alright within fifteen minutes and at about 7.00 p.m. when the pain became unbearable, the petitioner told the complainant that he would pull out the baby by using forceps. Ten minutes thereafter, the deceased was taken to the labour room and inside the labour room, the petitioner forcibly tried to pull out the baby by forceps as a result of which there was severe bleeding and then the petitioner called a vehicle and asked the complainant to immediately shift the deceased to D.H.H., Bolangir.

Even though there is no documentary evidence relating to the indoor admission of the deceased in the Nursing Home and the O.P.D. register of the Nursing Home indicates that the deceased was diagnosed as G3P2 in labour with antepartum haemorrhage but in view of the consistent statements of the witnesses relating to the admission of the deceased since morning on 24.03.2012 and time to time treatment given in the Nursing Home till in the evening when he was referred to D.H.H., Bolangir, at this stage, basing on the documentary evidence, such statements cannot be discarded. Needless to say, the Trial Court has to appreciate the evidence at appropriate stage

without getting influenced by the observations of this Court, as they are prima facie.

It is the prosecution case that even though only normal delivery facility was available in the Women's Care Nursing Home and patient was diagnosed as G3P2 in labour with antepartum haemorrhage, the conduct of the petitioner in detaining such patient from the morning till evening and attempting for a forceps delivery is nothing but reflects a case of gross medical negligence on the part of the petitioner which ultimately took away the life of the deceased and the unborn child. The hazard taken by the petitioner, according to the prosecution was of such a nature that the death which resulted was most likely imminent. Though it is the contention of the learned counsel for the petitioner that there was no such attempt of forceps delivery in the Nursing Home but it is too early to accept such contentions at this stage in view of the available materials on record.

9. Let me first discuss the cases cited at the Bar on medical negligence by the learned counsel for the petitioner. In the case of **Jacob Mathew -Vrs.- State of Punjab reported in (2005) 32 Orissa Criminal Reports (SC) 175,** it is held as follows:-

"49. We sum up our conclusions as under:-

(1) Negligence is the breach of a duty caused by omission to do something which a reasonable man guided by those considerations which ordinarily regulate the conduct of human affairs would do, or doing something which a prudent and reasonable man would not do. The definition of negligence as given 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 omission amounting to negligence attributable to the person sued. The essential components of negligence are three: 'duty', 'breach' and 'resulting damage'.

(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 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 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.

(3) A professional may be held liable for negligence on one of the two findings: either he was not possessed of the requisite skill which he professed to have possessed, or, he did not exercise, with reasonable competence in the given case, the skill which he did possess. The standard to be applied for judging, whether the person charged has been negligent or not, would be that of an ordinary competent person exercising ordinary skill in that profession. It is not possible for every professional to possess the highest level of expertise or skills in that branch which he practices. A highly skilled professional may be possessed of better qualities, but that cannot be made the basis or the yardstick for judging the performance of the professional proceeded against on indictment of negligence.

(4) The test for determining medical negligence as laid down in **Bolam's case** (1957) 1 W.L.R. 582 holds good in its applicability in India.

(5) The jurisprudential concept of negligence differs in civil and criminal law. What may be negligence in civil law may not necessarily be negligence in criminal law. For negligence to

amount to an offence, the element of mens rea must be shown to exist. For an act to amount to criminal negligence, the degree of negligence should be much higher i.e. gross or of a very high degree. Negligence which is neither gross nor of a higher degree may provide a ground for action in civil law but cannot form the basis for prosecution.

(6) The word 'gross' has not been used in Section 304-A of IPC, yet it is settled that in criminal law, negligence or recklessness, to be so held, must be of such a high degree as to be 'gross'. The expression 'rash or negligent act' as occurring in Section 304-A of the IPC has to be read as qualified by the word 'grossly'.

(7) To prosecute a medical professional for negligence under criminal law, it must be shown that the accused did something or failed to do something which in the given facts and circumstances no medical professional in his ordinary senses and prudence would have done or failed to do. The hazard taken by the accused doctor should be of such a nature that the injury which resulted was most likely imminent.

(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.

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53. Statutory Rules or Executive Instructions incorporating certain guidelines need to be

framed and issued by the Government of India and/or the State Governments in consultation with the Medical Council of India. So long as it is not done, we propose to lay down certain guidelines for the future which should govern the prosecution of doctors for offences of which criminal rashness or criminal negligence is an ingredient. A private complaint may not be entertained unless the complainant has produced prima facie evidence before the Court in the form of a credible opinion given by another competent doctor to support the charge of rashness or negligence on the part of the accused doctor. The investigating officer should, before proceeding against the doctor accused of rash or negligent act or omission, obtain an independent and competent medical opinion preferably from a doctor in government service qualified in that branch of medical practice who can normally be expected to give an impartial and unbiased opinion applying **Bolam's test** to the facts collected in the investigation. A doctor accused of rashness or negligence, may not be arrested in a routine manner (simply because a charge has been leveled against him). Unless his arrest is necessary for furthering the investigation or for collecting evidence or unless the investigation officer feels satisfied that the doctor proceeded against would not make himself available to face the prosecution unless arrested, the arrest may be withheld."

In the case of **Dr. Suresh Gupta –Vrs.- N.C.T. of Delhi, reported in (2004) 29 Orissa Criminal Reports (SC) 38,** it is held as follows:-

"20. For fixing criminal liability on a doctor or surgeon, the standard of negligence required to be proved should be so high as can be described as "gross negligence" or "recklessness". It is not merely lack of necessary care, attention and skill. The decision of the House of Lords in **R. V. Adomako (Supra)** relied upon on behalf of the doctor elucidates the said legal position and contains following observations:-

"Thus a doctor cannot be held criminally responsible for patient's death unless his negligence or incompetence showed such disregard for life and safety of his patient as to amount to a crime against the State."

21. Thus, when a patient agrees to go for medical treatment or surgical operation, every careless act of the medical man cannot be termed as 'criminal'. It can be termed 'criminal' only when the medical men exhibits a gross lack of competence or inaction and wanton indifference to his patient's safety and which is found to have arisen from gross ignorance or gross negligence. Where a patient's death results merely from error of judgment or an accident, no criminal liability should be attached to it. Mere inadvertence or some degree of want of adequate care and caution might create civil liability but would not suffice to hold him criminally liable.

22. This approach of the courts in the matter of fixing criminal liability on the doctors, in the course of medical treatment given by them to their patients, is necessary so that the hazards of medical men in medical profession being exposed to civil liability, may not unreasonably extend to criminal liability and expose them to

risk of landing themselves in prison for alleged criminal negligence.

23. For every mishap or death during medical treatment, the medical man cannot be proceeded against for punishment. Criminal prosecutions of doctors without adequate medical opinion pointing to their guilt would be doing great disservice to the community at large because if the courts were to impose criminal liability on hospitals and doctors for everything that goes wrong, the doctors would be more worried about their own safety than giving all best treatment to their patients. This would lead to shaking the mutual confidence between the doctor and patient. Every mishap or misfortune in the hospital or clinic of a doctor is not a gross act of negligence to try him for an offence of culpable negligence.

24. No doubt in the present case, the patient was a young man with no history of any heart ailment. The operation to be performed for nasal deformity was not so complicated or serious. He was not accompanied even by his own wife during the operation. From the medical opinions produced by the prosecution, the cause of death is stated to be 'not introducing a cuffed endotracheal tube of proper size as to prevent aspiration of blood from the wound in the respiratory passage'. This act attributed to the doctor, even if accepted to be true, can be described as negligent act as there was lack of due care and precaution. For this act of negligence he may be liable in tort but his carelessness or want of due attention and skill cannot be described to be so reckless or grossly negligent as to make him criminally liable."

In the case of **Mahadev Prasad Kaushik -Vrs.- State of U.P. reported in (2008) 41 Orissa Criminal Reports (SC) 825,** it is held as follows:-

> "23. Plain reading of the above section makes it clear that it is in two parts. The first part of the section is generally referred to as "Section 304, Part I", whereas the second part as "Section 304, Part II". The first part applies where the accused causes bodily injury to the victim with intention to cause death; or with intention to cause such bodily injury as is likely to cause death. Part II, on the other hand, comes into play when death is caused by doing an act with knowledge that it is likely to cause death, but without any intention to cause death or to cause such bodily injury as is likely to cause death.
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> 26. Before Section 304 can be invoked, the following ingredients must be satisfied;
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> (i) the death of the person must have been caused;
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> (ii) such death must have been caused by the act of the accused by causing bodily injury;
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> (iii) there must be an intention on the part of the accused
> (a) to cause death; or
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> (b) to cause such bodily injury which is likely to cause death; (Part I) or
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> (iv) there must be knowledge on the part of the accused that the bodily injury is such that it is likely to cause death (Part II).

27. Section 304-A was inserted by the Indian Penal Code (Amendment) Act, 1870 (Act XXVII of 1870) and reads thus;

304-A. Causing death by negligence

Whoever causes the death of any person by doing any rash or negligent act not amounting to culpable homicide, shall be punished with imprisonment of either description for a term which may extend to two years, or with fine, or with both.

28. The section deals with homicidal death by rash or negligent act. It does not create a new offence. It is directed against the offences outside the range of Sections 299 and 300, IPC and covers those cases where death has been caused without `intention' or `knowledge'. The words "not amounting to culpable homicide" in the provision are significant and clearly convey that the section seeks to embrace those cases where there is neither intention to cause death, nor knowledge that the act done will in all probability result into death. It applies to acts which are rash or negligent and are directly the cause of death of another person.

29. There is thus distinction between Section 304 and Section 304-A. Section 304-A carves out cases where death is caused by doing a rash or negligent act which does not amount to culpable homicide not amounting to murder within the meaning of Section 299 or culpable homicide amounting to murder under Section 300, IPC. In other words, Section 304- A excludes all the ingredients of Section 299 as also of Section 300. Where intention or knowledge is the `motivating force' of the act complained of, Section 304-A will have to make room for the graver and more serious charge of

culpable homicide not amounting to murder or amounting to murder as the facts disclose. The section has application to those cases where there is neither intention to cause death nor knowledge that the act in all probability will cause death."

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46. On the facts of the case, ailment of Buddha Ram *prima facie* could not be said to be of such a serious nature which would result in death during his treatment. The allegation of the complainant which has been corroborated by statements of other eye-witnesses is that immediately after administration of three injections, the colour of the body of Buddha Ram turned into blue and within half an hour he died. If in the light of the above facts and circumstances, proceedings have been initiated against the appellant for an offence punishable under Section 304-A, IPC (though not under Section 304, IPC), it cannot be said that no such action could be taken. We are, therefore, of the view that submission on behalf of the learned Counsel for the complainant deserves to be accepted to the above extent."

In the case of **A.S.V. Narayanan Rao -Vrs.- Ratnamala and another, reported in (2013) 56 Orissa Criminal Reports (SC) 789,** it is held as follows:-

"12. From the final report submitted by the police in the instant case, it can be gathered that the records pertaining to the treatment given to the deceased were forwarded to the Andhra Pradesh Medical Council and also the Medical Council of India which opined that the "doctors seem to

have made an attempt to do their best as per records".

13. However, the High Court thought it fit to continue the prosecution of the Appellant for two reasons (1) that the Appellant chose to conduct the angioplasty without having a surgical standby unit and such failure resulted in delay of 5 hours in conducting by-pass after the angioplasty failed; and (2) that the Appellant did not consult a Cardio Anesthesian before conducting an angioplasty. According to the High Court, both the above-mentioned 'lapses' on the part of the Appellant "clearly show the negligence" of the Appellant.

14. The basis for such conclusion though not apparent from the judgment, we are told by the learned Counsel for the first Respondent, is to be found in the evidence of Dr. Surajit Dan given before the A.P. State Consumer Redressal Commission in C.D. No. 38 of 2004. It may also be mentioned here that apart from initiating criminal proceedings against the Appellant and Ors., the first Respondent also raised a consumer dispute against the Appellant and others. It is in the said proceedings, the above-mentioned Dr. Dan's evidence was recorded wherein Dr. Dan in his cross-examination stated as follows:

"...Whenever Cardiologist performs an angioplasty, he requests for the surgical team to be ready as standby. I was not put on standby in the instant case...."

He further stated;

"...The failure of angioplasty put the heart in a compromised position of poor coronary perfusion that increases the risk of the emergency surgery

after that. In a planned coronary surgery, the risk is less than in an emergency surgery...."

However, the same doctor also stated;

"...The time gap between the angioplasty failure and the surgery is not THE FACTOR for the death of the patient. The time gap may or may not be a factor for the enhancement of the risk."

15. Unfortunately, the last of the above extracted statements of Dr. Surajit Dan is not taken into account by the High Court which statement according to us is most crucial in the context of criminal prosecution of the Appellant.

16. The High Court unfortunately overlooked this factor. We, therefore, are of the opinion that the prosecution of the Appellant is uncalled for as pointed out by this Court in **Jacob Mathew case** (supra) that the negligence, if any, on the part of the Appellant cannot be said to be "gross". We, therefore, set aside the judgment under appeal and also the proceedings of the trial court dated 11.12.2006."

In the case of **Kusum Sharma -Vrs.- Batra Hospital and Medical Research Centre, reported in A.I.R. 2010 S.C. 1050,** it is held as follows:-

"91. To prosecute a medical professional for negligence under criminal law, it must be shown that the accused did something or failed to do something which in the given facts and circumstances no medical professional in his ordinary senses and prudence would have done or failed to do. The hazard taken by the accused doctor should be of such a nature that the injury which resulted was most likely imminent.

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94. On scrutiny of the leading cases of medical negligence both in our country and other countries specially United Kingdom, some basic principles emerge in dealing with the cases of medical negligence. While deciding whether the medical professional is guilty of medical negligence following well known principles must be kept in view:-

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

II. Negligence is an essential ingredient of the offence. The negligence to be established by the prosecution must be culpable or gross and not the negligence merely based upon an error of judgment.

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

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

V. In the realm of diagnosis and treatment, there is scope for genuine difference of opinion and one professional doctor is clearly not negligent merely because his conclusion differs from that of other professional doctor.

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

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

VIII. It would not be conducive to the efficiency of the medical profession if no doctor could administer medicine without a halter round his neck.

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

X. The medical practitioners at times also have to be saved from such a class of complainants who use criminal process as a tool for pressurizing the medical professionals/hospitals particularly private hospitals or clinics for extracting uncalled for compensation. Such malicious proceedings deserve to be discarded against the medical practitioners.

> XI. The medical professionals are entitled to get protection so long as they perform their duties with reasonable skill and competence and in the interest of the patients. The interest and welfare of the patients have to be paramount for the medical professionals.
>
> 95. In our considered view, the aforementioned principles must be kept in view while deciding the cases of medical negligence. We should not be understood to have held that doctors can never be prosecuted for medical negligence. As long as the doctors have performed their duties and exercised an ordinary degree of professional skill and competence, they cannot be held guilty of medical negligence. It is imperative that the doctors must be able to perform their professional duties with free mind."

10. The expression "cognizance" indicates the point when a Magistrate or a Court takes judicial notice of an offence. It is the condition precedent for the initiation of proceeding by the Magistrate. At the stage of taking cognizance, adequacy of evidence for supporting the conviction shall not be seen by the Court. The Magistrate should not enter into meticulous examination and shifting of evidence as a Trial Court. At this stage, Magistrate is not required to consider the defence version nor is he required to evaluate the merits of the materials or evidence of the prosecution. If the Magistrate is prima facie satisfied that an offence has been committed, he has to pass necessary orders in consonance with section 190 of Cr.P.C. At

the stage of taking cognizance and issuing summons, the allegations contained in the charge sheet are assumed to be true unless the allegations are patently absurd and inherently improbable.

11. The petitioner was having degree of M.D. (Obstetrics and Gynaecology) and therefore, it can be presumed that there was no lack of competence to handle the case of the deceased. The records indicate that Director of Medical Education and Training, Odisha, Bhubaneswar has issued certificate of renewal of registration of the Women's Care Nursing Home which was valid at the time of occurrence. The report of the C.D.M.O., Bolangir indicates that Odisha Pollution Control Board had issued the certificate to keep four beds in the Nursing Home of the petitioner where there were only two beds. The report further indicates that normal delivery can be performed in the Nursing Home. The OPD register of the Nursing Home indicates that patient was diagnosed as G3P2 in labour with 'antepartum haemorrhage'.

What is G3P2 in labour? In medical science, gravidity is defined as the number of times that a woman has been pregnant and parity is defined as the number of times that she has given birth to a fetus with a gestational age of 24 weeks

or more, regardless of whether the child was born alive or was stillborn. For example, a woman who is described as 'gravida 2 para 2' (sometimes abbreviated to G2P2) has had two pregnancies and two deliveries after 24 weeks, and a woman who is described as 'gravida 2 para 0' (G2P0) has had two pregnancies, neither of which survived to a gestational age of 24 weeks. If they are both currently pregnant again, these women would have the obstetric resume of G3P2 and G3P0 respectively.

According to medical science, 'antepartum haemorrhage' is defined as bleeding from genital tract after 20 weeks of pregnancy and before completion of second stage of labour. It is a major cause of maternal morbidity, mortality and perinatal loss. Clinical presentation varies depending on the severity of blood loss and cause of bleeding. In mild haemorrhage, there may be no maternal or foetal compromise, while massive haemorrhage can lead to hypovolemic shock, coagulation failure, renal failure, foetal distress and may result in maternal and foetal death. All the patients of antepartum haemorrhage should be hospitalised in a well equipped centre with facilities for blood transfusion, emergency caesarean section and neonatal care unit.

If the placenta is introduced in the normal position in the superior part of the uterus, bleeding caused by premature separation is called accidental haemorrhage that can happen from pregnancy induced hypertension (high blood pressure) or appear for no apparent reason. If bleeding is moderate, there is no danger to the mother, but even a little amount can decrease the supply of oxygen and nutrients to the foetus.

An antepartum haemorrhage may precipitate into one of three main categories. Placenta praevia is a condition in which the placenta, alternatively of being linked to the upper part of the uterus, is touched to the lower part in the region of the lesser uterine segment or the cervix.

Accidental antepartum haemorrhage (abruption placentae) is a comparatively infrequent condition in which the placenta is commonly implanted in the upper part of the uterus but separate from it prematurely and generally results in vaginal bleeding.

Placental abruption (abruptio placentae) is an uncommon yet serious complication of pregnancy. The placenta is a structure that develops in the uterus during pregnancy to nourish the growing baby. If the placenta peels away from the inner wall of the uterus before delivery either partially or

completely, it is known as placental abruption. Placental abruption can deprive the baby of oxygen and nutrients and cause heavy bleeding in the mother. Placental abruption often happens suddenly. Left untreated, placental abruption puts both mother and baby in jeopardy.

Treatment depends on the severity of the separation, location of the separation and the age of the pregnancy. There can be a partial separation or a complete (also called a total*)* separation that occurs. There can also be different degrees of each of these which will impact the type of treatment recommended. In the case of a partial separation, bed rest and close monitoring may be prescribed if the pregnancy has not reached maturity. In some cases, transfusions and other emergency treatment may be needed as well. In a case with total or complete separation, delivery is often the safest course of action. If the fetus is stable, vaginal delivery may be an option. If the fetus is in distress or the mom is experiencing severe bleeding, then a caesarean delivery would be necessary. There is no treatment that can stop the placenta from detaching and there is no way to reattach it. Any type of placental abruption can lead to premature birth and low birth weight. In

cases where severe placental abruption occurs, approximately 15% will end in fetal death.

Incidental antepartum haemorrhage is a haemorrhage which appears from the venereal tract but not from the site of the placenta or its implantation. Such haemorrhage may produce from injury, infection, ulcers on the neck of the womb, polyps or, most normally, the onset of labour.

12. It is the prosecution case, even though only facility for normal delivery was available in the Nursing Home, the petitioner attempted a forceps delivery.

According to the medical science, a forceps delivery is a type of assisted vaginal delivery. It is sometimes needed in the course of vaginal childbirth. An assisted birth is necessary when the baby needs help to be born with instruments that attach to his head. It is also called an instrumental or operative vaginal birth. Assisted births are often needed when labour has been long and tiring. If the doctor thinks that an assisted birth is possible, but could be difficult, the patient will be moved to the operating theatre. This is in a case where caesarean is needed. Assisted birth is less likely to be successful if the body mass index (BMI) of the patient is over 30 or the baby is large or the baby is lying back to back or the baby's head is not low down in

the birth canal. A forceps delivery might be considered if the labour meets certain criteria i.e. the cervix is fully dilated, the membranes have ruptured and the baby has descended into the birth canal head first, but the patient is not able to push the baby out. Prerequisites for forceps delivery include that the clinical assessment of pelvic capacity should be performed. No disproportion should be suspected between the size of the head and the size of pelvic inlet and mid pelvis. The patient must have adequate analgesia. Adequate facilities and supportive elements should be available. The operator should be competent in the use of the instruments and recognition and management of potential complications. Forceps delivery has some benefits for a fetus. It can be used to quickly deliver a baby in distress, often preventing potential asphyxiation and brain damage, although both may still occur. Negative fetal effects from forceps use include possible facial bruising, lacerations, intracranial haemorrhage and skull fracture. In rare cases, death of the fetus can occur. Temporary facial nerve paralysis, with drooping noted on one side of the face, usually resolves within a few weeks. Use of forceps can cause cervical and vaginal lacerations and may extend an episiotomy or tear into the anus and rectum. If the bladder is not emptied with a catheter, damage to the bladder

may also occur. Infection, haemorrhage requiring transfusions, uterine lacerations and injury to the pelvic nerve are also possible complications. A forceps delivery is only appropriate in a birthing centre or hospital where a caesarean section can be done, if needed.

13. The enquiry report reveals that if the statements of the complainant and witnesses produced by him are to be believed then there was visible bleeding when the patient was referred from the Nursing Home to the D.H.H., Bolangir and therefore, the possibility of rupture of uterus of the deceased at the Nursing Home cannot be ruled out. The statements of Saroj Mohanty and Dillip Thakur who accompanied the complainant and the deceased to the Nursing Home indicate about severe bleeding from the vagina of the deceased after the attempt of forceps delivery by the petitioner. The statements of Rintu @ Rashmin Thakur who arrived at the Nursing Home at about 5 p.m. on the date of occurrence and Sadananda Gahir, the driver of the Bolero vehicle also indicate about such severe bleeding. The statement of Dr. Narayan Thanapati who treated the deceased at D.H.H., Bolangir also indicate there was rupture of uterus of the deceased when she was brought from the Nursing Home of the petitioner and there was risk to the lives of the

deceased and unborn baby. The statement of Chanchala Sahu who also delivered a child on that day in the Nursing Home indicates about the admission of the deceased in the Nursing Home at about 8 a.m. The enquiry report further indicates that the only option available to control the bleeding was laparotomy (surgical opening of abdomen) and repair of rupture/ subtotal hysterectomy which is a major surgical procedure and could not be undertaken even at D.H.H., Bolangir due to critically low condition of the patient.

It prima facie appears as per the report of CDMO, Bolangir that only normal delivery facilities were available in the Women's Care Nursing Home. The deceased was diagnosed as G3P2 in labour with 'antepartum haemorrhage'. According to medical science, patient of 'antepartum haemorrhage' should be hospitalised in a well equipped centre with facilities for blood transfusion, emergency caesarean section and neonatal care unit. Being a gynaecologist, the petitioner must be aware about nature of treatment to be provided to such patient and the consequence likely to follow if the safeguards are not properly taken. Even if no such facilities to deal with such patient was available in the Nursing Home, the petitioner did not advise the complainant to take the deceased to D.H.H., Bolangir rather

assured the complainant that the deceased was in normal condition. When there was heavy vaginal watery discharge after the petitioner inserted one tablet inside the vagina of the deceased and she felt severe pain, the petitioner gave one saline and injection and told the complainant that the deceased would be alright within fifteen minutes. Thus prima facie materials are available on record to show that the petitioner knowingly kept the deceased in the Nursing Home with assurance to the complainant for normal delivery even though he was aware that it was a critical case and there are no such facilities in the Nursing Home to deal with such case. The attempt of forceps delivery appears to have caused rupture of her uterus, as a result of which there was profuse bleeding and the condition of the deceased became serious. The forceps delivery was not appropriate in a birthing centre like the Nursing Home of the petitioner where a caesarean section could not have been done, if needed. It was not an unforeseen injurious occurrence which could not be reasonably anticipated but creation of a substantial and unjustifiable risk of harm to the deceased by a conscious disregard for that risk. Therefore, it is prima facie apparent that the petitioner did such a high degree of negligence while dealing with the case of the deceased which in the facts and

circumstances no medical professional in his ordinary senses and prudence would have done. The hazard taken by the petitioner was of such a nature that the rupture of the uterus and severe bleeding and risk to the lives of the mother and the unborn baby was most likely imminent. The petitioner prima facie appears to have not exercised the skill with reasonable competence and did not adopt the practice acceptable to the medical profession of that day. As a doctor, it was the duty of the petitioner to explain the deceased or at least the complainant, chances of success and the risk of failure of the suggested treatment and inform them about the foreseeable risks and possible negative effects of the treatment keeping in mind the patient's specific condition. The independent and competent medical opinion given by the team of doctors, the statements of the witnesses and the other surrounding circumstances raise accusing fingers at the petitioner which is not at all healthy sign for medical profession.

In order to attract the ingredients of offence under section 304 Part II of the Indian Penal Code, there must be commission of culpable homicide not amounting to murder i.e. the death of the person must have been caused, such death must have been caused by the act of the accused by causing bodily injury and there must be knowledge on the part of the

accused, but without any intention that the bodily injury is such that it is likely to cause death. To constitute the offence of 'culpable homicide' as defined in section 299 of the Indian Penal Code, the death must be caused by doing an act: (a) with the intention of causing death, or (b) with the intention of causing such bodily injury as is likely to cause death, or (c) with the knowledge that the doer is likely by such act to cause death.

Section 304-A of the Indian Penal Code on the other hand carves out a specific offence where death is caused by doing a rash or negligent act and that act does not amount to culpable homicide under section 299 Indian Penal Code or murder under section 300 Indian Penal Code. Where the intention to kill a person or knowledge that doing of an act was likely to cause a person's death are there, section 304-A of the Indian Penal Code has to make room for the graver and more serious charge of culpable homicide. Negligence and rashness are essential elements under section 304-A of the Indian Penal Code. In other words, the applicability of section 304-A of the Indian Penal Code is limited to rash or negligent acts which cause death but fall short of culpable homicide amounting to murder or culpable homicide not amounting to murder.

In case of **Alister Anthony Pareira -Vrs.- State of Maharashtra reported in (2012) 2 Supreme Court Cases 648**, it is held as follows:-

> "47. Each case obviously has to be decided on its own facts. In a case where negligence or rashness is the cause of death and nothing more, Section 304-A may be attracted but where the rash or negligent act is preceded with the knowledge that such act is likely to cause death, Section 304 Part II IPC may be attracted and if such a rash and negligent act is preceded by real intention on the part of the wrongdoer to cause death, offence may be punishable under Section 302 IPC."

14. Thus, looking to the matter from all angles, I have no doubt in my mind that knowledge cannot be attributed to petitioner that his act might cause such bodily injuries which may, in ordinary course of nature, be sufficient to cause death Thus, in my opinion, there are no prima facie materials for commission of an offence under section 304 Part II of the Indian Penal Code. However, there are sufficient materials to proceed against the petitioner under section 304-A of the Indian Penal Code as due to his rash or negligent acts, death of the deceased was caused which falls short of culpable homicide not amounting to murder.

15. Accordingly, the impugned order of taking cognizance of offence under section 304 Part-II of the Indian Penal Code by the learned S.D.J.M., Bolangir in G.R. Case No. 447 of 2013 stands quashed, instead the learned S.D.J.M., Bolangir is directed to proceed against the petitioner under section 304-A of the Indian Penal Code.

It is made clear that the observation of this Court that there are sufficient materials to proceed against the petitioner under section 304-A of the Indian Penal Code is confined to the stage of cognizance. The learned Trial Court is however free to assess the evidence which would come on record during trial and decide the guilt or otherwise of the petitioner of such charge while pronouncing the judgment.

With the aforesaid observations and directions, the criminal revision petition is disposed of.

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S. K. Sahoo, J.

Orissa High Court, Cuttack
The 27th February, 2017/Sisir