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IN THE SUPREME COURT OF INDIA
CIVIL APPELLATE JURISDICTION
SANJAY KUMAR; J., SATISH CHANDRA SHARMA; J.
CIVIL APPEAL NO. 1662 OF 2016; September 9, 2025
Deep Nursing Home and another *versus* **Manmeet Singh Mattewal and others**

Medical Negligence – Held, National Consumer Disputes Redressal Commission (NCDRC) overstepped its jurisdiction by creating a new case that was not based on original complaint - Complainant had not alleged any deficiency in antenatal care, rather, he had asserted that tests were prescribed and undergone - A decision must be based on the case pleaded and that a party cannot travel beyond its pleadings - Multiple medical boards, constituted at the request of the complaint, had reviewed the case and found no 'gross medical negligence' in the management of the patient by the treating doctors - The doctor cannot be held liable for an unfavourable outcome without strong evidence of negligence, and that Courts and Consumer Forums should not substitute their own views for those of medical specialists - Appeal allowed and directed complainant to return Rs. 10 lakhs. *[Relied on Jacob Mathew v. State of Punjab 2005 6 SCC 1; Martin F. D' Souza v. Mohd. Ishfaq 2009 3 SCC 1; Paras 23-30]*

For Appellant(s): Mr. Paramjit Singh Patwalia, Sr. Adv. Mrs. Kawaljit Kochar, Sr. Adv. Mr. Deepanshu, Adv. Mr. Utkarsh Vats, Adv. Mr. Shivam Jasra, Adv. Ms. Deveshi Chand, Adv. Mr. Drouhn Garg, Adv. Mr. Rajivkumar, AOR.

For Respondent(s): Mr. Satinder Gulati, Adv. Mr. Raj Kishor Choudhary, AOR Mr. Mohit Gupta, Adv. Ms. Meera Mathur, AOR Dr. Sushil Kumar Gupta, Adv. Mrs. Sunita Gupta, Adv. Mr. Manan Verma, AOR Mr. Shubham Arora, Adv. Mr. Sumit Kumar, Adv. Ms. Ipshita Gupta, Adv.

J U D G M E N T

SANJAY KUMAR, J

Manmeet Singh Mattewal, respondent No. 1, lost his wife, Charanpreet Kaur, and his newborn son within the span of a few hours. Shiraz Mattewal, respondent No.2, is his older son. Our sympathies aside, we are called upon to examine the validity of the finding that Dr. (Mrs.) Kanwarjit Kochhar, appellant No.2, the Obstetrician/ Gynaecologist who conducted the delivery is guilty of medical negligence and deficiency in service. By judgment dated 31.01.2007 in Complaint Case No. 56 of 2006, the State Consumer Disputes Redressal Commission, Union Territory, Chandigarh[1], had found her and Deep Nursing Home, Chandigarh, appellant No.1, medically negligent on the ground that they did not exercise due care and caution in treating Charanpreet Kaur but held that there was no fault on their part insofar as the death of the newborn child was concerned. The SCDRC directed them to pay ₹20,26,000/- to the complainants, Manmeet Singh Mattewal and Shiraz Mattewal. However, as they were covered by the insurance policy issued by New India Assurance Company Limited, respondent No. 3 herein, the company was directed to pay ₹20,00,000/- and the balance was directed to be paid by them. Interest @ 9 % was awarded if the amount was not paid in one month. Costs of ₹10,000/- were also awarded.

2. Deep Nursing Home, Chandigarh, and Dr. Kanwarjit Kochhar filed First Appeal No. 158 of 2007 before the National Consumer Disputes Redressal Commission, New Delhi[2], assailing the SCDRC's judgment. First Appeal No. 193 of 2007 was filed separately by

[1]for short, 'the SCDRC'
[2]for short, 'the NCDRC'

New India Assurance Company Limited. However, by order dated 09.05.2012, the NCDRC dismissed both appeals. Therein, the NCDRC came to the conclusion that no liability would attach to Deep Nursing Home, Chandigarh, and pinned the entire responsibility of paying ₹20,26,000/upon Dr. Kanwarjit Kochhar. As ₹6,00,000/- had already been deposited pursuant to its order dated 12.04.2007 and was withdrawn by Manmeet Singh Mattewal, the NCDRC directed her to pay the balance sum of ₹14,26,000/- in 6 weeks along with costs of ₹14,000/-. In the passing, we may note that the NCDRC reserved judgment in the appeals on 27.07.2010 but the order was pronounced by it nearly two years later, on 09.05.2012!

3. Despite the clean chit given to it by the NCDRC, Deep Nursing Home, Chandigarh, joined Dr. Kanwarjit Kochhar in filing the special leave petition from which the present appeal arises. By order dated 10.02.2014, this Court directed a further sum of ₹4,00,000/- to be paid to Manmeet Singh Mattewal and Shiraz Mattewal, respondent Nos. 1 and 2 herein. Leave was granted by this Court on 15.02.2016.

4. At the outset we may note that, in ***Universal Sompo General Insurance Co. Ltd. vs. Suresh Chand Jain and another***[3], this Court affirmed that a special leave petition under Article 136 of the Constitution is not the proper remedy against an appellate order passed by the NCDRC. However, as this matter was entertained and has been pending on the file of this Court for over twelve years, we do not think it proper to relegate the appellants at this late stage to the alternative remedy under Article 226 of the Constitution before the jurisdictional High Court.

5. We may now note the contents of Complaint Case No. 56 of 2006 filed before the SCDRC: Charanpreet Kaur, a co-operative bank manager on deputation as a lecturer in the Punjab Institute of Cooperative Training, was aged about 32 years and was earning a monthly salary of ₹25,682/-. She was in the 8th month of her pregnancy when she started consulting Dr. Kanwarjit Kochhar of Deep Nursing Home, Chandigarh. According to the complaint case, she visited the nursing home several times and also underwent the tests prescribed from time to time. Photocopies of the ultrasound tests done on 08.08.2005, 11.11.2005 and 16.12.2005 were filed in this regard. It was stated that the couple visited the nursing home on 10.11.2005, 29.11.2005 and 09.12.2005 for check-ups and were assured that all was well and that it would be a normal delivery. A copy of the prescription dated 10.11.2005, with entries, was also filed. Charanpreet Kaur was admitted on 21.12.2005 at about 11.00 AM for delivery. However, the newborn child died instantly after birth, which took place at 02.00 AM on the next day. It was alleged that the nursing home was 'inadequately and ill equipped' to handle emergencies during deliveries and there were no facilities available in that regard.

6. According to the averments made, the mother was informed about the death of the newborn child which resulted in her going into shock and caused profuse bleeding. It was alleged that no blood was readily available in the nursing home for transfusion and the delay in shifting her to the Post Graduate Institute of Medical Education and Research, Chandigarh[4], at 05.30 AM resulted in her being declared 'brought dead' on arrival. It was further alleged that the staff of Deep Nursing Home did not bring any reference papers or history sheet to facilitate her treatment at the PGI. The van in which she was taken was also ill-equipped and it was claimed that no doctor accompanied her in the said van. It was alleged that Dr. GS Kochhar, the husband of Dr. Kanwarjit Kochhar, who represented

[3](2024) 9 SCC 148
[4]for short, 'the PGI'

Deep Nursing Home, Chandigarh, chose to follow the van in his car separately and, therefore, there was no qualified doctor in the van.

7. Thus, the specific allegations levelled against the nursing home and the doctor were that the nursing home was not equipped to handle emergencies and complications during deliveries; the record of the treatment was fabricated later to escape prosecution; the blood group of Charanpreet Kaur was not checked and this led to delay in blood transfusions; the death of the newborn child was also due to negligence; there was negligence in causing trauma to Charanpreet Kaur by informing her of the death of the newborn which resulted in shock and bleeding; and the nursing home had no stock of blood readily available for transfusion. The complainants sought compensation of ₹95,21,000/- along with interest @ 18% per annum, medical expenses of ₹10,000/- and litigation expenses of ₹11,000/-. This complaint case was filed on 11.05.2006.

8. A lengthy written statement was filed by the opposite parties, *viz*., Deep Nursing Home and Dr. Kanwarjit Kochhar. Therein, they pointed out that Manmeet Singh Mattewal had earlier reported the matter to the Senior Superintendent of Police, Chandigarh, and an enquiry was conducted by a Medical Board, consisting of experts, to ascertain whether there was any medical negligence and the Board had negated the same. It was stated that Charanpreet Kaur had suffered atonic Post Partum Haemorrhage[5] which proved to be catastrophic as she did not respond to the treatment administered in the nursing home. It was stated that PPH is a failure of the uterus to properly contract after the child is born resulting in bleeding within the uterus, which cannot be controlled. It was asserted that proper treatment was given as per protocol but despite the same, she did not respond and ultimately died. Details were given of the experience and expertise of Dr. Kanwarjit Kochhar and the well-equipped status of the nursing home. It was stated that Dr. GS Kochhar, who ran the nursing home, was a renowned anaesthetist. Charanpreet Kaur was stated to have come to the nursing home on 10.11.2005 along with her mother and another person. Her date of delivery was approximated to be around 02.01.2006. As she wanted to have her delivery at the nursing home with Dr. Kanwarjit Kochhar, she was advised to continue with the intake of Iron and Calcium. It was stated that Charanpreet Kaur did not show the reports of her earlier check-ups, despite being asked by Dr. Kanwarjit Kochhar, and neither did she show records of her previous delivery. It was further stated that Dr. Kanwarjit Kochhar came to know from the hushed tones of Charanpreet Kaur that there was some problem in the delivery of the first child, but this was not divulged to her. She claimed that she later came to know that the first child was autistic, but this was also not disclosed to her. She asserted that, had this fact come to her knowledge earlier, she might have refused to undertake the delivery, as there were more chances of the second child having congenital abnormalities if the first child had them.

9. The written statement then went on to state as follows: Charanpreet Kaur's check-ups were on 29.11.2005 and 09.12.2005. As per their advice, Charanpreet Kaur had informed them that she had consulted a cardiologist but she did not show any report thereof. Again, on 16.12.2005, Charanpreet Kaur came for a routine check-up and was advised to continue with her earlier medication. On 21.12.2005, at about 11.00 AM, Charanpreet Kaur was admitted in the nursing home as she was suffering from back pain, but she was not in labour. Labour was induced and she was making good progress. At about 01.00 AM on 22.12.2005, she was having strong contractions. Dr. RP Bansal, a qualified paediatrician, was present with the patient from 02.15 AM onwards. The delivery

[5] for short, 'PPH'

took place at 02.40 AM, but the newborn child did not cry. The baby was handed over to the paediatrician for resuscitation and oxygen was administered through a nasal tube. However, all efforts to save the baby failed and he was declared dead at 03.10 AM. The mother was not informed about the death of the baby. The near relations were informed about it and were advised to get an autopsy done to ascertain the exact cause of death of the child. However, they refused to do so.

10. Details were furnished of the treatment given to Charanpreet Kaur post-delivery and it was stated that there were no placental tissue or membranes in her uterus. The cervix was also examined and no tear was found. However, as there was still bleeding, her relations were asked to secure two units of blood from the blood bank in Sector 37, Chandigarh. Dr. GS Kochhar telephonically informed the blood bank to keep the same ready without delay. Transfusion was commenced at about 04.15 AM. Owing to the complications which had arisen, two more doctors, *viz*., a senior Gynaecologist and a General Surgeon were contacted, and they reached the nursing home at 04.00 AM. All the doctors present conducted a thorough examination and opined that the patient was suffering from uterine inertia PPH and it was decided that she should be sent to the PGI. The staff of the septic labour room at the PGI were informed in advance to be ready to receive and treat her. She was shifted in an ambulance with running blood transfusion and an Ambu bag (oxygen). Two staff nurses from the nursing home accompanied her while Dr. GS Kochhar went there in his own car. He personally took the patient on a stretcher to the septic labour room. On his request, completion of the other formalities prior to admission were kept on hold. During the journey, the patient suffered a bout of bleeding and was in deep shock. After reaching the PGI, she was examined but no pulse and heart beat were palpable. Despite resuscitative measures, she did not survive. The patient developed uterine inertia PPH which is a disorder with poor prognosis and high mortality. Uterine Artery Embolization facility was available only in the PGI in the whole of North India. The blood group of Charanpreet Kaur was checked and the same was written on the prescription dated 10.11.2005 itself, which had been filed with the complaint. It was denied that the nursing home was illequipped to handle emergencies during deliveries. It was asserted that there was no delay in shifting the patient to the PGI.

11. No rejoinder was filed by the complainants to the above written statement.

12. The SCDRC, *vide* its judgment dated 31.01.2007, found fault with Dr. Kanwarjit Kochhar for not getting Charanpreet Kaur's blood group identified at the time of delivery and in arranging for transfusion by keeping blood supply ready. Reference was made to a textbook on Obstetrics and Gynaecology by the SCDRC and it was opined that, in a case of PPH, excessive bleeding after child birth is the single largest cause of maternal deaths worldwide. The SCDRC came to the conclusion that the nursing home and Dr. Kanwarjit Kochhar wasted almost two hours in getting blood and cross-matching it and this led to deterioration of the patient's condition. Examining the averments in the written statement, the SCDRC found fault with Dr. GS Kochhar for not accompanying the patient in the ambulance to the PGI. The SCDRC went to the extent of doubting his very presence there. The conclusion drawn by the SCDRC was that Charanpreet Kaur was already dead when she was taken to the PGI and this was done only to dump her dead body there. The affidavit filed by Dr. GS Kochhar was held to be a false and fabricated document and the SCDRC categorically recorded a finding that he did not go to the PGI. Reference was made to the Report dated 18.08.2006 of the Medical Board at Government Medical College and Hospital, Sector 32, Chandigarh, which opined that 'there did not appear any gross medical negligence in the management of the patient by the treating doctors' but

the same was discarded on the ground that it was a short report without reasons for recording such a finding. The SCDRC held that it was certainly a case of negligence on the part of the nursing home and Dr. Kanwarjit Kochhar and they had failed to exercise due care and caution in treating Charanpreet Kaur, even if it was presumed that there was no fault on their part insofar as the death of the child was concerned. The SCDRC, accordingly, directed payment of compensation as stated hereinabove.

13. In appeal, as demonstrated by the impugned order, the NCDRC observed that Charanpreet Kaur's death was investigated quite thoroughly by successive Medical Boards, appointed specifically for that purpose on complaints of gross negligence made by Manmeet Singh Mattewal to various authorities of the State Government. Before the NCDRC, it was stated on behalf of the appellants that the delivery was complete only at about 03.00 AM after the patient expelled the placenta. It was contended that in a normal delivery, as was the case here, the uterus would gradually contract on its own after the delivery and the bleeding would stop but, in this case, the uterus did not contract fully and went into a phase of relaxation after the initial contraction. It was stated that, the unusual nature of the bleeding could be known only after it was verified that it was not from any tear in the vagina or the cervix or from the site of the episiotomy and all this took some time, as detailed in the medical record. It could be concluded only around 03.15 AM that the uterus had not contracted. It was pointed out that, in the course of a normal delivery, units of blood are not kept ready for transfusion and, therefore, the assumption of the SCDRC, that there was delay and that the time taken to get the blood was two hours, was factually incorrect. It was asserted that the patient's medical record showed that the transfusion was started in less than an hour of the diagnosis of the possible cause of bleeding, i.e., atonic uterus. It was also pointed out that the SCDRC's conclusion that the patient's blood group was not recorded was erroneous. The first page of the medical record showed that the patient's blood group was noted right at the beginning but before starting blood transfusion, every unit of blood has to be necessarily cross-matched with that of the patient, and this was done in the present case also. It was asserted that there was no delay in shifting the patient to the PGI and that all possible care was taken during that process. She was accompanied by two nurses from the nursing home with a unit of blood being transfused simultaneously on each arm along with oxygen supply. Dr. GS Kochhar preceded the van in his car to ensure that there was no delay in taking her to the septic labour room. It was pointed out that five Medical Boards had examined the case record and concluded that, neither in dealing with the newborn's asphyxia nor in treating the mother for the sudden complication of atonic PPH, Dr. Kanwarjit Kochhar had committed any act of medical negligence. All the experts who constituted these Boards found that there was no negligence on her part or on the part of the nursing home.

14. The NCDRC dealt with each of the Medical Board Reports in turn, *viz*., the first Report dated 23.01.2006 by a Board of four doctors from the Government Hospital, Sector 16, Chandigarh; the second Report dated 20.03.2006 of a Board of five doctors from the Government Medical College and Hospital, Sector 32, Chandigarh; the third Report dated 03.04.2006 of the reconstituted Committee of four doctors from the Government Medical College and Hospital, Sector 32, Chandigarh; and the fourth Report dated 18.08.2006 of a Committee of seven doctors constituted under the Chairmanship of the Director, Health Services, Union Territory, Chandigarh. The undated fifth and final Report of four doctors was also from the Government Medical College and Hospital, Sector 32, Chandigarh, but it was not taken note of by the NCDRC.

15. The NCDRC, thereupon, looked into medical literature and copiously extracted from such literature in its order. It noted that Charanpreet Kaur was under the medical care of Dr. Kanwarjit Kochhar from the 32nd week of her pregnancy through childbirth. It was noted that she had gone to some other Obstetrician during the earlier part of her second pregnancy. Noting the claim made by Dr. Kanwarjit Kochhar that she was not told details of the delivery of the first child but her suspicion that there was some problem therewith, the NCDRC observed that it was the minimum professional requirement for her to have gathered such information. The NCDRC also found fault with the medical record maintained by the nursing home after Charanpreet Kaur's first visit. It was noted that Dr. Kanwarjit Kochhar had claimed that the prior medical record was not given to her and the NCDRC opined that she had failed to ascertain information which had crucial implications, i.e., with regard to Charanpreet Kaur's haematological status. We may observe, at this stage, that the NCDRC seems to have visualized itself in the role of a medical professional and expressed purported expert opinions on how Dr. Kanwarjit Kochhar ought to have acted as an Obstetrician when Charanpreet Kaur came to her initially and as to how she should have gone about prescribing tests!

16. In effect, the NCDRC opined that, though all the Medical Boards had opined that there did not appear to be any gross medical negligence in the management of the patient by the treating doctors after the delivery, the same did not mean that there was no medical negligence before the delivery. As per the NCDRC, there were several instances of departure from standard protocols in the antenatal care of the patient on the part of Dr. Kanwarjit Kochhar as she failed to insist on the patient getting standard haematological investigations done. According to the NCDRC, no case of tortious medical negligence was made out against Dr. Kanwarjit Kochhar in handling Charanpreet Kaur's labour, including the delivery, the management of the baby, the baby's problem and the post-delivery management at the nursing home, but there was enough evidence as well as expert opinion to hold that antenatal management of Charanpreet Kaur by Dr. Kanwarjit Kochhar, particularly, in respect of necessary haematological and cardiological investigations, was not in accordance with the standard protocols that an Obstetrician of average skill would adopt. It further held that no case of medical negligence/ deficiency in service was made out against the nursing home as there was nothing in the Medical Boards' Reports on this aspect and the complainants did not lead any reliable evidence in support of their allegations in this regard. The NCDRC, therefore, concluded that no liability could attach to the nursing home. The NCDRC noted that, pursuant to its direction on 12.04.2007, Manmeet Singh Mattewal had withdrawn ₹6,00,000/- deposited by the nursing home and the insurance company and directed that the balance amount due be paid by Dr. Kanwarjit Kochhar.

17. It would be apposite at this stage to note the contents of the Medical Boards/Committees' Reports. The first Report dated 23.01.2006 was furnished by the Board of doctors from Government Hospital, Sector 16, Chandigarh. This Board comprised Dr. Rupinder Kaur, Dr. Vidhu Bhasin and Dr. N.K. Kaushal. After perusing the record, the Board opined that the patient had died because of severe atonic PPH which did not respond to the treatment given at the nursing home. It was recorded that the treatment given was as recommended and that blood is not arranged beforehand for normal deliveries. It was noted that the blood samples were sent for cross-matching at 03.15 AM; that the patient went into shock at 03.45 AM, that blood was brought from Rotary and Blood Bank Society, Sector 37, Chandigarh; that blood transfusion was started at 04.15 AM on both arms; and she was then referred to the PGI.

18. The second Report dated 20.03.2006 was from a Board of doctors of Government Medical College and Hospital, Sector 32, Chandigarh. The doctors in this Board were Professor Veena Parmar, HoD of Paediatrics; Professor Anju Huria, HoD of Obstetrics & Gynaecology; Professor K.K. Gombar, HoD of Anaesthesia; Professor A.K. Attri, HoD of Surgery; and Professor Harsh Mohan, Medical Superintendent and HoD of Pathology (Chairman). The conclusion of the Board was that the patient had atonic PPH which was managed conservatively but without success. It was noted that PPH is a known complication of delivery and accounted for 8% of maternal mortality in developed countries. The Board opined that different patients may cope differently with blood loss in PPH - a healthy woman would be far more tolerant to blood loss of 3050% when compared to a woman with either pre-existing anaemia or underlying cardiac complications or pre-eclampsia. The Board opined that it could not be said with certainty from the record whether this patient had anaemia or hypotension and shock before delivery but in the presence of either or both of these conditions, atonic PPH was more likely to be catastrophic. This final conclusion of the Board did not indict Dr. Kanwarjit Kochhar but left the question open as it was not clear from the record whether the patient had any of these conditions before the delivery.

19. The third Report dated 03.04.2006 was submitted by a Committee of doctors from the Government Medical College and Hospital, Sector 32, Chandigarh, comprising Professor A.K. Attri, HoD of Surgery (Chairman); Dr. Satinder Gombar, Professor and HoD of Anaesthesia; Dr. Anju Huria, HoD of Obstetrics & Gynaecology; and Dr. Suksham Jain, Assistant Professor of Paediatrics. This Committee, after perusing the record submitted by the Office of the Director, Health and Welfare, Chandigarh Administration, discussed the previous reports submitted by the teams of doctors from the General Hospital, Sector 16, Chandigarh, and the Government Medial College and Hospital, Sector 32, Chandigarh, and upon perusal of the medical record and the medical reports and after thorough deliberations, the Committee opined that there was no gross medical negligence in the management of the patient.

20. The fourth Report from the Government Medical College and Hospital, Sector 32, Chandigarh was dated 18.08.2006. This report was consequential to the letter dated 15.06.2006 of the Senior Superintendent of Police, Union Territory, Chandigarh. This Committee consisted of Dr. Manjit Singh Bains, Director, Health Services, General Hospital, Sector 16, Chandigarh (Chairman); Dr. Usha Bishnoi, Medical Superintendent, General Hospital, Chandigarh; Professor Harsh Mohan, Medical Superintendent, Government Medical College and Hospital, Sector 32, Chandigarh; Professor K.K. Gombar, HoD of Anaesthesia; Professor Veena Parmar, HoD of Paediatrics; Professor Anju Huria, HoD of Gynaecology.; and Dr. A.K. Attri, HoD of Surgery. The Committee deliberated on the issue addressed in the letter and considered the records of the deceased mother and child provided by the police department. The Committee also discussed the reports submitted previously by the teams of doctors from the General Hospital, Sector 16, Chandigarh, and the Government Medical College and Hospital, Sector 32, Chandigarh. After considering the said records and reports, the Committee opined that there did not appear to be any gross medical negligence in the management of the patients by the treating doctors.

21. The fifth and final undated Report was also from the GovernmentMedical College and Hospital, Sector 32, Chandigarh. This Committee comprised Professor A.K. Attri, HoD of Surgery (Chairman); Dr. Satinder Gombar, Professor and HoD of Anaesthesia; Dr. Anju Huria, HoD of Obstetrics and Gynaecology; and Dr. Suksham Jain, Assistant Professor of

Paediatrics. The Committee perused the whole record submitted by the Office of the Director, Health and Welfare, Chandigarh Administration, and discussed the previous reports submitted by the teams of doctors. After thorough deliberations and perusal of the medical records and the reports, the Committee opined that there was no gross medical negligence in the management of the patients.

22. Significantly, all the above reports came about upon the instigation and at the behest of Manmeet Singh Mattewal himself, who seems to have approached various authorities voicing his grievance against Dr. Kanwarjit Kochhar and the nursing home in relation to the death of his wife and child. However, except for one report which, owing to lack of sufficient data, left one question open, i.e., the possible pre-existing conditions that may have led to the death of Charanpreet Kaur, none of the reports held Dr. Kanwarjit Kochhar negligent. Further, given the settled legal position that every failure in the treatment of a patient does not automatically lead to an assumption of medical negligence, we find that the opinions expressed by the doctors and experts, who constituted these Medical Boards/Committees, clearly tilted the balance in favour of Dr. Kanwarjit Kochhar, as none of them found any medical negligence on her part. As already noted hereinbefore, these bodies were constituted at the behest of Manmeet Singh Mattewal himself and he cannot, therefore, fight shy of the conclusions and findings rendered by them.

23. As pointed out in ***Jacob Mathew vs. State of Punjab and another***[6], simply because a patient did not favourably respond to the treatment given by a physician or if a surgery failed, the doctor cannot be held liable *per se* by applying the doctrine of *res ipsa loquitur.* This edict was reiterated in ***Martin F. D'Souza vs. Mohd. Ishfaq***[7] wherein, it was pointed out that no sensible professional would intentionally commit an act or omission which would result in harm or injury to a patient as the reputation of that professional would be at stake and a single failure may cost him or her dear in that lapse. It was also pointed out that sometimes, despite best efforts, the treatment by a doctor may fail but that does not mean that the doctor or surgeon must be held guilty of medical negligence, unless there is some strong evidence to suggest that he or she is. It was also pointed out that Courts and Consumer Fora are not experts in medical science and must not substitute their own views over that of specialists. While acknowledging that the medical profession had been commercialised to some extent and there were doctors who depart from their Hippocratic Oath for their selfish ends of making money, this Court held that the entire medical fraternity cannot be blamed or branded as lacking in integrity or competence just because of some bad apples.

24. On the same lines, in ***Devarakonda Surya Sesha Mani and others vs. Care Hospital, Institute of Medical Sciences and others***[8], it was held that unless a complainant is able to establish a specific course of conduct, suggesting a lack of due medical attention and care, it would not be possible for the Court to second-guess the medical judgment of the doctor on the line of treatment which was administered and, in the absence of such material disclosing medical negligence, the Court cannot form a view at variance, as every death in the institutionalised environment of a hospital does not necessarily amount to medical negligence on a hypothetical assumption of lack of due medical care.

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[6] (2005) 6 SCC 1
[7] (2009) 3 SCC 1
[8] 2022 SCC OnLine SC 1608

25. In any event, the NCDRC's ultimate conclusion was that there was negligence on the part of Dr. Kanwarjit Kochhar only in the antenatal care and management of Charanpreet Kaur. More importantly, the NCDRC rendered a clear finding that there was no medical negligence in the handling of Charanpreet Kaur's labour, including her delivery; the management of the baby's problem; and the post-delivery management at the nursing home. These conclusions, arrived at by the NCDRC, not only reversed the findings of the SCDRC but also turned the very case put forth by the complainants on its head. In fact, the NCDRC decided the matter by building up a new case altogether!

26. The specific claim of Manmeet Singh Mattewal in Complaint Case No. 56 of 2006 was that there was medical negligence on the part of Dr. Kanwarjit Kochhar and the nursing home in the post-delivery treatment only, as sufficient facilities were not available in the nursing home to deal with post-delivery emergencies, and Dr. Kanwarjit Kochhar failed to take adequate care and caution after the delivery to save the life of the patient. He categorically asserted that the nursing home was 'inadequately and ill equipped' to handle emergencies during deliveries and there were no facilities available in that regard. His further allegation was that Charanpreet Kaur was informed about the death of the newborn child which resulted in her going into shock and caused profuse bleeding. However, this was not proved and neither the SCDRC nor the NCDRC recorded a finding on this aspect. His further allegation was that there was delay in arranging for blood transfusions and there was negligence during the transfer of Charanpreet Kaur from the nursing home to the PGI. He made no allegations whatsoever to the effect that the antenatal care and management of Charanpreet Kaur were deficient in any manner. On the contrary, he specifically asserted that various tests were prescribed by Dr. Kanwarjit Kochhar and Charanpreet Kaur underwent all such tests.

27. The SCDRC had accepted Manmeet Singh Mattewal's case and held that negligence was attributable to Dr. Kanwarjit Kochhar and the nursing home in relation to the post-delivery care and treatment of Charanpreet Kaur. However, this finding was reversed by the NCDRC, as is evident from the impugned order, wherein the NCDRC held in clear terms that no liability attached to the nursing home and it was Dr. Kanwarjit Kochhar who was to be held responsible on the ground of medical negligence in the antenatal care and management. The specific finding of the NCDRC was that Dr. Kanwarjit Kochhar had not prescribed the requisite haematological tests for Charanpreet Kaur.

28. This was never the case of Manmeet Singh Mattewal. The entire focus of the NCDRC, however, was only upon the antenatal care and management of the patient and its pinpointed findings were also in relation to the said period and treatment only. The NCDRC's observation that there were several instances of departure from standard protocols in the antenatal management of the patient, such as, not getting proper tests done, and its final finding that no case of tortious medical negligence was made out against Dr. Kanwarjit Kochhar in handling Charanpreet Kaur's labour, her delivery, management of the baby and his problem, and the post-delivery management of both of them at the nursing home, demonstrated and settled in no uncertain terms that the case put forth by Manmeet Singh Mattewal was not proved and established. Once his case, as pleaded and projected, was not made out, the NCDRC clearly erred in building up a new case on his behalf and in pinning negligence and liability upon Dr. Kanwarjit Kochhar in the context of antenatal care and management of the patient, which was never the subject matter of the complaint case. In doing so, the NCDRC overstepped its power and jurisdiction as it was not for it to travel beyond the pleadings in the complaint case and build up a new case on its own (See ***A.V.G.P. Chettiar & Sons and others vs. T.***

Palanisamy Gounder[9]***, Venkataraman Krishnamurthy and another vs. Lodha Crown Buildmart (P) Ltd.***[1011], ***Rama Kt. Barman (Died) Thr. LRs. vs. Mohd. Mahim Ali and others***[11]).

29. Useful reference may also be made to the observations of this Court in ***Trojan and Company vs. Rm. N.N. Nagappa Chettiar***[12], as long back as in the year 1953, that it is well settled that the decision of a case cannot be based on grounds outside the pleadings of the parties and it is the case pleaded that has to be found. Again, in ***Ram Sarup Gupta (Dead) by LRs vs. Bishun Narain Inter College and others***[13], this Court observed that it is well settled that no party should be permitted to travel beyond its pleadings and that all necessary and material facts should be pleaded by a party in support of the case set up by it. It was pointed out that the object and purpose of pleadings is to enable the adversary party to know the case it has to meet as, in order to have a fair trial, it is imperative that a party should settle the essential material facts so that the other party may not be taken by surprise.

30. Viewed thus, the NCDRC clearly transgressed its jurisdiction in building a new case for the complainants, contrary to their pleadings. However, its finding that there was no negligence in the delivery and the post-delivery treatment of Charanpreet Kaur have attained finality as no separate appeal was preferred by the complainants. The impugned order passed by the NCDRC, confirming the SCDRC's judgment on the new grounds made out by it, therefore, cannot be sustained.

31. The appeal is accordingly allowed, setting aside the order dated 09.05.2012 passed by the National Consumer Disputes Redressal Commission, New Delhi, in First Appeal Nos. 158 and193 of 2007, as well as the judgment dated 31.01.2007 passed by the State Consumer Disputes Redressal Commission, Union Territory, Chandigarh, in Complaint Case No. 56 of 2006. In consequence, the said complaint case shall stand dismissed.

Manmeet Singh Mattewal, respondent No. 1, shall return and refund the sum of ₹10,00,000/- received by him, pursuant to the orders passed in this litigation, to Dr. Kanwarjit Kochhar, Dr. GS Kochhar and New India Assurance Company Ltd. in monthly instalments of ₹1,00,000/- each. The first three instalments, aggregating to ₹3,00,000/-, shall be paid to New India Assurance Company Ltd. and the balance sum of ₹7,00,000/- shall be paid to Dr. Kanwarjit Kochhar and Dr. GS Kochhar under acknowledgement, as we are informed that the nursing home is no longer in existence.

In the circumstances, parties shall bear their own costs.

[9](2002) 5 SCC 337
[10](2024) 4 SCC 230
[11] 4 SCC OnLine SC 4083
[12](1953) 1 SCC 456
[13](1987) 2 SCC 555