DISTRICT CONSUMER DISPUTES REDRESSAL COMMISSION, MALAPPURAM

(Present: Sri. Mohandasan K., President
Smt.Preethi Sivaraman C., Member
Sri. Mohamed Ismayil C.V., Member)

Date of filing: 03/09/2020

Date of Order: 30/06/2026

C.C.NO.201/2020

Nasan Bin Noushad @ Nishan Bin Noushad,
Aged 2 ½ years (Minor Rep: by Mother Jameela
Aged 31 years, W/o Noushad, Pazhakarayil House,
Maranchery, P. o) , Pin 679560,
Malappuram Dist.Phone: 9946150109.
(By:Adv. A.K.Shibu, Malappuram) — Complainant

Vs

1. Dr. Ashique, Aged 30, Kaliyarakath House,
Kalachal P.o, Alankode – 679 585,
Malappuram Dist.
(By:Adv. Shyampadman, Kochi)
2. Jaleel Aged 65, Kuvvakkaattayil House,
Para Perumpadappu P.o, Pin – 679580.
3. M/s K.V.M Hospital
Rep: by Proprietor, Jaleel Kuvvakkattuayil
House, Para, Perumpadappu P.o,
Pin – 679580, Malappuram Dist.
(By:Adv. Abdul Salam) — Opposite parties

ORDER

By Sri. MOHANDASAN.K, PRESIDENT

The complaint, in brief, is as follows:-

1. The complainant submitted that the first opposite party is a doctor attached to the third opposite party hospital, the second opposite party is the owner/management

of the said establishment, and the third opposite party is the hospital where the complainant's son underwent circumcision.

2. According to the complainant, on 18.04.2018, she took her son, Nishan Bin Naushad, aged 23 days, to the third opposite party hospital for circumcision. The procedure was performed at the hospital and took an unusually long time. After the procedure, the child was handed over to the complainant with the circumcision site completely covered with dressing. The complainant was advised to observe whether the child was able to pass urine and to inform the hospital in case of any difficulty.

3. At the time of discharge, a prescription was issued by the doctor. Since the prescribed medicines were not available in the hospital pharmacy, the complainant approached a nearby medical shop. The pharmacist expressed surprise regarding the dosage prescribed for the child. Thereupon, the complainant again approached the hospital and informed the nurse, who stated that the prescription had been issued by the doctor and that the pharmacist had no role in prescribing medicines.

4. Thereafter, when the child attempted to pass urine, it was noticed that urine was leaking through the dressing over the circumcision site. The matter was immediately informed to the duty nurse, who stated that the concerned doctor would be informed. At about 7.00 p.m. on the same day, the complainant was advised to bring the child back to the hospital. The duty nurse then re-dressed the circumcision site, leaving an opening for the passage of urine.

5. However, even thereafter, the child was able to pass urine only in a spraying manner. The complainant was assured that the condition would improve with time,

but no improvement was noticed. The child continued to cry persistently following the circumcision procedure.

6. The complainant further submitted that, even after taking the child home, there was no improvement in his condition. Therefore, the complainant contacted the hospital over the telephone and was advised to administer breast milk to the child, and it was assured that the condition would become normal and that the child would be able to pass urine without difficulty. The first opposite party allegedly informed the complainant that such symptoms were common following circumcision.

7. The complainant alleged that the first opposite party was inexperienced in performing circumcision procedures and that the third opposite party hospital lacked the necessary facilities and arrangements for carrying out such a procedure. According to the complainant, these deficiencies resulted in serious complications to the child.

8. On the third day after the procedure, the child developed further discomfort and was taken back to the hospital. The complainant was informed that the child had developed an infection. After cleaning the affected area, the complainant was advised to consult a surgeon at the Mother and Child Hospital, Changaramkulam. Despite the continuous crying and distress of the child, the opposite parties allegedly sent the child back without providing adequate treatment.

9. Thereafter, the child was taken to the Mother and Child Hospital, Changaramkulam. However, there was no improvement in his condition. When the child was again taken to the said hospital, the doctor to whom he had been referred by the first opposite party was on leave. The surgeon who examined the child opined

that the condition was beyond the scope of management at that hospital and advised that the child be shifted immediately to a higher medical centre. It was further advised that any delay could endanger the life of the child.

10. Consequently, the child was referred to Amala Hospital, Thrissur. Upon examination, the doctors there allegedly informed the complainant that the child was in a serious condition, that there was severe infection, accumulation of pus, pain, and impairment of blood circulation to the affected area. The complainant was informed that a surgical opening had to be created in the abdomen for the passage of urine. As the necessary facilities were allegedly not available there, the child was referred to Jubilee Mission Hospital, Thrissur.

11. The child was admitted to Jubilee Mission Hospital, Thrissur, where surgery was performed on the same day and a urinary diversion was created through an opening in the abdomen. The complainant submitted that the child continues to pass urine through the said opening. It is further alleged that the child's penis suffered severe damage and was almost completely lost.

12. The complainant further submitted that a complaint was lodged before the Perumpadappu Police on 02.08.2018, pursuant to which Crime No. 88/2018 was registered and is stated to be pending investigation. Subsequently, the complainant approached the District Medical Officer, who conducted an enquiry into the matter. According to the complainant, the enquiry revealed serious deficiencies in the opposite parties' institution, including lack of proper precautions, inadequate knowledge regarding sterilization procedures, and lack of awareness among the staff

regarding sterilization practices. It is alleged that stringent action was recommended against the institution and that the hospital was subsequently closed down.

13. The complainant also approached the Human Rights Commission. It is submitted that the Human Rights Commission recommended payment of an interim compensation of Rs.2, 00,000/- to the complainant; however, the said amount has not been paid

14. The complainant further submitted that substantial amounts were incurred towards medical treatment, hospitalization, travel expenses, and related costs. It is also contended that the child continues to undergo treatment and may require additional surgeries in the future. Therefore, alleging medical negligence and deficiency in service on the part of the opposite parties, the complainant seeks compensation for the injuries, suffering, and losses sustained.

15. The complainant further submitted that an earlier complaint claiming compensation of Rs.90, 00,000/- was filed on 29.12.2019. However, in view of the pecuniary jurisdiction of the District Consumer Commission, the complainant was directed to present the complaint before the appropriate forum having jurisdiction. Subsequently, owing to the change in the pecuniary jurisdiction of the District Commission, the complainant reduced the claim amount to Rs.50, 00,000/- so as to bring the matter within the jurisdiction of this Commission.

16. The complainant further submitted that, during the relevant period, the husband of complainant was employed abroad and was therefore unable to approach the appropriate forum immediately. It is also contended that the period in question

coincided with the COVID-19 pandemic and the consequent lockdown restrictions, which prevented the complainant from promptly re-presenting the complaint before the District Commission.

17. Accordingly, the complainant contends that there was sufficient cause for the delay, if any, in filing/re-presenting the complaint and that the delay was neither wilful nor deliberate.

18. The complainant, therefore, seeks a direction to the opposite parties to pay compensation of Rs.50, 00,000/- for the alleged negligence and deficiency in service, together with the costs of the proceedings and such other reliefs as this Commission may deem fit and proper.

19. Upon admission of the complaint, notice was issued to all the opposite parties. On receipt of notice from the Commission, the opposite parties entered appearance and filed their respective versions.

20. The first opposite party raised a preliminary objection regarding the maintainability of the complaint. It was contended that the complaint is not maintainable either in law or on the facts and circumstances of the case. According to the first opposite party, an earlier complaint, CC No. 299/2019, had been filed by the complainant on the same cause of action and the matter had been considered by this Commission pursuant to the order dated 29.12.2019 passed in IA No. 87/2019 in compliance with the directions of the Hon'ble State Commission in Revision Petition No. 22/2019. Hence, the present complaint is not maintainable.

21. The first opposite party further contended that the complainant is not entitled to any of the reliefs claimed in the complaint and that the complaint is liable to be dismissed in limine. It was also contended that the complainant is not a consumer as defined under the Consumer Protection Act. According to the opposite party, there was no negligence, carelessness, deficiency in service, or unfair trade practice on its part. The minor child of the complainant was examined and treated in accordance with universally accepted medical standards and protocols, with due care, caution, and attention.

22. It was further alleged that the complainant had not approached the Commission with clean hands and had suppressed material facts. According to the opposite party, the complaint contains untrue, untenable, and misleading allegations, disentitling the complainant from claiming any relief under the Act. It was also contended that the claim for compensation on account of indirect or remote damages is not legally maintainable.

23. The first opposite party further submitted that there is no order from any competent court authorizing Ms. Jameela to represent and prosecute the complaint on behalf of the minor Nishan Bin Naushad. It was also pointed out that, as evident from the complaint itself, the child had undergone further treatment at Mother and Child Hospital, Changaramkulam, Amala Institute of Medical Sciences, Thrissur, and Jubilee Mission Medical College and Research Institute, Thrissur. According to the opposite party, those institutions are necessary parties for the effective and complete

adjudication of the dispute, and therefore the complaint is bad for non-joinder of necessary parties.

24. The first opposite party also furnished details regarding his educational qualifications and professional experience. It was submitted that he completed MBBS from Vinayaka Missions University, Salem, in the year 2013. Thereafter, he completed internship training at the District Hospital, Kozhikode, and subsequently worked as Resident Medical Officer in various hospitals, including Mother and Child Hospital, Changaramkulam, KVM Hospital, Puthenpally, TMH Hospital, Kadalundi, Ansar Hospital, Perumpilavu, and Sree Valsam Institute of Medical science, Naduvattam as resident medical officer. He further submitted that he had also worked as a General Practitioner under the Ministry of Health, Oman, and is presently working as Casualty Medical Officer at Sunrise Hospital.

25. The first opposite party further contended that the complainant had deliberately suppressed material documents relating to the treatment of the child. According to the opposite party, the complainant ought to have produced the complete treatment records relating to the subsequent treatment undergone by the child. Failure to produce such documents, according to the opposite party, would adversely affect the credibility of the complainant's case and would warrant drawing an adverse inference against her.

26. It was also contended that the documents referred to in the complaint had not been furnished to the opposite parties. According to the first opposite party, such non-furnishing amounts to a violation of Regulation 10(5) of the Consumer Protection

(Consumer Commission Procedure) Regulations, 2020. The opposite party submitted that the said documents are essential for filing a comprehensive and effective version and that the absence of such documents has caused serious prejudice to its defence. Therefore, the version was filed reserving the right to submit an additional version upon receipt of the relevant documents from the complainant.

27. The first opposite party further contended that the dispute involves allegations of medical negligence requiring detailed medical and expert evidence. According to the opposite party, such issues cannot be effectively adjudicated in a summary proceeding before the Consumer Commission and therefore the parties should be relegated to a competent civil court. It was also contended that the complainant had failed to establish even a prima facie case of medical negligence by producing relevant materials and documents.

28. On the above grounds, the first opposite party prayed that the question of maintainability of the complaint be considered and decided as a preliminary issue before proceeding further with the matter.

29. The opposite party specifically denied each and every allegation and averment contained in the complaint. According to the opposite party, the complaint has been deliberately drafted by suppressing the true facts with the sole intention of obtaining undue financial gain from the opposite parties.

30. It was contended that the minor child was brought to the hospital of the third opposite party on 18.04.2018 at about 7.25 a.m. for circumcision. After a detailed examination, the child was found fit for the procedure and accordingly circumcision

was performed on the same day by the first opposite party. It was submitted that bipolar cautery was used during the procedure for cauterization purposes. Though monopolar and bipolar cautery facilities were available in the same machine, bipolar cautery alone was utilized during the surgery.

31. According to the opposite party, the procedure was completed without any complications. The child remained stable after the surgery and the bleeding was well controlled. During the post-operative observation period, no complications were noticed. After confirming satisfactory condition and urination, the child was discharged from the hospital. Proper post-operative instructions were given to the mother and medicines including antibiotic syrup and analgesic drops were prescribed.

32. It was further submitted that on the same day afternoon, the parents contacted the hospital and informed that the child was crying and urine was leaking through the dressing. They were immediately advised to bring the child back to the hospital for examination. Upon examination, it was found that the dressing around the urethral opening had become loose. The old dressing was therefore removed and a fresh dressing was applied.

33. The opposite party contended that the parents were advised to bring the child for follow-up examination on 19.04.2018. However, they failed to comply with the said advice and reported only on 20.04.2018. During that visit, they complained of difficulty in urination. On examination, infection was noticed at the surgical site. On enquiry, the parents allegedly informed the doctors that they had not properly followed the prescribed medication schedule. It was also stated by them that a pharmacist had

advised that the prescribed dosage was high for a child of that age. According to the opposite party, the parents were instructed to continue the medicines strictly as prescribed and the child was referred to a surgeon at Mother and Child Hospital for further management.

34. The opposite party further submitted that it subsequently came to know that the child was examined at Mother and Child Hospital, where the infection at the surgical site was managed by dressing and medications. However, the parents allegedly failed to continue regular follow-up treatment and were carrying out dressing at home by themselves. It was further contended that when the child was again examined after a few days, the infection had worsened due to non-compliance with medical advice, following which the parents were advised to shift the child to a higher centre for specialized treatment.

35. The opposite party therefore contended that the subsequent complications, if any, were not attributable to any negligence on its part. According to the opposite party, the allegations contained in the complaint are contrary to the true facts and circumstances of the case and are therefore specifically denied.

36. The opposite party also denied the allegations that the child was returned to the complainant after an undue delay following the surgery; that the urethral opening was completely covered by the dressing; that the complainant was directed merely to observe whether the child urinated; that the prescribed medicines were unavailable in the hospital pharmacy; that a pharmacist had commented on the dosage of the medicines; that the complainant had informed the hospital staff regarding such advice;

that the child continued to pass urine abnormally after repeated dressings; that the child cried continuously after the procedure; and that the complaints raised by the parents were ignored by the hospital authorities.

37. The opposite party further submitted that the allegations that the child was subsequently admitted to the Emergency Department of Jubilee Mission Medical College and Research Institute, Thrissur, that a surgical procedure was performed on the child's abdomen for urinary diversion, that the child continues to pass urine through the said opening, that a portion of the child's penis was lost, and that the size of the genital organ has been permanently reduced, are not true or correct to the knowledge of the opposite party and are therefore denied.

38. The opposite party also denied the allegations that the complainant had lodged a complaint before the District Medical Officer, Malappuram, and that upon inspection it was found that the third opposite party hospital had failed to comply with infection control protocols, that the staff lacked adequate knowledge regarding sterilization procedures, that disciplinary action was recommended against the hospital and its employees, or that the hospital was consequently closed down. The opposite party further denied the allegations relating to the intervention of the State Human Rights Commission and the alleged direction to pay interim compensation of Rs. 2, 00,000/- to the complainant.

39. The opposite party specifically denied the allegation that the child lost his penis or suffered permanent deformity due to the inefficiency, lack of knowledge, inexperience, or negligence of the opposite party, or due to the alleged lack of facilities

for conducting circumcision at the third opposite party hospital. The allegations that the future sexual and reproductive capacity of the child has been permanently affected, that the complainant incurred huge expenditure for surgeries, treatment, transportation, and future medical care, and that further surgeries would be required in the future, are also denied.

40. The opposite party further contended that the allegations regarding physical suffering, mental agony, and financial loss allegedly sustained by the complainant and the child are unfounded. According to the opposite party, the circumcision procedure was performed with due care and in accordance with accepted medical standards. It was denied that the child suffered complications due to any lack of facilities, inadequate preparation, failure to maintain sterilization standards, or any deficiency in service on the part of the opposite parties.

41. The opposite party also denied the allegation that the opposite parties are jointly and severally liable to pay compensation of Rs. 50, 00,000/- as claimed in the complaint. According to the opposite party, the amount claimed is highly excessive, arbitrary, baseless, and unsupported by any reliable evidence.

42. The allegations contained in the complaint regarding jurisdiction, delay, and the circumstances under which the complaint was filed were also denied. The opposite party contended that the alleged loss, injury, hardship, and damages claimed by the complainant are not admitted. It was further contended that no loss or damage was caused to the complainant on account of any act or omission attributable to the

opposite party and that the opposite party cannot be held liable for any of the consequences alleged in the complaint.

43. According to the opposite party, the complaint is founded upon incorrect and misleading allegations made without regard to the true facts of the case and has been instituted solely with the intention of obtaining monetary gain from the opposite parties. It was specifically contended that there was absolutely no medical negligence, deficiency in service, or breach of duty on the part of the opposite party in the treatment rendered to the complainant's child and, therefore, no liability can be fastened upon the opposite party either individually or jointly with the other opposite parties.

44. The opposite party further submitted that the complaint lacks bona fides and is false, frivolous, vexatious, speculative, and motivated by ulterior considerations. It was contended that the complaint has been filed by misrepresenting material facts with the intention of extracting money from the opposite party without any lawful basis. The quantum of compensation claimed was described as wholly arbitrary, exaggerated, unsupported by evidence, and devoid of any rational basis.

45. The opposite party therefore contended that the complainant has no valid cause of action and the complaint is liable to be dismissed. Accordingly, the opposite party prayed that the complaint be dismissed with costs.

46. The second and third opposite parties filed their version denying all the averments and allegations contained in the complaint. They contended that the complaint has been filed without bona fides and on the basis of false allegations.

According to them, the complaint is not maintainable. It is submitted that an earlier consumer complaint, C.C. No. 299/2019, was considered with respect to maintainability in I.A. No. 87/2019. The matter was subsequently considered by the District Commission and thereafter in Revision Petition No. 22/2019 before the State Commission. Pursuant to the directions issued therein, the District Forum, by order dated 28.12.2019, disposed of the complaint directing the complainant to approach the proper forum. The complainant did not prefer any appeal against the said order and, therefore, the order has attained finality. Hence, according to the opposite parties, the present complaint is not maintainable as the complainant failed to comply with the earlier order.

47. The opposite parties further submitted that the child was brought to the hospital on 18.04.2018 for circumcision at about 7.25 a.m. and was admitted to the minor operation theatre. It is stated that, after observing all necessary precautions and exercising due care and caution, the circumcision was performed. Thereafter, the child was handed over to the complainant at about 8.15 a.m. The opposite parties contend that they ensured that there was no complication and verified that the child was passing urine without any obstruction. The child was kept under observation in the post-operative period and, after ensuring that there were no complications, was discharged. At the time of discharge, medicines were prescribed and the complainant was advised to bring the child for review on the very next day, i.e., 19.04.2018, which was duly recorded in the discharge card.

48. However, the child was brought back to the hospital only on 20.04.2018. On examination, pus was noticed at the circumcision site. The opposite parties denied the allegation that the medicines prescribed by the doctor were unavailable in the pharmacy. According to them, the medicines prescribed after circumcision were essential to prevent infection and other complications and were commonly available in most medical stores. It is further submitted that when the child was brought on 20.04.2018, the presence of pus at the circumcision site was noticed and, upon enquiry, the mother disclosed that the prescribed medicines had not been administered to the child. Consequently, she was advised to consult a surgeon. Thereafter, the complainant did not return to the opposite parties and no further information regarding the child was made available to them.

49. The opposite parties reiterated that the complainant had been specifically advised to bring the child for review on 19.04.2018, but failed to do so. They further submitted that the first opposite party is a qualified medical practitioner duly registered with the Travancore-Cochin Council of Modern Medicine and possesses the requisite experience and expertise to perform circumcision procedures. It is stated that several circumcisions had been successfully performed at the hospital and that the casualty and minor operation theatre were equipped with the necessary facilities and supported by competent and qualified nursing staff. The opposite parties also submitted that circumcision camps had been organised under their auspices and that no complaints had ever been reported in connection with such procedures. It is further

stated that the main operation theatre was not functioning at the relevant time and, therefore, only minor surgical procedures were being conducted.

50. The opposite parties further submitted that, after the complainant was advised to consult a surgeon, the minor child was not brought back to the hospital and no further information regarding the child's condition was furnished to them. According to the opposite parties, after a few days, the complainant and his supporters raised baseless allegations against the hospital and demanded a substantial amount as compensation, failing which they allegedly threatened to teach a lesson to the opposite parties. It is further submitted that they organised agitations in front of the hospital, attempted to attack the hospital premises and obstructed its normal functioning. The opposite parties contended that the complainant and his supporters carried out a false propaganda campaign against the hospital, conspired to tarnish its reputation and spread misinformation among patients visiting the hospital, thereby causing obstruction to its day-to-day activities.

51. The opposite parties further submitted that the complainant lodged a complaint before the District Medical Officer on 14.09.2018, pursuant to which an inspection of the hospital was conducted. It is also submitted that the complainant approached the Human Rights Commission. However, according to the opposite parties, they did not receive any notice from the Human Rights Commission and are unaware of any direction allegedly issued by the Commission directing payment of Rs.2, 00,000/- to the complainant.

52. The opposite parties specifically contended that the hospital possessed all necessary facilities for conducting circumcision procedures and that there was no lapse, negligence or deficiency in service on their part. According to them, the complications experienced by the child were attributable to the complainant's failure to comply with the medical advice given by the doctor and to administer the prescribed medicines, which resulted in infection and the formation of pus at the circumcision site. They denied all allegations of medical negligence and deficiency in service.

53. The opposite parties further denied the allegation that the minor child had suffered loss or damage to his genital organ as alleged in the complaint. It is submitted that only the essential medicines required after circumcision were prescribed in order to prevent infection and facilitate proper healing. According to the opposite parties, the treatment was administered with due care and skill and there was no negligence on the part of the attending doctor or the hospital. They therefore contended that they are not liable to pay any compensation as claimed by the complainant. It is further submitted that no cause of action has arisen for filing the present complaint and, therefore, the complaint is liable to be dismissed with costs.

54. The complainant as well as the opposite parties filed proof affidavits and produced documentary evidence in support of their respective contentions. The documents produced by the complainant were marked as Exhibits A1 to A16, the documents produced by the opposite parties were marked as Exhibits B1 to B8, and the records summoned from various hospitals were marked as Exhibits X1 to X3.

On the side of the complainant, PW1 to PW3 were examined. PW1 is Dr. Sakkeena, District Medical Officer. PW2 is Ms. Jameela, the guardian of the victim/complainant. PW3 is Mr. Ismail Maranchery, the Pharmacist.

55. On the side of the opposite parties, DW1 to DW3 were examined. DW1 is Dr. Ashique, DW2 is Dr. Beena, and DW3 is Dr. Shaheer.

56. Upon consideration of the pleadings, evidence, and materials available on record, the following points arise for consideration:-

1) Whether the complaint is maintainable.

2) Whether there is medical negligence on the part of opposite parties.

3) Whether there is deficiency in service on the side of third opposite party.

4) Relief and cost.

Point No. 1. Whether the complaint is maintainable.

57. The opposite parties filed version contending that the complaint is not maintainable before this commission due to various reasons. As per the version of the first opposite party, it is submitted that the complaint is not maintainable before the commission, contending that complainant is not a consumer as contemplated under the Consumer Protection Act. It is submitted the complainant, Ms Jameela, is not authorized to represent and file the present complaint on behalf of the minor Nishan Bin Noushad. It is submitted that there was an earlier complaint before this Commission as 299/2019 filed by the complainant on the same cause of action and there is an order of the Commission dated 29.12.2019 in IA 87/2019. As per the decision of the Honourable State Consumer Commission in revision petition 22/2019,

the above complaint was disposed holding as not maintainable, and that ground itself it is prayed to dismiss the present complaint.

58. The second and third opposite parties also contended that there was an IA in CC 299/2019 and the maintainability issue was heard and thereafter the District Commission passed an order and thereby disposed the complaints by the District Commission directing the complainant to approach the appropriate authority to file the complaint. Thereafter the complainant did not file any appeal or prefer any petition before any authority and so the present complaint is not legally maintainable and to be dismissed holding the complaint is not maintainable.

59. The opposite parties contended that the complainant had earlier filed Complaint No. CC 299/2019 before this Commission claiming compensation of Rs.90, 00,000/-. In the said proceedings, the State Commission directed this Commission to consider the issue of pecuniary jurisdiction. Accordingly, by order dated 28.12.2019, this Commission returned the complaint with a direction to present the same before the competent forum, holding that it lacked pecuniary jurisdiction to entertain a complaint claiming compensation of rupees 90,00,000/-. It was further contended that the complainant did not challenge the said order and, therefore, the present complaint is not maintainable before this Commission.

60. It is pertinent to note that CC No. 299/2019 was filed under the Consumer Protection Act, 1986, under which this Commission found that there is no pecuniary jurisdiction to entertain a complaint involving a claim of Rs.90,00,000/-. It is true that the complainant did not thereafter approach the State Consumer Disputes Redressal

Commission. However, the complainant submitted that the victim is a minor child aged less than two years and that his father was employed abroad during the relevant period. Owing to such circumstances, the mother of the complainant was unable to approach the State Commission and subsequently filed the present complaint before this Commission under the Consumer Protection Act, 2019.

61. The present complaint was filed on 03.09.2020, after the coming into force of the Consumer Protection Act, 2019. On the date of filing, Section 34 of the Act conferred jurisdiction on the District Commission to entertain complaints where the value of the goods or services paid as consideration did not exceed Rs.1 core. Subsequently, by virtue of the Consumer Protection (Jurisdiction of the District Commission, the State Commission and the National Commission) Rules, 2021, the pecuniary jurisdiction of the District Commission was reduced to Rs.50 lakh.

62. The complainant had originally claimed compensation of Rs.90, 00,000/-. Thereafter, an application was filed seeking permission to restrict the claim to Rs.50, 00,000/- so as to bring the complaint within the pecuniary jurisdiction of this Commission.

63. The Commission has considered the rival contentions. The first opposite party also raised an objection regarding non-joinder of necessary parties, contending that the complainant had undergone treatment at Amala Hospital, Thrissur, and Jubilee Mission Hospital, Thrissur, and that those hospitals had not been impleaded as parties to the complaint.

64. On a consideration of the pleadings and materials on record, this Commission is of the view that it possesses jurisdiction to entertain the present complaint under the Consumer Protection Act, 2019. Section 34 of the Act provides that, subject to the other provisions of the Act, the District Commission shall have jurisdiction to entertain complaints where the value of the goods or services paid as consideration does not exceed rupees 1 crore. It is also provided that the Central Government may prescribe a different pecuniary limit. Subsequently, the pecuniary jurisdiction was reduced to Rs.50 lakh.

65. In the present case, although the complainant had initially claimed compensation of Rs.90, 00,000/-, she has subsequently restricted the claim to Rs.50, 00,000/-. Therefore, the complaint presently falls within the pecuniary jurisdiction of this Commission. It is also relevant that the complaint was filed on 03.09.2020, when the pecuniary limit was Rs.1 crore. The jurisdiction is ordinarily determined on the date of institution of the complaint, and the subsequent reduction of pecuniary limits in 2021 would not divest the Commission of jurisdiction already validly assumed. Moreover as per section 34 of the Consumer Protection Act 2019, the amount of consideration determines the pecuniary jurisdiction and not the amount claimed as compensation.

66. It was further contended by the opposite parties that the mother of the minor complainant had no authority to institute the present complaint. This contention cannot be accepted. Section 2(5) of the Consumer Protection Act, 2019, defining "complainant", specifically provides that in the case of a consumer who is a minor, the

complaint may be filed by his parent or legal guardian. In the present case, the complaint has been instituted on behalf of the minor victim by his mother. There is no dispute regarding the fact that she is the natural guardian of the minor. Therefore, the contention that she lacked authority to file the complaint is devoid of merit.

67. The opposite parties also contended that the complaint is bad for non-joinder of necessary parties, as the complainant had undergone treatment in Amala Hospital, Thrissur, and Jubilee Mission Hospital, Thrissur, and those hospitals have not been impleaded as parties to the proceedings. This contention is also unsustainable. It is for the complainant to choose the parties against whom relief is sought. Merely because certain other hospitals, where the complainant subsequently underwent treatment, have not been impleaded, the complaint cannot be dismissed as not maintainable. The question whether any other party is necessary for the effective adjudication of the dispute has to be considered in the facts and circumstances of the case. In the present case, the non-impleadment of the aforesaid hospitals does not render the complaint non-maintainable.

68. Hence, this Commission finds no merit in the objections raised by the opposite parties regarding maintainability. Accordingly, it is held that the complaint is maintainable before this Commission.

Point Nos. 2&3. Whether there is medical negligence on the part of opposite parties& whether there is deficiency in service on the side of third opposite party.

69. This complaint arises out of the alleged negligent circumcision of a 23-day-old male child. The case of the complainant is that the infant was taken to the first

opposite party on 18.04.2018 for circumcision. According to the complainant, the circumcision was not performed properly and, as a consequence, more than 75% of the genital organ of the child was lost, resulting in permanent deformity and suffering. The complaint has been filed by the mother of the minor child seeking compensation of Rs.5, 000,000/- for the alleged medical negligence and deficiency in service.

70. The opposite parties are respectively the treating doctor, the owner of the hospital, and the hospital where the procedure was performed. They contested the complaint by filing their versions, contending, inter alia, that the complaint is not maintainable either in law or on facts. The opposite parties further submitted that the circumcision was done strictly in accordance with accepted medical protocol and standards of care. According to them, the hospital was equipped with adequate facilities for carrying out the procedure and there was no deficiency in service, unfair trade practice, or medical negligence on their part. They therefore prayed for dismissal of the Complaint.

71. The admitted case of the opposite parties is that the infant was brought to the third opposite party hospital on 18.04.2018 at about 7.25 a.m. for circumcision. Upon examination, the baby was found fit for the procedure and, accordingly, circumcision was performed on the same day by the first opposite party at the third opposite party hospital. It is their case that bipolar cautery was used for cauterization during the procedure, though both monopolar and bipolar cautery facilities were available in the same machine.

72. According to the opposite parties, the procedure was completed without any complication. The baby was stable after surgery, bleeding was well controlled, and no complications were noticed during the observation period. After the child passed urine, he was discharged from the hospital. Post-operative instructions were allegedly explained to the mother and medications, namely Syp Ampiclox 250 mg/5 ml, 1.5 ml four times daily for one week, and Syp Ibujesic, 10 drops twice daily for three days, were prescribed.

73. The opposite parties further contended that, on the afternoon of the same day, the parents contacted the hospital and informed that the baby was crying and urine was leaking through the dressing. They were immediately advised to bring the child to the hospital. On examination, it was noticed that the dressing had become loose around the urethral opening. The old dressing was therefore removed and a fresh dressing was applied.

74. The opposite parties further submitted that the child was advised to report for follow-up on 19.04.2018, but the parents failed to do so and brought the child back only on 20.04.2018. During that visit, they complained of difficulty in urination. On examination, an infection was noticed at the operated site. Upon enquiry, the parents allegedly informed the opposite parties that they had not administered the prescribed medicines as advised. They further stated that a pharmacist, whom they had consulted for purchasing the medicines, had informed them that the dosage prescribed was too high for a baby of that age and was therefore not advisable.

75. According to the opposite parties, they strongly advised the parents to administer the medicines as prescribed and, considering the condition of the child, referred him to a surgeon at Mother and Child Hospital, Changaramkulam, for further evaluation and management.

76. A careful comparison of the pleadings of the complainant and the version filed by the opposite parties reveals certain inconsistencies regarding the events that allegedly transpired on 18.04.2018. The case pleaded in the complaint is that, on the evening of the date of circumcision itself, the baby was again taken to the opposite party hospital as there was a problem with the dressing, and that the dressing was redone by the duty nurse. There is no averment in the complaint that the first opposite party doctor personally examined the child on that occasion but redressing was done by staff available in the hospital.

77. On the other hand, the opposite parties have specifically pleaded that, when the child was brought back to the hospital, the first opposite party examined the baby, found that the dressing had become loose around the urethral opening, removed the old dressing, and applied a fresh dressing. Thus, there is a material divergence between the versions of the parties regarding the person who attended the child on the evening of 18.04.2018 and the extent of medical supervision provided at that time.

78. Another discrepancy is seen with regard to the prescribed medicines. The complainant's case is that the medicines prescribed by the doctor were not available in the pharmacy attached to the opposite party hospital and, therefore, an outside medical shop was approached for purchasing the medicines. According to the

complainant, the pharmacist of the said medical shop informed them that the dosage prescribed was too high for a baby aged only 23 days.

79. Therefore, there are conflicting versions regarding both the availability of the prescribed medicines in the pharmacy of the opposite party hospital and the circumstances under which the parents allegedly received advice from the pharmacist. These contradictions assume relevance while appreciating the evidence.

80. Exhibit A1 is the prescription-cum-cash receipt issued from the third opposite party hospital. During his examination, the first opposite party DW 1 admitted that the said document was issued by him and that it bears his signature. However, a perusal of Exhibit A1 does not reveal any instruction or advice directing the parents to bring the child for review on the very next day. The document is dated 18.04.2018, the date on which the circumcision procedure was performed.

81. The specific contention of the opposite parties is that the parents were advised to bring the child for review on the following day. However, no such direction is recorded in Exhibit A1 or in any other document produced by the opposite parties. The only material available in support of such contention is the oral testimony of the first opposite party and the averments contained in the version. In the absence of any document, it is difficult to place reliance on the said contention.

82. The materials on record further disclose that some complication or concern arose at the circumcision site on the very day of the procedure. It is admitted that the child was taken back to the opposite party hospital on the evening of 18.04.2018 itself, where the dressing at the wound site was redone. The evidence further shows that

the child was again taken to the hospital on 20.04.2018. These circumstances indicate that the parents had been vigilant regarding the condition of the child and had sought medical attention whenever they noticed any abnormality.

83. In such circumstances, the contention of the opposite parties that there was delay on the part of the parents in taking the child to the hospital cannot be accepted. Since there is no documentary evidence to establish that the parents were specifically instructed to report for review on the very next day, and in view of the fact that the child was admittedly brought back to the hospital on the evening of the date of surgery itself, we are not inclined to accept the version of first opposite party.

84. The first opposite party has a specific contention that the medicines prescribed after the circumcision procedure were not administered to the child by the complainant. According to the opposite parties, when the complainant approached a medical shop for purchasing the prescribed medicines, the pharmacist allegedly advised that the dosage prescribed was excessive for a baby aged only 23 days, and on that basis the complainant refrained from administering the medicines to the child.

85. However, the complainant has denied the said allegation. In order to substantiate her case, the complainant examined PW3, Mr. Ismail, a pharmacist conducting a medical shop at Maranchery. PW3 deposed that the complainant had purchased medicines from his shop after the circumcision procedure. He further stated that he remembers the transaction as there was subsequently an issue relating to the circumcision of the child. The testimony of PW3 lends support to the case of the complainant that the prescribed medicines were in fact purchased. It is also pertinent

to note that the child was taken back to the opposite party hospital on the very same evening of the procedure owing to problems experienced at the circumcision site. At that point of time, the opposite parties had an opportunity to ascertain whether the prescribed medicines had been purchased and administered. No material has been placed before the Commission to show that the opposite parties recorded any complaint on that day regarding non-administration of medicines.

86. In the above circumstances, the Commission is inclined to accept the case of the complainant that the medicines prescribed by the first opposite party were purchased and administered to the child. The evidence of PW3, coupled with the surrounding circumstances, probabilises the complainant's version and renders the contrary contention of the opposite parties unacceptable.

87. Another issue raised by the complainant is regarding the propriety of the dosage prescribed to a baby aged 23 days. The prescription reveals that Syrup Ampiclox 250 mg was prescribed at the rate of 1.5 ml for one week. It is an admitted fact that the child was only 23 days old at the relevant time. Ordinarily, the appropriate dosage of medicine depends upon various factors, including the age, weight, and clinical condition of the patient. In the present case, no reliable material has been placed before the Commission regarding the weight of the child or other relevant clinical parameters. Further, no expert medical evidence has been adduced to establish that the dosage prescribed by the first opposite party was excessive or improper.

88. Therefore, this Commission is not in a position to arrive at any definite conclusion regarding the correctness or otherwise of the dosage prescribed by the first opposite party. Nevertheless, on the basis of the evidence of PW3 and the attendant circumstances, the Commission finds that the medicines prescribed by the first opposite party were purchased and administered substantially in accordance with the prescription.

89. The complainant, Smt. Jameela, was examined as PW2 and was subjected to cross-examination by the learned counsel for the first opposite party. During cross-examination, a specific suggestion was put to her that, acting upon the advice allegedly given by the pharmacist that the prescribed medicines were of excessive dosage for a 23-day-old infant, the complainant had not administered the medicines to the child and that the subsequent complications were a consequence of such omission. The witness denied the suggestion.

90. PW2 deposed that when the pharmacist expressed doubt regarding the dosage prescribed, the matter was immediately communicated to the nursing staff of the opposite party hospital. According to her, after obtaining clarification from the hospital, the medicines were purchased and administered to the child as instructed. This part of her testimony has remained substantially unshaken in cross-examination. ഡോക്ടർ നിർദേശിച്ച പ്രകാരം antibiotics ഉം മറ്റ് മരുന്നുകളും നൽകുന്നതിൽ വീഴ്ച വരുത്തിയതു കൊണ്ട് infection ഉണ്ടായെന്നും പറഞ്ഞാൽ ശരിയല്ല. ഫാർമസിസ്റ്റ് പറഞ്ഞതു കേട്ട് മരുന്നുകൾ വാങ്ങാതിരിക്കുകയും കുട്ടിക്ക് കൊടുക്കാതിരിക്കുകയും

ആണ് ചെയ്തത് എന്നു പറഞ്ഞാൽ ശരിയല്ല. ആ വിവരം sister നെ വിളിച്ച് അറിയിച്ചപ്പോൾ മരുന്ന് വാങ്ങിക്കൊടുക്കാൻ പറഞ്ഞതനുസരിച്ച് വാങ്ങികൊടുത്തു

The evidence of PW2 is also consistent with the testimony of PW3, the pharmacist, who stated that the medicines were purchased from his shop. The evidence on record, therefore, does not support the contention of the first opposite party that the complainant failed to administer the prescribed medicines to the child. On the contrary, the probabilities arising from the evidence indicate that the complainant, after seeking clarification regarding the dosage, purchased the medicines and administered them in accordance with the instructions received from the hospital.

91. Accordingly, the contention of the first opposite party that the complications developed solely on account of non-administration of medicines by the complainant cannot be accepted in the absence of convincing evidence to substantiate the same.

92. The opposite parties contended that bipolar cautery was used for cauterization during the circumcision procedure. According to them, both monopolar and bipolar cautery systems were available in the same machine. It was further contended that after completion of the circumcision, the baby remained stable, the bleeding was well controlled, no complications were noticed during the observation period, and the child was discharged after passing urine.

93. However, the complainants side specifically contended that monopolar cautery, and not bipolar cautery, was used during the procedure.

94. In this context, Exhibit A11 assumes significance. Exhibit A11 is the enquiry report prepared pursuant to the directions of the District Medical Officer. The report

was prepared by a team of doctors comprising Dr. Ahmad Afzal, Dr. Krishnadas, Consultant in Medicine, and Dr. Momal Salim, Consultant General Surgeon. The team conducted an inspection of the hospital and carried out enquiries on 11.09.2018.

95. The report reveals that the team examined the staff and facilities available at the hospital. During the enquiry, Ms. Ayisha, the staff nurse who was present at the time of the circumcision procedure, disclosed that only a monopolar diathermy unit was available in the hospital and that the same was used during the circumcision procedure. The report further notes that Dr. Ashique admitted that cauterization was resorted to instead of suturing the operative site.

96. The above findings contained in Exhibit A11 clearly indicate that monopolar cautery was used during the procedure and that monopolar cautery was the only cautery equipment available in the hospital at the relevant time. Therefore, the contention of the opposite parties that bipolar cautery was used and that both monopolar and bipolar cautery systems were available in the same machine cannot be accepted.

97. It is pertinent to note that the version containing the above explanation was filed only after institution of the complaint and after the issue regarding the nature of cautery used had been specifically raised. On the other hand, the enquiry conducted by the expert medical team was carried out on 11.09.2018, much prior to the filing of the version, and the findings therein were based on contemporaneous verification and statements obtained during the enquiry. Hence, greater evidentiary value is liable to be attached to the findings recorded in Exhibit A11.

98. The opposite parties contended that during the post-operative observation period no complications were noticed and that the baby was discharged only after passing urine. It was further contended that proper post-operative instructions were given to the mother and necessary medicines were prescribed.

99. However, a perusal of Exhibit A1 discharge summary does not reveal any specific post-operative instructions, the procedure undergone before the first opposite party, the use of cautery whether monopolar or bipolar, advice for review, or direction to bring the child for follow-up examination on the next day, as subsequently contended by the opposite parties. During the proceedings before this Commission, the first opposite party admitted that no such instruction directing the parents to bring the child for review on the following day was recorded in the discharge documents.

100. It is an admitted fact that on the very same day after discharge, the baby developed continuous crying and urine leakage through the dressing. Consequently, the child was taken back to the hospital. The opposite parties have admitted that, on examination, the dressing was found to be loose around the urethral opening and therefore the original dressing was removed and a fresh dressing was applied. Thereafter, the parents were advised to bring the child for follow-up on 19.04.2018. According to the opposite parties, the complainants failed to report on the said date and brought the child only on 20.04.2018.

101. Significantly, none of these events find place either in the discharge summary or in the treatment records produced by the opposite parties. There is also a specific

allegation from the complainants that during the initial dressing following the circumcision procedure, the urinary opening was covered by the dressing, resulting in difficulty in urination and subsequent complications.

102. The records further reveal that when the child was brought to the hospital on 20.04.2018 with complaints of difficulty in passing urine, infection was noticed at the operative site. The opposite parties contended that, upon enquiry, the parents disclosed that they had not properly followed the prescribed medications. However, the materials available on record indicate that the medicines prescribed by the opposite parties had in fact been administered to the child. Therefore, the contention that the complications arose solely due to non-compliance with medication instructions cannot be accepted.

103. The records further show that the child was thereafter taken to the mother and child Hospital, Changaramkulam, for further management. However, no definitive treatment could be provided there and the child was referred to Amala Institute of Medical Sciences, Thrissur, as the condition could not be effectively managed. It is also stated that the concerned specialist was not available at the Mother and Child Hospital at the relevant time, which was one of the reasons for referring the patient to Amala Institute of Medical Sciences.

104. The treatment records from Amala Institute of Medical Sciences assume considerable significance. At the time of admission, the clinical history was recorded as follows:

«"29-day-old male baby, post circumcision on 18.04.2018 at a local hospital, presented with pus discharge from the surgical site since post-operative day two. The discharge had increased in quantity along with colour changes over the skin of the penis. The baby initially had poor urinary stream, which later improved. There was no history of fever, excessive crying, or poor feeding."»

105. On local examination, the following findings were recorded:

«"Sloughing of skin over the ventral aspect of the penis extending up to the base and involving the dorsum. Glans penis dusky in colour and firm in consistency. Meatus stenotic. Voiding present through the tip with a thin stream. Both testes normal."»

The hospital records further describe the clinical course as follows:-

«"29-day-old baby, post-operative day seven following circumcision done elsewhere, presented with non-healing wound and discharge. Clinically, the viability of the distal part of the penis was difficult to assess. The child was managed conservatively with saline soaks and intravenous antibiotics. The case was discussed with the plastic and reconstructive surgery team and the urologist regarding the feasibility of hyperbaric oxygen therapy following wound debridement and suprapubic catheterisation. The patient was referred for further management. The parents were informed regarding the possibility of penile sloughing, urethral fistula, meatal stenosis and the need for multiple reconstructive procedures."

106. These contemporaneous medical records clearly establish that within a few days of the circumcision procedure, the child had developed serious complications

including infection, tissue sloughing, meatal stenosis, and compromised viability of the distal penis, necessitating specialised tertiary care management.

107. The treatment records further reveal that, after undergoing treatment at Amala Institute of Medical Sciences, Thrissur, from 24.04.2018 to 26.04.2018, the child was referred to and admitted at Jubilee Mission Medical College Hospital, Thrissur, where he remained as an inpatient from 26.04.2018 to 10.05.2018.

108. The case summary issued by Jubilee Mission Medical College Hospital records that the patient was a 43-day-old male infant who presented with necrotizing penile skin following a circumcision procedure performed elsewhere on 18.04.2018. At the time of admission, the glans penis was noted to be black in colour and the child was passing urine as a thin spray through the expected site of the urethral meatus. The penile skin extending over the shaft up to its root was found to be unhealthy.

109. The records further reveal that the child underwent vesicostomy on 27.04.2018 for urinary diversion and management of the complications. The patient was also evaluated by a plastic surgeon and, based on the specialist's advice, hyperbaric oxygen therapy was commenced. The hospital records further note that the child was passing urine through an opening at the penoscrotal junction and that the ultimate anatomical status and requirement for reconstructive procedures could be assessed only after complete wound healing by secondary intention.

110. The above records clearly demonstrate that the complications suffered by the child were not minor or routine post-operative events. On the contrary, the child developed severe tissue necrosis involving the penis, discoloration of the glans,

unhealthy penile skin, urinary complications necessitating vesicostomy, and the formation of an abnormal urinary opening. The need for prolonged hospitalization, specialist consultations, hyperbaric oxygen therapy, and the possibility of future reconstructive procedures indicate the grave nature of the injuries sustained by the child following the circumcision procedure.

111. The medical records and other documents produced by the complainants disclose serious allegations of medical negligence against the opposite parties. The complainants have produced and marked Exhibits A1 to A16 in support of their case. Apart from the treatment records issued by various hospitals, the complainants have also relied upon reports prepared by competent authorities pursuant to enquiries conducted into the alleged medical negligence.

112. Exhibit A5 is the enquiry report submitted by Dr. V.R. Raju, Additional Director (Vigilance), who conducted an enquiry into the incident on receipt of complaint against hospital. The report contains, inter alia, the following findings:

1. The circumcision procedure was performed on a 23-day-old infant.
2. The surgery was conducted by Dr. Ashique, who possessed an MBBS degree and approximately three years of professional experience.
3. It was revealed that after the circumcision procedure the child was unable to pass urine properly, resulting in retention of urine and discomfort. Consequently, the child was taken back to the hospital on the very same evening. It was further reported that the dressing was again adjusted at the hospital.

4. It was understood that, on examination of the child on the third day after surgery, signs of infection were noticed.

5. Antibiotics had been prescribed by the treating doctor.

6. For local anaesthesia, approximately 1 to 2 ml of Lignocaine had been administered to the infant.

7. The drug administered was Lignocaine without Adrenaline.

8. It was intended that the child be brought back to the hospital for review within two days of the surgery. However, it was reported that the child was brought only on the third day.

9. It was reported by the parents that they had already incurred medical expenses of approximately Rs.1, 25,000/- towards the treatment of the child. In addition, recurring monthly expenses were being incurred for medicines and transportation to Jubilee Mission Medical College Hospital, Thrissur, for follow-up treatment.

10. Upon enquiry, it was found that the child had suffered loss of approximately 75% of the penile tissue.

113. The complainants have also produced Exhibit A6, which is the proceedings and order dated 27.12.2018 passed by the Kerala State Human Rights Commission in relation to the incident. A perusal of the said order reveals that the Human Rights Commission considered various reports submitted by competent authorities and medical experts who had conducted enquiries into the circumstances leading to the injury sustained by the child.

114. The Human Rights Commission noted the conclusions contained in the enquiry reports, which indicated that the injury was caused by the use of monopolar diathermy during the circumcision procedure, resulting in partial necrosis of the glans penis and gangrene of the penile shaft skin. The order further records that monopolar diathermy is known to cause severe complications such as penile necrosis, gangrene and burns when used in circumcision procedures, particularly in neonates and young infants.

115. The Human Rights Commission also examined the actions taken by various authorities in connection with the incident and made observations regarding the manner in which the matter was dealt with by the concerned officials. The Commission observed that the procedure in question was not a life-saving emergency intervention but an elective procedure performed on a new-born child. In such circumstances, a higher degree of care and caution was expected from the treating doctor and the hospital authorities.

116. The order further refers to the decision of the Hon'ble Supreme Court in Kishan Rao v. Nikhil Super Speciality Hospital, while considering the requirement of expert evidence in cases where negligence is apparent from the facts and circumstances of the case. The Human Rights Commission observed that the circumstances disclosed prima facie negligence and deficiency in service on the part of the treating doctor and the hospital.

117. Another aspect considered by the Human Rights Commission was the hygienic condition of the hospital where the procedure had been performed. The Commission expressed concern regarding the maintenance of hygiene standards in the hospital,

particularly in the operation theatre, and consequently directed the Government to examine the matter and take appropriate action regarding the hospital's compliance with the required standards of hygiene and patient safety.

118. The Human Rights Commission further recommended payment of compensation of Rs.2, 00,000/- to the family of the victim under Section 18(a) (i) of the Protection of Human Rights Act. However, it is seen from the records that the said recommendation had not been implemented at the relevant time.

119. Though the findings of the Human Rights Commission are not conclusive on the issue of civil liability, they constitute a relevant piece of evidence in the present proceedings.

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125. Though the findings of the Human Rights Commission are not conclusive on the issue of civil liability, they constitute a relevant piece of evidence in the present proceedings.

126. The complainants have further produced Exhibit A11, the enquiry report submitted by Dr. Ahamed Afzal pursuant to the directions of the District Medical Officer. The enquiry was conducted by a team comprising Dr. Ahamed Afzal, Dr. Krishnadas, Consultant in Medicine, and Dr. Mohammed Saleem, Consultant General Surgeon. The team inspected the hospital facilities, verified the available records, and interacted with the hospital staff as well as the relatives of the child.

127. The report discloses several serious deficiencies in the functioning and maintenance of the hospital, particularly with respect to infection control measures, sterilization procedures, operation theatre maintenance, and patient safety protocols. The enquiry team found that the hospital did not maintain proper records relating to fumigation procedures or the dates on which such procedures were conducted. Registers relating to operation theatre maintenance and microbial culture surveillance were also not available for verification.

128. The report further notes that the floors and walls of the operation theatre were not maintained in a hygienic condition and were found to be dusty, mould-infested, and deteriorated in several places. The vertical autoclave used for sterilization was found to be rusted, dirty, and inadequately maintained. The staff nurse entrusted with operating the autoclave was not fully aware of the proper sterilization procedures. Sterilized instrument bins did not bear sterilization indicators or records of the dates of sterilization. Opened instrument bins were reportedly used for prolonged periods without re-sterilization. No annual maintenance contract was available for the autoclave or for any of the operation theatre equipment.

129. The enquiry team also found that no proper records were maintained regarding surgical procedures conducted in the operation theatre. Registers relating to anaesthetic drugs and controlled medications were unavailable. Essential emergency equipment required in an operation theatre, including emergency trays, intubation equipment, laryngoscope, endotracheal tubes and Ambu bag, were reportedly absent.

With respect to the pharmacy, the enquiry team observed that medicines requiring refrigeration were stored without maintaining the prescribed temperature standards. The refrigerator was found in an unhygienic condition, with dead insects and pests inside. No proper stock registers were maintained for medicines. Registers relating to controlled and habit-forming drugs were also unavailable. Biomedical waste management practices were found to be grossly inadequate and not in compliance with the prescribed rules.

130. The report further records that used syringes and needles were being stored without adequate safety precautions. In the dressing room, sterilization equipment was found to be kept adjacent to bedpans used for collection of urine and faeces. Sterile dressing materials were not maintained in accordance with accepted sterilization protocols. Records regarding procedures performed and medicines administered in the procedure room were also not maintained. The enquiry team additionally observed deficiencies in the functioning and safety measures relating to the hospital's X-ray unit.

131. Significantly, the enquiry team recorded the statement of Ms. Ayisha, the staff nurse who was present during the circumcision procedure. According to the report, she disclosed that the only diathermy unit available in the operation theatre at the relevant time was a monopolar diathermy unit and that the same was used during the circumcision procedure. The report further records that Dr. Ashique admitted that cauterization had been employed during the procedure instead of suturing.

132. The enquiry team also opined that proper sterilization protocols had not been followed and that surgical instruments were used without adherence to accepted standards of sterilization, which could have contributed to the early onset of infection noticed in the child.

133. The ultimate conclusion of the enquiry report is of considerable significance. The team concluded that the injury sustained by the child was caused by the use of monopolar diathermy, resulting in partial necrosis of the glans penis and gangrene of the skin of the penile shaft. The report specifically observes that monopolar diathermy is notorious for causing penile necrosis, gangrene, and burn injuries when used for circumcision procedures and that such complications are particularly severe when the procedure is performed on neonates.

134. Exhibit A11 has been signed by Dr. Sakkeena K., who was the District Medical Officer at the relevant time. She was examined before this Commission as PW1. During her deposition, PW1 categorically stated that, upon receiving information regarding the incident and the allegations of medical negligence, she had constituted a team of expert doctors to conduct an enquiry into the matter. The enquiry team comprised Dr. Ahamed Afzal, Dr. Krishnadas, Consultant in Medicine, and Dr. Mohammed Saleem, Consultant General Surgeon.

135. PW1 further deposed that the enquiry team conducted an inspection of the hospital, verified the available records, interacted with the hospital staff and the relatives of the child, and thereafter submitted its report. According to PW1, Exhibit

A11 is the report prepared by the said expert team and the same was forwarded and authenticated by her in her official capacity as District Medical Officer.

136. Nothing substantial could be elicited in the cross-examination of PW1 to discredit the authenticity of Exhibit A11 or the manner in which the enquiry was conducted. The evidence of PW1 establishes that Exhibit A11 is not a private opinion or an individual assessment, but a report prepared by a team of qualified medical experts pursuant to an official enquiry ordered by the District Medical Officer. Therefore, Exhibit A11 carries considerable evidentiary value and deserves due weight while appreciating the allegations of medical negligence and deficiency in service raised in the present complaint.

137. It is pertinent to note that the enquiry team did not stop with identifying the immediate cause of the injury sustained by the child. The report contained in Exhibit A11 also records serious observations regarding the overall functioning of the hospital and the conditions prevailing therein.

138. The enquiry team specifically opined that the functioning of KVM Hospital, Perumpadappu, was highly unsafe and posed a serious threat to the health and safety of patients and the general public. The report records that the institution had failed to implement even the basic precautions and protocols required under accepted hospital infection control standards. The enquiry team further observed that the staff entrusted with sterilization and infection control procedures lacked adequate knowledge and training regarding proper sterilization practices and patient safety measures.

139. Having regard to the numerous deficiencies noticed during the inspection, including the absence of proper sterilization protocols, inadequate infection control measures, poor maintenance of operation theatre facilities, improper biomedical waste management, and lack of essential records, the enquiry team recommended that immediate steps be taken by the competent authorities to examine the continuance of the institution and to take appropriate action in accordance with law.

140. The report further records that the injuries suffered by the minor child, son of the complainants, following the circumcision procedure were attributable to the acts and omissions of the hospital authorities and the personnel involved in the treatment. Accordingly, the enquiry team recommended that appropriate action be initiated against the persons responsible for the incident.

141. These observations contained in Exhibit A11 assume significance as they were made by a team of qualified medical experts after a detailed inspection of the hospital and enquiry into the circumstances surrounding the incident. The commission do not find any reason to discard the findings in Ext A11.

142. On the side of the opposite parties, the first opposite party was examined as DW1. In addition, Dr. Beena S.V. was examined as DW2 and Shaheer P.M. was examined as DW3.

143. DW1 is Dr. Ashique, the treating doctor and the first opposite party, who performed the circumcision procedure on the infant. His evidence was adduced to explain the circumstances under which the procedure was conducted and to rebut the allegations of medical negligence raised by the complainants.

144. DW2, Dr. Beena S.V., is a Professor and Head of the Department of Paediatric Surgery. At the relevant time she was attached to the Department of Paediatric Surgery, Government Medical College, Thiruvananthapuram, and is presently serving at Government Medical College, Kottayam. She was examined as an expert witness on behalf of the opposite parties to offer her professional opinion regarding the circumcision procedure, the possible causes of the complications suffered by the child, and the standard of care expected in such cases.

145. DW3, Shaheer P.M., was also examined on behalf of the opposite parties in support of their defence and to substantiate the contentions raised in the written version.

146. DW2, Dr. Beena S.V., deposed that she had furnished an expert opinion in connection with Crime No. 88/2018 of Perumpadappu Police Station. According to her, before rendering the opinion, she had perused the medical records relating to the child, including Exhibits A1 to A6, Exhibit B4, and Exhibits X1 to X3. She stated that her opinion was based on the documents made available to her during the course of the enquiry.

147. During cross-examination, DW2 admitted that Exhibit B4 was issued as part of the proceedings before the State Level Apex Body constituted for considering the allegations raised in the criminal complaint. She further admitted that Exhibit B4 does not specifically record that she had verified Exhibits A1 to A6 before rendering her opinion.

148. DW2 also deposed that culpable negligence would necessarily include negligence. She further stated that she had not personally performed circumcision procedures on new-born infants except when medically indicated. According to her, bipolar cautery would ordinarily be preferred if available; however, monopolar cautery could also be used in appropriate circumstances. At the same time, she admitted that bipolar cautery is comparatively safer and more convenient for such procedures.

149. DW2 further conceded that conducting a surgical procedure in a non-hygienic operation theatre would amount to a deficiency in the standard of care expected from a hospital. She also admitted that before issuing Exhibit B4 she had neither examined the minor child nor personally assessed the condition of the child's penis or the extent of the injury sustained. Her opinion was therefore based solely on the records placed before her and not on any direct clinical examination of the patient. At the same time she admitted that B4 document does not reveal the documents verified by her before issuance of B4 document.

150. The evidence of DW2 shows that her opinion was rendered primarily for the purpose of the criminal proceedings and was based on the materials made available to her at that stage. Since she had no occasion to personally examine the child and since Exhibit B4 itself does not disclose the precise records verified by her before rendering the opinion, the evidentiary value of her testimony has to be assessed with caution.

151. DW3, Dr. Shaheer P.M., was examined on behalf of the opposite parties. He deposed that infection following a surgical procedure is a medically recognized and well-documented complication and may occur for various reasons. On being shown Exhibit A1, he stated that the first medicine prescribed therein was an antibiotic and the second medicine was an analgesic and that the dosage prescribed was within the accepted range for a child of the age concerned. After perusing Exhibit X1, he further deposed that the records disclosed features suggestive of infection and, according to him, the same did not necessarily indicate a complication attributable to cautery. He also stated that Exhibit A1 did not specifically disclose any cautery-related complication.

152. During cross-examination, DW3 admitted that he had not been given sufficient opportunity to examine the records in detail before entering the witness box. He further conceded that where an expert committee has already conducted an enquiry and rendered findings after detailed verification of the records and relevant materials, an opinion formed merely by perusal of selected documents at a later stage would have only limited evidentiary value.

153. DW3 initially stated that he was not acquainted with DW1, Dr. Ashiq. However, he admitted that he had been contacted and requested to appear before the Commission by a doctor, though he could not initially recollect the name. He further admitted that verification of his telephone records would reveal that DW1 had contacted him in connection with his appearance before the Commission.

154. DW3 also admitted that bipolar cautery is generally more suitable while performing circumcision on a new-born child. He further conceded that he was not personally aware of the factual circumstances surrounding the present case and that although he had seen Exhibits X1, X2 and X3, he had not examined those documents in detail prior to giving evidence. His opinion was therefore not based upon an independent examination of the patient or a detailed scrutiny of the entire medical records available in the case.

155. The evidence of DW3 indicates that his opinion was of a general nature regarding post-operative infections and possible complications of surgical procedures. Admittedly, he had neither treated nor examined the child at any point of time. He had also not undertaken a detailed evaluation of the complete medical records, expert committee reports, or enquiry findings before deposing before this Commission. So the version of DW 3 cannot be considered as an independent version and so his evidence requires careful scrutiny since he appeared before the commission at the instance of DW 1.

156. The complainants have a case that the third opposite party hospital was not properly equipped for conducting circumcision procedures, that the doctor who performed the procedure lacked adequate experience, and that the unhygienic condition of the operation theatre resulted in infection and subsequent complications to the minor child.

157. The Commission has carefully gone through the pleadings, oral evidence and documents produced by the parties. Among them, Exhibit A11 assumes considerable

significance. Exhibit A11 is the report submitted by the Expert Medical Team constituted by the District Medical Officer to enquire into the incident.

158. The report reveals several serious deficiencies in the maintenance and sterilization practices of the operation theatre. The Expert Team found that there were no records relating to proper fumigation procedures and their implementation. Records regarding annual maintenance of the operation theatre and microbiological culture swab testing were also not available. The floors and walls of the operation theatre were found to be inadequately cleaned, with accumulation of dust, mould and dirt.

159. The report further notes that the vertical autoclave used in the sterilization room was found rusted, dirty and poorly maintained. The nursing staff responsible for operating the autoclave did not possess adequate knowledge regarding its proper use. Autoclaved bins were not properly labelled or monitored, and opened bins were reportedly used for up to one week without re-autoclaving.

160. The aforesaid findings of the Expert Medical Team clearly disclose the unsatisfactory and unhygienic condition of the operation theatre maintained by the third opposite party hospital. Significantly, the witnesses examined on behalf of the opposite parties also admitted that conducting a surgical procedure such as circumcision in a non-hygienic operation theatre would amount to deficiency in service and is not expected from a qualified medical practitioner.

161. Therefore, the evidence on record establishes that the operation theatre maintained by the third opposite party hospital was not maintained in accordance with

accepted standards of hygiene and sterilization. These deficiencies materially support the complainants' allegation that the unhygienic conditions prevailing in the hospital contributed to the post-operative infection and the complications that subsequently arose in the treatment of the minor child.

162. The arguments advanced on behalf of opposite parties 1 to 3 are substantially similar in nature. The learned counsel appearing for the opposite parties contended that medical negligence cannot be presumed merely because an adverse outcome occurred following a medical procedure. According to the opposite parties, the complainants have failed to establish any act of negligence on the part of the treating doctor or the hospital by acceptable evidence.

163. It was further argued non-administration of antibiotics is the cause of the complication. The opposite parties contend that no material has been produced to establish that the treatment administered to the child was contrary to accepted medical practice. It is also submitted that there is no expert medical opinion specifically attributing the injuries sustained by the child to any negligent act or omission on the part of the opposite party doctor.

164. The opposite parties further contend that the observations contained in Exhibit A11 report submitted by the Expert Medical Team constituted by the District Medical Officer relate only to administrative and regulatory deficiencies in the maintenance of the institution and do not constitute proof of medical negligence in the conduct of the circumcision procedure. According to the opposite parties, the findings regarding sterilisation practices, maintenance of records and operation theatre management

cannot, by themselves, establish a causal connection between the treatment rendered and the injuries subsequently suffered by the child.

165. It was also argued that the allegation that the child may suffer future sexual incapacity or other permanent functional disabilities is purely speculative and unsupported by any reliable medical evidence. According to the opposite parties, such contentions are based on assumptions and apprehensions rather than established facts and therefore cannot form the basis for awarding compensation.

166. The first opposite party also filed a detailed argument note and relied upon various decisions of the Hon'ble Supreme Court of India, the Hon'ble National Consumer Disputes Redressal Commission and other judicial authorities in support of its contentions.

167. It was argued that the complainants have failed to specifically plead and prove that the injuries sustained by the minor child were the direct consequence of any negligent act or omission on the part of the opposite parties. According to the first opposite party, the burden of proving medical negligence lies upon the complainants and the same has not been discharged in the present case.

168. It was further contended that any alleged non-compliance by the patient or attendants with post-operative instructions cannot be attributed to the treating doctor or hospital as negligence. The first opposite party submitted that the treatment administered to the child was in accordance with accepted medical standards and established medical protocol prevailing at the relevant time.

169. It is further argued that, since the present complaint involves allegations of medical negligence, the complainants were required to adduce reliable expert evidence establishing breach of the standard of care and the causal connection between such breach and the injuries complained of. According to the first opposite party, no such expert evidence has been produced by the complainants.

170. It was specifically contended that the principle of ***res ipsa loquitur*** is not attracted to the facts of the present case and that negligence cannot be inferred merely because complications developed following the procedure. The first opposite party further submitted that the expert evidence adduced on behalf of the opposite parties remains unchallenged by any contrary expert opinion from the side of the complainants.

171. The first opposite party also contended that statements recorded under Section 161 of the Code of Criminal Procedure and the materials collected during the criminal investigation do not possess binding evidentiary value in proceedings under the Consumer Protection Act. Similarly, it was argued that the findings, observations and recommendations of the Human Rights Commission are not binding upon this Commission and cannot, by themselves, constitute proof of medical negligence.

172. It was further argued that no satisfactory evidence has been produced to establish the existence of any present disability, permanent impairment or functional incapacity suffered by the minor child as a consequence of the procedure. According to the first opposite party, the allegations regarding future complications and disability are unsupported by reliable medical evidence.

173. The learned counsel for the opposite parties vehemently contended that there is no pleading in the complaint regarding improper use of cautery or cautery-induced injury and therefore the complainants cannot be permitted to travel beyond the pleadings and set up a new case during the course of evidence. Reliance was placed on the decision in **Deep Nursing Home v. Manmeet Singh Mathewal** reported in AIR 2025 SC 4220 to contend that parties are bound by their pleadings and that no relief can be granted on a case not pleaded.

174. The said contention does not merit acceptance in the facts and circumstances of the present case. The complainant is the parent of a 23-day-old infant who underwent circumcision as part of religious ceremony. Admittedly, the parent is not present inside the operation theatre and had no knowledge regarding the precise procedure adopted by the doctor, the nature of the instruments used or the manner in which the surgery was performed. Therefore, it cannot reasonably be expected that the complainants should have specifically pleaded the use of monopolar or bipolar cautery at the time of institution of the complaint. It is also disclosed later that no document is kept with opposite party regarding the procedure undergone before opposite party. Hence the complainant is not aware of what transpired inside the operation theatre.

175. It was only after filing of the versions by the opposite parties and upon production of the treatment records and other materials that the complainants became aware of the case set up by the opposite parties regarding the use of cautery during the procedure. The records and the reports subsequently brought on record

disclose the use of cautery during the surgery. Further, the Expert Medical Team appointed by the District Medical Officer has specifically reported that one and only monopolar cautery was available in the hospital. Therefore, the issue regarding cautery usage emerges from the evidence and records produced by the opposite parties themselves and cannot be treated as an altogether new and inconsistent case introduced by the complainants.

176. The opposite parties also contended that the statements recorded under Section 161 Cr.P.C. cannot be treated as substantive evidence and cannot be relied upon to prove the truth of their contents. Reliance was placed on various judicial precedents in support of the said proposition. There cannot be any dispute regarding the legal principle that statements recorded during criminal investigation are not substantive evidence in judicial proceedings. However, in the present complaint, this Commission has not relied upon such statements as substantive evidence for arriving at its conclusions. Therefore, the said contention is of no consequence in the adjudication of the present dispute.

177. On the other hand, the findings relied upon by the complainants are not based on the statements recorded during investigation but on the reports prepared by competent medical experts. Exhibit A11, namely the report of the Expert Medical Team constituted under the supervision of the District Medical Officer, assumes considerable significance. The report was prepared after inspection of the hospital, operation theatre and relevant records and after examining the circumstances leading to the incident. The report represents the opinion of a team of qualified medical

professionals and therefore constitutes relevant expert evidence. Apart from the said report, the materials on record also disclose that a medical expert associated with the vigilance inquiry had independently examined the matter and submitted a report. Thus, the contention that there is no expert evidence in support of the complainants' case cannot be accepted.

178. The further contention of the opposite parties that medical negligence has not been established also requires consideration. Admittedly, the minor child was only 23 days old and was taken to the hospital solely for circumcision performed as part of a religious practice called “sunnath”. There is no case that the child was suffering from any pre-existing disease, infection or abnormality necessitating treatment. The complications admittedly developed only after the procedure performed by the opposite parties.

179. The complainant submitted that immediately after the procedure the circumcision site was tightly dressed without providing a proper opening for passage of urine. The evidence further discloses that even when the child was brought back to the hospital on the same day with complaints, the dressing continued to cover the urinary outlet. These circumstances provide a plausible explanation for the development of infection and complications. The complainants have also consistently alleged that the hospital lacked adequate facilities, that the staff involved were inexperienced and that the operation theatre was maintained in unhygienic conditions.

180. The findings contained in Exhibit A11 reveal serious deficiencies in the maintenance and sterilization practices of the operation theatre, including absence of proper fumigation records, deficiencies in autoclaving procedures and unhygienic conditions prevailing in the theatre complex. These findings lend substantial support to the complainants' allegation that the infection was attributable to the deficient conditions prevailing in the hospital.

181. It is further relevant that the treatment records themselves disclose the presence of burn injury and sloughing of tissues in the genital region. The occurrence of such injury immediately following a circumcision procedure is a material circumstance. While no witness has directly deposed as to the precise manner in which the burn injury occurred during surgery, the medical records themselves constitute contemporaneous evidence regarding the condition of the child after the procedure. The records speak for themselves regarding the nature of the injury sustained.

182. In the peculiar facts of the present case, where a healthy 23-day-old infant underwent a routine circumcision procedure and thereafter suffered extensive tissue loss, burn injury, infection and grave complications, the surrounding circumstances assume considerable significance. The sequence of events, the nature of the injuries reflected in the treatment records and the findings of the expert medical team collectively constitute circumstances from which negligence can reasonably be inferred. Therefore, this Commission is unable to accept the contention of the opposite parties that the principle of *res ipsa loquitur* has no application whatsoever to the facts of the case.

183. The learned counsel for the opposite parties relied upon the decisions **in Jacob Mathew v. State of Punjab and Deep MNA Medical Centre v. Sunita** and contended that medical negligence cannot be presumed merely because a treatment or procedure did not produce the expected result.

184. There can be no dispute regarding the legal principles laid down in the aforesaid decisions. However, the facts of the present case are materially different. The finding of negligence in the present complaint is not based solely on the adverse outcome of the procedure. The evidence on record discloses specific circumstances indicating deficiency in service and negligence on the part of the opposite parties.

185. The materials on record, particularly Exhibit A11 report submitted by the Expert Medical Team constituted under the supervision of the District Medical Officer, disclose serious deficiencies in the maintenance of the operation theatre and sterilization procedures in the third opposite party hospital. The report reveals absence of proper fumigation records, deficiencies in autoclaving procedures and unhygienic conditions prevailing in the operation theatre. These findings have not been effectively discredited by the opposite parties.

186. More importantly, the expert witness examined on behalf of the opposite parties, Dr. Beena, admitted during evidence that conducting a surgical procedure in a non-hygienic operation theatre would itself amount to deficiency in service and would not be consistent with accepted standards of medical practice. Thus, the evidence on record establishes not merely an adverse outcome but a specific instance of deficiency in the conditions under which the procedure was performed.

187. The treatment records produced from Amala Hospital and Jubilee Mission Hospital further disclose the presence of burn injury and tissue damage at the circumcision site. The existence of such injury immediately following the circumcision procedure is reflected in the contemporaneous medical records. No material has been placed before this Commission to indicate any cause other than the procedure performed by the opposite parties for the occurrence of such burn injury.

188. The complainants have successfully established that the circumcision procedure was performed by the first opposite party in the third opposite party hospital and that serious complications, including infection, tissue damage and burn injury, developed immediately thereafter. Once such facts are established, it is not for the complainants to explain the precise mechanism by which the injury occurred inside the operation theatre. The details of the procedure, the instruments used and the circumstances under which the injury occurred are matters especially within the knowledge of the doctor and hospital concerned.

189. In the present case, the opposite parties have not offered any satisfactory explanation as to how the infection developed or how the burn injury occurred at the surgical site. No alternative cause has been established through evidence. In the absence of any convincing explanation from the opposite parties, an adverse inference necessarily arises against them.

190. The opposite parties attempted to attribute the complications to possible congenital anomalies of the penis and urethra, including hypospadias. However, the evidence on record shows that the child was examined prior to the procedure and was

found fit to undergo circumcision. The opposite parties themselves have admitted that the circumcision was performed only after clinical evaluation of the baby. In such circumstances, the contention regarding previously undiagnosed hypospadias or similar anomalies remains purely speculative and unsupported by any convincing evidence. Therefore, this Commission is unable to accept the said contention.

191. The further argument that the principle of *res ipsa loquitur* is inapplicable to the present case is also not acceptable. The evidence establishes that a healthy 23-day-old infant was taken for a routine circumcision performed for religious purposes and thereafter developed severe complications, including infection, tissue loss and burn injury. The circumstances surrounding the occurrence are such that the opposite parties were under an obligation to furnish a satisfactory explanation regarding the cause of the injuries. Having failed to do so, the opposite parties cannot successfully contend that no inference of negligence can be drawn.

192. Therefore, upon an overall appreciation of the oral and documentary evidence on record, this Commission is unable to accept the contentions advanced by the opposite parties. On the contrary, the complainant could establish negligence and deficiency in service on preponderance and probabilities.

193. The opposite parties further contended that the criminal proceedings initiated in connection with the incident came to be closed on the basis of the opinion rendered by the Apex Medical Board, which reportedly found absence of culpable medical negligence on the part of the treating doctor. According to the opposite parties, the

said finding supports their contention that no negligence has been established in the present case.

194. This Commission is unable to accept the above contention in the manner advanced by the opposite parties. The concept of culpable medical negligence required for fastening criminal liability is fundamentally different from the negligence required to establish civil liability under the Consumer Protection Act. Criminal liability arises only when the negligence is of such a gross or reckless nature as to attract penal consequences, whereas consumer disputes are decided on the basis of deficiency in service and negligence established on the preponderance of probabilities.

195. Therefore, a finding that there was no culpable negligence sufficient to attract criminal prosecution does not automatically lead to the conclusion that there was no negligence or deficiency in service for the purpose of consumer proceedings. The standards applicable in criminal proceedings and consumer proceedings are distinct and operate in different fields.

196. It has also come out in evidence that during the examination of DW2, questions were raised regarding the materials considered by the Apex Medical Board while arriving at its conclusions. The complainants have specifically contended that all relevant records were not placed before the Apex Medical Board and that appropriate proceedings have been initiated challenging the said findings. The complainants have also produced materials to show that the findings of the Apex Medical Board have been questioned before the Hon'ble High Court of Kerala through WP©16311 of year 2026.

197. Further, DW2 was unable to specify in detail the documents and materials that were considered by the Apex Medical Board while rendering its opinion B4. It is also evident that Exhibit A11, namely the report of the Expert Medical Team constituted under the supervision of the District Medical Officer, contains detailed findings regarding the circumstances surrounding the incident, the condition of the operation theatre and the deficiencies noticed in the hospital. There is nothing on record to show that the said report and its findings were considered by the Apex Medical Board while arriving at its conclusion.

198. This Commission also notes that Exhibit A11 is the opinion of a team of qualified medical experts who conducted an independent inquiry into the incident and submitted a detailed report after examining the relevant circumstances. The findings contained therein cannot be ignored merely because another medical body expressed an opinion regarding the absence of culpable negligence for the purpose of criminal proceedings.

199. Accordingly, the finding of the Apex Medical Board regarding absence of culpable negligence cannot be treated as conclusive or binding in the present consumer dispute. The absence of culpable negligence sufficient to attract criminal liability does not necessarily exclude the existence of negligence or deficiency in service under consumer law.

200. Therefore, this Commission is of the view that the closure of the criminal proceedings and the opinion regarding absence of culpable negligence do not absolve the opposite parties from civil liability if negligence and deficiency in service are

otherwise established by the evidence available on record. Consequently, the said contention raised by the opposite parties is rejected. The Supreme Court has repeatedly held that criminal negligence requires a much higher degree of negligence ("gross negligence" or "recklessness") than civil negligence, and therefore acquittal or closure of criminal proceedings does not by itself bar a consumer forum from finding negligence on the basis of the civil standard of proof.

201. The evidence on record, both oral and documentary, discloses that the circumcision procedure was performed on a 23-day-old infant at the hospital of the opposite parties. The materials available before the Commission reveal serious deficiencies in the manner in which the procedure was undertaken and in the facilities available at the hospital.

202. The evidence further discloses that the procedure was performed in a hospital where hygienic standards were found to be inadequate. The reports of the expert committees and the inspection conducted under the supervision of the District Medical Officer reveal deficiencies in sterilization practices, maintenance of operation theatre records, and maintenance of equipment and overall hygiene of the operation theatre. The evidence also indicates absence of adequate facilities and deficiencies in trained supporting staff required for conducting such procedures on a neonate.

203. It has also come out in evidence that electro cautery was used during the procedure. The subsequent medical records from the referral hospitals disclose, sloughing of skin and extensive loss of penile tissue following the circumcision. Sloughing of skin can occur as a result of burn injury. The opposite parties have not

been able to furnish a satisfactory explanation for the occurrence of such injuries. The records do not disclose any pre-existing abnormality or disease which could reasonably account for the injuries sustained by the infant.

204. The complainant has a specific case that the post-operative dressing was improperly applied and that adequate provision for passage of urine was not left open. It is also in evidence that the child had to be taken back to the hospital on the very same day and the dressing had to be redone. These circumstances lend support to the allegation that the post-procedure care was not carried out with the degree of care expected from a reasonably competent medical practitioner.

205. The Commission is mindful that the parents of a 23-day-old infant could not have personal knowledge of the exact surgical technique employed during the procedure. The details of the procedure, instruments used, precautions taken and post-operative management were matters exclusively within the knowledge of the treating doctor and hospital. Therefore, it was incumbent upon the opposite parties to maintain proper medical records and produce them before the Commission. However, the evidence reveals that proper and complete records regarding the procedure were not maintained. Failure to maintain and produce relevant treatment records gives rise to an adverse inference against the opposite parties regarding the conduct of the procedure.

206. The medical records produced from the subsequent treating hospitals clearly disclose extensive tissue loss and serious injury to the genital organ of the infant following the circumcision. There is no evidence to suggest that the injuries were

attributable to any negligence or omission on the part of the parents. The contention regarding lack of care by the parents is wholly untenable in the case of a 23-day-old infant who was entirely dependent upon the treatment and instructions provided by the opposite parties.

207. The opposite parties were under a duty to provide a convincing medical explanation for the injuries sustained by the infant. No such satisfactory explanation has been forthcoming. On the contrary, the evidence on record establishes lack of adequate hygiene, deficiencies in facilities, inadequate expertise and failure to maintain proper records relating to the procedure.

208. The Commission has also considered the reports of the Expert Medical Committee, the Medical Board and the findings rendered during the inquiries conducted by the competent authorities. Though the findings of the Human Rights Commission and the Expert Medical Committee are not binding on this Commission, they are nevertheless relevant pieces of evidence. The reports were prepared by competent authorities after inquiry into the incident and after examining the available materials. The findings therein consistently point to deficiencies in the facilities available at the hospital, lack of adequate expertise and lapses in the treatment rendered to the infant.

209. The opposite parties have not produced convincing rebuttal evidence sufficient to discredit or outweigh the conclusions contained in those reports. Consequently, the said reports lend substantial support to the complainant's case and reinforce the

conclusion that there was deficiency in service and medical negligence on the part of the opposite parties.

210. The contention that no criminal offence or culpable negligence was found against the opposite parties is of little assistance in the present proceedings. Criminal liability and civil liability operate in distinct fields and are governed by different standards of proof. The absence of criminal culpability does not preclude a finding of medical negligence or deficiency in service where the evidence establishes negligence on the touchstone of preponderance of probabilities.

211. **In Jacob Mathew v. State of Punjab,** the Supreme Court explained the distinction between criminal negligence and civil negligence and recognized that failure to establish criminal liability does not automatically absolve a medical professional from civil liability.

212. Considering the entire evidence on record, the Commission is satisfied that the complainant has succeeded in establishing medical negligence and deficiency in service on the part of the opposite parties. Accordingly, Points No 2 and 3 is answered in favour of the complainant and against the opposite parties.

Point No.4 Relief and cost

213. The evidence on record establish that the infant who was only 23 days old underwent circumcision and developed serious complications immediately thereafter. The medical records disclose sloughing penile skin, dusky glans, meatal stenosis and the necessity for prolonged treatment at multiple hospitals including higher centres.

The circumstances reveal that the opposite parties were unable to effectively manage the complications and had to refer the child for specialized treatment.

214. It is pertinent to note that prior to the procedure no abnormality or contradiction was recorded in the child. The procedure was therefore undertaken on an otherwise healthy infant. The evidence of PW1 to PW3, read along with the documentary evidence and the testimony of DW1 to DW3 establishes deficiency in service and medical negligence on the part of opposite parties.

215. The injury involved a vital and sensitive organ of the body. The records disclose permanent genital deformity and prolonged suffering. Considering the tender age of the child, pain and suffering undergone, future medical care and reconstructive treatment including multiple surgeries, loss of amenities of life, psychological consequences and the uncertainty regarding future urinary, sexual and re productive functions, this commission is of the view of substantial compensation is warranted.

216. The complainant have claimed Rs. 50, 00,000/-as compensation but there is no specific yardstick for determining compensation in cases of this nature. This is not a case of occupational disability or loss of earning capacity. Hence the Commission consider rupees 25,00,000/-as compensation on account of pain and suffering undergone by the infant, loss of amenities in the entire future life, psycolological consequences including lifelong stress, and uncertainty regarding future urinary, sexual and reproductive functions considering also the tender age of victim. The treatment records including Ext A16 disclose the requirement of multiple surgeries in future and so we consider Rs. 25,00,000/- towards future treatment expense. Having

regard to the facts and circumstances of the case the Commission considered Rs.50,00,000/- as just, fair and reasonable compensation.

217. The complainant have also claimed medical expenses already incurred. However in the absence of satisfactory documentary evidence regarding the actual expenditure incurred, the said claim cannot be separately allowed. The commission also finds the complainant is entitled cost of the proceedings and we find the same as Rs. 25,000/-.

218. Accordingly opposite parties 1 to 3 are respectively being the treated doctor of the infant, the owner of the third opposite party hospital and the hospital are held jointly and severally liable for the deficiency in service and negligence established in this complaint.

219. In the result the complaint stands allowed as follows:-

1) The opposite parties 1 to 3 shall be jointly and severally liable to pay a sum of Rs.25,00,000/- (Rupees twenty five lakh only) as compensation to the complainant on account of the deficiency in service and negligence established in the complaint, which caused pain and suffering to the infant, loss of amenities in throughout future life, and psychological consequences, including lifelong stress, and uncertainty regarding future urinary, sexual, and reproductive functions having due regard to the tender age of the victim.

2) The opposite parties 1 to 3 are further directed to pay a sum of Rs.25,00,000/- (Rupees twenty five lakh only) to the complainant towards future treatment expenses, including multiple surgeries, as disclosed in the

documents, particularly Ext .A16 document.

3) The opposite parties 1 to 3 shall jointly and severally pay Rs.25, 000/-(Rupees twenty five thousand only) to the complainant towards the cost of the proceedings.

The above amounts shall be paid within one month from the date of receipt of copy of this order, falling which the entire amount shall carry interest at the rate of 9% per annum from the date of filing this complaint until realization. All the inter locutory applications filed in this complaint stands disposed in accordance with this final order.

(Dictated to the Confidential Assistant Sri. Haridasan .V.P transcribed and typed by him, corrected by me and pronounced in the Open Commission on this 30th day of June, 2026).

Mohandasan. K, President

Preethi Sivaraman.C, Member

Mohamed Ismayil.C.V, Member

APPENDIX

Witness examined on the side of the complainant: PW1 to PW3

PW1: Dr. Sakkeena, District Medical Officer.

PW2: Ms. Jameela, the guardian of the victim/complainant.

PW3: Mr. Ismail Maranchery, Pharmacist.

Documents marked on the side of the complainant: Ext.A1 to A16

Exhibit A1: Cash receipt dated 18.04.2018 for Rs.1, 500/- along with the prescription issued by KVM Medical Centre on the same date.

Exhibit A2: Prescription issued by Mother and Child Hospital, Changaramkulam, dated 24.02.2018, prescribing Neosporin for local application.

Exhibit A3: Discharge summary issued by Amala Institute of Medical Sciences for the treatment period from 24.04.2018 to 26.04.2018.

Exhibit A4: Discharge summary issued by Jubilee Mission Medical College Hospital, Thrissur, relating to the treatment period from 26.04.2018 to 27.04.2018.

Exhibit A5: Inquiry report submitted by the Additional Director of Vigilance. The inquiry was conducted on 07.08.2018 and the report is dated 04.09.2018.

Exhibit A6: Report of the Human Rights Commission dated 27.12.2018.

Exhibit A7: Copy of FIR No. 88/2018 of Perumpadappu Police Station dated 21.05.2018.

Exhibit A8: Copy of the memorandum of evidence in connection with Crime No. 88/2018.

Exhibit A9: Statement of Dr. Krishnadas.

Exhibit A10: Copy of the FIR in Crime No. 88/2018 along with the F.I.S.

Exhibit A11: Inquiry report obtained from the office of the District Medical Officer.

Exhibit A12: Set of photographs relating to the circumcision procedure.

Exhibit A13: Expert Panel Circular dated 18.02.2018.

Exhibit A14: Report issued by the Forum for Advanced Paediatric Evaluation Services (FAPES) dated 03.07.2020.

Exhibit A15: Statement of Dr. Ashique recorded before the Additional Director of Vigilance on 07.08.2018.

Exhibit A16: Certificate relating to the physical condition of the victim.

Witness examined on the side of the opposite party: DW1 to DW3

DW1: Dr. Ashique

DW2: Dr. Beena,

DW3: Dr. Shaheer.

Documents marked on the side of the opposite party: Ext. B1 to B7

Exhibit B1: Certificate of Registration of the hospital.

Exhibit B2: Interim order passed by the Hon'ble High Court of Kerala granting stay.

Exhibit B3: Minutes of the State Level Apex Body Meeting held at the Library Hall, Government Guest House, Ernakulum.

Exhibit B4: Opinion of the expert body regarding the allegation of medical negligence.

Exhibit B5: Communication addressed to the learned Advocate General from the Directorate of Health Services.

Exhibit B6: Copy of the order dated 25.07.2025 passed by the Hon'ble High Court of Kerala in O.P. (Crl.) No. 648 of 2024.

Exhibit B7: Copy of the e-mail communication relied on by the opposite parties.

Exhibit B8: Copy of the order in ST 708/2019 JFCM , Ponnani dated 17/10/2025.

Exhibit X1: Case history records obtained from Amala Institute of Medical Sciences, Thrissur.

Exhibit X2: Case history records obtained from Jubilee Mission Medical College Hospital, Thrissur.

Exhibit X3: Copy of enquiry file obtained from District Medical Office, Malappuram dated 27/01/2025.

Mohandasan. K, President

Preethi Sivaraman.C, Member

Mohamed Ismayil.C.V, Member