DMC/DC/F.14/Comp.2654/2/2020/ 04th March, 2020

**O R D E R**

The Delhi Medical Council through its Disciplinary Committee examined a representation from Dy. Commissioner of Police, South District, New Delhi, seeking medical opinion on a complaint of Shri Sanjay Kumar, B-13/B Khanpur Extension, New Delhi-110062, forwarded by the Department of Health & Family Welfare, Govt. of NCT of Delhi, alleging medical negligence on the part of doctors of Max Smart Super Specialty Hospital, Mandir Marg, Press Enclave Road, Saket, New Delhi-110017, in the treatment of complainant’s brother Shri Ranjeet Singh, resulting in his death on 15.11.2018.

The Order of the Disciplinary Committee dated 17th February, 2020 is reproduced herein-below:-

The Disciplinary Committee of the Delhi Medical Council examined a representation from Dy. Commissioner of Police, South District, New Delhi, seeking medical opinion on a complaint of Shri Sanjay Kumar, B-13/B Khanpur Extension, New Delhi-110062 (referred hereinafter as the complainant), forwarded by the Department of Health & Family Welfare, Govt. of NCT of Delhi, alleging medical negligence on the part of doctors of Max Smart Super Specialty Hospital, Mandir Marg, Press Enclave Road, Saket, New Delhi-110017 (referred hereinafter as the said Hospital), in the treatment of complainant’s brother Shri Ranjeet Singh(referred hereinafter as the patient), resulting in his death on 15.11.2018.

The Disciplinary Committee perused the representation from Police, copy of complaint of Shri Sanjay Kumar, written statement of Dr. Sahar Qureshi Medical Superintendent of Max Hospital enclosing written statement of Dr. Jitendra Maheshwari, Dr. Nitin Bahl, Dr. Shikha Singh, Dr. Arun Dewan, copy of medical records of Max Hospital, Post Mortem report no. 1625-18, viscera chemical analysis report, Histopathology report, subsequent opinion in respect of post mortem no. 1625-18 and other documents on record.

The following were heard in person :-

1. Shri Sanjay Kumar Complainant
2. Dr. Jitendra Maheshwari Senior Consultant & Head of Department

of Orthopaedics, Max Smart Super Specialty Hospital

1. Dr. Nitin Bahl Senior Consultant Anaesthesia, Max

Smart Super Specialty Hospital

1. Dr. Shikha Singh Physiotherapist, Max Smart Super

Specialty Hospital

1. Dr. Arun Kumar Dewan Director Critical Care & Med., Max Smart

Super Specialty Hospital

1. Shri Moaniken DGM-Admn., Max Smart Super Specialty

Hospital

1. Dr. Sahar Medical Superintendent, Max Smart Super

Specialty Hospital

The complainant Shri Sanjay Kumar alleged that the he would like to bring notice of the Delhi Medical Council about the grave negligence at play in the treatment of his brother the patient Shri Ranjit Singh. He was a specially-able person who had a road accident on the evening of 10th November, 2018 in front of Max Super Speciality Hospital, Saket. Bystanders intervened and admitted his brother to the same Hospital where the doctors found out that the bone connecting the knee and ankle (Tibia/Fibula) was broken. Apart from that, there were no other injuries. Accordingly, the doctors at Max Super Speciality Hospital, Saket operated the leg on 12th November, 2018 and informed them that the hospital will be able to discharge the patient, within next two days. However, in the evening of 13th November, 2018, the patient complained of having breathlessness, pain in chest and collapsed on the floor. According to the staff of Max Super Speciality Hospital, the patient’s heart stopped working but was resuscitated after CPR. This happened several times within a span of few hours and his brother had collapsed into comatose. The hospital administration did not bother to inform them about these incidents that night and they were informed the next day. When confronted, the administration confessed about not taking cognizance of a large lump of blood-clot during operation which was left in the body during the operation and later travelled internally to various body parts causing kidney, heart and brain failure. On 15th November, 2018, his brother was fighting for his life at Max Super Speciality Hospital, Saket. The doctors were abusive, avoiding commenting on the status of his health and their family was in a very vulnerable situation. Around midnight, his brother died under mysterious circumstances that involved organ failure while he was admitted in the hospital for leg injury. His family faced life loss because of laxity and gross negligence in his brother treatment at Max Super Speciality Hospital, Saket. Please consider this complaint against Max Super Speciality Hospital, Saket and he urges the Delhi Medical Council to take needful and justified action on his brother death. His family wants the case to be investigated thoroughly and guilty should be punished.

It is noted that the police in its representation has averred that one Ranjeet Singh s/o late Sh. Rajpal (the deceased) H.No.B-13/B, Khanpur Extn., New Delhi was admitted in Max Hospital Saket on 10th November, 20185 after he had sustained injuries in a road traffic accident vide MLC No.604/18. During the treatment on 13th November, 2018, he was shifted to ICU, as his condition deteriorated. A case vide FIR no.679/18 dated 13th November, 2018 U/s 279/337 IPC was registered PS Saket. On 15th November, 2018, he expired at Max Hospital, Saket, New Delhi. The family members of the deceased are leveling allegations and have lodged a complaint that he had got one fracture only in the accident and was treated for the same on 10th November, 2018 but he was shifted to ICU only on 13th November, 2018 where he subsequently died due to negligence of hospital. The post-mortem of the deceased was got conducted at AIIMS Hospital on 16th November, 2018 and viscera have been preserved. In view of the above facts, it is requested to opine whether any case of medical negligence is made out or any other action is required in the matter.

Dr. Jitendra Maheshwari, Senior Consultant & Head of Department of Orthopaedics, Max Smart Super Specialty Hospital in his written statement averred that the patient, Mr. Ranjeet Singh, 33 years male was brought to the emergency room (ER) of the Max Smart Super Speciality Hospital (A unit of Gujarmal Modi Hospital & Research Centre for Medical Sciences) from Max Super Speciality Hospital, Saket on 11th November, 2018 at 2:22 a.m. with history of RTA on 10th November, 2018(outside MLC). The patient was reported to have met with an accident while driving motorcycle. The patient was admitted under him in the hospital. At the time of admission, the blood alcohol level of the patient was 202/mg/dl. After primary emergency treatment in the ER, the patient was seen by ortho-Senior Resident. Thereafter, upon discussing the case with him, all necessary treatment was given and shifted to the ward. He saw the patient in the ward, on the morning of 11th November, 2018. On evaluation, the patient was observed to be deaf and dumb but understood his communications/instructions well. On reviewing, the x-ray film, it was observed that the patient had sustained comminuted complex fracture of left tibia and fibula. In view of the fracture, the patient was advised and planned for Open reduction and internal fixation of tibia (surgery) next day and advised for necessary investigations and clearances. After evaluating all the investigations and upon receipt of clearance from all angles, including pre-anaesthesia check (PAC); the patient was operated by him on 12th November 2018. The surgery was done as per internationally followed norms. The operation went well and after observations, the patient was shifted to the ward. He again visited the patient before leaving for the day. The patient was observed to be doing well. Next morning, on 13th November 2018, the patient was again evaluated by him alongwith treating team and observed that everything was found to be in order. The patient had recovered fully from anaesthesia and had breakfast, and was pain free. Thus, as is the protocol in such cases, the patient was referred to the physiotherapist for mobilization. In the afternoon of 13th November, 2018, while the patient was being mobilized by the physiotherapist, the patient became restless. Immediate attention was given by the ward team. Senior anaesthetist was called to attend. While the patient was being attended, he lost consciousness at around 4.30 p.m. on 13th November, 2018, and it was found that, the patient had developed cardiac arrest. Immediately Code blue was announced and the patient was resuscitated and shifted to ICU by the Code Blue team for further monitoring and treatment. In the ICU, the patient was consulted by a team of multi-speciality consisting the doctors of the treating surgeon, anaesthetist and intensivist and a provisional clinical diagnosis of pulmonary embolism was made, as such sudden cardiac arrests after attempt mobilization indicates pulmonary embolism, as per Medical Literature and started with requisite treatment while necessary tests were conducted. Later the preliminary diagnosis was confirmed by echocardiography. Required treatment with multidisciplinary teams continued and strict monitoring was done. In the evening of 1st November, 2018, the patient had repeated cardiac arrests. Repeated CPRs were done and rhythm recovered, however, the patient remained on large inotropic support. The patient again had bradycardia followed by cardiac arrest at 10:45 pm. CPR was started according to ACLS guidelines. Despite all efforts, the patient could not be revived and was declared dead at 11.20 p.m. on 15th November, 2018.

Dr. Arun Kumar Dewan, Director Critical Care & Med., Max Smart Super Specialty Hospital in his written statement averred that the patient Mr. Ranjit Singh was shifted to ICU on the evening of 13/11/2018 after being resuscitated from cardiac arrest in the ward. The patient was operated upon on 12/11/2019 for comminuted complex fracture left tibia and fibula. The patient was deeply comatosed (GCS 3), on large inotropic support, intubated and ventilated. The patient was jointly assessed by ICU and cardiology teams. Further, assessment with ECG and ECHO suggested massive pulmonary embolism. In view of very unstable hemodynamics, he was in no condition to confirm the diagnosis by CT pulmonary angiography. Hence, the patient was initiated on IV anticoagulants after bolus dose of unfractionated Heparin; the patient was continued on Heparin infusion with PTT monitoring. Simultaneously, cooling was initiated for brain preservation alongwith sedatives and paralytics. Seriousness of condition was explained all along to the relatives. The patient also became oliguric and had worsening acute kidney injury with increasing serum creatinine. On 14/11/2018, the patient was seen by nephrology for initiation of hemodialysis support; however, hemodialysis including SLED was not feasible due to unstable hemodynamics. The patient developed myoclonic jerks which were unresponsive to ongoing anti seizure medications; hence, Propofol infusion was initiated. Cooling was stopped after 24 hours; however, the patient remained deeply comatosed. Hemodialysis was initiated on the night of 14/15th November on large inotropic support, however, had to be stopped after 1 hour 45 minutes due to marked drop of blood pressure. The patient was also assessed by the cardiology and neurology and advice was incorporated. On 15/11/2018, the patient remained critically unwell on high inotropic support, severe acidosis, worsening AKI, ventilated, deeply comatosed on multiple antiseizure medications. On the evening of 15/11/2018, the patient had cardiac arrest twice which was revived after CPR for 5 minutes and 3 minutes respectively. The patient again had bradycardia followed by cardiac arrest at 10:45 p.m. on 15/11/2018; CPR was started as per ACLS guidelines. Despite all efforts, the patient could not be revived and declared dead at 11:20 p.m. on 15/11/2018. (Dr Arun Dewan).

Dr. Nitin Bahl, Senior Consultant Anaesthesia, Max Smart Super Specialty Hospital in his written statement averred that the patient Mr. Ranjeet Singh, 33 years male was admitted to hospital with a history of road traffic accident. The patient was deaf and dumb but understood the instruction well. The patient was planned for surgery for compound fracture of left tibia and fibula. Thus, pre-anaesthesia check-up was done and the patient was observed to be fit for anaesthesia. The patient was planned for surgery on 12th November 2018. The patient was given combined spinal epidural anaesthesia. As a protocol, he (Dr. Nitin Bahl) was in the operation theater (OT). Intra-operative period was stable and uneventful. Post-operative, the patient was shifted to recovery for observation. The patient was stable and was further shifted to ward. The patient was reviewed in postoperative rounds by him alongwith the Dr. J. Maheshwari team and the patient was stable. On 13th November 2018, afternoon, he received a call from the ward team that the patient is restless following physiotherapy session. He immediately attended the patient in the ward. The patient reportedly had an episode of dizziness and sweating following physiotherapy. When he saw the patient, the patient was restless, pulse was feeble and BP not recordable, intravenous fluid was started. After few minutes, the patient suddenly collapsed. At that time, the pulse was not palpable, BP was un-recordable, and CPR was initiated. The patient trachea was immediately intubated and code blue was announced. The patient was resuscitated. Code Blue team shifted the patient to ICD for further management.

Dr. Shikha Singh, Physiotherapist, Max Smart Super Specialty Hospital in her written statement averred that the patient, Mr. Ranjeet Singh, 33 yeas male was brought to the emergency room (ER) of the Max Smart Super Speciality Hospital (A unit of Gujarmal Modi Hospital & Research Centre for Medical Sciences) from Max Super Speciality Hospital, Saket on 11th November, 2018 at 2:22 a.m. with history of RTA on 10th November, 2018 (outside MLC). The patient was reported to have met with an accident while driving motorcycle. The Patient was admitted under Dr. J. Maheshwari, Senior Consultant & Head of Department of Orthopedics in the Hospital. The Patient underwent Open Reduction and Internal Fixation of Tibia (Surgery) on 12th November, 2018 under Dr. J. Maheshwari. Post-operation, the patient was referred for physiotherapy by the treating team. Accordingly, she visited the patient, in ward, for the physiotherapy session in the morning of 13th November, 2018 but the patient was not willing to do any exercise at that moment. Although the patient was differently-abled, the patient was communicating through sign gestures which were further explained by the patient’s mother, who was there attending the patient. She visited the patient later in the afternoon of 13th November, 2018 alongwith the ortho team for rounds. After the rounds, the patient was advised for mobilization out of bed as was observed to be doing well and also eager to walk. Later in the afternoon on 13th November, 2018 at 4: 15 pm, she visited the patient again for mobilization out of bed. Before going to his (the patient) bed side, progress notes of the patient recorded in the computerized Patient Record System (CPRS) were checked in the computer placed in the ward. Thereafter, she reached the patient. The patient was conscious and oriented and was willing to do the exercises. The patient was given bed exercises physiotherapy, as per the protocol. Following exercises were given:

• Active ankle toe movements,

• Static Quads, Hip abduction exercises.

• Then the patient insisted for mobilization out of bed and sat on the bed by himself for 5 mins (Long sitting). Since the patient was comfortable after that, she supported the operated leg and made him sit on the bed side. The patient was comfortable, in high sitting with his operated leg support on her knee. After 3-4 mins., the patient complained of sudden dizziness which the patient communicated to her by sign gestures. Thus, the patient was immediately laid back on the bed by herself in the presence of the attendants. At that time, the patient was conscious and responding to commands but was still complaining of dizziness. So, she rang the emergency call bell kept on the bed side. The floor nursing staff and duty doctor immediately came and vitals were checked. The patient was restless but was responding to their commands.

After some time, the patient complained of chest pain, which was explained by his brother to them. By this time, the team of anaesthetists along with Dr. Nitin arrived and necessary intervention was given. The patient was put on oxygen support but as the saturation level was dropping down so Code Blue was announced. And the patient was taken over by the Code Blue team. Thereafter, although she was there as a multidisciplinary team member, she played no active role in the management of the Patient.

Dr. Sahar Qureshi, Medical Superintendent, Max Smart Super Specialty Hospital in her written statement averred that the patient Ranjeet Singh, 33 years, male was brought to the emergency room (“ER””) of the hospital, Max Smart Super Speciality Hospital (A unit of Gujarmal Modi Hospital and Research Centre for Medical Sciences) from Max Super Speciality Hospital, Saket on 11th November, 2018 at 2.22 a.m. with history of RTA on 10th November, 2018 (outside MLC). The patient was reported to have met with an accident while driving motorcycle. At the time of admission, the blood alcohol levels of the patient were 202/mmg/dl. After thorough initial assessment, he was found to be dumb and deaf and have sustained comminuted complex(multiple pieces) fracture of left tibia and fibula. The patient was admitted under Dr. J. Maheswhari vide patient IP No.52706. After Primary emergency treatment in the ER, the patient was shifted to the ward and was evaluated for the surgery (open reduction and internal fixation). He was operated on 12th November, 2018 at evening. Open reduction and internal fixation of tibia with IM nailing under spinal anaesthesia was done as per internationally followed norms, after obtaining duly informed consent from the patient. The operation went well. Post-operation, the patient was put on broad spectrum antibiotics, pain killers, DVT prophylaxis and other supportive measures. The patient recovered well. Next morning, the patient was again evaluated by the treating team, and everything was found to be in order. The patient recovered fully from anaesthesia and had breakfast, and was pain free on 13th November, 2018 at morning rounds. As is the protocol in such cases, the patient was referred to physiotherapist for mobilization. Around 4.15 p.m. on 13th November, 2018; in the presence of the attendants, the patient was given bed exercises physiotherapy viz. active ankle toe movements, static quads, hip abduction exercises, long sitting on the side of the bed with support to the operated leg by the physiotherapist, which all went comfortably. After around 10-12 minutes of starting with the physiotherapy session, the patient complained of sudden dizziness. Thus, the patient was immediately laid back on his bed by the physiotherapist. Due to the complaints of continued dizziness, the physiotherapist rang the emergency call bell that is on the bed side. The floor nursing staff and duty doctor immediately responded and checked the vitals. Senior anaesthetist reached the spot from the next door OT within minutes. The patient became restless but was responding to the commands. After a while around 4.30 p.m., the patient complained of chest pain (in sign gestures), which was explained by the brother of the patient. Meanwhile Dr. Nitin, Senior Consultant Anaeshthesia intervened and the patient was put on oxygen support but as the saturation level was dropping down and the patient became un-responsive. The patient developed cardiac arrest. Immediately code blue was announced the patient was resuscitated. ROSC was achieved after 10 minutes of resuscitation, following which, the patient was shifted to ICU and put on ventilator support. The patient had severe hypotension and was deeply comatosed, so he was put on high vasopressor support. Targeted temperature management was initiated. Cardiology consultation was taken. In ICU, the patient was assessed by a team doctors comprising of the treating surgeon, anaesthetist and intensivist and a provisional clinical diagnosis of pulmonary embolism was made, and started with requisite treatment. The preliminary diagnosis was confirmed by the ECG and bedside echocardiography. CTPA could not be done because of hemodynamic instability. Heparin bolus was given followed by Heparin infusion. The patient’s sensorium remained poor, so neurology consultation was sought and their advice incorporated. Nephrology opinion was taken in view of anuric AKI. HD was initiated, however, after one hour 45 minutes hours of dialysis was stopped due to hemodynamic instability. In the intervening night of 14th and 15th November, 2018, the patient developed recurrent seizures that were controlled with high dose anti-epileptics and propofol infusions. The patient’s attendants were briefed about the patient’s condition in detail and grave prognosis was explained in detail. In the evening of 15th November, 2018, the patient had repeat cardiac arrest in the ICU. Repeated CPRs were done and rhythm recovered, however, he remained on large inotropic support. The patient again had bradycardia followed by cardiac arrest at 10.45 p.m. CPR was started according to ASLC guidelines. Despite of all efforts, the patient could not be revived and was declared dead at 11.20 p.m. on 15th November, 2018.

She further averred that it is wrong and denied that the doctors of the hospital informed that the patient will be discharged within two days of operation. It is wrong and denied that the hospital staff did not bother to inform the complainant and the relatives of the patient repeated cardiac arrest. In this regard, it is submitted that the patient’s attendants were briefed about the patient’s condition in detail and grave prognosis was explained in detail in frequent intervals. Multi Disciplinary Team (MDT) meeting was done on 14h and 15th November, 2018 with the family members. The complainant was also a part of the MDT meeting which is recorded at pages Nos. 135 and 136 of the submitted medical records. It is also wrong and denied that the administration (of the hospital) confessed about not taking cognizance of a large lump of blood-clot during the operation which was left in the body during operation and later travelled internally to various body part causing kidney, heart and brain failure. In this regard, it is submitted that pulmonary embolism following leg injuries and subsequent mobilization is a well understood phenomena in medical sciences and unfortunately happened in this case too. It is a rare but a known dreaded complication. All due precautions were taken on necessary treatment was done as per protocol. The relevant medical literature on pulmonary embolism following leg injuries and subsequent mobilization has been submitted. It is also wrong and denied that the doctors were abusive, avoiding commenting on the status of the patient. It is submited that the patient’s attendants were regularly updated with the prognosis and the line of the treatment of the patient, even, including MDT meeting. The patient was declared dead on 15th November, 2018 at 11.20 p.m. in the ICU, as the patient could not be revived from his cardiac arrest, despite of the best efforts by the Multi-Disciplinary Committee team of doctors managing the patient. Thus, it is wrong that the patient died under mysterious circumstances.

In view of the above, the Disciplinary Committee makes the following observations :-

1. It is observed that the patient Shri Ranjeet Singh, 33 years old male who was deaf and dumb by birth, with history of alleged road traffic accident on 10th November, 2018 was admitted in Max Hospital, Saket on 11th November, 2018 at 2.22 a.m. He was diagnosed with fracture midshaft tibia and fibula left leg. He underwent the surgical procedure of Open Reduction Internal fixation with IM Nailing under consent on 12th November, 2018. The surgery was performed by Dr. Jitendra Maheshwari. Post-op, the patient was put on broad spectrum antibiotics, pain killers, DVT prophylaxis and other supportive measures. Next day (13th November, 2018), the patient was recovering well and was mobilized out of bed. However, around 4.30 p.m. on 13th November, 2018, the patient became unresponsive, had cardiac arrest, CPR was initiated. ROSC (resumption of sustained perfusing cardiac activity) was achieved after ten minutes of resuscitation, following which, the patient was shifted to ICU and put on ventilator support. The patient had severe hypotension with multi-organ failure, so he was put on high vasopressor support. Targeted temperature management was initiated. Cardiology consultation was taken; ECG and ECHO were suggestive of pulmonary embolism. CTPA (CT pulmonary angiography) could not be done because of hemodynamic instability. Heparin bolus was given followed by Heparin infusion. The patient’s sensorium remained poor, so neurology consultation was sought and their advice incorporated. Nephrology opinion was taken in view of anuric AKI. Hemodialysis was initiated, however, after two and half hours of dialysis was stopped due to hemodynamic instability. In the intervening night of 14th and 15th November, 2018, the patient developed status epilepticus that was controlled with high dose antiepileptics and propofol infusion. The patient’s attendants were briefed about the patient’s condition in detail and grave prognosis was explained. In evening of 15th November, 2018, the patient again had cardiac arrest, CPR was done for around five minutes and he revived. The patient had similar episodes of cardiac arrest twice in the evening of 15th November, 2018 which was revived after three minutes of CPR. The patient again had bradycardia followed by cardiac arrest at 10.45 p.m. The CPR was started according to ACLS guidelines. Despite of all efforts, the patient could not be revived and declared dead at 11.20 p.m. on 15th November, 2018.

The cause of death as per the subsequent opinion in respect of post mortem report No.-1625/18 of Department of Forensic Medicine and Toxicology, All India Institute of Medical Sciences was ‘complication of injury sustained to left leg consequent upon bluntforce/surface impact. All injuries are ante mortem in nature. This could be possible in Road Traffic Accident’.

1. It is observed that the patient who suffered from fracture of midshaft of tibia and fibula left leg was rightly operated through open Reduction Internal fixation with IM Nailing, under consent, as per standard protocol. The events which unfolded on 13th November, 2018, are indicative of the fact that the patient who was recovering well post-surgery, must have suffered from Deep Vein thrombosis (pulmonary embolism), which resulted in cardiac arrest, from which he was revived but had to be put on ICU treatment and unfortunately succumb at 11.20 p.m. on 15th November, 2018.

It is further observed that pulmonary embolism is a known complication of any surgical procedure which can prove to be fatal, as it happened in this case, inspite of appropriate treatment.

In light of the observations made herein-above, it is the decision of the Disciplinary Committee that no medical negligence can be attributed on the part of doctors of Max Smart Super Specialty Hospital, Mandir Marg, Press Enclave Road, Saket, New Delhi-110017, in the treatment of complainant’s brother Shri Ranjeet Singh.

Matter stands disposed.

Sd/: Sd/:

(Dr. Subodh Kumar) (Dr. Ashwini Dalmiya)

Chairman, Delhi Medical Association,

Disciplinary Committee Member,

Disciplinary Committee

Sd/: Sd/:

(Dr. Sumit Sural) (Dr. U.C. Biswal)

Expert Member, Expert Member,

Disciplinary Committee Disciplinary Committee

Sd/: Sd/:

(Dr. A.K. Sethi) (Dr. S.K. Verma)

Expert Member, Expert Member,

Disciplinary Committee Disciplinary Committee

Sd/: Sd/:

(Dr. Sandeep Garg) (Dr. Vimal Mehta)

Expert Member, Expert Member,

Disciplinary Committee Disciplinary Committee

The Order of the Disciplinary Committee dated 17th February, 2020 was confirmed by the Delhi Medical Council in its meeting held on 28th February, 2020.

By the Order & in the name

of Delhi Medical Council

(Dr. Girish Tyagi)

Secretary

Copy to:-

1. Shri Sanjay Kumar, B-13/B, Khanpur Extension, New Delhi-110062.
2. Dr. Arun Kumar Dewan, Through Medical Superintendent, Max Smart Super Specialty Hospital, Mandir Marg, Press Enclave, Saket, New Delhi-110017.
3. Dr. Jitendra Maheshwari, Through Medical Superintendent, Max Smart Super Specialty Hospital, Mandir Marg, Press Enclave, Saket, New Delhi-110017.
4. Dr. Nitin Bahl, Through Medical Superintendent, Max Smart Super Specialty Hospital, Mandir Marg, Press Enclave, Saket, New Delhi-110017.
5. Dr. Shikha Singh, Through Medical Superintendent, Max Smart Super Specialty Hospital, Mandir Marg, Press Enclave, Saket, New Delhi-110017.
6. Medical Superintendent, Max Smart Super Specialty Hospital, Mandir Marg, Press Enclave, Saket, New Delhi-110017.
7. Dy. Commissioner of Police, South District, Hauz Khas, New Delhi-110016-w.r.t.letter No.1768/SO/DCP/SD/AC-IV dated New Delhi, the 26.11.2018-**for information**.
8. Section Officer, Department of Health & Family Welfare, Govt. of NCT of Delhi, 9th Level, A-Wing, Delhi Secretariat, Delhi (CD# 112271704)-w.r.t. letter F.No.14/05/Misc./H&FW/2014/2912-13 dated 07.02.2018-**for information**.
9. Director General, DGHS (HQ), Directorate General of Health Services, Govt. of NCT of Delhi, F-17, Swasthya Sewa Nideshalaya Bhawan, Karkardooma, Delhi-110032-w.r.t. letter No.F.7(1534)/DHS/HQ/CC/2013/Part-I/513 dated 05-08.2019-**for information**.
10. Dr. R.N. Das, Medical Superintendent, Nursing Homes, Directorate General of Health Services, Govt. of NCT of Delhi (Nursing Home Cell), 3rd Floor, Delhi Government Dispensary Building, S-1, Schook Block, Shakarpur, Delhi-110092-w.r.t. letter No.F.23/comp/SD/206/DGHS/HQ/NHC/2018/3785 dated 21/1/19-**for information**.
11. Station House Officer, Police Station Saket, New Delhi-110017-.w.r.t case FIR No.679/18 U/s 279/337/304A IPC PS Saket, New Delhi-**for information.**

(Dr. Girish Tyagi)

Secretary