MAHARASHTRA STATE HUMAN RIGHTS COMMISSION, MUMBAI
9, Hajarimal Somani Marg, Opp. Chhatrapati Shivaji Maharaj Terminus,
(CSMT) Mumbai – 400 001
Tel : 022-22092857
E-mail: court3-mshrc@mah.gov.in

MSHRC/SK/C2026/10981

Date: 29/06/2026

Case No. 7496/2018

Name of Complainant : **Jotiba Dhondiba Navar**

Respondent : **1. The Civil Surgeon,**
Kolhapur.

2. The Chief Executive Officer,
Zilla Parishad, Kolhapur.

3. Superintendent of Police,
Kolhapur.

4. Secretary, Public Health Department,
Mantralaya, Mumbai.

5. Dr. Dileep S Ambole
Gadhinglaj, Kolhapur

6. Dr. Suraj M Patne,
PHC Watangi, Tal. Ajra

Date : **29.06. 2026**

Coram : **Sanjay Kumar**

ORDER

1. Complainant, Jotiba Dhondiba Navar, is present.
2. PSI, Sanjay N Patil, Ajara Police Station is present.
3. None present on behalf of other respondents.

4. The complaint was filed by grieved husband, Jotiba Dhondiba Navar, for the death of his wife, Mrs. Priyanka Jotiba Navar, Age 23 years, r/o Alyachiwadi, Post Gawase, Taluka Ajara, Dist. Kolhapur, due to negligence during delivery, inappropriate management of his critical wife after development of complications and apathy shown by medical officials of different hospitals. He has asked for enquiry and necessary actions against concerns and payment of compensation for the violation of Human Right of life of his wife. He further mentioned that his wife died of negligence in treatment by the Doctors and staff of primary health Centre, Watangi and other referral Hospitals on 23.11.2018.
5. He informed that after pregnancy, his wife was registered at Primary Health Centre, (PHC), Watangi, as a pregnant lady. As per the advice of Medical Officer of PHC, Watangi, Dr. Patne, the pregnant lady underwent all the prenatal tastes and required sonography. There was no complication about pregnancy, and everything was normal. The expected date of delivery was conveyed as 24.11.2018. However, the wife of the complainant started experiencing labour pain on 22.11.2018 at 19.30 hrs. The Medical Health Worker of the village, by dialing 108, called ambulance which reached the village at 20:30 hrs.
6. On the advice of Dr. Patane, Medical Officer of PHC, Watangi, the pregnant lady was taken to Ajara Rural Health Center, considering the distance of Centre from village. There was no Doctor available at the Rural Health Center, Ajara. The Doctor in the ambulance called Primary Health Center, Bhadvan, but unfortunately no Doctor was

available, thereto. Thereafter, the doctor in the ambulance Dr. Priyanka called Medical Officer of Watangi PHC, Dr. Patane, and after consultation with Dr. Patane, the patient was brought to Watangi PHC. They reached Watangi PHC, at 10.45 hours. The complainant was informed by the medical assistants about the delivery at 11.05 pm. After some time, one of the family members entered the delivery room to see the condition of mother of the child and flabbergasted. After delivery the mother was profusely bleeding and staff therein unable to control it. Then only, at 00.15 hours (23.11.2018), the Medical Officer of Watangi, PHC was called from his house, and the complainant was informed of the critical condition of his wife due to inversion of uterus. The pregnant lady was referred to Dr. Hatti (Private Doctor) by treating Medical Officer, Dr. Patane of PHC, Watangi. After reaching Gadhinglaj, Dr. Hatti examined complainant's wife Priyanka and asked him to procure the blood, as patient suffered from excessive bleeding and required immediate transfusion of blood. Two bottles of blood was transfused to the patient, and the complainant was asked to arrange for more blood. While the complainant was busy in arranging blood for the patient, the staff of Watangi PHC shifted the patient to Dr. Shanbaug's Hospital, another private clinic. When the complainant reached to the Shanbaug's Hospital with blood, Dr. Shanbaug after examining the Patient, in Ambulance only, asked to take her to Kolhapur. The condition of Priyanka became critical, and the patient was taken to Gadhinglaj Sub-District Hospital for treatment as well as ambulance. No ambulance was available at

hospital at that time. The patient was referred to Kolhapur. They reached Kolhapur at 05.45 hours and admitted to Easter Aadhar Hospital where she was declared dead at 07.45 hours, during treatment. The complainant has mentioned that due to apathy and negligence in the treatment by inexperienced Doctors at PHC, absence of Doctors at Rural center Ajra as well as Sub District Hospital Gadhinglaj, he lost his wife.

7. In view of the above complaint the Commission asked respondents to submit their fact-finding inquiry reports in this matter.

8. The submissions received by the respondents as well as the complainant are enlisted below:

   a. The report by District Mother Child Care Officer, Kolhapur dated 21.04.2025.

   b. The report by SP Kolhapur dated 25.06.2025.

   c. The affidavit of District Medical Officer, Zilla Parishad, Kolhapur Dr. Aniruddh Pipale dated11.08.2025.

   d. The letter addressed to SDPO, Gadhinglaj dated 02.06.2025 by Medical Officer Class – I, District Sub Hospital Gadihnglaj.

   e. The report by District of Kolhapur Civil Surgeon dated 20.07.2019 addressed to Deputy Director Medical Services Kolhapur Division Kolhapur.

   f. The letter dated 03.03.2026 of API, Ajara Police Station

g. The explanation of Dr. Suraj Patane dated 02.03.2026.

h. Letter dated 09.01.2026 from SDPO, Gadhinglaj.

i. The letter dated 12.03.2026 of Dr. Ambole District Sub-Hospital Gadhinglaj.

j. Letter dated 21.03.2026 API, Ajara incorporating the report of Sir J J Hospital letter dated 10.09.2026 of the complainant expressing his dissatisfaction over the District Civil Surgeon report and asking for examination of the case papers from Sir J J Hospital.

k. A letter of District Civil Surgeon dated 20.03.2026 a letter of any Dr. Dileep S Ambole retired Medical Officer District Sub-Hospital Gadhinglaj.

9. Considering all the submissions made by the complainant as well as respondents, the picture which emerged of the incident at intervening night of 22.08.2018 and 23.08.2018 is as follows:

i) This was second pregnancy of Priyanka Jotiba Navar. She was registered as pregnant lady at PHC, Watangi, and her prenatal tastes and treatment was done from the time of her conception, at PHC Watangi.

ii) On 17.11.2018, Medical Officer, of PHC, Watangi gave the expected date of delivery as 24.11.2018.

iii) In pre-natal examinations all necessary parameters of pregnant lady (Priyanka) was normal.

iv) On 22.02.2018 at 07.00 hours the pregnant lady started experiencing labour pain, on which the husband has talked with the local Asha worker, who in turn called the ambulance and on advice of Dr. Patane of PHC, Watangi, the pregnant lady was taken to Ajara Rural Hospital. The advice of Dr. Patane was due to proximity of Ajara Rural Hospital, with the village than the Watangi, PHC.

v) The Medical Officer at Ajara Rural Hospital was absent when the ambulance reached Ajara, Rural Hospital, Medical Assistant, Priyanka Lugade has examined the pregnant lady and consulted her Medical Officer, Dr. Fernandes, on phone.

vi) The blood pressure of Priyanka was high i.e. 140/90, pulse was 84 and dilation was 4 to 5 cm. On the advice of the Doctor of Rural Hospital, Ajara, Medical Assistant referred the pregnant lady to Gadhinglaj Sub-District Hospital.

vii) Considering the distance between Ajara and Gadhinglaj which is about 24 km and condition of the patient with dilation of 4 to 5 cm, the

complainant through the doctor available in the ambulance consulted Medical Officer Watangi and decided to take pregnant lady to PHC, Watangi, which was at the distance of 13 km.

viii) At Watangi PHC, the Medical Officer was not present when ambulance reached Watangi. At 11.05 hours the delivery was conducted by Medical Assistant, Geetanjali Shinde and Deputy Medical Assistant Sheetal Sathe in absence of medical officer, Dr. Patane. Due to inversion of uterus the delivery became complicated, which the two Medical Assistants present were unable to manage. The Medical Officer, of Watangi Dr. Patane was called by Medical Assistant and he arrived at the Hospital at about 11.30 hours. (Time differs in different reports and complaint) He tried to treat the pregnant lady, but she became critical. He consulted on phone Dr. Gadde, a private Gynecologists of Ajara, but she submitted that there was no anesthetist available at Ajara and thus she could not entertain a critical patient.

ix) Thereafter, Dr. Patane referred the pregnant lady to Sub-District Hospital Gadhinglaj. After referring the patient and departure of the

pregnant lady, Dr. Patane contacted Superintendent of Sub-District Hospital, Gadhinglaj. He was informed by the then Superintendent of Sub-District Hospital that it was not possible to arrange for Gynecologist and Anesthetist for the critical pregnant lady and Dr. Patane was advised to send the pregnant lady to private Gynecologist Dr. Hatti of Gadhinglaj. The pregnant lady reached the Hospital of Dr. Hatti at 01.00 hours on 23.11.2018.

x) As excessive bleeding had taken place, the complainant was asked to make arrangement for blood and 2 units of blood transfused to the patient. As the surgery was required to the patient, the patient again was shifted to local Gynecologist, Dr. Shanbaug, who examined the patient in the ambulance only, and advised that the pregnant lady to be taken to the Aster Aadhar Hospital, Kolhapur.

xi) To arrange for the ambulance and to get treatment, the pregnant lady was taken to the Sub-District Hospital, Gadhinglaj. As no doctor or ambulance were available, pregnant lady was taken into ambulance designated under dial 102. to Kolhapur as suggested by Dr. Shanbaug.

Later, at Bahirewadi pregnant lady was shifted in 108 ambulance and taken to Aster Aadhar Hospital, Kolhapur. Where she reached at 05.30 hours. At 07.45 hours of 23.11.2018, pregnant lady was declared dead by the Medical Officer of Aster Aadhar Hospital, Kolhapur.

10. In this regard, an inquiry was conducted by Dr. F A Desai, District Mother and Child Care Officer, Zilla Parishad, Kolhapur. In inquiry he has recorded the statements only of the Doctors and the Medical staff associated with the incident. He has not drawn any conclusion about the negligence or mismanagement by the medical staff and gave his opinion about the requirement of Gynecologist at Sub-District Hospital, etc.

11. The report submitted by the Civil Surgeon Kolhapur, dtd.04.04.2025 gave clean chit to Dr. Patane and nurse Shinde and Sathe by saying that no negligence is found through the papers submitted before the committee.

12. The report submitted by Shri Yogesh Kumar, SP, Kolhapur, revealed that for the death of Priyanka an A D vide no. 38/2018 under section 174 Cr.P.C. was registered at Ajara Police Station on 01.12.2018. The SP has concluded the inquiry as thus;

अर्जदारांच्या पत्नी मयत सौ. प्रियांका ज्योतीबा नवार यांचा मृत्यू प्राथमिक आरोग्य केंद्र, वाटंगी येथील वैद्यकीय सेवेतील त्रुटी आणि समन्वयाच्या अभावामुळे झाला.

डॉ. सुरज पाटणे यांची बाळंतपणादरम्यान अनुपस्थितो आणि सौ. गितांजली शिंदे यांनी गर्भाशय वाहेर येण्याच्या गुंतागुंतीवर तात्काळ उपचार न केल्याने रुग्णाची प्रकृती बिघडली.

ग्रामीण रुग्णालय, आजरा आणि उपजिल्हा रुग्णालय, गडहिंग्लज येथे स्त्रीरोग तज्ज्ञ आणि भूलतज्ज्ञ अनुपलब्ध असल्याने उपचारात विलंब झाला.

रुग्णवाहिका सेवांमधील समन्वयाचा अभाव आणि कर्मचाऱ्यांचे दुर्लक्ष यामुळे रुग्णाला वेळेत उपचार मिळाले नाहीत.

चौकशी अधिकारी यांनी त्यांचे अहवालात नमुद केले प्रमाणे यातील गैर अर्जदारांचा निष्काळजीपणा हा प्रकरण सिव्हील लायबिलिटी स्वरूपाचे असल्याबाबत नोंदविलेले अभिप्राय योग्य असल्याचे दिसून येत आहे

13. As per the SP, death has occurred due to negligence in the treatment at PHC Watangi and absence of Dr. Patane at the time of delivery in spite of prior intimation. Besides, there was absence of Gynecologist and Anesthetist at Rural Hospital Ajara. Besides, he mentioned that the negligence is in nature of Civil liability, thus, no offence against the responsible person was registered.

14. API, Ajara Police Station, submitted report of the expert committee appointed by the Dean of Sir J. J. Hospital on the request of investigating officer, to examine the alleged negligence in the treatment provided to the deceased, Priyanka Jotiba Navar. The report mentioned as:

"The details required about the antenatal care, reports of sonography etc. are not provided to the committee. The delivery notes provided to them do not reveal what was the difficulty that came across while delivering the placenta. The length of the umbilical cord is not mentioned in the notes. Was the patient a high risk and prone for the complication of acute inversion of uterus cannot be made out. Acute inversion needs an immediate replacement by the person performing the delivery and is to be done immediately after the inversion is noted. However, the health workers working at a primary health Centre are not expert enough to manage such a life-threatening acute emergency. So, what was exactly the underlying cause responsible for the acute inversion of the uterus cannot be commented upon by this committee. The primary health Centre at Watangi has offered services which rural Hospital Azara could not offer. After noticing the acute inversion of the uterus, the doctor on duty at Watangi has attended the patient. The required primary aid which could be done at the primary health Centre was done. Then the patient was referred to a higher center. This referral is correct as acute inversion of uterus is a life-threatening Emergency which is very difficult to manage at primary

health Centre level and needs expertise management and infrastructure which is available at higher care center. Hence, it is not that reasonable care was not taken considering the manpower, expertise and infrastructure available at a set-up of Primary health Centre in the management of the patient".

15. It required mention that the inquiry committee of Sir J J Hospital has candidly opined that "The PHC, Watangi has offered service which Rural Hospital at Ajara could not offer". It is to be noted that the process of delivery has already started, and pregnant lady was suffering from high blood pressure, when she first arrived at Rural Hospital, Ajara.

16. The expert committee of Sir J J Hospital opined "Was the patient a high risk and prone for the complication of acute inversion of uterus cannot be made out?... So, what was exactly the underlying cause responsible for the acute inversion of the uterus cannot be commented upon by this committee? It could not be said with the conviction that uterine inversion was a result of natural process.

17. In pursuant to section 16 of PHR Act, the notice was issued to Dr. Patane, Primary Health Center Watangi, Dr. Sadashiv Ambole, the then Superintendent of District Sub-District Hospital Gadhinglaj. Dr. Patane, in his submission, stated that he has done his best to treat the patient. In his submission he has said;

"As nearest first referral center R H Ajara out of operation, I called a private Gynecologist in Ajara for

her prime intervention but to my agony she had not an anesthetist available at that hour. I have had no option other than to send her to next referral center i.e. SDH Gadhinglaj. With supportive life saving measures, I immediately arranged for pregnant lady referral along with the PHC staff by PHC ambulance. No sooner the ambulance left for Gadhinglaj, I called the then Medical Superintendent of SDH Gadhinglaj briefing him shortly and told the patient is on the way to SDH, Gadhinglaj. Adding to my agony he reported that no expert is available in SDH, Gadhinglaj. Then for immediate intervention eventually I called one of staff in ambulance to take the patient to an experienced private Gynecologist who had recently relived from Government service. The concerned Gynecologist attended the case and reported to me that pregnant lady had excessive blood loss. He gave her blood transfusion and told me that she needs emergency hysterectomy of the uterus but dismally he told that he could not find an anesthetist and she be taken to tertiary center, the scenario was become gloomy as time kept ticking on, he further mentioned that the incident had an unprecedented impact on him".

18. Dr. Ambole was the Superintendent of Sub-District Hospital Gadhinglaj at that time. The complainant has raised objection on the

conduct and apathy shown by the Sub District Hospital Gadhinglaj. Dr. Ambole was one of the members of the committee constituted by civil surgeon to examine the case of maternal death of Priyanka Nawar. The complainant in his submissions raised objection over the composition of the committee constituted for inquiry by civil surgeon. This was against the provision of natural justice; rule against bias. Dr. Ambole in his submission submitted that there was no direct allegation against him in the complaint filed by the complainant. The enquiry report of civil Surgeon was vitiated by the violation of principle of natural justice.

19. Although, committees constituted for looking into the negligence, apathy and mismanagement during delivery of Priyanka Jotiba Navar gave clean chits to the Doctors and Medical Staff involved. However, the chronological scrutiny of the incident and treatment extended to critical pregnant lady by the different Health Institutions and Medical Officer thereof, clearly shows complete apathy, mismanagement and casual approach in treatment of critical pregnant lady by Medical Officers and Health Institutions, leading to her death. The Commission consider following negligence on part of Medical Officers and Medical Institutions responsible for the death of a pregnant lady, Priyanka Nawar, whose pre-natal condition was normal.

i) When Dr. Patane has asked the complainant to take the patient in labor pain to Ajara Hospital, considering the distance from the patient's residence, it was the prime duty of Dr. Patane to confirm the availability of Doctor at Ajara Rural

Hospital and inform Ajara Rural Hospital about the patient and her condition. The pregnant lady was under treatment of Dr. Patane and registered at Watangi PHC for the pre-natal examination. **No intimation or confirmation was made.**

ii) The Medical Officer of Ajara Rural Hospital has not taken pain to come and examine the patient who was **having high blood pressure, 4 to 5 cm of dilation and under labor pain,** by herself. The concerned Medical Officer, instead of attending the pregnant lady has preferred to instruct Assistant Medical Officer, on phone to refer the pregnant lady to Gadhinglaj Sub-District Hospital. The Medical Officer, of Ajara Rural Hospital and its staff have not thought proper to inquire about availability of doctor at Gadhinglaj Sub-District Hospital, before referring the critical pregnant lady to the said hospital. The expert committee of Sir J J Hospital, in its reports commented that **"The primary health Centre at Watangi has offered services which rural Hospital Azara could not offer".**

iii) Considering the condition of the patient and time taken to reach Gadhinglaj, after consulting Dr. Patane, complainant has decided to take his wife to Watangi Primary Health Center. **After reaching the**

Watangi Primary Health Center, the Doctor remained absent and the delivery was conducted by two Medical Assistant Officers, who were not experts to treat and handle the critical situation which occurred at the time of delivery. Although, Dr. Patne was informed about the condition of the Pregnant Lady in advance.

iv) The Medical Assistants, instead of immediately calling the doctor, tried to treat the pregnant lady by themselves. The issue was raised by the family members of the victim when the family member after delivery entered the labour room and saw the condition of the patient.

v) After reaching the hospital with delay of about half an hour, the medical officer of Watangi, **instead of confirming the presence of anesthetist and gynecologist at Sub-District Hospital Gadhinglaj, referred the critical pregnant lady to Sub-District Hospital Gadhinglaj**. It requires mention that the then Superintendent Sub-District Hospital Gadhinglaj has informed the Medical Officer of Watangi of non-availability of gynecologist and anesthesiologist at the Hospital.

vi) **A letter dated. 02.06.2025 of Medical Superintendent Group-A, Sub-District**

Gadhinglaj Kolhapur addressed to SDPO, Gadhinglaj informed that on 22.11.2018 anesthesiologist Dr. Swati Patil was deployed at the Hospital. Besides, under National Scheme, the Gynecologist based on call, Dr. Brahandan S Deshmane was available. However, the Superintendent of Sub-District Hospital, Gadhinglaj had informed the Medical Officer of PHC, Watangi of unavailability of expert doctors which includes Gynecologist and anesthetist at that time. However, Dr. Ambole Superintendent of Sub-District, Gadhinglaj has explained the reasons of unavailability of two doctors, but **the reasons are not supported by any documentary evidence. Besides, it is not shown in any of the statements and inquiry that efforts were made by the Superintendent to look for gynecologist and anesthesiologist for the pregnant lady.**

vii) **When the pregnant lady taken to District Sub-Hospital, none of the Doctors deployed at Gadhinglaj Sub- District Hospital has taken pain to see the critical pregnant lady and assess the medical condition of the lady but instructed on phone the staff to refer her to CPR Hospital**

Kolhapur, based on the assessment of the Medical Staff.

20. This is a case of mournful maternal death of a young pregnant lady, Priyanka Navar. Priyanka Navar got herself registered as pregnant lady, in time and underwent all prescribed prenatal routine checkups by the Local Health Center and ASHA workers. All parameters during routine checkups were normal. The pregnant women died due to complication during delivery. The complication was natural or created by Medical Assistant due to their inept handling of pregnancy could not be ascertained. The death occurred due to absence of the doctors and mismanagement by the medical administration in taking proper care of a critical situation during delivery and postpartum complications. Empathy and professionalism were found missing at each stage. Each doctor and hospital were seen passing the buck to others for one reason or other, making complete disregard to Hippocratic Oath and Charaka Shapath. A helpless husband with her bleeding wife with postpartum emergency of uterine inversion, was moving in search of a doctor who can take care of his critical wife throughout the night, visiting one to another hospitals and doctors, and at last lost his wife. His wife succumbed to apathy, wrong treatment and mismanagement of medical professionals assigned for taking care of such situations and medical emergencies for the public.

21. Maharashtra Government provides one of the best cares in the country of its pregnant women, starting from registration as pregnant women till delivery, under the various Government run Schemes and

programs. There is no dearth of schemes and Government funds, but the problem lies in its implementation, execution and respect for the Hippocratic Oath and Charaka Shapath. In this case it is not the failure of the Government but that of agents of the Government who were supposed to implement the schemes and programs of the Government. They have failed to perform their duty and responsibility, ethically and professionally, leading to death of a young mother of productive age, leaving behind two young daughters including one 1 days old and 3 years old.

22. In a welfare State the primary duty of the Government is to secure the welfare of the people. Providing adequate medical facilities for the people is an essential part of the obligations undertaken by the Government in a welfare State. The Government discharges this obligation by running hospital and health center which provide medical care to the person seeking to avail those facilities. Article 21 of the Constitution of India imposes obligations on the State to safeguard the right to life of every person. Preservation of Human Life is of paramount importance. The Government Hospitals run by the State and the medical officers employed therein are duties bound to extend medical assistance for preserving human life. Failure on the part of the Government Hospital to provide timely medical treatment to a person in need of such treatment results in violation of right to life guaranteed under article 21.

23. In view of the above, the State Commission, is of the view that the death of Priyanka Navar has occurred due to negligence on the part of the doctors, in treatment, absence of the doctors at nighttime at their

PHC/Hospitals, delivery conducted by inexperienced hands, and mismanagement of critical pregnant lady. The State Commission is prima facie of the view that family members of the victim deserve to be compensated for the death of Priyanka Navar, due to apathy and mismanagement by Medical Infrastructure of the State.

24. In pursuant to above observations the State Commission has come to the conclusion that Death has occurred due to negligence and medical mismanagement by the local medical infrastructure created by the state and its agents working therein. As relief has to be granted by the State, before granting relief, in pursuant to section 16 of The Protection of Human Rights Act, 1993 (PHR Act), the state is required to be heard. The State Commission under sec. 16 of PHR Act issued summons to The Secretary, Public Health Department, Government of Maharashtra to submit its say, but unfortunately, no submission was received by the commission by the representative of State.

25. It is now a well-accepted proposition in most of the jurisdictions that monetary or pecuniary compensation is appropriate and indeed an effective and sometimes perhaps the only suitable remedy for redressal of the established infringement of the fundamental right to life of a citizen by the public servants and the State is vicariously liable for their acts. The claim of the citizens is based on the principle of strict liability to which the defense of sovereign immunity is not available, and the citizen must receive the amount of compensation from the State.

26. The complainant in her submission informed that his wife Priyanka Navar was of 23 years of age, at the time of her death. In support of age

of his wife, he has submitted her birth certificate issued by Gram Sewak, Gram Panchayat Shelap, having birth date of deceased as 08/12/1995. She was a housewife and survived by two children namely; Pranjal Jotiba Navar, age 13 and Priya Jotiba Navar age 7. He further submitted that he with his family living with his father and mother. In total 5 family members are staying together.

27. The compensation in the present case is computed on the basis of guidelines issued by various judgments in case of death of housewife in motor vehicle accidents and otherwise due to negligence. As per guidelines notional income of a housewife is considered above minimum wage of an unskilled labour. Here, while computing compensation, notional income of deceased Mrs. Priyanka Jotiba Navar is considered as minimum wage at Agriculture employment in Zone III, prescribed as Minimum wages in Maharashtra from 1.1.2026 to 30.06.2026, which is Rs. 8315 /month. The computation is as follows:

a. Notional monthly income of deceased: Rs.8315/-
b. Future prospects (age below 40) 40%: Rs.8315+Rs.3326= Rs.11,641/-
c. Annual Income: Rs. 11,641X12=Rs. 1,39,692/-
d. Personal expenses deducted, 5 dependent 1/4: Rs.1,39,692-34,923= Rs. 1,04,769/-
e. Multiplier of 17 for age 21-25: Rs.1,04,769 X 17= Rs. 17,81,073/-
f. Funeral expenses: Rs. 15000/-

g. Total compensation: Rs.17,81,073 + 15,000/- = 17,96,073/-(rounded to Rs. 17,95,000/-)

28. The State Human Rights Commission by invoking its power given in section 18(a)(i) gives following recommendations:

a. The State is recommended to pay compensation of Rs. 17,95,000 (Seventeen Lakhs Ninety-five thousand only) to, the next of the kin of deceased, husband of deceased Mrs. Priyanka Jotiba Navar, Jotiba Dondiba Nawar, for the violation of Human Right to Life of his wife, leading to her death, as follows:

b. Out of total Rs. 17, 95, 000/- (Seventeen Lakhs Ninety-five thousand); 5,00,000/-(five lakhs) should be given in the form of a fixed deposit for five years in the name of Prajnal Jotiba Navar, elder daughter, and 7,00,000/- (seven lakhs) in the form of fixed deposit for 10 years in the name of younger daughter, Priya Jotiba Navar. Rest of the compensation amount of Rs. 5,95,000/- (Five Lakh ninety-five thousand) should be given to the husband of deceased, Shri Jotiba a Dhondiba Navar.

c. The payment should be made within 90 days from the date of order, otherwise the state will have to pay an interest of 6% on the total

compensation amount till date of actual realization.

d. The Hon'ble Secretary of the State Commission is directed to communicate the recommendation as per procedure to the Secretary, Public Health Department, Maharashtra State and Nodal Officer of State of Maharashtra, as per the Government order of Home Department, dated 04 February 2026, to Joint Secretary, POL – 14, Home Department, for the compliance as per sec. 18 (e) of the Protection of Human Rights Act, 1993, in stipulated time.

e. The office is directed to intimate Complainant as well as all the respondents of this case of the order by sending them copy of the order.

f. With this recommendation, **Case No7496/2018** stands closed and disposed.

(Sanjay Kumar)
Member, MSHRC