

MEDICOLEGAL ISSUES : GUIDELINES TO MEDICAL OFFICERS

Introduction

1. Medicolegal cases (MLC) are an integral part of medical practice that is frequently encountered by Medical Officers (MO). The occurrence of MLCs is on the increase, both in the Civil as well as in the Armed Forces. Proper handling and accurate documentation of these cases is of prime importance to avoid legal complications and to ensure that the Next of Kin (NOK) receive the entitled benefits.

2. All medical officers working in hospitals / field medical units / non medical units encounter medicolegal issues which should be handled in accordance with the law of the land and directives issued by service headquarters.

3. The purpose of this memorandum is to provide general guidelines for Medical Officers of the Armed Forces Medical Services (AFMS) while dealing with commonly encountered situations which fall within the medicolegal domain.

4. Since law and order is a state subject, there are differences in the legal procedures being followed by different states. Medical Officers should acquaint themselves with medicolegal procedures that are in vogue in the state in which they are serving.

MLCs in Medical Practice

5. **MLC.** A MLC is defined as “any case of injury or ailment where, the attending doctor after history taking and clinical examination, considers that investigations by law enforcement agencies (and also superior military authorities) are warranted to ascertain circumstances and fix responsibility regarding the said injury or ailment according to the law”.

6. **Labelling a case as MLC.**

(a) RMO / Casualty medical officer / MO in charge of MI Room / Duty Medical Officer (DMO) / MO In charge ward who is attending to the case, may label a case as a MLC.

(b) The decision to label a case as MLC should be based on sound professional judgement, after a detailed history taking and thorough clinical examination.

7. **Examples of MLCs.** The following are some of the examples of MLCs and medical officers should use their professional judgement to decide any other cases not enumerated in the list:

- (a) Assault and battery, including domestic violence and child abuse
- (b) Accidents like Road Traffic Accidents (RTA), industrial accidents etc.
- (c) Cases of trauma with suspicion of foul play
- (d) Electrical injuries
- (e) Poisoning, Alcohol Intoxication

- (f) Undiagnosed coma
- (g) Chemical injuries
- (h) Burns and Scalds
- (j) Sexual Offences
- (k) Criminal abortions
- (l) Attempted suicide
- (m) Cases of asphyxia as a result of hanging, strangulation, drowning, suffocation etc.
- (n) Custodial deaths
- (o) Death in the operation theatre
- (p) Unnatural deaths
- (q) Death due to Snake Bite or Animal Bite
- (r) Fire Arm injuries
- (s) Drug overdose
- (t) Drug abuse
- (u) Dead brought to the Accident and Emergency Dept / MI Room (Found dead) and deaths occurring within 24 hours of hospitalization without establishment of a diagnosis

8. **General Guidelines for dealing with Medicolegal cases**

- (a) In emergencies, resuscitation and stabilization of the patient will be carried out first and medicolegal formalities may be completed subsequently. The consent for treatment is implied in all emergencies.

(b) Emergency medical care will be administered to all cases brought to any AFMS Health Care Establishment irrespective of their entitlement. In non-entitled cases, after the initial stabilization, the patient may be transferred to the nearest Government hospital, and if necessary by service ambulance.

(c) Cases of trauma will be labeled as MLCs, if there is a suspicion of foul play, even if the incident is not of recent origin. All cases of injury to service personnel should be reported on IAFY 2006 (Injury Report) with the appropriate classification viz., trivial, moderately severe or severe.

(d) All MI Rooms and hospitals will maintain a MLC register and the MLC will be initiated and documented in the register. Personal particulars, identification marks, finger prints of the individual will be noted. Particulars of the person accompanying the patient will also be noted.

(e) Medicolegal documents should be prepared in duplicate, with utmost care giving all necessary details, preferably written with a ball-point pen and avoiding overwriting. If any overwriting or correction is made, it should be authenticated with the full signature and stamp of the MO. Abbreviations should be avoided.

(f) The Commanding Officer (CO) / Commandant and Senior Registrar and equivalent in other hospitals should be immediately informed as and when a MLC is registered or admitted. The particulars of the patient and a short summary of the case will be mentioned in the DMO report book.

- (g) The patient will be placed on SIL / DIL, when required.

- (h) NOK will be informed if the address is available.

- (j) The police should be informed. Under Section 39 of Criminal Procedure Code, the attending MO is legally bound to inform the police about the arrival of a MLC. Any failure to report the occurrence of a MLC may invite prosecution under Sections 176 and / or 202 of I.P.C. Simultaneously, the information should be given to ADH, Station Headquarters (HQ), Corps of Military Police (CMP) and to the unit concerned (by telephone). The verbal communication should invariably be followed by communication in writing subsequently.

- (k) In case of discharge / transfer / death of such a case in the hospital, the police should be informed.

- (l) Medicolegal documents should be considered as confidential records and should be stored under safe custody to avoid tampering. Medical records must be thorough, complete and should document each and every significant event in the course of care of the patient. All the documents including case sheets, X-rays and investigation reports will be preserved meticulously in the medical record section indefinitely and handed over to the concerned authorities (Police Investigating Officer / Court / Court of Inquiry) as and when required.

(m) Prompt attention, correct triage and safe transfer of a patient from one facility to another as required should be carried out in all cases and not delayed because of the medicolegal nature of the case.

(n) Opinion on severity of injuries should be given after the X-ray reports are received in cases of injury to bones / joints.

(o) Samples and specimens collected for medicolegal purposes will be properly sealed, labeled and handed over to the investigating officer detailed by the police. Commandant/CO of the hospital will ensure that the documents are kept in the custody of an appropriate officer till the case is finally decided or cleared by the police and judicial authorities.

(p) Dying Declaration. In cases where the patient wishes to make a dying declaration, the magistrate will be intimated. If the Magistrate is unable to come and record a statement or where the MO feels that he might not be able to reach the patient in time, the MO may record the dying declaration himself in presence of two independent witnesses whose signatures are also affixed in the document. The MO will certify the soundness of mind of the person making the dying declaration.

(q) Battle Casualties (BC) and Battle Accidents (BA) are not to be reported as MLCs. The medical cause of death in these cases may however be certified by the RMO. RMOs must obtain the certification of BC / BA from the unit, duly signed by the CO, before mentioning the same in the medical documents. AO 20/2001/ DV deals with details on declaration of BC / BA.

(r) Where civil police cover is not available, a military inquest will be held by the military administrative authority to decide cause and other facts pertaining to death. Normally, the service pathologist carries out clinical autopsy. Exceptionally, medico-legal autopsies may be carried out by the service pathologist (RMSAF para 58 refers). In such cases necessary clearance will be obtained from local civil police. The documentary prerequisites are:

- (i) Inquest report by the police / military court of inquest
- (ii) Requisition by the police / military court of inquest to the CO of the hospital for carrying out medico-legal autopsy in the military hospital addressed
- (iii) Express written orders of the CO of hospital to the service pathologist to carry out the autopsy.

(s) If a death has been reported by the hospital authorities as medicolegal and is decided otherwise by the police after investigation, a certificate to that effect is required to be obtained from the investigating officer in the format attached as Enclosure 1, along with a copy of the Panchnama when the body is returned to the hospital.

9. Precautions to be taken in MLCs

(a) The complete available particulars of the patient should be noted down along with two identification marks. Particulars of the person accompanying the patient will also be noted down.

(b) One should not rely on memory while writing reports or during recording of evidence in a court of law.

(c) Complicated cases should be discussed with seniors and colleagues.

(d) No cause of death will be mentioned in the death certificate. The statement that "Exact cause is to be ascertained by post mortem examination" is to be endorsed.

(e) In MLCs, the body will not be handed over to the NOK / relatives. The civil police will be informed and the body handed over to them. The police will, after the medicolegal formalities, handover the body to the NOK / relatives.

(f) Death of a service person, in an accident involving a military aircraft will not be reported as a MLC to the civil police. The enquiry conducted by the competent military authorities will suffice. As per Govt of India, Ministry of Home Affairs Letter No. 8/179/71-GP A, dated 25 Nov 72, there is no need for an inquest under Section 174 or 176 of Cr PC in deaths due to an accident, in which the aircraft belongs to the Navy, Army, Air Force or Para military forces and the deceased person is an active member of any service at the time of accident. A certificate from the CO of the deceased person or a Senior Armed Forces Officer to this effect may be accepted for dispensing with the necessity of an inquest.

(g) A MLC should be reported by the first health care establishment in which the individual is received. In cases where a patient has been

transferred before initiation of a report, the hospital to which he is transferred can initiate the report. It is important to ensure that the medical records are comprehensive before a patient is transferred. The fact as to whether or not medicolegal formalities have been initiated should invariably be mentioned in the transfer notes.

10. Guidelines for Preservation of Medicolegal Evidence

(a) Medicolegal evidence should be preserved and subsequently sent or handed over to the investigating authorities for forensic examination and production as evidence in a court of law. All evidences will be identified, sealed and labeled properly. They will be kept in safe custody and handed over to the investigating officer of the case. Once collected, loss / destruction of evidence is a punishable offence. Failure to collect, destruction or loss of such an exhibit is punishable under Sec 201 of I.P.C.

(b) The evidence required to be preserved is related to the nature of a case. In injury cases, the following articles should be preserved in sealed envelopes:

(i) Clothing worn by the patient showing evidence of injury such as tears, bullet holes, cuts, blood stains etc.

(ii) In case of multiple tears, cuts or holes etc., each piece of evidence will be encircled and numbered with matching description in the MLC report and case sheet.

(iii) Bullets recovered from a body should be marked by etching an initial or a mark on the bottom before preservation.

(iv) All evidence collected should be mentioned in medicolegal documents to establish the chain of custody in a court of law subsequently.

(c) In cases of suspected poisoning the following articles will be preserved and ensured that they are forwarded for forensic examination:

(i) Gastric lavage / gastric contents / vomitus and soiled clothing

(ii) Blood, urine and any other relevant body fluid depending on the poison ingested.

(d) In cases of Burns and Carbon Monoxide poisoning the following articles should be preserved in sealed envelopes:

(i) Articles soiled with inflammable substances like burnt pieces of clothing, scalp hair etc.

(ii) Blood (and not serum) for carbon-monoxide levels.

(e) In Sexual offences, the following articles should be preserved in sealed envelopes:

(i) Clothing worn by the patient and showing evidence of blood stains or seminal stains, stains of mud, tears/cuts etc.

(ii) Vaginal swab preferably from posterior fornix / anal swab.

11. Guidelines for preservation of Medicolegal documents

- (a) Original copies of all medicolegal documents will be produced whenever asked for in a court of law.
- (b) All original copies of certificates and reports issued for medicolegal purposes are to be preserved till the finalization of case in the court of law.
- (c) Commandant/CO of the hospital will ensure that the documents are kept in the custody of an appropriate officer till the case is finally decided or cleared by the police and judicial authorities. In the case of units other than hospitals, the safe custody will be under unit arrangements.
- (d) Documents pertaining to admitted fatal MLCs are to be processed and preserved as laid down in concerned policy letters.

12. Guidelines for handling of Death in Unit Lines

- (a) On receipt of information of suspected death in unit lines, the duty NCO should inform the Duty JCO and proceed to inspect the place of incidence. The Duty JCO should further inform the Duty Officer. The Duty Officer should intimate the following:
 - (i) Authorized Medical Attendant (AMA)
 - (ii) CO of the unit
 - (iii) Civil Police

(iv) CMP

(b) The AMA will proceed to the place of incident and examine the individual suspected to be dead, taking care not to disturb any evidence present. The AMA should assess the condition of the individual and attempt resuscitation measures if required. If the individual cannot be revived, then the AMA should declare the individual dead and prepare a death certificate (AFMSF -93 Part I), specimen attached as Enclosure 2 in which he should mention the cause as 'Found Dead Cause Unknown (Exact cause to be determined by post mortem examination)'.

(c) The AMA will also initiate a Case sheet (AFMSF- 7A) in which he gives the details of the deceased, details of the person who identified the body, two identification marks, examination findings and the diagnosis as 'Found Dead'. The identification marks are corroborated with the identification marks as mentioned in Soldier's Personal Book (IAB-64) and Identity card of the deceased.

(d) The body will be handed over to the civil police. According to Section 174 of Criminal Procedure Code (1973), in all cases of death due to suspected or un-natural causes, police may hold an inquest and send the body to the civil hospital, for post mortem examination for establishing the cause of death. The civil police will initiate an inquest report (Panchnama) and send the body for post mortem examination to a civil Hospital. After post mortem examination, the body may be kept in the mortuary of a service hospital for preservation and embalming. Post mortem examination can also

be conducted in a service hospital, subject to necessary police clearance vide Enclosure '1'.

(e) The unit will initiate the Initial Report in signal form, specimen of which is attached as Enclosure '3'. The initial report will be followed by a detailed report within 48 hours, specimen of which is attached as Enclosure '4'. Instructions of respective service headquarters will be followed for Navy and Air Force.

(f) The NOK should be informed about the incident telephonically and in writing (Telegraphic message).

(g) The Station / Formation HQ can order a Staff Court of Inquiry to ascertain the circumstances of the death. The Staff Court of Inquiry will take into consideration the Inquest report of the civil police and post mortem findings as available.

(h) If civil police is not available in the area, a military inquest will be held by the military administrative authorities to decide the cause and other facts pertaining to the death.

(j) In AFMS, Medical Certificate of Cause of Death on AFMSF – 93 Part I (shown as Enclosure 2) will be initiated by the DMO / AMA in a case of natural death or if there is no foul play suspected. The formal death certificate will be issued by the Registrar of Births and Deaths / Cantonment board / Municipal authorities as applicable after submitting the medical certificate of cause of

death. In unnatural deaths, the cause of death will be established by a post mortem examination. A formal death certificate is required for all legal purposes.

(k) Attributability / aggravation shall be decided in accordance with GOI, MOD letter No 1(2)/2002/D(Pensions) dated 01 Sep 05 as amended by DGAFMS letter No 16050/DGAFMS/ MA (Pensions) dated 25 Jan 07 and administrative instructions issued by respective service headquarters.

(l) After the post mortem examination, the body may be disposed off locally under unit arrangement or may be embalmed and hermetically sealed in a body bag within a coffin for transportation. Necessary certificate should be issued by the embalming authority. A 'No Objection Certificate' is needed to be obtained from the civil police for transportation of the body.

(m) The unit should mention all relevant information as applicable in the initial report and the detailed report. If any information is not available at that time it should be mentioned specifically as it may lead to infructuous correspondence and delay in processing of the deceased's family pension and other claims.

(n) Precautions to be taken in case of death in unit lines. In case of an individual found dead in the unit lines, the AMA and the civil police should be called to the place where the incident has taken place. The body and its surroundings should not be disturbed before their arrival.

13. **Guidelines to be followed in case of Death in hospital**

(a) During working hours, the MO in charge of the case will inform the CO/ Registrar of any death. In case of death during off-duty hours, MO in charge of case / DMO will inform CO / Registrar of any death occurring in the hospital.

(b) MO in charge Ward / DMO will arrange for removal of the body to the mortuary for preservation and safe custody after packing the body at the earliest.

(c) The dead body will be marked with a skin marking pencil. The Number, rank and name of the deceased will be written on the left leg (inner aspect). At the time of handing over the body to the Mortuary, an identification disc will be tied to the right great toe of the deceased for easy identification, on which the name of the deceased will be written. This will be the responsibility of Nursing Officer / JCO in charge of ward. A copy of medical certificate of cause of death will be kept along with the dead body.

(d) Ward Master / Duty NCO will hand over the dead body to NCO in charge of Mortuary. When a female dead body is transferred from the ward to the mortuary, the Medical Officer will ensure that a female attendant accompanies the body and when such transfer is done at night, a male staff is additionally detailed.

(e) The hospital authorities will contact NOK / CO unit / Station Headquarters as applicable, for getting willingness for clinical postmortem examination if required. If NOK is not available for giving consent, the CO of the unit may give the same.

(f) Soldier's Personal Book (IAB-64) and valuables of the deceased will be taken over by the MO / DMO. List of personal items should be prepared and handed over to the representative of the unit after obtaining receipt in case of local units. For out-station units these will be handed over to Registrar of the hospital for safe custody.

(g) All efforts will be made to carry out clinical post mortem in case of death of serving soldier for easy settlement of claims. However, in case of known malignancy and HIV Positive cases, if a specialist officer gives in writing that the cause of death is solely due to known preexisting cause, the post mortem examination can be dispensed with. Post mortem examinations in cases of AIDS can be carried out after taking all recommended safety precautions. (Auth: AHQ Letter No. 5496 / DGAFMS / DG 3A dated 13 Nov 92).

(h) The Chief Ward Master will hand over the dead body to the NOK if they are unwilling for Post mortem examination. He will check the particulars of the deceased as given in the authority letter, with the death certificate, identification marks and identification disc. In MLCs, the body will be handed over to the civil police. A dead body handing-taking over certificate will invariably be obtained.

(j) The Chief Ward Master will also take 'Willingness / Unwillingness Certificate' from the NOK of the deceased for conducting clinical post mortem examination in service hospitals, in non-medicolegal cases. Hospital will obtain permission from the Station Commander for conducting post mortem examinations of the deceased if his NOK can not be contacted and his unit is not located in the same station.

(k) The fatal case documents should be processed at the earliest to avoid delay in release of pension and other benefits to the NOK of the deceased.

14. **Special precautions in cases of Death in the hospital**

(a) It should be ensured that proper packing is done before transferring the dead body to the mortuary.

(b) The mortuary staff will note down two identification marks of the deceased and confirm the particulars of the deceased as noted on the metal identification disc on the right great toe of the deceased by checking with the accompanying documents.

(c) Willingness / Unwillingness certificate for autopsy and body handing taking over certificate will be obtained.

15. **General guidelines for Sudden Death / Found Dead Cases**

(a) Deaths, which require medicolegal investigation, may be divided into three main groups: -

(i) Deaths either known or suspected to have been caused by unnatural causes.

(ii) Sudden death cause unknown.

(iii) Found dead – Unattended death.

(b) As per ICD 10, “sudden death cause unknown” could be as follows:

(i) R96.0 - Instantaneous death

(ii) R96.1 - Death occurring less than 24 hours from onset of symptoms, not otherwise explained

(iii) R98 - Death in circumstances where the body of the deceased was found and no cause could be discovered. Found dead.

(iv) R99 – Death NOS (Not Otherwise Specified). Unknown cause of mortality.

(c) Deaths due to natural causes fall within the medicolegal domain when they occur in custody, clashes, accidents and sometimes even during violent arguments. Therefore a Medical Officer should not certify the cause of death

in such cases without holding a post mortem examination, even if there is strong evidence of the underlying cause.

(d) The deceased will be examined in detail by attending MO and resuscitation will be attempted, failing which death will be confirmed and AFMSF – 93 Part I will be initiated.

(e) Two identification marks will be noted.

(f) Circumstances leading to death will be ascertained from person bringing and identifying the body.

(g) All particulars and address of the person(s) bringing the deceased will be noted in the case sheet and history given by them will be endorsed in the case sheet as alleged history.

(h) MO i/c MI Room / DMO will inform the CO / Registrar and Stats Section / Duty Clerk immediately.

(j) MO i/c MI Room / DMO will inform higher authorities and unit of the individual and NOK, besides CMP and civil police. Civil Police is to be informed in writing with copies to all concerned.

(k) Body will be handed over to civil police for further disposal. Under no circumstances will the body be handed over to next of kin directly. Alternately

clearance in writing should be obtained from civil police for disposal of the body.

(l) In case the body is being sent for medicolegal autopsy to civil hospital, brief summary of the case will be given to civil police.

(m) A receipt for handing over the body to police will be taken and kept along with the case documents.

(n) The following documents will be initiated:

- (i) Admission Flimsy (AFMSF - 8A)
- (ii) Case Sheet (AFMSF - 7A)
- (iii) Death certificate (AFMSF 93 Part - I)
- (iv) Record of summary in the medicolegal case register
- (v) Dead body handing taking over certificate.

16. **Special precautions for Sudden Death / Found Dead Cases**

(a) The particulars of the people accompanying the body, a brief history of the circumstances in which the death took place or they came across the deceased, should be recorded.

(b) The medical cause of death should not be endorsed in AFMSF- 93 Part-I whenever an unattended death case is received. The AFMSF – 93

Part-I should mention only 'Found dead, Cause unknown - to be ascertained by Post Mortem examination'.

(c) Nothing will be handed over to the civil police or the NOK without taking a receipt (including the written report about the death, samples collected from the body of the deceased).

17. **Death of Individual While on Sick Transfer.** A patient, who is proceeding on sick transfer may or may not be accompanied by a sick attendant. The patient accompanied by a sick attendant may be on a list (DIL/SIL). The patient may be transferred by various means of transport, like by road (Ambulance), rail or air. The patient proceeding on sick transfer may die either due to a complication of the disease for which he is being transferred or due to an unrelated cause. The patient may also be found dead during transfer either by his sick attendant or by his fellow passengers.

18. **Death of Patient not accompanied by Sick Attendant**

(a) Transfer by rail

(i) In the event of a patient on sick transfer by rail being found dead, the fact is usually discovered by either coach attendant / TTE / fellow passengers, who in turn inform the Guard. The train guard usually contacts the Station Master of the next station having GRP for necessary formalities.

(ii) The inquest and post mortem is arranged by railway police who also inform the NOK, nearest military unit / Station headquarters and referring hospital, subject to identification of the deceased and through other available documents.

(iii) Receipt of dead body, its transportation to NOK for last rites, ordering a C of I and other documentation is done under arrangements of nearest Station headquarters. The death certificate and autopsy report in such cases is obtained from the civil hospital where the body was taken for autopsy and necessary documentation completed accordingly. A representative from the unit is usually detailed to facilitate the same.

(b) Transfers by Road. The patient may be traveling by an ambulance or by bus/ taxi. In case the patient is traveling by ambulance, the driver or co-driver of the ambulance, will inform the nearest civil police, or / and nearest Station headquarters, the unit of the deceased, the referring hospital and the hospital to which he is being transferred / referred to for necessary action.

(c) Transfer by Air

(i) In case of death of patient while proceeding on sick transfer by service aircraft that meets with an accident, the death need not be reported to the civil police as a MLC and the same is exempted from the purview of Cr PC 174.

(ii) Where the patient is being transferred by civil aircraft, the civil police and the station headquarters will be informed and will carry out further tasks. The nearest Station headquarters will collect the body of the deceased, pack it hermetically and arrange for transportation of the patient to the NOK.

19. **Guidelines in case of Death of Patient accompanied by Sick Attendant**

(a) As per AHQ Policy Letter No. 11952 / DGMS - 5A (31305/Pol/DGMS-5A) Dated 28 Jan/19 Feb 88, in case of death of patient during sick transfer the receiving hospital is to admit the case as "Found dead". Where there is no possibility/ suspicion of foul play, the cause of death will be recorded as the disease from which the patient was suffering and a clinical post mortem is to be carried out. In case death occurs at a place which is far away from the destination, the sick attendant should immediately contact the nearest Station headquarters and the civil police (railway police in case of transfer by rail) for further action.

(b) In case of death of patient while proceeding on sick transfer by air the sick attendant should contact the nearest Station headquarters who should further contact the civil police, arrange for transportation of the body to either a mortuary of a nearby hospital or transport the deceased's body to the NOK or arrange for funeral / last rites in the station itself.

(c) Precautions for sick transfer. It is incumbent upon all MOs / Specialist Officers ordering sick transfer to properly assess the condition of the patient

and fitness to undertake the journey by the selected mode of transfer. The sick attendant will be properly briefed and provided necessary wherewithal to manage the patient enroute. Patients traveling without a sick attendant should carry a card giving the identification, diagnosis, treatment and important contact telephone numbers in case of any emergency.

20. **Medico-legal aspects of sexual offences**

(a) Victims of alleged Sexual offences like rape may be brought to the MI Room or may come on their own. In the event the victim comes directly, the civil police will be informed and necessary action will be taken to register a case. The examination may be carried out at a centre authorized for medicolegal work with forensic experts. Where the examination is carried out by a service MO, it should preferably be done by a lady MO or Gynaecologist or by MO i/c MI room in the presence of a female attendant. In cases of sodomy, the victim may be examined by the MO i/c MI Room.

(b) **Guidelines for attending alleged victim of sexual offence**

(i) The date and time of examination will be mentioned in the case sheet.

(ii) Case sheet will be initiated, noting personal particulars of the victim, along with date and the time of reporting.

- (iii) MLC will be initiated after filling the MLC Register available at MI Room.
- (iv) The alleged victim will be admitted if the medical condition is serious.
- (vi) The civil police will be informed telephonically followed by in writing after filling up the MLC Register.
- (vii) The Senior Registrar / CO of the hospital, CO of the unit, CMP and Station HQ will be informed.
- (viii) At least two identification marks of the victim will be mentioned in the case sheet as well as in MLC register.
- (ix) Report to the police will be given by name of the victim or as an unknown case (If name of the victim is not known). Care must be taken to preserve the confidentiality of the victim from others not related with the case.
- (x) Police will register a case under the relevant section of the IPC.
- (xi) The police may take the victim and the accused for medical examination at a hospital which is authorized to carry out medicolegal work.

(xii) The proformae for recording medical examination of alleged rape victim and the accused are enclosed as Enclosure '5' & '6' respectively.

(xiii) Consent of the victim must be obtained before starting the examination. The steps of examination and their purpose should be explained to the victim in a language she understands. The examination is to be carried out in the presence of a female attendant.

(xiv) All injuries present on the body will be recorded. Line diagrams depicting the front and back of the body may be used for a better description of location of the injuries.

(xv) If the clothes are the same as those worn during the occurrence of alleged sexual offence, they should be carefully examined for the presence of blood, seminal stains, mud etc.

(xvi) If there are any marks of suspicious stains, the clothes should be preserved with a view to forwarding them to the Chemical Examiner of dependent Forensic Science Laboratory (FSL). The format to be used for is enclosed as Enclosure '7'.

(xvii) If there are foreign hairs, fibers, debris under the nails etc, they must be carefully preserved and sent to experts of FSL for comparison with those found on the accused. Specimens should include vaginal swab, preferably from the posterior fornix.

(xviii) In case the victim reports herself directly to the hospital after the alleged crime, she should not be sent to the police station for legal formalities; instead the police will be called to the hospital for the necessary requirements.

(c) Special precautions in case of sexual offence.

(i) The date and time of arrival of the victim must be mentioned, both in the case sheet and the MLC Register. The duplicate copy of case sheet and Medicolegal Report shall be preserved for future reference.

(ii) Care must be taken to preserve various samples of medicolegal importance for their submission to respective police authority.

(iii) Where the accused in a case of sexual offence in police custody is brought for medical examination, consent is not required. Samples may be collected and handed over to the police for forensic examination.

(iv) All injuries shall be recorded in cases of alleged victims of sodomy.

(v) Care must be taken to preserve the vaginal / anal swab for forensic examination.

(vi) Neither the victim nor accused in cases of sexual offences should be permitted to wash or take a bath till the medical examination is completed.

21. **Medicolegal aspects of Poisoning**

(a) Poison may be defined as any substance which when absorbed into the body or by local action on the tissues injures health or destroys life.

(b) Medicolegal aspects of Poisons. Sections 284, 299, 300, 304A, 324, 326 and 328 of IPC deal with offences relating to handling and administration of Poisonous substances. As per Indian law, administration of any substance with the intention of causing hurt or death is punishable.

(c) Guidelines in case of Poisoning

(i) When poisoning is suspected, every attempt must be made to save the patient's life. The patient shall be shifted immediately to the hospital / MI room nearby.

(ii) Case sheet shall be initiated, noting personal particulars of the victim, along with date and time of reporting. The particulars of the person accompanying the patient will also be noted.

- (iii) The victim will be protected from further exposure of poisoning but no clothing shall be thrown away, as they might be useful for chemical analysis.
- (iv) MLC will be initiated after filling the MLC Register available at MI Room.
- (v) The patient will be admitted if the medical condition is serious.
- (vi) Civil police must be informed.
- (vii) The CO / Registrar of the hospital, CMP, Station HQ and CO of the unit will also be informed.
- (viii) The treating doctor / authorized nursing staff will only be permitted to administer food and medicines to the patient.
- (ix) A careful history is to be elicited including relationship of food or medicine taken and the toxic manifestations. All signs and symptoms are to be noted carefully.
- (x) The vomitus, urine, faeces, stomach wash, sample of food or medicine taken should be preserved in a sterile bottle. Any suspicious bottle or utensil seen near the victim, the clothes and bed clothes used last by the victim are all to be preserved for chemical analysis. Suitable preservatives may be used for these purposes depending upon the

nature of the sample. The name and concentration of preservative used should invariably be mentioned in the label and / or accompanying documents. The proforma for sending samples other than viscera is enclosed as Enclosure 7.

(xi) It is advisable to take the second opinion and advice of a senior professional colleague in all matters regarding diagnosis and treatment. Use of Poison information services may also be made.

(xii) If there is any indication of danger to the general public, for example, food poisoning from a hotel, the public health authorities must be notified at once so that suitable remedial measures are taken.

(xiii) In case of food poisoning from unit cookhouse, the AMA has to inform the incident to SHO/ SEMO/ DADH/ADH and administrative authorities.

(xiv) Where required, a magistrate should be called to take down the dying declaration.

(d) Precautions to be taken in cases of poisoning

(i) Emergency medical treatment will be administered. Senior colleagues will be consulted and Poison Information Services will be made use of wherever available.

(ii) Medical certification and cause of death will be issued with mention that 'Cause of death to be ascertained after chemical analysis'.

(iii) Various samples of medicolegal importance will be preserved and handed over to the police for forensic examination.

(iv) A receipt shall be obtained from the police for all samples that are handed over for forensic examination.

22. **Consent**

(a) This is an important responsibility of the doctor. Consent is defined as "Two or more persons are said to consent when they agree upon the same thing in the same sense" (Sec 13, The Indian Contract Act). For the purpose of clinical examination, diagnosis and treatment, any person who is conscious, mentally sound and is above 18 years of age can give consent.

(b) Consent is not legally valid when given under fear, fraud or misrepresentation of facts or is given by a person who is under 12 years.

(c) **Types of consent**

(i) Implied consent

(ii) Express consent, which may be verbal consent or written consent

(iii) Informed consent

(d) Implied consent. This is most common type of consent in both general practice and hospital practice. The fact that a patient comes to a doctor for an ailment implies that he is agreeable to medical examination in general sense. In clinical practice, implied consent can be used for general examination and systemic examination including inspection, palpation, percussion and auscultation.

(e) Expressed consent. In expressed consent, a patient specifically grants permission to a physician to undertake diagnosis and treatment of a specific problem. Expressed consent may be given either verbally or in writing. Expressed consent must conform to the doctrine of informed consent to be legally acceptable. Once a patient has forbidden any action, the question of implied consent does not arise. Expressed written consent should be obtained for the following:

- (i) All invasive and major diagnostic procedures
- (ii) General anesthesia
- (iii) Surgical operations
- (iv) Medicolegal examinations for determining age, potency, virginity etc, where the person being examined is not in police custody.

(f) Doctrine of Informed consent: The doctrine of informed consent aims at giving sufficient information to a patient to enable him to make a knowledgeable and informed decision about the use of a drug, device or procedure in the course of treatment. The duty to warn a patient of any likely harm in the course of treatment has also been included in the doctrine.

(g) In order to conform to the doctrine of informed consent, the following conditions should be fulfilled:

- (i) Disclosure of information
- (ii) Free and voluntary decision-making by the patient
- (iii) Patient is legally competent to decide

(h) The treating physician must ensure that the patient is explained the following in a language he / she understands:

- (i) Provisional Diagnosis
- (ii) Nature of procedure / treatment
- (iii) Risks involved
- (iv) Prospect of success
- (v) Likely outcome in case the procedure is not performed
- (vi) Alternative methods of treatment.

(j) Situations where consent is not required. Consent is not required to be obtained in the following situations:

- (i) Medical emergencies: consent to emergency treatment is implied.
- (ii) Treatment of notifiable diseases: in the interest of public health.
- (iii) Medical examination under Sec 53, Cr PC.
- (iv) Psychiatric examination / treatment by court order.

(k) Under Section 53 (1) of Cr P.C., a person can be examined at request of the police by use of force. Section 53 (2) lays down that whenever a female is to be examined, it shall be done only by or under the supervision of a female doctor.

(l) As far as possible, consent must be obtained from the patient, when he / she is competent to give it.

(m) Consent to treatment or a procedure or an operation is limited to the parameters that were expressed before the commencement of medical intervention. However in certain circumstances, extension of the scope of consent would be legally permissible. This principle of extension applies in cases of consent to treat an emergency.

(n) Consent should be obtained when procedure has finally been decided and planned and not while the investigation is still contemplated.

(o) Consent should be obtained in the presence of a witness before the pre-operative medication is administered and the same documented in writing.

(p) Only in situations where the patient is minor, unconscious or mentally unsound, consent should come from legal guardian/ NOK, who are present.

(q) In case of an unconscious patient, consent to emergency treatment is implied.

(r) Legally it is essential to take consent for the following reasons:

(i) It provides a practitioner legal protection in case of an action for negligence. The practitioner can cite proof of consent as evidence of disclosure, thereby protecting him from an action based on failure to disclose material facts.

(ii) Secondly, protection has been provided to practitioners who have obtained informed consent in accordance with the provisions of Sec 88, I.P.C.

(iii) Thirdly, it may be pertinent to note that exercise of reasonable skill and care is not sustainable in law as a defence against assault and battery.

23. **Guidelines in case of Medical Mishap**

(a) The patients and their relatives expect a kind and compassionate attitude from a doctor. A scientifically sound approach, good behaviour and care of a reasonable standard usually protect a Medical Officer from professional complaints.

(b) There are occasions when something untoward happens following a diagnostic or therapeutic procedure. In such a situation, the physician must take the following steps: -

(i) Complete the patient's record and recheck the written notes.

(ii) Be honest and inform about the mishap. Show genuine concern about the unfortunate incident. Answer all the queries of patient / relatives. Doctors, who are open-minded and communicative, are much less likely to face complaints.

(iii) The doctor may contact other doctors, Forensic Medicine experts and professional protection bodies to seek advice.

24. **Medical Negligence (Malpractice)**

(a) Medical negligence or malpractice is defined as "lack of reasonable care and skill or willful negligence on the part of a doctor in the treatment of a patient whereby the health or life of a patient is endangered". The term "damage" means mental or functional injury to the patient, while "damages" are assessed in terms of money by the court on the basis of loss of concurrent and future earnings, treatment costs and reduction in qualities of life.

(b) In order to establish charges for negligence, the following points are required to be established to the satisfaction of the court, by the consumer, that:

(i) The doctor (defendant) owed him a duty to conform to a particular standard of professional conduct.

- (ii) The doctor breached that duty
- (iii) The patient suffered actual damage
- (iv) The doctor's conduct was the direct or proximate cause of the damage.

(c) The burden of establishing all above elements is upon the patient / consumer. Failure to provide substantial evidence on any one element may result in "No compensation".

(d) In an emergency situation the medical officer has to attend the patient at the place where the patient is, if the medical condition so warrants. Inability to do so without a valid reason will constitute medical negligence.

(e) Criminal Negligence. Here the negligence is so great as to go beyond a matter of mere compensation; not only the doctor has made the wrong diagnosis and treatment, but he has shown gross ignorance, gross carelessness or gross neglect for life and safety of the patient. For this, the doctor may be prosecuted in a criminal court for having caused injury or death of the patient by a rash and negligent act amounting to culpable homicide under Sec 304-A of Cr. P.C., under following conditions:

- (i) Injecting anesthetic in fatal dosage or in wrong tissues
- (ii) Amputation of wrong finger, operation on wrong limb, removal of wrong organ etc.
- (iii) Operation on wrong patient
- (iv) Leaving instruments or sponges inside the part of body operated upon
- (v) Leaving tourniquet too long resulting in gangrene
- (vi) Transfusing wrong blood
- (vii) Applying too tight plaster or splints, which may cause gangrene or paralysis
- (viii) Performing a criminal abortion.

25. **Guidelines for action in case a patient is found missing from the hospital**

(a) Where a patient is reported missing from the Hospital, all efforts will first be made by the hospital to locate him / her. Information will be sent to the unit, Station HQ, CMP, Civil Police and NOK regarding his / her absence from the hospital. When all efforts to locate the patient do not succeed, he / she will be discharged in absentia.

(b) After being discharged in absentia, should the patient report again to the hospital, he/ she will be re-admitted for further treatment, if required. The period of absence from the hospital will be reported to the unit of the individual in case of serving soldiers, for necessary investigation and action.

26. **Domestic violence and Abuse of Women.** Domestic violence is a leading cause of injury to women. It is a pattern of physical assaults, threats, and coercive behaviors used to maintain control over a partner. Behaviors can include ongoing verbal, emotional, sexual, physical, psychological, and economic abuse, and typically get worse over time. Such behavior may result in death, serious injury, isolation and emotional damage for the victims. The medical officer should remain vigilant about such incidences.

27. **Child Abuse**

(a) Instances of child abuse are on the rise. Medical Officers need to be vigilant in clinical practice to detect these cases.

(b) “Child Abuse” may be defined as the “physical and psychological effects produced by deliberate repetitive physical injury or sexual abuse of a child”.

(c) Role of Physician. Physicians have a duty to recognise and report suspected abuse to the police and other statutory investigative agencies. Physicians need to work together with statutory agencies in cases of child abuse. Role of a physician includes recognition, diagnosis and treatment of injuries, ongoing care and monitoring of children following suspected abuse. It also includes prevention of abuse by counseling and teaching, training, supervision, and education of the community to heighten awareness about the problem.

28. **Review of important legislations**

(a) **Consumer Protection Act – 1986.** In view of the Supreme Court affixing its seal of approval on the applicability of the Consumer Protection Act (COPRA/ CPA) to the services provided by the medical profession, it has become imperative for medical professionals to exercise a greater degree of caution while undertaking diagnosis and treatment of patients. A good doctor – patient relationship, open channels of communication, patient education and transparency can minimize litigations.

(b) **Bio-medical Waste (Management and Handling) Rules 1998 (as amended in 2003).** It shall be the duty of every occupier of an institution generating bio-medical waste which includes a hospital, nursing home, clinic,

dispensary, veterinary institution, animal house, pathological laboratory, blood bank by whatever name called to take all steps to ensure that such waste is handled without any adverse effect to human health and the environment. These rules apply to all persons who generate, collect, receive, store, transport, treat, dispose or handle bio-medical waste in any form. Bio-medical waste shall be treated and disposed of in accordance with Schedule I, and in compliance with the standards prescribed in Schedule V. DGAFMS is the prescribed authority for implementation of this Act in establishments of Armed Forces.

(c) **Transplantation of Human Organs Act 1994 (as amended in 2003).**

Under this Act, registration of hospitals is must for the removal, storage and transplantation of human organs. No such activity is permitted unless registered under the Act. Application on prescribed form with fees is required. Certificate is given for specific period and the same has to be renewed when due. Further, Registration can be cancelled after giving notice to hospital. Appeal against cancellation of registration is to be made within 30 days of receipt of notice. Criminal action can be initiated with or without notice.

(d) **The Drugs & Cosmetics Act, 1940 with the Drugs, Cosmetics (Amendment) Act 1995 and the Drugs & Cosmetics Rules, 1945 (as**

amended in 2006). An Act to regulate the import, manufacture, distribution and sale of drugs and cosmetics. Amendment 2006 is related to importing of drugs, (to be tested in India before release for sale in India). Few salient features of the above mentioned Act:

- (i) Provision to empower the Drug Inspector to stop and search any vehicle, vessel or other conveyance when he has reason to believe that those are being used for carrying any drug or cosmetic in respect of which an offence under the Act is being committed.
 - (ii) Enhancement of the quantum of punishment for offences relating to the manufacture or sale of adulterated, spurious drugs.
 - (iii) The main objective of the Act is to prevent sub-standards in drugs, presumably for maintaining high standards of medical treatment.
 - (iv) Substances governed by the Act can nevertheless be applicable to narcotic or intoxicating liquor which are subject to Excise by State under Entry 51, List II of the Constitution.
 - (v) Blood banks are required to regulate their services in accordance with the provisions of Ministry of Health and Family Welfare, Dept of Health, notification dated April 1999 and need license to operate. However, blood transfusion services of Field Medical Units are exempted from this provision.
- (e) **The Pre-natal Diagnostic Techniques (Regulation and prevention of misuse) Act 1994 and amended Preconception and Prenatal Diagnostic Techniques (PNDT) Act, 2003.** The Act covers pre-conceptual techniques and all prenatal diagnostic techniques. All diagnostic centers must be registered with the Appropriate Authority. They are required to maintain

detailed records of all pregnant women undergoing test there. These records must include the referring doctor, medical and other details of the woman, reason for doing the test, and signatures of the doctors. These records must be submitted to the authorities periodically. Doctors will be reported to the state medical council which can take the necessary action including suspension. In the AFMSF, the powers have been delegated to DGAFMS, who has nominated appropriate authority for each state for all AFMS units located there.

(f) **MTP Act 1971 and MTP (Amendment) Act 2002.** Medical Termination of Pregnancy Act, 1971 provides for the termination of certain pregnancies by registered medical practitioners and for matters connected therewith or incidental thereto. It extends to the whole of India except the State of Jammu and Kashmir. In accordance with this Act, a MTP may be carried out either in a hospital established or maintained by Government, or at a place for the time being approved for the purpose of this Act by Government. Consent of the patient / legal guardian in case of minors or mentally handicapped persons must be obtained before performing MTP. A pregnancy may be terminated by a registered medical practitioner in the following conditions: -

- (i) Where the length of the pregnancy does not exceed twelve weeks if such medical practitioner is, or

- (ii) Where the length of the pregnancy exceeds twelve weeks but does not exceed twenty weeks, if not less than two registered medical practitioner are,

of opinion, formed in good faith, that -

- The continuance of the pregnancy would involve a risk to the life of the pregnant woman or of grave injury to her physical or mental health

(or)

- If there is a substantial risk that if the child were born, it would suffer from such physical or mental abnormalities to be seriously handicapped.

(g) **Right to Information Act 2005.** An Act to provide for setting out the practical regime of right to Information for citizens to secure access to information under the control of public authorities, in order to promote transparency and accountability in the working of every public authority, the constitution of a Central Information Commission and State Information Commissions and for matters connected therewith or incidental thereto. The AFMS is not kept out of the purview of the said Act. All members of AFMS are required to know the details of the content of the letter No. 17732 / 6 / Info Act / AG / DV-1(C), dated 18 Nov 2005 issued from Human Rights Cell, Addl Dte Gen, Discipline and Vigilance, AG's Br, Army HQ, New Delhi and Office of DGAFMS letter No 43244/ RTI/ DGAFMS/ DG – 1C dated 16 Dec 2005.

29. **Medical examinations of apprehended persons.** During Counter Insurgency Operations, MOs may be called upon to medically examine and render a fitness certificate before / after interrogation or handing over of an apprehended person to civil police / release. MOs must exercise great caution and minutely note down all findings and maintain a record of the same. While courts may not rely upon the report rendered by service MOs, terming them as Departmental reports, any major discrepancy in findings of the service MO and that of a civil MO may invite adverse comments by the Court.

30. **Conclusion.** The way in which medicolegal issues are handled has a profound impact on the public image of the AFMS. Therefore, MLCs must be handled tactfully by the MOs. The administrative authorities must also help in maintaining goodwill and avoiding legal complications. It is hoped that this collation of directives on handling of medicolegal issues will act as a safeguard against procedural lapses and maintain the elite image of the AFMS.

(Yogendra Singh)

Lt Gen

DGAFMS

Enclosure 1 (Refers to Para 8 s)

Appendix 'A' to Army HQ Letter No.
111952/Pol/DGMS-5A Dt. 13 Sep 90

POLICE CLEARANCE (VIDE Cr PC SEC -174)

1. The police authorities do not intend sending the dead body of _____ for postmortem and have decided not to hold an inquest. The police have no further interest in this case.

2. There is no objection from the local police to carry on the enquiry/postmortem examination in the death case of No _____ Rank _____ Name _____ and also further disposal of the dead body by the Military authorities, as may be considered necessary by them.

Station :

Signature _____

Date :

(To be signed by the SHO police Station)

Name _____
 (In block letters)

Enclosure 2 (Refers to Para 12 b)**AFMSF 93 Part I (Ver 2002)****MEDICAL CERTIFICATE OF CAUSE OF DEATH**

Certified that (Name)	
Rank	No Unit / Ship
Died / was Killed / was Killed in Action onathrs.	
Disease or Condition directly leading to * Death	
.....	
Due to (or as a consequence of)	
.....	
<i>** Antecedent Cause of Death of (Morbid condition or any, giving rise to the above, stating the underlined conditions last) due to (or as a consequence of)</i>	
a)
b)
<i>Other significant conditions if any contributing to the death but not related to the disease or conditions causing it</i>	
Signature of M.O	
Place	Rank & Name in full
Date	Designation
<i>* This does not mean the mode of dying for example Heart failure, asthenia etc. It means the disease, injury or complication which causes the death</i>	
<i>** Parts (a) &(b) are not to be completed if the disease or condition directly leading to the death describes completely the train of events.</i>	
<i>Note:</i>	
<i>(A) this form is designed to elicit the information which will facilitate the selection of underlying cause of the death when two or more causes are jointly recorded</i>	
<i>(B) See Paragraph 77 Chapter II of regulations for Medical Service of the Army in India</i>	

Enclosure 3 (Refers to Para 12 e)**Format for the Initial Report**In lieu of msg formOp Immediate

From:

To: Indarmy AG's Branch MP 5(D)

Indarmy (DGMS-5(B))

Indarmy (AGI Dte)

Fmn HQ

Fmn HQ

FMN HQ (Med)

Record Office concerned

or equivalents in Navy/Air Force

Initial report (.) refer AO 1/2003/MP (.) Firstly (.) alfa (.) No. _____ (.) Bravo (.) Rank _____ (.) Charlie (.) Name _____ (.) Secondly (.) Physical cas/Battle cas/battle accident (.) Thirdly (.) died (.) Fourthly (.) date (.) Fifthly (.) loc of death (.) sixthly (.) diagnosis (.) seventhly (.) Name of NOK (.) Present and permanent address (.) village (.) post (.) Teh (.) Dist (.) Pin code (.) Eighthly (.) NOK informed or not telegraphically (.)

Lt Col XYZ

Adm Offr

Tele:

Case File No. _____

Lt Col _____

Date ; _____

TOR

Enclosure 4 (Refers to Para 12 e)**FORMAT FOR DETAILED REPORT**

Tele : Mil

Unit
Pin No

Case File No:

Date

Adjutant General Branch (MP-5 (D))
Army Headquarter
New DelhiAdjutant General Branch (CW Dte)
Kashmir House
Army Headquarter
New DelhiRajya Sainik Board

_____Dte Gen Resettlement
MOD
West Block –IV
RK Puram, New DelhiDSS& A Board

_____**DETAILED REPORT OF PHYSICAL CASUALTY**

1. Ref to this unit sig NO _____ dt _____.
2. Detailed report of physical casualty as per appx 'E' to AO 1/2003/MP is as under:-

(a) Personal Details

- (i) Army NO
- (ii) Rank
- (iii) Name
- (iv) Unit
- (v) Regt/Corps
- (vi) Arms/Services
- (vii) Religion/caste

(b) Casualty Details

- (i) Operations
- (ii) Battle casualty/Physical casualty/battle accident
- (iii) Nature of cas

Enclosure 4 (Refers to Para 12 e)**Copy to:-**

AGIF
AGI Bhavan, Rao Tula Ram Marg
Post Bag No-14, Vasani Vihar,
New Delhi

Fmn HQ
Fmn HQ (Med)
Record Office

Enclosure 5 (Refers to Para 20 b xii)**PROFORMA FOR EXAMINATION OF ALLEGED RAPE CASE
(FEMALE)**

Requisition from _____ of Police Station _____

vide his letter No. _____ Dated _____

Name (In full) _____

Age as assessed _____ Sex _____ M.L.C. No. _____

Occupation _____ Address _____

Date of Examination _____ Time of Examination _____

Alleged time of offence _____ AM/PM _____ Married/Unmarried

Brought by _____

Consent for examination – Victim _____

Guardian _____

Identification Marks (1) _____

(2) _____

History/Detailed account of occurrences as given by woman, especially about the following :

- a) Date, Time & Place of Occurrence _____
- b) Exact position of parties _____
- c) Did she struggle or cry for help? _____
- d) Was she conscious all the time? _____
- e) Did she urinate or defecate after the act ? _____
Pain? _____
- f) Date and time of lodging the complaint _____
Explain delay _____

Enclosure 5 (Refers to Para 20 b xii)

Menstrual History:_____

M.C._____--Regular/Irregular

L.M.P._____

Age at Menarche_____

Whether bath was taken Yes/No_____When_____

Whether clothes are changed. Yes/No_____

Any other relevant information :

Physical Examination

General behavior :

Gait

- 1) Height (cms) _____Weight _____Kgs
- 2) General build_____
- 3) Condition of teeth (broken etc)_____
- 4) Abrasions, bite marks etc over the body (Face, Back of Shoulders, Arms and Thighs) _____
- 5) Breast, Developed/Not Developed_____
- 6) Secondary Sexual characters Fully developed/Not developed._____
- 7) Examination of clothes: Presence of tears on clothes
Presence of Mud/Blood/Seminal stains.
- 8) Matting of public Hairs due to semen: Present/Absent
(Public Hairs to be cut & preserved for examination)_____
- 9) Presence of Blood or Seminal Stains on the genitals : Present/Absent
(Stains to be preserved on saline swabs for examination)_____
- 10) Examination of Genitals:
Development of Genital organs : Developed/Not Developed_____
Vulva . _____Vagina_____
Perineum_____ Forchette_____
P/S Examination_____
P/V Examination_____

Enclosure 5 (Refers to Para 20 b xii)

- 11) Swabs for examination:
- a) Vaginal swabs i. Vulval _____ ii Low Vaginal _____
 iii. High Vaginal _____
- b) Urethral Smear for Gonococci _____
- 12) Venereal diseases if any, _____
- 13) Blood Group examination if there is bleeding injury _____
- 14) Nails _____

Signature/Thumb impression of person examined.

OPINION:

Date :
 Place:

Signature of the Medical Officer
 Name Degree
 Designation Reg No.

To,
 The Police Sub Inspector,
 Police Station

NOTE:

- a) When the age is disputed, as has to be determined as per proforma for age estimation.
- b) Specimen to be Preserved for examination:
- 1) Public Hairs 2) Blood & Urine 3) Blood Stain
- 4) Clothes for exam of stains 5) Vaginal smear/Swab 6) Nails
- 7) Head hair (control) 8) Bite mark swabs.

Enclosure 6 (Refers to Para 20 b xii)**PROFORMA FOR EXAMINATION OF RAPE ACCUSED
(MALE)**

Requisition form _____ of Police Station _____

vide his letter No. _____ Dated _____

Name (in full) _____

Age by appearance _____ Sex _____ M.L.C. No. _____

Occupation _____ Address _____

Date of Examination _____ Time of Examination _____

Alleged time of offence _____ AM/PM Married/Unmarried _____

Brought by _____

Consent for examination _____

(Note : Explain to the individual that the physical examination findings will be used as evidence whether or not in his interest and he is free to refuse being examined if he chooses)

Thumb Impression/Signature

Identification Marks (1) _____

(2) _____

History

Specifically enquire about

- | | | |
|----|----------------------------|------------------------------------|
| a. | Whether bath was taken? | If yes, When ? |
| b. | Whether motion was passed? | If yes, When? |
| c. | Clothing changed? | If no, describe any damage/stains. |

Enclosure 6 (Refers to Para 20 b xii)**Physical Examination**

1. Height _____ cms
2. Weight _____ Kgs.
3. General Build and Appearance.
4. Marks of general violence on the body as bite marks, scratches etc.
5. General Behaviour (Mental condition & Signs of Drunkenness, if any):
6. Pubic region and thighs. (look for matting of hair, stains)
7. injuries on Genitals/Scars.
8. Has Vasectomy been performed? If yes, look for the Scar.
9. Is there any evidence of S T D?
10. Genitals : Public Hair Length _____ Matted or Not
 Penis Normal/Abnormal, describe the Abnormality:
 Prepace Circumcised Yes/No Any Injury:
 Smegma Present/Absent Any Evidence of Impotence
11. Microscopic examination of discharge if present:
12. Blood Group examination (if necessary)

OPINION:

Station :
Date :

Signature of Medical Officer
Name: Degree
Designation Reg No.

To,
SI _____ of _____ Police
Station

Note :

- a. Examination for Age Estimation to be carried out, if necessary.
- b. If impotence is the plea, examination in detail for Impotence to be carried out.

Enclosure 7 (Refers to Para 20 b xvi)

**Form of Report to be used when Forwarding Substances
other than Viscera to The Chemical Analyser**

No:

From :

To

The Chemical Analyser,

Dated:

Forwarding the articles mentioned below for examination for

_____ in connection with the case of

DESCRIPTION OF ARTICLES

Mode of packing and weight of parcel	Copy of label and impression of seal
If standard boxes and bottles are used a) Box No b) Bottle No	
Mode of dispatch Date :	Date and receipt in Chemical Analyser's Office

Facts of Medico-legal importance in connection with case:

Station:

Date:

Civil Surgeon or Medical Officer in-charge